NHS

Sheffield Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts

2021-22

PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Sheffield Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2021-22

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Chair's Introduction

2021/22 saw the whole world turned upside down and life as we knew it became very different for everyone. For the NHS and our Trust, the full impact of Covid-19 hit every part of our organisation and meant we had to rethink how we delivered care, protected our staff and patients and, at the same time led the successful roll out of a mass vaccination programme for South Yorkshire and Bassetlaw.

The incredible resolve, dedication, and innovation of our 18,500 army of heroes working across our hospitals and community services has enabled us to meet these challenges and to date care for over 9,500 patients with Covid-19, as well as continuing to deliver emergency, cancer and maternity care along with thousands of operations and appointments. It was not just the impact on our hospitals either, our community teams pulled out all the stops to continue to deliver care to people in their homes and helped hospital and nursing home colleagues with invaluable practical advice and support.

This Annual Report describes our performance in many areas against national and local standards, but this year so much of our normal way of delivering care has had to change or, in some cases, be paused to keep our most vulnerable patients safe from the virus. This has had an impact on our previously good waiting times, which we are working hard to recover as we do not want patients to wait any longer than necessary to get their planned operations or care. Emergency care demand has also been exceptionally high, and we have seen longer waits in our Accident and Emergency (A&E) department as a result. Again, this is something we are making a top priority to improve.

Whilst we have had to devote a lot of time and resources to managing the pandemic, we have also moved forward with several of our key priorities. Following a period of engagement with staff, partners, patients, and the public we finalised our new corporate strategy called '*Making a difference – the next chapter*'. Whilst our mission and vision remained the same, we have added a sixth corporate aim which is to create a sustainable organisation. We now intend to develop a comprehensive Sustainability Plan that contains a wide range of carbon reduction initiatives and broader sustainability goals.

I am delighted that we have recruited over 500 new nurses and midwives to support our services and wards. We have also reopened the Hadfield Wing following the completion of remedial works which were required. We invested over £47 million in refurbishing wards, facilities and buying new equipment. You can read more about this later in the report.

We also began the procurement process for a new multi-million-pound electronic patient record system. This is the catalyst for the next phase of our digital transformation to support the delivery of safe, high-quality care. The new system will be in place by 2024.

We continued to develop how we deliver care to make it more convenient for patients where appropriate. As well as continuing to offer outpatient appointments virtually or by

phone for many patients, we also provide appointment letters by email rather than post for patients who would like to choose that option. Patients undergoing treatment for cancer can also receive some of their treatment closer to home, due to a partnership with Burleigh Medical Centre in Barnsley. Known as WestonPark@BurleighMedicalCentre, this is an extension of the day case unit at Weston Park Cancer Centre and consists of a dedicated treatment suite with seven treatment chairs suitable for patients receiving systemic anti-cancer therapy (SACT). This new collaboration means that some patients from the Barnsley area who used to travel to Sheffield for their cancer treatment are now able to receive treatment closer to home.

Caring for patients has been a priority but so has caring for our staff. We have ensured they had the protective equipment they needed, increased the wellbeing support on offer, including setting up additional Calm Rooms across our Trust thanks to Sheffield Hospitals Charity, and expanded the 24-hour mental health support service to staff family members.

During the year we continued to progress the other ambitions in our People Strategy, and we have been engaging with staff to develop a PROUD behaviours framework to support our PROUD values and we plan to launch and embed this across the Trust in the summer of 2022.

In partnership with the City's universities, we have continued to lead and contribute to international and national research not just on Covid-19, but across the spectrum of health conditions we provide care for. Our clinical research facility at the Royal Hallamshire and Northern General hospitals in Sheffield, was awarded £7.9 million in funding which will support the development and testing of new treatments for diseases, many of which currently have no cure. The funding from the National Institute for Health Research (NIHR) is more than twice the amount of the £3.1 million which was awarded in the previous round of funding in 2017. More information about research work we have been involved in is included later in the report.

At the height of the pandemic, we also had two inspections by the Care Quality Commission. The first inspection in March 2021 looked at our maternity services and then in October 2021 we had another inspection which looked at some services and wards at the Royal Hallamshire Hospital and the Northern General Hospital, as well as one of our community Rehabilitation Units. Regrettably, the inspections resulted in our previously good rating being changed to requires improvement for the Trust overall. For maternity services, the rating has been changed to inadequate. We are devastated by the outcome because all staff are committed to providing good quality care for our patients and contributing to a positive experience for staff working in our service. Whilst we cannot ignore that the pandemic has had an impact on our services, staff, and performance, it is also clear that we have improvements to make.

Whilst it has been an exceptionally challenging year, the support we have had from our local communities has been overwhelming, and it is times like these that foster new relationships which we intend to build upon as we continue our recovery and reset of

services. This work has already started and will remain our focus as we continue into 2022/23.

As well as looking to do as much as we can internally, we also want to play our part in re-building the communities we serve, especially given the inequalities Covid-19 has further exposed across many parts of our City and wider region. As a partner in the Sheffield Health and Care Partnership, the South Yorkshire and Bassetlaw Acute Federation, and the South Yorkshire and Bassetlaw Integrated Care System, we have the opportunity to shape our future, and the past year has already shown the power of what working collectively can achieve.

Finally, I must mention the outstanding contribution of our volunteers, who have taken on new challenges without question, including supporting the vaccination programme.

I would also like to acknowledge the unfaltering support of our Governors, charities, and fellow Board members. I thank them all for their dedication and support during another unprecedented year for the NHS and for our own organisation.

Annette Laban

Chair

Performance Report

Overview of performance

This section provides an overview of the Trust, its purpose, key risks to the achievement of its objectives and how it has performed during the year.

Annual performance statement from the Chief Executive

There is no doubt that this has been another extraordinary year as the pandemic continued to change all aspects of our lives. For our Trust and the rest of the NHS, 2021/22 was characterised by continued restrictions in the way we could deliver care and fluctuating numbers of Covid-19 cases, with several peaks in demand which at times exceeded the first wave of the pandemic.

During those peaks we also had two Care Quality Commission (CQC) Inspections which regrettably have seen our rating change from good to requires improvement overall. I will talk more about this later, and most importantly the work we have already carried out to address the issues raised.

Since the start of the pandemic, we have cared for over 9,500 patients with Covid-19, which is a phenomenal achievement. Testament to that care is the fact that our outcomes for patients with the virus were amongst the best in the NHS.

As well as supporting those patients who had the virus, our teams never stopped providing emergency or urgent care to those with other illnesses and conditions like strokes, heart attacks and cancer care. Our community teams also worked exceptionally hard to deliver care to some of the most vulnerable in our communities at a time when isolation and loneliness were also significant issues for those patients. New initiatives like our Social Prescribing project, developed in conjunction with community groups and Sheffield City Council, were particularly impactful during the past year, enabling community teams to signpost patients who were isolated and lonely to have social support and buddying.

Throughout 2021 a major priority was the roll out of the Covid-19 vaccination programme, and whilst we were lead provider for South Yorkshire and Bassetlaw, the delivery of the programme was a collective Herculean effort by the region’s NHS organisations, local authorities, our incredible volunteers, and public health colleagues. As well as establishing mass vaccination centres and hundreds of community pop-up clinics we also delivered a vaccination programme for NHS, social care, and nursing and care home staff. This work continues into 2022/23 with the expansion of cohorts and booster doses.

As we came to the end of 2021, most of our services were back up and running and we continued to adapt how we delivered care so that as many patients as possible could have their appointments or treatment safely. We continued to have a particular focus on

treating those people whose operation or procedure had to be postponed due to the pandemic as well as managing the surge in new referrals we received in the latter part of 2021. Previously we have had some of the best waiting times in the NHS and we want to return to that position because it is what our patients expect from us. Many of these plans have been severely tested by the post-Christmas wave of Omicron and Covid-19 admissions.

We have seen a rise in demand for emergency care over the year and the impact of Covid-19 has been a major factor in waiting times in our A&E department for several reasons. Apart from the reduced physical capacity in waiting areas, due to social distancing and increased time needed to test patients coming in for the virus, we have had less beds available to admit patients into because of the number of Covid-19 patients in our hospitals. We have also had more delays in patients moving on from our care to nursing homes or other settings because of Covid-19 outbreaks and reduced social care capacity.

In addition to the re-design of services, other factors were pivotal to being able to manage both Covid-19 and non-Covid-19 patients simultaneously. One was the incredible work our laboratory services continued to do in respect of staff and patient testing and being fleet of foot in adapting to the changing national guidance. This had a huge impact on our ability to plan the available workforce to respond to demand and was fundamental to protecting our staff as well as patients.

Whilst our staff have been incredible, we should not underestimate the demands which have been placed on them. Particularly in the last year, these demands increased as we continued to provide Covid-19 care but also began our recovery work to restart care, which had to be paused for so many patients. Of course, our staff were also victims of the virus, which at times saw our sickness rate more than double the figure we would normally expect, and this also had an impact on our ability to progress our recovery work as quickly as we had hoped. To manage the constantly changing demands and operational pressures, we continued to have a robust incident command structure in place, with daily Gold, Silver and Bronze Commands for a large part of the year, so that we could plan and respond quickly to the different challenges and opportunities we were faced with. Decision making was informed by our Clinical Expert Group who ensured there was constant consideration of national and local guidance and best practice.

Whilst a lot of our attention has been consumed by Covid-19, I would like to mention some other developments, investments and performance which were also achieved in 2021/22. A year when innovation, improvement and learning was our mantra.

Prior to the pandemic we were already focussed on how we reduce the time patients need to wait for care, stay in hospital or indeed if we can prevent admission at all.

Some examples of this work included trialling day case hip replacement surgery to enable patients to go home on the day of their surgery instead of a potential hospital stay of three or more days. The trial was successful following the design of a new pathway. Our aim is

to use this method to perform 20 per cent of total hip and knee replacements as day cases and aim for 80 per cent of uni-compartmental knee replacements to be day case.

Wherever possible we re-design our services in collaboration with patients and staff and encourage patients to be in control of their care where it is safe and possible to do so. A great example of this is the work we have done on Patient Initiated Follow Up. After careful testing, we now encourage patients to manage their condition proactively, in collaboration with their clinician, by giving them the freedom to access follow up outpatient appointments when they need it. This is instead of creating a planned appointment which they may feel they do not need and cause them inconvenience by having to come to hospital. This is avoiding unnecessary hospital appointments and freeing up clinic appointments for patients who need it most.

Another example of shaping care around the needs of patients is a new virtual screening system for patients with Motor Neurone Disease (MND). Respiratory assessments are essential to identify MND patients that may be in early respiratory failure, with screening required every three months. Prior to the pandemic this was done in the hospital, but after working with a patient group, a new virtual system was launched which enables symptom assessments to be conducted by either video or telephone by the MND Respiratory Physiotherapist. A drive-through blood gas clinic was also set up at Sheffield Arena, alongside the drive through phlebotomy service. Vulnerable patients no longer need to attend hospital for regular assessments unless it is necessary, also decreasing the risk of them catching Covid-19.

The award winning Long Covid Service is another fantastic example of how co-creation with patients and partner organisations can meet a need quickly and effectively. The Sheffield Post Covid Rehabilitation Hub was set up in January 2021 by our Trust and NHS Sheffield Clinical Commissioning Group to help patients with symptoms of long Covid. The team who developed the service also included patients who had long Covid, known as ‘experts by experience’, to ensure their needs were central to the service design. It has so far had more than 1,200 patients referred to it for help assessing their needs and accessing relevant services.

As well as innovating we recognise that we need to remove variation in our systems and processes to support optimal patient care and flow. This work will also be an important pre-requisite for the implementation of our new electronic patient record system, which is the catalyst for the next phase of our digital transformation to support the delivery of safe, high-quality care. The new system will be in place by 2024.

Removing variation will also ensure consistency in our patients’ experience of our services and care. In July 2021, the Trust-wide Vanquishing Variation Group established a Patient First Group consisting of patient and carer representatives. So far, the group have provided feedback on our PROUD behaviours consultation, communication with patients, outpatient booking systems, the My Pathway Patient App and patient discharge process.

The Group provides us with valuable insights which help transform and improve services for patients by putting their experience at the core of changes.

Patient, staff, and partner insight along with learning from the past 12 months and the findings of the CQC inspections have helped shape our future direction of travel. This has been set out in our new corporate strategy called '*Making a difference – the next chapter'*. Our mission, vision, values, and strategic aims have remained broadly the same, but we have added a sixth aim which is to create a sustainable organisation.

We intend to develop a comprehensive Sustainability Plan that contains a wide range of carbon reduction initiatives and broader sustainability goals. We are very aware that our size means we have a significant impact on our environment and the prosperity of the City and wider region. We take these responsibilities very seriously and during the year we began to look at how we could accelerate the work already undertaken on sustainability, job creation, widening education opportunities and improving population health.

With respect to sustainability, over two million patient contacts a year means it is important we consider how we deliver care and where possible reduce reliance on transport or multiple visits. We have started an exercise to look at how we work now and how we can adapt. Our response to the Covid-19 outbreak has informed this, particularly for outpatient appointments which have switched rapidly to video and telephone consultations due to the rules around physical distancing. Our new strategy for sustainability will widen our approach on this agenda during 2022/23.

Care Quality Commission findings

In March 2021 we had an unannounced visit by the Care Quality Commission (CQC) to inspect maternity services at the Trust. The inspection did not cover the Neonatal Unit, Gynaecology, or Jessops Fertility services. During the visit, the CQC Inspectors found several areas of good practice within the maternity service and felt staff were focused on the needs of the women receiving care. Doctors, midwives, and other healthcare professionals worked together as a team to benefit families. Medical staffing, including on site consultant cover, was very good both in and out of hours. Infection control and cleanliness was also of a good standard and there is a culture where staff felt respected, valued, and supported. They also commented that the service promoted equality and diversity in daily work.

However, several areas were identified for significant improvement and consequently the rating was changed from outstanding to inadequate. We have begun to take a number of actions to address the CQC recommendations and work continues to embed these changes.

Some of the changes made include the recruitment of additional midwives, midwifery support assistants and nurses as well as overhauling our governance and risk processes. Elements of our assessment process needed further review which we have also done. In addition, we are one of the first four hospitals in England to offer the Tommy's App. The

Tommy's App personalises maternity care by identifying each woman's chance of having a premature birth (when baby is born early) and of developing complications during pregnancy such as problems with placental function. By identifying the chance of complications early, the Tommy's App ensures that the right monitoring and care can be offered throughout pregnancy according to each woman's individual needs.

In October 2021, the CQC carried out another inspection of maternity services, along with a selection of other services and some wards at the Trust. Whilst the CQC did highlight positive aspects of the care and services we provide, they also found areas where we needed to make improvements. Some of those improvements we were already working on and have made progress, but we know we still have more work to do. As a result, the Trust's overall rating was changed from good to requires improvement.

The need to recruit more staff in some areas, including nursing, was a significant concern, and I am pleased to report that we have already recruited over 500 new nurses since the inspection. Recruitment continues to be a key focus as we move into 2022/23. An improvement in care for patients with mental health conditions, was another area where we had already started to make improvements internally, but also with partners across the City who also have responsibility for the care of people with mental health conditions. Improved waiting times for treatment or care was a concern we had prior to the inspection and continues to be driven as part of our Covid-19 recovery plans.

Risk assessment processes including recording and mitigation of potential risks is another focus for improvement. We recognise that our current processes are complex, and often the practical actions to recognise and mitigate risks are taken by staff, but this is not always recorded as expected because we do not make the process as simple or quick as it could be. This work on our systems and processes, along with the procurement of the new electronic patient record system, will also address the need to improve aspects of our record keeping.

We work hard to get things right but when we don't, we want to record what happened and learn from it to limit the chance of it recurring. We encourage staff to report incidents, but we also need to be better at responding to the reports, making changes where it is appropriate more quickly and sharing learning from incidents more widely and as soon after the incident as we can. Earlier references to how we have co-created services and developments, demonstrate our commitment to patient and public engagement and involvement, but we agree with the CQC that we should do this more routinely. We are also reviewing how we collect and use patient feedback to inform our priority and improvement areas. Addressing the remaining issues raised following both inspections will continue to be at the heart of our improvement and recovery programme.

Caring for our staff

Caring for patients has been a priority but so has caring for our staff. Without them we would not have got through this year, and it has been gruelling on every single person, not just those involved in direct patient care. We have invested a lot of time listening to what our staff needed during the past year and trying to do all that we could to keep them well physically and mentally during such difficult times. We extended our 24-hour mental health counselling service to staff family members, encouraged people to take their leave, developed toolkits for managers to be able to give additional support to teams and increased the number of 'Calm Rooms' to create a peaceful place where staff can go to recharge, have something to eat and drink and just take a few moments away from what is happening.

As well as using digital technology to provide care for patients we also encouraged its use for team working especially given a proportion of colleagues were remote working. However, I think the biggest thing we continued to do was focus on being kind to each other, encouraging a culture of recognition and understanding of the situations people were in professionally and personally and taking time to say thank you.

During the year we also continued to progress the ambitions set out in our People Strategy and I am particularly pleased that we have expanded our staff networks to include a new Women's Network. I am also delighted that we have been given a Stonewall Silver Award for our commitment to inclusion of lesbian, gay, bi, trans and queer (LGBTQ+) people in the workplace. We have been engaging with staff to develop a PROUD behaviours framework to support our PROUD values and we plan to launch and embed this across the Trust in the summer of 2022.

We also launched our first Race Equality Charter during Black History Month 2021 to improve the experience, representation, and progression of black, Asian and colleagues from an ethnic minority group within our organisation. The Charter was created in collaboration with the Race Equality and Inclusion Staff Network Group and signals a step change in terms of the Trust's commitment to being anti-racist in everything we do and stand for.

Since its launch in June 2021, 68 Trust colleagues have benefitted so far from participating in the Trust's Reciprocal Mentoring Programme. The programme matches senior leaders from across all areas of the Trust and members of the Staff Network Groups. Leaders gain an insight into the lived experiences of our Staff Network Group members, who in return are coached and supported in terms of their personal and career aspirations.

One area I would particularly like to highlight, and which has proven to be even more important during the past year, in our work on equality, diversity, and inclusivity relates to the specific impact of Covid-19. There was clear evidence that colleagues including those from a Black, Asian or Minority Ethnic heritage, those with underlying health conditions, those with a high body mass index (BMI) or those over a certain age may be more affected by Covid-19. As a result, we offered additional health assessments for those potentially

more at risk from complications of Covid-19. We have also worked hard with colleagues across the organisation to raise awareness of the importance of vaccination. Our clinical experts ran staff question and answer (Q&A) sessions, and we encourage one to one conversations between clinical experts and individual staff who had questions or concerns.

It was encouraging that despite another unusual and exceptionally busy year our staff survey results for recommending the Trust as a place to work and for family and friends to be treated remained above average. However, in line with many other Trusts, our scores in many areas of the survey dropped and we will be looking to work with colleagues to identify how we can make improvements where it matters most to staff. You can read more about this later in this report.

Financial performance and investment in facilities

We achieved a surplus of £0.5 million but that is in the context of an unusual year where some of our planned activity was paused. Further information can be found later in this report.

Despite the pandemic, we continued to invest in our facilities where it was safe to do so and in total, we have invested over £47 million in 2021/22. We continued to progress the overhaul of our theatres and lifts at the Hallamshire Hospital along with ward refurbishments at both the Hallamshire and Northern General Hospitals. We also refurbished the Breast Clinic and Endocrine Investigation Unit at the Hallamshire along with the Pharmacy at the Northern General. We invested heavily in additional and replacement major medical equipment and expanded the Wheata Place Community Dentistry Centre. Other remaining investments were in new equipment, infrastructure and adaptions to departments or services to enable us to manage the pandemic as safely and effectively as possible.

Throughout the year we continued to work with our private finance initiative (PFI) partners to rectify issues identified with the Hadfield Building at the Northern General Hospital site and were able to re-open the facility in the summer of 2021.

We continued to invest in information technology (IT) systems to enhance clinical safety, efficiency, and patient experience. One of the most significant investments we have planned is a new electronic patient record system. A preferred supplier has now been chosen for this following an extensive engagement and procurement process. The system is due to be implemented by 2024.

Partnership working

The events of 2020 and 2021 fundamentally changed how our organisation served patients. This has left a legacy with all staff that work across our services, resulting in the need to adopt different approaches to how we work together locally and more widely across health and social care. Our patients are now experiencing a lengthened time to access care and treatment, in both primary and secondary care settings, and will continue to do so for some time. All our efforts will therefore need to focus on building our services back up to be stronger than ever to support patients. This can only be done by having a workforce that is able to recover and feels supported. Where there are significant shortfalls in staffing we are committed to addressing these by building on the ways that we worked with our partners during the pandemic, by overcoming traditional boundaries and through a collective intent and desire to improve our services.

Prior to the global pandemic, demand for NHS services was increasing rapidly due to a growing and aging population requiring increasingly complex care. This has exacerbated longstanding pressures facing the NHS. To meet these challenges, the health and care system is transforming. A major part of this transformation is the Health and Care Bill, which signalled the establishment of Integrated Care Systems (ICSs) that aim to bring together NHS organisations with local authorities and wider system partners to collectively plan to meet population needs, deliver better integrated care and tackle health inequalities.

ICSs will be placed on a statutory footing from July 2022 and will see the introduction of a statutory Integrated Care Board. An important aspect of the establishment of the ICS is the development of Provider Collaboratives with other trusts in one or more ICS; place-based partnerships that involve the NHS, councils, voluntary organisations, residents and service users, working together to design and deliver integrated services in a specific, geographical area; and working with Primary Care Networks through integrated multi-disciplinary teams that provide services across primary and secondary care.

This presents exciting opportunities to collaborate and integrate where appropriate. We have learnt how to successfully integrate and transform services across community and acute interfaces over many years. We have also learnt how to provide services locally at scale across a broad geography in partnership with other local trusts. We can see that further opportunities also exist to build a resilient network of health and social care for the people we serve, and our existing and emerging partnerships will bring these to fruition. One example is the development of the South Yorkshire and Bassetlaw Pathology network which we will host and are currently designing with our partner NHS trusts.

Another example is for patients undergoing treatment for cancer, who are now able to receive some of their treatment closer to home due to a partnership with primary care. WestonPark@BurleighMedicalCentre is an extension of the day case unit at Weston Park Cancer Centre where suitable patients can receive systemic anti-cancer therapy (SACT). This new collaboration means that some patients from the Barnsley area who used to travel to Sheffield for their cancer treatment can now receive treatment closer to home.

The Sheffield Health and Care Partnership has continued to develop from the early work of the Accountable Care Partnership. I am the Accountable Officer for the Partnership for which a health and care vision has been developed for 2030 that focuses on integration of care across services within the City; the need to reduce and remove inequalities; and to ensure we involve those people and communities that use the services we collectively provide.

As an anchor institution, we need to demonstrate how we can positively influence the wider social determinants of health for example tackling the climate emergency, access to good quality education, employment and our impact on economy alongside action on prevention and healthier lifestyles. These complex issues require collective action both internally and externally, working in partnership to deliver a clear place-based strategy, aligning discrete interventions so that we are greater than the sum of our parts.

Strong relationships with the City's universities and business community have given us an opportunity to consider how together we can tackle the wider implications of the pandemic's impact on our region. A vision document was submitted to Government in 2021 outlining how this would be approached and we are excited to take this forward over the next few years.

Research and innovation

As one of the most research active trusts in England, we have played a leading role in major flagship Covid-19 trials. To date the Trust has supported over 50 Covid-19 studies, including a number which were given urgent public health status by the Chief Medical Office and the Department of Health and Social Care. This has contributed to the development of treatments for Covid-19 and ways of diagnosing and preventing the virus.

In partnership with the City's universities, we have continued to lead and contribute to international and national research not just on Covid-19 but across the spectrum of health conditions we provide care for. We continue to be one of the National Institute for Health Research (NIHR) Yorkshire and Humber Clinical Research Networks top 10 NHS organisations for recruitment volumes and actively seek to increase the involvement of patients in all parts of the research process.

Our clinical research facilities at the Royal Hallamshire and Northern General hospitals in Sheffield were awarded £7.9 million in funding which will support the development and testing of new treatments for diseases, many of which currently have no cure. The funding from the NIHR is more than twice the amount of the £3.1 million which was awarded in the previous round of funding in 2017.

Some of the examples of the research and innovation work we have been involved in outside of Covid-19 include the development of CFHealthHub which is a digital learning health system developed to help patients with Cystic Fibrosis monitor their condition and reduce the need for hospital admission. Now used in 60 per cent of adult Cystic Fibrosis centres in England, CFHealthHub allows patients to monitor their health from home

using real-time data collected from their nebuliser and transferred to an app on their phone. The data includes information such as how much medication they have successfully taken each day, which can help them to identify the reason for any changes or decline in their condition. Patients can also share this data with their clinical team who can use it to provide strategies to manage their treatment.

We have also secured a £1 million grant to trial a novel technique of haemorrhoid surgery using radiofrequency ablation. The pioneering research, named the ORION trial, is being conducted in partnership with The University of Sheffield and will assess whether radiofrequency ablation is as effective as existing surgical methods of treating haemorrhoids. It will also investigate whether this method is superior in terms of pain and recurrence. Funded by the NIHR, the trial will include16 hospitals within the UK.

Colleagues in our Gastroenterology service have developed a new national training programme to improve early and effective treatment of acute upper gastrointestinal bleeding. Acute upper gastrointestinal bleeding (UGIB) is a medical emergency causing 50-70,000 hospital admissions each year in the UK. The programme, which was developed in line with the British Society of Gastroenterology's Endoscopy Quality Improvement Project (BSGEQIP) initiative, aims to improve early and effective treatment of UGIB to reduce mortality and the length of hospital stay for patients.

Building on the success of the Sheffield Institute for Translational Neuroscience we have put forward an ambitious bid for an NIHR Biomedical Research Centre with a much expanded clinical remit. The plans include improving early diagnoses of dementias and pulmonary vascular disease; optimising care pathways for patients with motor neurone disease and HIV; developing new vaccines for infectious diseases and treatments that delay the progression of neurodegenerative disorders; and, improving outcomes for patients with cardiovascular disease. We will do this by building on a strong existing partnership between our leading expert clinical teams, and top-performing academic departments at The University of Sheffield. This partnership already has an established track record in delivering impactful benefits for patients with debilitating conditions. We expect to know the outcome of our bid later this year.

Conclusion

After another challenging year, I want to pay tribute to everyone who has contributed to the incredible response to the situation we have found ourselves in. Our partners and charities have been unrelenting in their support and our Board and Governors have provided the stability, discussion and challenge which is so important during such turbulent times. Above all I am so very proud of all our staff and volunteers for their tremendous commitment, flexibility, and sheer hard work to deliver the care needed and the biggest vaccination programme many of us will see in our lifetime.

As we move forward into 2022/23 the context within which we will need to deliver our priorities will be dominated by the continuation of the pandemic, the need for us to recover our performance and address the issues raised by the Care Quality Commission. Our overriding priority will be to deliver safe, high-quality care for all our patients and provide a brilliant place to work for our staff.

We will need to significantly change all that we do in the coming years if we are to deliver our future strategic ambitions. We will need the support and efforts of the whole of *Team STH* as well as our patients and partner organisations. We will need to go further than we have ever gone before, be more responsive, proactive and lead with courage. I am confident that as we do this together, we will continue to thrive and will see tangible benefits for those we serve.

Kirsten Major
Chief Executive
21 June 2022

History, purpose and principal activities of the Trust

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's largest and busiest NHS foundation trusts. Above all, patients lie at the heart of everything we do, and we have a history of delivering high quality care, clinical excellence and innovation in medical research.

Formed in 2001, we provide, acute, elective, community, and specialist healthcare services for over two million patients each year. We achieved Foundation Trust status on 1 July 2004.

We are one of the largest integrated NHS trusts in England. During the past year we have seen and treated over 1.1 million outpatients, over 660 thousand nurse contacts with community patients, over 80 thousand inpatients, over 121 thousand day case patients and over 154 thousand attendances to our Accident and Emergency Department. This year (2021/22) we have also cared for approximately 5,200 patients with Covid-19.

Our staff provide a full range of local hospital and community services for adults in Sheffield, as well as specialist care for patients from further afield including cancer, spinal cord injuries, renal and cardiothoracic services. In addition to community health services, the Trust comprises five of Yorkshire's best known teaching hospitals.

The Northern General Hospital is the home of the City's Accident and Emergency Department which is also one of three Major Trauma Centres for the Yorkshire and Humber region. Several specialist medical and surgical services are also located at the Northern General Hospital including cardiac, orthopaedics, burns, plastic surgery, spinal injuries and renal, to name a few. A state-of-the-art laboratories complex provides leading-edge diagnostic services.

The Royal Hallamshire Hospital has a dedicated Neurosciences Department including an Intensive Care Unit for patients with head injuries, neurological conditions such as stroke and for patients who have undergone neurosurgery. It also has a large Tropical Medicine and Infectious Disease Unit, a specialist Haematology Centre and other medical and surgical services.

Sheffield Teaching Hospitals is home to the largest dental school in the region, a women's hospital with a specialist Neonatal Intensive Care Unit and a Fertility Unit. The Weston Park Cancer Centre is also part of our Trust.

The Trust also provides community health services to deliver care closer to home for patients and prevent admissions to hospital wherever possible.

We aim to reflect the diversity of local communities and have developed strong partnerships with local people, patients, neighbouring NHS organisations, local authorities, charitable bodies and GPs. We are one of the region's largest employers and we take our responsibility to be a good corporate citizen very seriously.

We have a proud history of pioneering medical advances that have now become established NHS treatments. We also undertake high quality research that provides the NHS with the evidence it needs to introduce new treatments and care. Together with our partners at The University of Sheffield and Sheffield Hallam University we are leading the way on the development of world class clinical research in a wide range of disease areas. This includes cancer, progressive diseases such as dementia, stroke, multiple sclerosis, as well as heart disease and many other lesser known conditions.

Overview of the Trust's strategy

Our '*Making a Difference*' corporate strategy was originally developed in 2012 and then refreshed in 2017. In 2021 we carried out an engagement exercise with our staff, public and partners to develop our new strategy called '*Making a Difference – the next chapter*.'

Our vision, mission and PROUD values were felt to still be appropriate, but we have added a sixth corporate aim which is to become a sustainable organisation. We now intend to develop a comprehensive Sustainability Plan that contains a wide range of carbon reduction initiatives and broader sustainability goals.

Whilst our purpose remains constant, our approaches and what we deliver need to be very different – transforming what we do right across the organisation, ensuring that we recover from the pandemic and that we drive the improvements that were identified as part of our recent CQC inspection.

In addition to the new corporate strategy, we also progressed our work on developing a behaviours framework to support the PROUD values. We have spent a lot of time during the year talking to our staff, patients and partners about this work which looks to set out what behaviours we want to see exhibited and those we do not feel fit with our values. The framework is due to be launched across the organisation in 2022 and will be embedded into many of our processes and practices moving forward.

Our Vision

To be recognised as a brilliant place to work, a provider of inclusive and high-quality health care, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant, healthy and sustainable City region.

Our Mission

We are here to improve health and wellbeing, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. We aim to work at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most to people.

Our Aims

- Deliver the best clinical outcomes;
- Provide patient centred services;
- Employ caring and cared for staff;
- Become a sustainable organisation;
- Spend public money wisely; and
- Deliver excellent research, education and innovation.

Our Values

- Patient first - Ensure that the people we serve are at the heart of all we do;
- Respectful - Be kind, respectful to everyone and value diversity;
- Ownership - Celebrate our successes, learn continuously and ensure we improve;
- Unity - Work in partnership and value the roles of others; and
- Deliver - Be efficient, effective and accountable for our actions.

Trends and factors likely to affect the Trust's future development, performance and position

In the context of delivering the Trust's strategy, a number of key issues and risks facing the Trust have been identified.

The Trust's risk management arrangements support the identification, management and oversight of risks which may, should they be realised, impact on the delivery of high-quality services and our strategic aims and objectives.

By taking into account the profile of significant operational risks that are recorded on the Trust's Risk Register and both the external strategic landscape and challenges to be addressed through the delivery of our Recovery Plan, the Board of Directors is developing a set of refreshed strategic risks which will be entered onto the Board Assurance Framework.

While still being developed within a newly formatted Board Assurance Framework these areas of strategic risk are summarised below as:

Failure to deliver the best clinical outcomes

due to:

- Inability to embed effective quality governance arrangements and to learn from incidents and patient feedback;
- Failure to deliver Maternity Services and Urgent and Emergency Care; Services in a consistently safe and effective way; and
- Sub-optimal management of staffing, systems and resources.

causing:

- Adverse impact on the health outcomes of patients and public health in the longer term;
- Continued regulatory intervention and potential loss of public confidence; and
- Negative effect on staff well-being, motivation and recruitment / retention.

Failure to provide patient centred care

due to:

- Disparity between capacity and demand;
- Lack of cultural competency across our service delivery;
- Ineffective or inconsistent implementation of new models of care across Sheffield and South Yorkshire and Bassetlaw partners; and
- Sub-optimal management of staffing and infrastructure (estates and IT).

causing:

- Poor patient experience and outcomes;
- Underperformance against national quality and performance standards; and
- Negative effect on staff well-being motivation and recruitment / retention.

Failure to employ caring and cared for staff

due to:

- High rates of staff absence, combined with workforce shortages leading to insufficient capacity and gaps in capability;
- Inability to provide a safe working environment and support the health and wellbeing of our staff;
- Failure to utilise all the talent across our workforce through not optimising a diverse and inclusive workforce; and
- Sub-optimal recruitment and retention.

causing:

- Poor staff experience;
- Adverse impact on staff health, wellbeing and resilience; and
- Negative effect on patient care.

Failure to spend public money wisely

due to:

- Changing funding / contracting arrangements creating uncertainty around future income;
- Ineffective financial controls;
- Inability to deliver the required level of efficiency savings; and
- Failure to secure sufficient capital funding for necessary investment in the maintenance and development of our capital infrastructure and in the development of our services.

causing:

- Lack of financial stability;
- Regulatory intervention; and
- Unstable environment for services / lack of investment.

Failure to create a sustainable environment

due to:

- Insufficient capacity and capability to deliver long-term sustainability; and
- Competing pressures and priorities deflecting focus and resources from delivery of our sustainability plans.

causing:

- Inability to realise our ambition to embed NHS Net Zero principles; and
- Potential non-compliance with Government policy

Failure to deliver excellent research, education and innovation

due to:

- Lack of a clear innovation strategy and / or unclear internal processes;
- Focus on Covid-19 studies deflecting resources from other areas of research; and
- Reduced placement provision / educational activity due to service pressures and limitations of social distancing.

causing:

- Missed opportunities to improve patient care and operational efficiencies;
- Reduced research funding;
- Adverse impact on organisational reputation as a teaching hospital; and
- Inadequately trained staff / future workforce compromised.

Failure to be a well-led organisation

due to:

- Ineffective leadership of recovery from regulatory intervention;
- Lack of capacity and capability;
- Sub-optimal systems and processes and limitations of social distancing; and
- Uncertain external environment (e.g. system partnerships, financial regime, regulatory).

causing:

- Poorer patient outcomes;
- Sub-optimal staff experience / satisfaction; and
- Regulatory intervention.

Overview of Going Concern

After making enquiries Directors have a reasonable expectation that Sheffield Teaching Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Analysis of operational performance

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's largest and busiest NHS foundation trusts.

Last year continued to be a challenging one for the NHS with all trusts expected to provide the highest standards of care whilst achieving demanding efficiency savings and responding to the Covid-19 pandemic.

Despite the enormous challenge of Covid-19, we treated around 82 per cent inpatients and day cases as well as almost 99 per cent outpatients compared to 2019/20, the most recent comparator year prior to the pandemic. The number of attendances to our Accident and Emergency Department was at 97 per cent of 2019/20.

There are several national standards for waiting times, which we endeavour to achieve, alongside continuing this growth in activity following Covid-19, whilst still ensuring the best possible patient care. We consider rigorous infection prevention and control and clean facilities to be fundamental to our care standards and we continue to work hard to minimise the number of hospital acquired infections.

Further details of activity trends and the Trust's performance across key performance indicators are set out in the following tables:

Fig: Trust activity by activity type

	Number of patients				
Activity type	2017/18	2018/19	2019/20	2020/21	2021/22
Day cases	121,764	126,100	127,975	89,984	121,941
Elective Inpatient spells	30,065	29,236	28,857	19,151	24,498
Non-Elective spells	87,288	88,333	89,177	78,934	86,159
New Outpatient attendances	302,812	311,159	312,481	230,305	281,620
Follow up Outpatient attendances	778,084	803,395	803,815	750,270	825,132
Accident and Emergency attendances	149,531	156,967	158,561	121,300	154,319

Fig: 2021/22 Operational performance against key performance indictors

	2021/22 Performance			2021/22 Quarterly Trend			
		Target	Annual	Q1	Q2	Q3	Q4
Accident and Emergency (A&E)	95% of A&E patients wait less than four hours	95%	73.7%	77.99%	74.29%	72.25%	71.21%
Referral To Treatment	Patients waiting less than 18 weeks for treatment	92%	77.5%	82.08%	79.53%	76.04%	73.44%
Diagnostics	Patients waiting less than six weeks for diagnostic test	99%	80.97%	86.82%	82.00%	80.62%	76.25%
Cancelled Operations	Non Urgent operations cancelled on the day	N/A	0.61%	0.3%	0.69%	0.73%	0.74%
Cancer access initial appointment	Urgent GP referrals seen within two weeks	93%	84.3%	80.8%	84.3%	82.2%	89.4%
	Breast symptomatic referrals seen within two weeks	93%	20.8%	15.2%	50.7%	19.3%	5%
Cancer access initial treatments	First treatment within 31 days	96%	91.1%	92.8%	89.6%	91.3%	90.7%
	Treatment within 62 days of an urgent GP referral	85%	60.8%	60.8%	61.1%	63.8%	57.6%
	Treatment within 62 days of referral from screening	90%	65%	75.9%	65.2%	63.2%	57.5%
Cancer access subsequent treatments	Subsequent treatment (surgery) within 31 days	94%	72.4%	84.4%	73.5%	65.3%	66.1%
	Subsequent treatment (chemotherapy) within 31 days	98%	98.8%	98.8%	99.8%	99.3%	97.1%
	Subsequent treatment (radiotherapy) within 31 days	94%	96.4%	97.6%	95.5%	96.7%	96.1%
Infections	MRSA	0	0	0	0	0	0
	MSSA	63	62	13	22	14	13
	Clostridioides difficile (Community Onset)	144	36	13	9	5	8
	Clostridioides difficile (Hospital Onset)	100	119	26	33	37	23

Fig: Community performance 2021/22

Service measure	Target	Q1	Q2	Q3	Q4	2021/22
Intermediate Care Community Beds – number of admissions *(Includes SPARC - Excludes the Community Off Site 'Route 2' Beds)*	N/A	**248**	**280**	**245**	**232**	**1,005**
Intermediate Care Community Beds – Average Stroke Length of Stay	35 days	**26.3**	**30.4**	**34.4**	**39.1**	30.8
Intermediate Care Community Beds – Average Orthomedical Length of Stay	35 days	**35.1**	**35.7**	**40.0**	**42.9**	**36.8**
Intermediate Care at Home – Patients assessed within required timescales *(Data only available for Active Recovery Assessment and Community Stroke Service - Not ICT Active Recovery)*	98%	**99%**	**95%**	**99%**	**97%**	**98%**
Intermediate Care Number of packages delivered at home *(Active Recovery Assessment and Community Stroke Service and ICT Active Recovery)*	N/A	**985**	**782**	**727**	**611**	**3,105**
Community Nursing Referrals *(Includes additional information and resumptions)*	N/A	**9,582**	**9,080**	**8,572**	**8,335**	**35,569**
Community Nursing Contacts	N/A	**172,046**	**171,091**	**159,812**	**154,417**	**657,366**

Analysis of performance against quality priorities

To ensure this overview provides a balanced report on the Trust's performance over the last 12 months, this section describes progress against quality priorities for improvement during 2021/22. These are also set out in our Quality Report published separately which reports in more detail on the quality of services delivered by the Trust during 2021/22.

Quality priorities for improvement 2021/22

The Trust agreed the following three quality important priorities for 2021/22.

Improve the assessment of, and care provided to, those at the highest risk of inpatient falls.

Background

Inpatient falls is one of the highest reported incidents within the Trust, with some areas having more patients at risk of falls than others. The focus of the objective was on improving the assessment and care provided to those patients on the wards with the highest number of falls.

Achievement against objective

The Strategic Falls Group worked with 10 wards with the highest number of falls over the previous 12 months, this work involved:

- Developing and undertaking a monthly audit against nationally recognised key interventions, as recommended in the National Institute for Health and Care Excellence (NICE) guidance, assessment and prevention of falls in older people;
- Undertaking ward-based education for staff; and
- Relaunching safety huddles – regular multidisciplinary meetings where patients at risk are discussed to increase awareness of these risks within the team.

Measures of success for this work were agreed and include, for these 10 wards:

- Each area will achieve 95 per cent completion of the audit by the end of March 2022;
- The audit results will show incremental improvement in compliance; and
- Falls safety huddles will be embedded across seven days of the week.

A final report from the audit is being produced with the support of the Clinical Effectiveness Unit, this will inform next steps and future actions. Initial review of the data has shown good compliance with the audit with improving results and all 10 wards are undertaking falls safety huddles. Individual ward areas are developing local action plans related to the audit outcomes. The Strategic Falls Group will continue to monitor this work.

Develop and improve individualised end of life care for patients and their carers

Background

National guidance relating to End of Life Care (EoLC) promotes personalised care planning as the gold standard. For example, the 'Leadership Alliance for the Care of Dying People' outlines the priority that "an individual plan of care, which includes food and drink, symptom control, and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion".

Care Quality Commission (CQC) visit reports (2016 and 2018) and the Trust's 'National Audit of Care at the End of Life' results (2018-2021) identified an ongoing need to improve the delivery and documentation of personalised EoLC for our patients and those important to them. Staff feedback also highlighted their need for a document to provide prompts to aid them in the delivery of care at the end of life.

In response to this, a 'Caring for Dying Patients: Personalised Plan of Care' document and digital nursing care plans were developed to ensure that patients who are in their last days of life have a documented personalised plan which establishes and addresses their individual needs, wishes, and priorities for their EoLC.

Achievement against the objective

Over the past 12 months:

- The 'Caring for Dying Patients: Personalised Plan of Care' document has been rolled out to phase one inpatient wards at the Trust: Weston Park Hospital wards, Geriatric Medicine wards and the Palliative Care Unit;
- Training in caring for dying patients was delivered to the phase one wards to include recognition of dying, communication of dying, and developing a personalised plan of care to support dying patients and those important to them;
- An audit associated with the first phase of the roll-out is underway to assess whether the new document improves the quality of documentation and the care of patients at the end of life;
- Engagement and awareness communications have taken place to increase nursing staff knowledge of and use of the digital nursing care plans; and
- Following City-wide conversations the implementation of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) across Sheffield has been agreed and a Project Manager has been appointed to lead the roll-out across the City.

Improve patients' mealtime experience and communication of patients' texture modified diet and fluids

Background

It is important that there is robust communication of patients' texture modified diet and fluid needs. This ensures that patients with swallowing difficulties are provided with an appropriate consistency of food and drink which they can safely swallow. A positive mealtime experience promotes optimal nutritional care and health and wellbeing. Implementation of a bedside meal ordering system is one of the national priorities identified as a result of the 'Independent Review of NHS Food' (October 2020[1]).

Achievement against the objective

A series of actions and outcome measures were agreed at the start of the process. Outcome measures in relation to communication of patients' texture modified diet and fluid needs have all been achieved. An audit undertaken in August 2021, which will be repeated in August 2022, demonstrated:

- Electronic whiteboard Knife and Fork (icon appropriate identification of patients requiring additional support with eating and drinking) completion for 95.9 per cent of admissions against a target of 95 per cent;
- Compliance with pre-meal safety huddles on 92.5 per cent of occasions against a target of 90 per cent;
- Compliance with Meal Service Safety training of 94.3 per cent in the acute Trust and 93 per cent in community against a target of 90 per cent; and
- In addition, audit demonstrated 91.9 per cent compliance with use of bedside posters reflecting dietary needs.

In addition, Continuing Professional Development (CPD) funding was secured to appoint a Lead Nurse for nutrition to support this important patient safety work for 12 months until January 2023.

Work is ongoing to create a paper version of a bedside safety information board until an electronic solution is available, and a Care Group representative task and finish group aims to have this finalised before the end of May 2022. Progress will be monitored through the Nurse Director Meeting and Trust Nutritional Steering Group.

[1] **NHS England (2020) The Independent Review of NHS Food** https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food

Implementation of an electronic bedside meal ordering system was delayed due to the Covid-19 pandemic. Ongoing collaboration with the digital team has enabled a pilot on three wards in the Trust. The benefits realised so far from this pilot are:

- Improved patient experience – receiving meals of their choice, ordered in a timely way;
- Use of the data to assess popularity of menu items which will help future menu planning; and
- Reduction in waste compared to pre pilot analysis of waste.

Quality performance indicators

The analysis of operational performance incorporates performance against a number of quality indicators that are linked to patient safety, clinical effectiveness and patient experience.

Additionally, the scope of mandated indicators that the Trust is required to report includes the following:

Fig: Additional mandated quality performance indicators - SHMI

The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust for the reporting period	2019/20	2020/21	2021/22
National Average: 1.00 Highest performing Trust score: 0.72 Lowest performing Trust score: 1.19 *(Figures for December 2020 – November 2021)*	1.00 Banding: as expected	1.00 Banding: as expected	0.98 Banding: as expected
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National average:39% Highest trust score: 64% Lowest trust score: 11% *(Figures for December 2020 – November 2021)*	34%	34%	39%

Note - The SHMI makes no adjustment for patients who are recorded as receiving palliative care because there is considerable variation between trusts in the way that palliative care codes are recorded. Adjustments based on palliative medicine treatment specialty would mean that those organisations coding significantly for palliative medicine treatment specialty would benefit the most in terms of reducing the SHMI value (the ratio of Observed/Expected deaths would decrease because the expected mortality would increase).

Hence, SHMI routinely reports percentage patient deaths with palliative care coding as a contextual indicator to assist with interpretation of data.

The Trust is taking action to improve this coding rate, and so the quality of its services by implementing a business-as-usual process relating to palliative care coding. This process ensures all activity is captured by using additional sources of information within the Coding Department to improve accuracy and utilising an Information Services User Report to help ensure the process of palliative care coding is streamlined. In 2021/22 the Trust rate of palliative care coding increased to be in-line with the national average.

Fig: Additional mandated quality performance indicators – Never Events

Never Events (Count)	2019/20	2020/21	2021/22
Sheffield Teaching Hospitals NHS Foundation Trust achievement	9	3	6

Never Events are defined by NHS England as ‘Serious Incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers’.

During 2021/22 six Never Events occurred at the Trust. Three were in relation to ‘wrong site surgery’, and three in relation to a ‘retained foreign object post procedure’.

Learning from Serious Incidents and Never Events is shared through multiple forums within the Trust, including the Trust’s Safety and Risk Forum, Management Board Briefing, relevant subject committees and via Trust-wide monthly safety messages from the Medical Director (Operations).

Fig: Additional mandated quality performance indicators – Friends and Family Test (Staff)

Friends and Family Test (FFT) - Staff who would recommend the Trust (from Staff Survey)	2019/20	2020/21	2021/22
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: Combined Acute and Community Trusts – 66.9%. All Trusts – 59.4% Highest performing Trust score:(Combined Acute and Community Trusts): 89.5% Lowest performing trust score: (Combined Acute and Community Trusts): 43.6%	80.9%	84.0%	76.2%

The Trust continues to work to improve this percentage by involving staff in service improvements and redesign, through seeking staff views via both the full census NHS

staff survey and the Quarterly NHSI People Pulse and utilising our Microsystems Academy approach.

Fig: Additional mandated quality performance indicators – Friends and Family Test (Patients)

Friends and Family Test (FFT) – Positive Score (patients who have scores either two 'Good', or one 'Very Good')	2019/20	2020/21	2021/22
The percentage of patients who attended the Trust during the reporting period who scored either two for 'Good' or one for' Very Good', when asked for their overall experience of the service.	All areas 94% Inpatient 96% A&E 85% Maternity 97% Outpatient 95% Community 90%	All areas 93% Inpatient 93% A&E 85% Maternity 88% Outpatient 94% Community 93%	All areas 90% Inpatient 91% A&E 77% Maternity 80 % Outpatient 94% Community 91%

The Trust continues to take the following actions to improve this rate, and through this the quality of its services:

- A monthly report is circulated across the Trust informing staff of scores and the number of responses, as well as enabling them to review the comments that patients have left about their experience;
- Monthly FFT[1] scores are compared with the 12 month Trust score as well as the 12 month national score to monitor performance; and
- The Patient Experience Committee monitors FFT monthly for all elements of the FFT to identify any trends or concerns and takes the necessary action should the positive score fall in any particular area of the Trust.

[1] Due to Covid-19 the use of FFT feedback cards was paused in March 2020, this was predominantly in Inpatient and Maternity. FFT activity was stopped in all Community areas. FFT restarted in Inpatients in October 2020 and in Maternity and Community Services in November 2020. Since restarting, only electronic methods have been used.

Other quality metrics

Complaints

The Trust values complaints as an important source of patient feedback. We provide a range of ways in which patients and families can raise concerns or make complaints. All concerns, whether they are presented in person, in writing, over the telephone or by email are assessed and acknowledged within three working days and wherever possible, our Patient Access and Liaison Service (PALS) team take a proactive working approach to resolving problems 'on the spot'.

All contacts received by the PALS are assessed to see if they can be dealt with quickly, for example by taking direct action, or by putting the enquirer in touch with an appropriate member of staff. This course of action is agreed with the patient and the enquiry is recorded as a concern (informal complaint). During 2021/22, we received 2,251 informal concerns which we were able to respond to quickly.

If the concern or issue cannot be dealt with informally or if the enquirer remains concerned, the issue is categorised as a formal complaint and processed accordingly. During 2021/22 1,198 formal complaints were received.

A monthly breakdown of formal complaints and concerns received during 2021/22 is provided below.

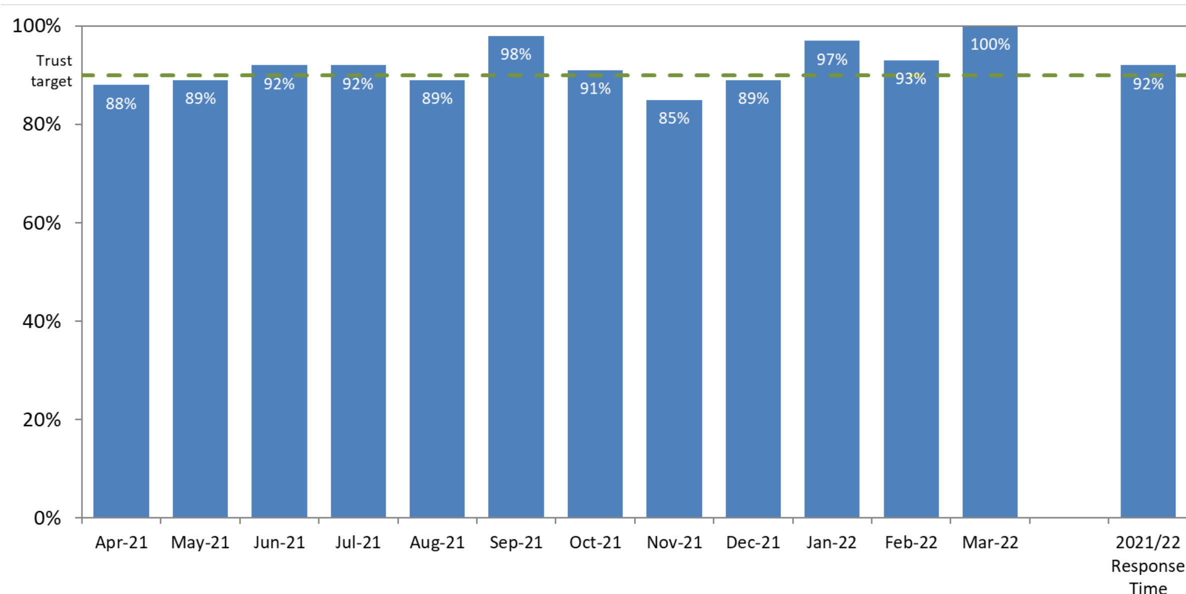
Fig: Complaints received during 2021/22 by month

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New informal concerns received	152	143	156	195	178	183	216	202	158	231	195	242	2251
New formal complaints received	107	92	116	108	113	123	109	86	81	84	84	95	1198
Total	**259**	**235**	**272**	**303**	**291**	**306**	**325**	**288**	**239**	**315**	**279**	**337**	**3449**

Of the formal complaints closed during 2021/22 519 (44 per cent) were upheld or partially upheld by the Trust.

Where complainants remain unhappy with the Trust's response, they can refer to the Parliamentary and Health Service Ombudsman (PHSO) to get an independent and objective body to review their complaint. The PHSO investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. During 2021/22 the Parliamentary and Health Service Ombudsman closed two cases regarding the Trust, one (50 per cent) was upheld. The other case was not upheld.

Fig: Breakdown of complaints response times by month



The complaint response time target is that at least 90 per cent of complaints are closed within the agreed timescale. This target was achieved in aggregate in 2021/22, with 92 per cent being responded to in time, or with an extension.

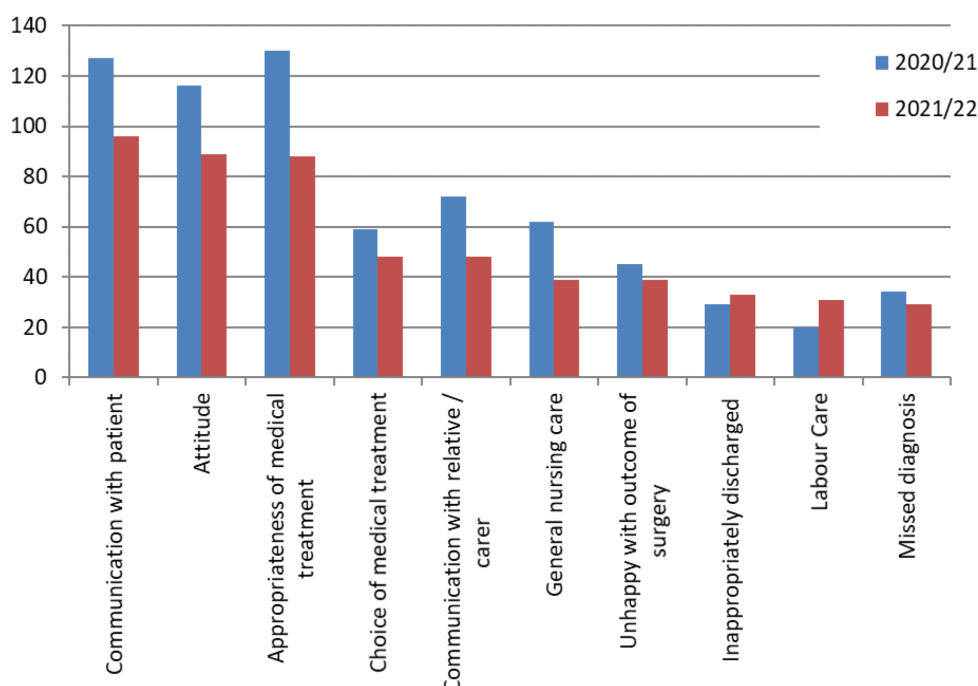
Monthly complaints reports are produced for the Patient Experience Committee showing the number of formal complaints received and response times at directorate level. Open concerns (informal complaints) have also recently been added to this monthly report to ensure these are being followed up and responded to appropriately.

This reporting aims to ensure that the Trust is continually reviewing information, so that serious issues, emerging themes or areas where there is a notable increase in numbers of formal complaints and concerns, can be investigated and reviewed.

When presented as a percentage, complaints relating to ‘Attitude’ are 1.4 per cent lower than last year, showing a continued year on year decrease. Complaints relating to ‘Communication with patient’ have decreased by 1.6 per cent and those relating to ‘Communication with Relative/Carer’ have decreased by 1.2 per cent. Work has been ongoing with the Complaints and PALS team to review the categories used to ensure consistency in reporting.

The Trust remains committed to learning from, and taking action as a result of, complaint investigations. In order to share learning the Patient Experience Committee receives regular presentations, on a rolling programme, from the Nurse Director of each Care Group. The presentation reviews in detail how a complaint was managed and demonstrates the reflective learning and improvements which have been implemented as a direct result of the complaint.

Fig: Breakdown of complaints by theme



Delivering same-sex accommodation

The Trust is committed to ensuring that men and women do not share sleeping accommodation, except when it is in the patient's overall clinical best interest, or reflects their personal choice.

During 2021/22 there were three breaches of this standard, all of which occurred on a single occasion in January 2022. Due to a period of exceptional operational demand combined with closure of a number of beds due to Covid-19 a decision was made, after careful clinical consideration, to place three surgical patients in the Northern General Hospital Post Anaesthetic Care Unit (PACU) overnight. Due to further clinical implications changes were made to the patients identified for transfer, resulting in two women and one man being placed in PACU overnight. There were no other surgical patients being nursed in PACU at the time and the PACU staff kept curtains around the patients at all times. The following morning the three patients were able to be moved to suitable accommodation or discharged home. This is the first time a breach of same sex accommodation has occurred at the Trust since January 2019.

Environmental matters

Sustainability and climate change

Sustainability Plan

The Trust is one of the largest employers in Sheffield, and taken as a whole, consumes a huge amount of energy and other resources and is therefore a major carbon producer, and it is also a significant procurer of goods and services from local, national and international economies.

For these reasons the Trust has now developed and agreed its Sustainability Plan. Our ambitious plan is an example of public sector best practice in sustainable development in general, and carbon reduction in particular.

The Trust is conscious of its core role in delivering safe and cost-effective healthcare, while simultaneously operating economically and ethically, recognising its broader obligations to the health of the population and the planet.

The Sustainability Plan views sustainability as about striking an effective balance between the key areas of:

- Economic sustainability;
- Social sustainability; and
- Environmental sustainability.

The successful delivery of our Sustainability Plan therefore contributes directly to our goals of using our resources efficiently and reducing our direct operating costs. To implement this Plan we have established a sustainability committee and appointed a new role of Head of Sustainability.

Progress

The Trust continues to make annual energy and emissions.

The Trust's gas, electricity and water consumption for the reporting year April 2021 to March 2022 is as follows:

- Gas – 73,618,835kWh, which equates to a reduction of 16.79 per cent when compared to the previous year;

- Electricity – 57,570,919.8kWh, which equates to a 2.95 per cent reduction when compared to the previous year, which reflects the Trust's strategy to move energy usage from gas to electricity;

- Water - 593,076m^3, which equates to a 16.2 per cent increase when compared with the previous year; and

- The overall annual CO_2 emissions have reduced by 14.5%. This includes a 17.1 per cent reduction in carbon emissions from the use of gas, and a 11.6 per cent reduction in carbon emissions from the use of electricity (see figure overleaf).

Carbon emissions are an important indicator of the environmental impact an organisation has on the local community. The Trust continues to invest in major infrastructure schemes which reduce energy consumption and emissions and also provides year on year cost savings throughout the life cycle of the investment and enables savings to be reinvested to patient care and wellbeing.

The scheme to convert the Royal Hallamshire site heating system from steam to low temperature hot water (LTHW) has now been completed. In 2018/19 the Trust approved an investment of £2.56 million, this was delayed due to Covid-19 related issues, but completed in 2021. The scheme will significantly reduce gas consumption and emissions produced by the Royal Hallamshire Hospital central boiler house. Additional savings will also be realised by reductions in water consumption, maintenance, chemicals and a reduction in electricity consumption used for providing cooling in the months where both cooling and heating is required. Reducing energy consumption reduces the Trust's exposure to future cost pressures relating to carbon emission penalties, rising energy costs, taxes and the climate change levy and enables further heat recovery opportunities.

This scheme is similar to the one that was completed at the Northern General site, which delivered significant savings and reductions in carbon emissions. Steam was switched off to the Northern General site in June 2015.

We are continuing to install LED lighting across all areas of the Trust. This initiative reduces our electricity consumption and also improves the lighting levels, with the additional benefit of reducing maintenance and replacement costs.

The Trust has to comply with various statutory environmental Regulations, Acts and national NHS guidelines and is committed to limiting the Trust's impact both in the local and global environment.

The Trust is a member of the United Kingdom Emission Trading Scheme (UK ETS formerly EU ETS) and as a member of this scheme, we are set annual emissions targets by the Environment Agency, which are designed to encourage reduced gas and oil consumption. The Trust is achieving these nationally set targets on an annual basis.

The Trust needs to meet the requirements of the Energy Performance of Building Regulations 2012. The Trust is obliged to display the operational energy efficiency rating of each building over a gross internal area of 250m^2. This requires an annual energy assessment and the displaying of a Display Energy Certificate (DEC). All the main buildings across the Trust are rated and achieving a better than typical rating for their type of construction and use.

The following table shows Trust's carbon emissions due to gas and electricity consumption since 2008/09:

Fig: Annual carbon dioxide emissions (tCO_2)

Year	Annual carbon dioxide emissions (tCO_2)	
	Gas	Electricity
2008/09	29,834	36,171
2009/10	27,677	34,712
2010/11	24,660	32,005
2011/12	19,071	30,038
2012/13	20,962	29,061
2013/14	18,270	29,220
2014/15	16,754	29,488
2015/16	15,327	29,594
2016/17	15,403	29,949
2017/18	15,810	29,609
2018/19	14,869	14,137
2019/20	15,291	12,592
2020/21	16,268	13,831
2021/22	13,484	12,224

Comparing gas and electricity consumption emissions over the above period the Trust has reduced gas emissions by 54.8 per cent and electricity emissions by 66.2 per cent. This equates to a total reduction of 61.05 per cent in carbon dioxide emissions to the atmosphere in 2021/22 compared to 2008/09.

In 2008/09 the Trust's annual spend on energy (gas and electricity) was over £11 million, during 2021/22 it is estimated to be under £9 million, a total cumulative saving approaching £50 million. These savings are set against the Trust's ever-increasing patient demands and activity levels.

The Trust's waste hierarchy initiatives continue to produce ongoing environmental benefits through aiming to reduce, reuse, recycle before considering energy recovery through incineration or landfill. The table below highlights the waste produced by the Trust, and the proportion that was either recycled or reused or was incinerated and used for energy.

Fig: Waste minimisation and management (April 2021 – March 2022)

Waste	Tonnes
Sent to landfill (predominantly offensive and infectious waste alternative treatment residues)	434.33
Recycled/reused	482.89
Incinerated/energy from waste	914.89
Domestic	2739.68
Total waste	**4571.79**

Analysis of financial performance

For the 2021/22 financial year, bespoke national financial arrangements were continued to reflect the Covid-19 pandemic and best enable its management by NHS organisations. These were built on the 2020/21 arrangements and were again largely successful.

In simple terms, the financial arrangements for 2021/22 resulted in block contracts (fixed regardless of activity undertaken) with top-up funding to the level of expenditure in 2019/20 (plus inflation). Additional funding was then provided for the direct additional costs of the pandemic and there were also incentive schemes for recovery of elective activity. There was also a small amount of growth funding with attempts to return to normal levels of efficiency targets in the second half of the year. There were many operational and financial uncertainties throughout the year as the services oscillated between manging waves of Covid-19 and attempts at recovery.

Whilst the Trust reported a £3.3 million deficit in its Statement of Comprehensive Income, after adjusting for non-cash technical items (predominantly impairments / reversals and the impact of capital donations / grants), the Trust's 'Adjusted Financial Performance' shows a surplus of £596,000 (0.04 per cent of turnover). Turnover increased by 2.7 per cent to £1,358.9 million, largely due to funding for inflation.

Pay costs rose by 3.8 per cent over 2020/21 levels and drugs costs by 8.2 per cent. Clinical supplies / services reduced by 10.4 per cent and general supplies and services reduced to normal levels, given the central procurement of Personal Protective Equipment (PPE) for the whole of 2021/22. Premises costs, including IT, increased by 11.7 per cent and the Clinical Negligence Premium increased by 18.1 per cent. The combined depreciation, loan interest and Public Dividend Capital (PDC) dividend charges increased by 1.3 per cent. Activity levels generally recovered partly from the reductions in 2020/21 but were still below pre-pandemic levels. The impact of Covid-19 on services was still significant.

There was limited opportunity to drive normal cash releasing efficiency improvements, but services still managed to deliver £4.5 million of savings over the year.

Capital investment

Total capital expenditure for the year was £47.1 million and has been analysed below. The key focus of expenditure has again been to support service developments in line with the Trust's corporate strategy and plans to resume services, maintaining investment in replacement medical equipment, promoting information technology initiatives, and improving facilities and infrastructure to reduce risk and enhance the patient experience.

Fig: Capital Investment 2021/22

	£,000	£,000
Medical Equipment	**15,302**	
Equipment Replacement Programmes (e.g. Scopes, Ultrasounds, Fundus Cameras, Foetal Heart Monitors)		6,716
7th MRI Scanner, Royal Hallamshire Hospital		2,380
Replacement Linear Accelerator (LA4), Weston Park Hospital		2,070
3rd CT Scanner, Northern General Hospital		993
Royal Hallamshire Hospital SPEC-CT Gamma Camera		670
Other		2,473
Information Technology	**5,371**	
IT Infrastructure		1,521
Picture Archiving and Communication System		1,460
Patient App Software		1,200
Other		1,190
Service Development	**10,899**	
Northern General Hospital Hip Fracture Ward (Huntsman 5)		2,434
Pharmacy Aseptic Unit, Weston Park Hospital		1,379
Community Dental Services		1,327
Hyper Acute Stroke Unit, Royal Hallamshire Hospital		858
Royal Hallamshire Hospital C Floor Breast Clinic Refurbishment		794
Endocrine Investigation Unit, Royal Hallamshire Hospital		710
Weston Park Hospital Redevelopment/Expansion		643
Other smaller schemes/adjustments		2,754
Infrastructure	**15,571**	
Royal Hallamshire Hospital Ward H1 Refurbishment		2,996
Royal Hallamshire Hospital B Road Water Proofing		2,090
Charles Clifford Dental Hospital Covid-19 Restart		1,509
Royal Hallamshire Hospital A Floor Theatres		1,492
Other		7,484
Total Expenditure	**47,143**	

This level of overall expenditure was funded from a combination of the initial Operational Capital Allocation and in year Public Dividend Capital approvals; and was contained within the expenditure target notified by the South Yorkshire and Bassetlaw Integrated Care System (ICS) for 2021/22.

Cash flow and balance sheet

The Trust's net assets employed at 31 March 2022 were £444.1 million compared with £436.9 million at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2022 was £438.7 million with the increase in 2021/22 reflecting the high level of capital expenditure referred to above. Outstanding 'borrowings' relating to loans, the Hadfield Private Finance Initiative (PFI) contract and the Gamma Knife Finance Lease totalled £32.6 million at the year-end (a reduction of £2.5 million).

The working capital position remained relatively healthy with cash balances of £218.0 million and net current assets of £32.8 million.

Conclusion

Whilst 2021/22 was more stable than the previous year, it was still an exceptional year as the Covid-19 pandemic continued to impact heavily on services and many other areas, including financial management processes. However, the Trust has maintained financial control, managed the Covid-19 pandemic whilst maintaining other services as much as possible; and delivered significant investments. Looking forward, the environment will continue to be challenging as we seek to recover from the pandemic and manage the consequences of the changing NHS management and financial management arrangements.

Performance Report signed by the Chief Executive
in capacity as Accounting Officer

Kirsten Major

21 June 2022

Accountability Report

Directors' Report

The Directors' report is presented in the name of the Directors of the Board of Directors.

Composition of the Board of Directors

Led by a Non-Executive Chair, the Board of Directors comprises of eight other Non-Executive Directors and up to eight Executive Directors, including the Chief Executive. The individuals occupying position on the Board during 2021/22 are listed below with their attendance at Board meetings recorded later in this report.

Annette Laban, Trust Chair, appointed 1 January 2021

Annette was appointed to the Board as a Non-Executive Director in July 2013 and was appointed Trust Chair from 1 January 2021.

Annette has more than 35 years' experience working within the NHS and local government in senior positions and throughout her career she has been responsible for overseeing many innovations which have directly impacted on frontline NHS care. Her past roles have included Chief Executive for NHS Doncaster, Director of Performance and Operations at NHS North of England - Strategic Health Authority and Executive Director of Performance and Delivery at NHS Yorkshire and the Humber.

Annette also holds independent Non-Executive Director roles at Marie Stopes International and Cheswold Park Hospital.

Other Non-Executive Directors

Tony Buckham, Non-Executive Director and Vice Chair, appointed 1 September 2015

Tony brings a wealth of experience from his time working within complex global organisations. He has provided strategic support to the HSBC Group Management Board Directors, with particular expertise within IT and Corporate Real Estate for over 10 years. Tony has led divisions of up to 7,000 staff with particular focus on people development to enable global transformational change. He has also made a significant contribution to mentoring and coaching programmes.

Professor Chris Newman, Non-Executive Director, appointed 1 November 2017

Chris joined the Board of Directors in November 2017. He is Interim Vice President and Head, Faculty of Medicine, Dentistry and Health at The University of Sheffield, Dean of the Medical School, Professor of Clinical Cardiology and Honorary Consultant Cardiologist at

the Trust. He also directs the National Institute for Health Research Sheffield Clinical Research Facility, a joint facility between the Trust and The University of Sheffield.

John O'Kane, Non-Executive Director, appointed 1 October 2014

John is an experienced Finance Director, with a wealth of knowledge of managing change in a number of companies. He has worked as Group Finance Director at Redhall Group, Jarvis, Ecobat Technologies, Peterhouse Group and Kelda Group.

Maggie Porteous, Non-Executive Director, appointed 1 May 2021

Maggie joined the Board of Directors in May 2021. She has more than 30 years of business experience working for John Lewis, where she was Director of Shop Trade until 2020 and responsible for the leadership of 51 John Lewis shops.

She is also Chair of the John Lewis Foundation, working with a wide variety of non-governmental organisations and charities on international and UK projects, and is a Non-Executive Director of Silva Homes, a not for profit social housing association.

Rosamond Roughton, Non-Executive Director appointed 1 December 2019

Rosamond brings widespread experience of working in policy at national level, as well as experience at board level in the NHS. Most recently, she was the Director-General of Adult Social Care at the Department of Health and Social Care (DHSC). Rosamond stepped down from her role at the department in the summer of 2020 in order to care for and support her parents.

Prior to her DHSC role, Rosamond was an Executive Director at NHS England, where, from 2014 she had national responsibility for general practice and primary care services and the commissioning of armed forces healthcare, national screening and immunisation programmes, healthcare for people in the criminal justice system, and sexual assault referral services. Her NHS career has also included Director of Workforce and HR at the Christie Hospital NHS Trust and Director of Strategy for Yorkshire and the Humber NHS. She is an honorary fellow of the Royal College of General Practitioners.

Martin Temple, Non-Executive Director, appointed 1 July 2013

Martin was Chair of the Health and Safety Executive until August 2020 and has served on the Boards of a wide range of companies around the world, including the Board of The Great Exhibition of the North. He was Chairman of the Design Council, on the Council of the University of Warwick, as well as the Chair of the Warwick Business School Advisory Board. He has also been Vice President of Avesta-Sheffield AB, Director-General and later Chair of EEF, he served as an independent Chair for different UK Governmental Reviews and a Non-Executive Director and Chairman of The 600 Group PLC.

Dr Toni Schwarz, Non-Executive Director, appointed 1 May 2021

Toni joined the Board of Directors in May 2021. She has had a 35-year career working within the health sector and the NHS, and is the Dean of the College of Health Wellbeing and Life Sciences at Sheffield Hallam University.

She trained as a nurse and worked in clinical practice in hospital and the community for almost 20 years before moving into higher education. Toni moved to Sheffield in 2014 to take up the role of Head of Department for Nursing and Midwifery at Sheffield Hallam before stepping up to the position of Dean.

Shiella Wright, Non-Executive Director, appointed 1 April 2019

Shiella joined the Board during April 2019, bringing with her over 11 years' experience as an NHS Non-Executive Director. She was also a Trustee with several voluntary and charitable organisations and between 2017 and 2021 she was the Chair of Age UK Nottingham and Nottinghamshire, and a Race Equality Commissioner with Sheffield Council for Race Equality.

Shiella is the former Deputy Chief Executive / Director of Operations of Nottinghamshire Probation Trust, and has held Senior Leaderships roles across, South Yorkshire, Humberside, and the East Midlands.

She is currently an appointed Independent member of the Parole Board for England and Wales and a member of the South Yorkshire Police and Crime Commissioner Independent Ethics Panel.

Executive Directors

Kirsten Major, Chief Executive

Kirsten was appointed as Chief Executive in 2019. She joined the Trust in February 2011 as Director of Strategy and Planning. Kirsten took up the position of Interim Chief Executive in August of 2018. She has held a number of Director level positions within the NHS, including Health Boards in Scotland and at the North West Strategic Health Authority. Kirsten is a health economist by profession and was active in a range of professional and research-based collaborations.

She is presently Vice-Chair of the Shelford Group (The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England).

David Black, Medical Director, from 1 February 2022

David was appointed in February 2022. Prior to this David was acting regional medical director for NHS England and improvement north-east and Yorkshire region. He was also part time deputy medical director at the Rotherham NHS FT. Since 2012 David has

worked for NHS England, and his responsibilities included specialised commissioning, systems oversight and also responsible officer and experienced medical appraiser.

David was director of public health in Derbyshire from 2002 until 2012. David began his career in general practice, and he also worked overseas in a psychiatry and general practice. David has a longstanding interest in clinical effectiveness and he was a member of a NICE Technology Appraisal Committee for nine years. David is interested in reducing health inequalities and the part the NHS can play in meeting the needs of vulnerable and disadvantaged patients.

Anne Gibbs, Director of Strategy and Planning, until 13 December 2021

Anne was appointed in February 2018, prior to which she worked for NHS Improvement in a joint role with Greater Manchester Health and Social Care Partnership. Previously, she has worked at Board level for a number of trusts in London and Birmingham.

Mark Gwilliam, Director of Human Resources and Staff Development

Mark is Director of Human Resources and Staff Development. He took up his original post as Director of Human Resources and Organisational Development in May 2009 bringing with him a wealth of experience.

He was previously an Associate Director of Human Resources at Central Manchester University Hospitals NHS Foundation Trust. Mark joined the NHS in 2004 through the Gateway to Leadership Programme and was assigned on placement at Sheffield Teaching Hospitals NHS Foundation Trust. Prior to this he worked in the fast-moving consumer goods sector in numerous operational management and human resource management roles.

Michael Harper, Chief Operating Officer

After completing a Business Management and Mathematics degree at Salford University Michael joined the NHS Management Training Scheme and undertook placements at Bassetlaw Hospital, Sheffield City Council and Good Samaritan Hospital Phoenix, Arizona USA.

Upon completion of the Scheme, he joined the Northern General Hospital in 2000 and has worked in a number of operational leadership roles in A&E, Medicine, Cardiothoracics, Orthopaedics and Surgical Services throughout the Trust since this time.

He became Chief Operating Officer in January 2015. From June 2019, the position of Chief Operating Officer has been an Executive member of the Board of Directors.

David Hughes, Medical Director (Development), until 31 January 2022

Dr David Hughes was appointed as Medical Director in 2018 and held this position until stepping down from the Board at the end of January 2022 to return to clinical work.

A nationally renowned Consultant Histopathologist, David was previously Deputy Medical Director at the Trust from 2013 to 2018, prior to which he was Associate Medical Director for Cancer for many years.

David began his Consultant career in 1998 and is a specialist sarcoma pathologist. Having trained in Sheffield, Edinburgh and San Antonio, Texas, David worked as a consultant in the sarcoma teams at the Royal Orthopaedic Hospital, Birmingham, then the Robert Jones and Agnes Hunt Orthopaedic Hospital before joining Sheffield Teaching Hospitals in 2005.

Jennifer Hill, Medical Director (Operations)

Jennifer joined the Trust in 1999 as Consultant Respiratory Physician having trained in Nottingham, Leeds and Glasgow. Jennifer was Clinical Director for Respiratory Medicine and Deputy Medical Director before taking up the post of Executive Medical Director (Operations) in December 2020.

Chris Morley, Chief Nurse

Chris joined the Trust as Chief Nurse in October 2018 from The Rotherham NHS Foundation Trust where he also held the position of Chief Nurse. Prior to this Chris was Deputy Chief Nurse here at Sheffield Teaching Hospitals.

He has previously held a number of leadership roles in healthcare governance, patient safety and nursing management.

Chris is a Visiting Professor in the College of Health, Wellbeing and Life Sciences at Sheffield Hallam University and the nominated Chief Nurse for the North-East and Yorkshire Genomic Medicine Service Alliance

Neil Priestley, Chief Finance Officer

Neil was appointed to the post of Director of Finance of the newly merged Sheffield Teaching Hospitals in February 2001. He had previously held the post of Head of Finance at the NHS Executive Trent Regional Office, from where he had been seconded to the Northern General Hospital as acting Director of Finance prior to the Trust merger.

Neil is a Fellow of the Chartered Association of Certified Accountants.

Other senior managers who attend Board as Participating Directors

Paul Buckley, Interim Director of Strategy and Planning (from September 2021)

Paul joined the NHS in 1996 and has worked in a range of senior operational, project and strategic leadership roles. From September 2020 Paul has attended meetings of the Board of Directors in his capacity as Interim Director of Strategy and Planning. Paul has held his substantive role within the Trust as Deputy Director of Strategy and Planning since October 2013.

Sandi Carman, Assistant Chief Executive

Sandi has over 28 years' experience working in NHS acute, community, and commissioning organisations. Sandi's career started in Occupational Therapy at the Northern General Hospital and she has since gained a wealth of experience in operational and managerial roles.

Sandi is a Non-Executive Director and Vice Chair for South Yorkshire Housing Association, Director for Legacy Park Limited and a Joint Independent Audit Committee Member for the South Yorkshire Police and Crime Commissioner.

Julie Phelan, Communications and Marketing Director

Julie spent her early career as a journalist in both print and broadcast media before moving into public sector communication in local government and health. She was previously Head of Communications at Sandwell and West Birmingham Hospitals NHS Trust, Head of Communications for Birmingham Women's Hospital and Director of Communications for Worcestershire Acute Hospitals and Worcester Health Authority.

Before joining the Trust in June 2008, Julie was Director of Communications for University Hospitals Coventry and Warwickshire NHS Trust.

Statement on the balance, completeness and appropriateness of the membership of the Board

The Board of Directors' Nomination and Remuneration Committee has carried out an in-year review of the composition of the Board. This has been in the context of current and anticipated issues and challenges impacting the Trust, and the skills and qualities needed on the Board. This exercise is undertaken routinely as part of the process of considering appointments and reappointments to the Board.

As outlined in the above biographies, the Board comprises individuals with senior level experience in the public and private sectors, across a range of disciplines including clinical and patient care, finance, strategic and operational planning, commercial development, governance, risk management, human resources and change management.

The Board is satisfied that its current membership allows it to function effectively.

All Directors on the Board of Directors have, on appointment, confirmed that they met the Fit and Proper Persons Test and complete an annual declaration confirming that they continue to be a fit and proper person in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement.

To strengthen these arrangements the Trust has recently implemented a process to carry out Disclosure and Barring Service checks every three years for members of the Board of Directors and the Council of Governors. In addition, disqualified directors and insolvency checks are now repeated every three years, along with an annual cross check review of professional registration status (as recorded on the electronic staff record (ESR)).

Board members' Register of Interests and Gifts and Hospitality

Company directorships and other declarations including receipt of gifts and hospitality were declared by all Board members. The Trust has updated its Standards of Business Conduct Policy to reflect guidance from NHS England and the full register of interests can be accessed from the following link.

The Board has determined that the current Chair and all Non-Executive Directors are independent in character and judgement. This includes the appointed representatives of The University of Sheffield, Professor Chris Newman, Dean of the Medical School, and of Sheffield Hallam University, Dr Toni Schwarz, Dean of the College of Health Wellbeing and Life Sciences at Sheffield Hallam University, notwithstanding the Trust's relationship during this reporting period with both these organisations.

Arrangements in place to ensure that the Trust is well-led

Review of the effectiveness of the Board of Directors and the outcomes from assessment of performance is used to inform ongoing development of the Board. This is done both collectively, and of individual Board members, as part of a formal annual appraisal system and the review and agreement of a Board work programme for the year.

The Board undertakes in-year self-assessment of its leadership and governance arrangements against governance best practice, using well-led guidance[2] to inform the continued development of the Trust's governance arrangements.

On an annual basis a Board effectiveness review is conducted. The review aligns to the eight key lines of enquiry (KLoE) of the well-led framework and covers the scope of the operation of the Board of Directors and its committees. This ensures that the Board of

[2] Development reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (Jun 2017)

Directors is using the well-led framework as a key instrument to critically evaluate its own performance to feed into continuous development of the Trust's leadership and governance arrangements.

Additionally, during 2021/22 the Trust commissioned an independent Trust-wide governance review to identify good practice and provide a view on areas for improvement. This followed the Care Quality Commission (CQC) inspection of Maternity Services in March 2021 which suggested that there were some weaknesses in systems to continually monitor and improve the quality and safety of services.

The Good Governance Institute (GGI) undertook assessment work between January and March 2022 which focused on a selection of the CQC well-led key lines of enquiry (KLoEs) and findings from this review will facilitate continuous improvement of our healthcare governance arrangements to support the delivery of excellent care for patients.

The Trust received a requires improvement rating following the CQC well-led inspection that took place between the 9 and 11 November 2021. Outcomes from both this CQC well-led inspection and the independent governance review will be used to develop and implement a robust action plan for oversight at Board level focused on the continuous development of leadership and governance arrangements. Undertaking a developmental review against the well-led framework will form part of the CQC action plan.

Financial and other public interest disclosures

Cost allocation and charging requirements

Sheffield Teaching Hospitals NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury. There are no additional charges made for material made available to meet the needs of particular groups of people, for example, in Braille or other languages.

Following the introduction of the General Data Protection Regulation and the UK Data Protection Act 2018 in May 2018, fees, as set by the Information Commissioner's Office, are no longer chargeable for subject access requests for personal data, including copies of medical records. Similarly, no fees are chargeable for the supply of medical records of deceased patients under the auspice of the Access to Health Records Act 1990.

The Trust does not impose any fees for responding to requests under the Freedom of Information Act unless the amount of information exceeds the appropriate limit as defined in section 12 of the Freedom of Information Act.

Political donations

There are no political donations to disclose.

Employee benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.6 of the accounts. Details of senior employee's remuneration can be found in the Remuneration Report section of this Annual Report.

Non-NHS income

As required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Directors confirm that the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

In addition to the above, the Directors confirm that the provision of goods and services for any other purposes, has not materially impacted on our provision of goods and services for the purposes of the health service in England. Further details of the income sources to the Trust can be found in note 3.2 of the accounts.

Payment of creditors

The Trust aims to comply with the Better Payment Practice Code. Performance for the financial year is set out in note 6 of the accounts.

Countering fraud and corruption

The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates or any person or body acting on its behalf. Maintaining fraud levels at an absolute minimum ensures that more funds are available for patient care and services.

The Trust engages 360 Assurance as its Local Counter Fraud Specialist (LCFS) to support the Board of Directors' commitment to maintaining an honest and open culture, ensuring that all concerns involving potential fraud have been identified and rigorously investigated. In all cases appropriate civil, disciplinary and / or criminal sanctions have been applied, where guilt has been proven. This supports the embedding of deterrence and prevention measures across the organisation.

The Trust's Audit Committee agrees the annual work plan for the LCFS and receives routine reports on progress against its delivery. The Committee has agreed the Trust's policy for dealing with suspected fraud, bribery and corruption and the Trust's Standards of Business Conduct Policy.

Effective from 1 April 2021 the NHS Counter Fraud Authority (NHSCFA) implemented the Government Functional Standard 013: Counter Fraud (‘the Functional Standard’) within the NHS. During 2021/22, the NHSCFA have developed their requirements in relation to the Functional Standard.

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

The Trust is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the Trust’s Counter Fraud Functional Standard Return (CFFSR). This requires prior sign off by the Trust’s Chief Finance Officer and the Audit Committee Chair.

Remuneration Report

The Remuneration Report outlines appointments and payments made in-year to Trust Executive Directors, Non-Executive Directors and the Trust's most senior employees, and includes the senior managers' remuneration policy.

Annual statement on remuneration

I am pleased to present the Remuneration Report for the financial year 2021/22 on behalf of the Board of Directors' Nomination and Remuneration Committee.

The Committee is responsible for making decisions on matters relating to the nomination, appointment, remuneration and terms and conditions of office of the Trust's Executive Directors and other individuals on locally determined pay, including salary, pensions, termination and / or severance payments and allowances.

In discharging its responsibility for setting the remuneration and conditions of service for the Trust's most senior managers, its key objective is to ensure that the remuneration packages are sufficient to recruit and retain individuals of the calibre required for the successful operation of the Trust, while avoiding paying excessively for this purpose.

There have been no changes made to the Trust's remuneration policy for senior managers in 2021/22. Decisions made in line with this policy during the past year or impacting on this reporting period include:

- A 2021/22 pay award for very senior managers, staff on ad hoc spot salaries, and for application to management responsibilities, consistent with that made to staff on Agenda for Change terms and conditions of service;
- An equivalent consolidated 2021/22 pay award for Executive Directors;
- The salary ranges for appointments to the posts of Executive Director of Strategy and Planning and Executive Medical Director (Development);
- The salary range for appointments to new roles of full-time Deputy Medical Director (Operations) and Quality Director;
- Incentive payment arrangements (short term) for specific staffing groups in response to staffing pressures / for additional sessions to increase planned care activity;
- A £200 one-off thank you payment to all staff to acknowledge the extraordinary efforts of the whole workforce in responding to and managing the pressures of the Covid-19 pandemic;
- Non-consolidated payment for the Deputy Director of Strategy and Planning including the recognition of additional responsibilities undertaken as Interim Director of Strategy and Planning and lead for the Covid-19 vaccination programme; and

- Discretionary rate of payment rate for training doctors (fixed term) to cover gaps in on call rotas.

Annette Laban
Chair of the Board of Directors' Nomination and Remuneration Committee

Senior managers' remuneration policy

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nomination and Remuneration Committee taking into account market levels, key skills, performance and responsibilities.

The Trust's overarching approach is to ensure that senior managers' remuneration supports delivery of our vision to be recognised as the best provider of healthcare, clinical research and education in the UK, and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy City region.

As such, the principle underpinning the Trust's remuneration policy is that rewards to senior managers should enable the Trust to recruit, motivate and retain individuals with the necessary skills, experience and ability, to support delivery of the Trust's strategic aims.

Future policy table senior managers (other than Non-Executive Directors)

Executive Director remuneration for 2021/22 was set at an appropriate level to recognise the significant responsibilities of directors in foundation trusts of similar size and complexity, and to attract and retain individuals with the necessary skills, experience and ability.

The future policy table overleaf provides detail on each element of Executive Directors' remuneration packages for 2021/22, how the level of pay is determined, how change is enacted and how Executive Directors' performance is managed.

Directors with remuneration (total) greater than £150,000

The Trust takes steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS foundation trusts, and that this rate enables the Trust to attract and retain senior managers with the necessary abilities to lead and develop the Trust's activities fully for the benefit of patients. In making decisions about whether to pay any individual Executive Director more than £150,000[3] per annum, as outlined in guidance

[3] *The threshold set out in NHSI guidance above which NHS foundation trusts should make a disclosure.*

issued by the Cabinet Office, regard is paid to remuneration benchmarking data, market conditions, and the individual director's level of experience and development of the role.

Fig: Future policy table

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to access performance
Base pay			
Base pay is determined using benchmarked data (reviewed annually) in order to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and priorities.	Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board's Nomination and Remuneration Committee, chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle but are made by the Nomination and Remuneration Committee.	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (senior managers are proportionally not treated more favourably than other staff).	The Chief Executive and the Executive Directors participate in annual performance reviews undertaken by the Trust Chair and Chief Executive respectively. The individual's agreed objectives are linked to the Trust's corporate objectives. The Trust does not operate a system of performance related pay. Failure to meet objectives is managed via our Trust policies and performance frameworks.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of directors to attract high-calibre staff to enable the Trust to meet its strategic objectives.	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider).	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with the HMRC method.	Not applicable.
On-call payment			
Senior managers receive on-call payment in line with on-call responsibilities.			
Learning account funds			
Senior managers at Directorate Triumvirate level (Nurse Directors, Operations Director and substantive Clinical Directors) receive learning account funds as part of their remuneration package.			
Benefits			
The Trust operates a number of salary sacrifice schemes including childcare vouchers, white goods scheme and a lease car scheme. These are open to all members of staff.			
Travel expenses			
Appropriate travel expenses are paid for business mileage.			
Covid-19 thank you gift			

A £200 one-off thank you payment to all staff in 2021/22.

Payments for loss of office*

There is no entitlement to any additional remuneration in the event of early termination. During 2021/22 no senior manager (or past senior manager) received payments for loss of office.

* subject to audit

Statement of consideration of employment conditions elsewhere in the Trust

In determining the pay and conditions of employment for Executive Directors and senior managers, the Board of Directors' Nomination and Remuneration Committee takes account of national pay awards given to medical and non-medical staff groups subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

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

Policy on diversity and inclusion used by the Nomination and Remuneration Committee

The Board is committed to ensuring that its composition comprises an appropriate balance of skills, knowledge and experience. Diversity is a vital part of the continued assessment and enhancement of board composition, and the Board recognises the benefits of diversity amongst its members.

Appointments to the Board of Directors are subject to a formal, rigorous and transparent procedure. While new appointments are always based on merit, careful consideration is given to the benefits of improving and complementing the diversity, skills, experience and knowledge of the Board. Under the Trust's equality, diversity and inclusion (EDI) work programme, representative recruitment panels introduced during 2020/21 ensure ethnicity and gender representation throughout recruitment processes.

Before any appointment is made to the Executive team an evaluation of the composition of skills, knowledge, experience and diversity on the Board of Directors informs the description of the role and capabilities required for a particular appointment. The appointment process is designed to attract the best candidates, through the use of a range of open advertising or the services of external advisers to facilitate the search.

Likewise, at the outset of each Non-Executive Director recruitment and selection process, a review is undertaken of the composition of the Board of Directors for balance of diversity, skills and experience to inform its search. The output of which informs recommendations from the Board of Directors' Nomination and Remuneration Committee to the Council of

Governor's Nomination and Remuneration Committee responsible for undertaking the recruitment and selection processes.

Annual report on remuneration 2021/22

Service contract obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. In order to attract Executive Directors of sufficient calibre, the Chief Executive and Executive Directors have permanent employment contracts with appropriate notice periods in line with employment law, rather than a fixed term. This is in line with similar contracts in the sector. The process to recruit to Executive Director positions involves the Chair, Chief Executive and Non-Executive Directors.

The following table contains details of the service contracts in place during 2021/22 for Executive Directors.

Fig: Service contracts

Name	Date of service contract	Unexpired term	Notice period
David Black	February 2022	Open ended	6 months
Anne Gibbs	February 2018	Stepped down December 2021	6 months
Mark Gwilliam	May 2009	Open ended	3 months
Michael Harper	June 2019	Open ended	6 months
Jennifer Hill	December 2020	Open ended	6 months
David Hughes	February 2019	Stepped down January 2022	6 months
Kirsten Major	March 2019	Open ended	6 months
Chris Morley	October 2018	Open ended	6 months
Neil Priestley	February 2001	Open ended	3 months

The Board of Directors' Nomination and Remuneration Committee

The Board of Directors' Nomination and Remuneration Committee is chaired by the Trust Chair and its membership includes all Non-Executive Directors.

The role of the Committee is outlined in its terms of reference which are annually reviewed and approved by the Board of Directors. Its responsibilities in relation to remuneration are to:

- Decide upon and review the terms and conditions of the office of the Trust's Executive Directors and most senior employees, in accordance with all relevant Trust policies, including:
  - Salary, including any performance-related pay or bonus
  - Provision for other benefits, including pensions
  - Allowances;
- Monitor and evaluate the performance of individual Executive Directors;
- Adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective;
- Advise upon and oversee contractual arrangements for Executive Directors, including (but not limited to) termination payments and agreements. This also relates to any matter that requires Treasury approval, or any matter that may give rise to public concern; and
- Determine arrangements for annual salary review for all staff on Trust contracts.

The Committee met a total of six times during 2021/22, attendance at which was recorded.

Fig: Board of Directors' Nomination and Remuneration Committee membership and attendance

Name	Attendance (actual / possible)
Annette Laban, Chair	6 from 6
Tony Buckham	3 from 6
Chris Newman	4 from 6
John O'Kane	5 from 6
Maggie Porteous (appointed 1 May 2021)	4 from 5
Rosamond Roughton	6 from 6
Toni Schwarz (appointed 1 May 2021)	3 from 5
Martin Temple	5 from 6
Shiella Wright	4 from 6

At the invitation of the Committee, meetings are attended by the Chief Executive, the Director of Human Resources and Staff Development, and the Assistant Chief Executive, who acts as Committee Secretary. Executive Directors are not involved in any decisions or discussions regarding their own remuneration or in decisions where there may be a conflict of interest.

The remuneration of Non-Executive Directors is the responsibility of the Council of Governors' own Nomination and Remuneration Committee. The work of this Committee is outlined within the Governance Section of this Annual Report.

Disclosures required by the Health and Social Care Act

Expenses for Executive and Non-Executive Directors

The expenses for Executive and Non-Executive Directors and Governors are reimbursed on a receipts basis, evidencing the business mileage or actual travel / subsistence costs incurred. Reimbursement rates for mileage are those applied to all Trust employees and do not exceed national guidelines.

Total expenses for 2021/22 are detailed in the table below:

Fig: Expenses for Executive and Non-Executive Directors and Governors

	2021/22	2020/21
Executive and Non-Executive Directors		
Number who claimed expenses during the year	3	3
Number of Executives / Non-Executives who held office during the year	18	16
Amount claimed in total	£897.43	£492.80
		Governors
Number who claimed expenses during the year	0	4
Number of Governors who held office during the year	32	36
Amount claimed in total	£0.00	£273.84

Remuneration of Executive and Non-Executive Directors

In reporting on remuneration within the tables provided on the next pages, the Trust has applied the definition of senior managers, as proposed within the NHS Foundation Trust Annual Reporting Manual and included senior managers who influence the decisions of the Trust, rather than the decisions of individual directorates or sections of the Trust. As well as referring to Executive and Non-Executive Directors, this extends to the Assistant Chief Executive, and the Communications and Marketing Director. In addition, for 2021/22 this included the post of interim Director of Strategy and Planning.

Table 1 - Single total remuneration for senior managers*

	Single total remuneration 2021/22						Single total remuneration 2020/21					
	Salary	Taxable benefits	Annual Performance Related Bonuses	Long-term Related Bonuses	All pension related benefits	Single Total Remuneration	Salary	Taxable benefits	Annual Performance Related Bonuses	Long-term Related Bonuses	All pension related benefits	Single Total Remuneration
Name	Bands of £5,000	to the nearest £00	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	to the nearest £00	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
David Black, Medical Director (Development) (from 01 Feb 2022)	25 - 30	0	0	0	-	25 - 30	-	0	0	0	-	-
Tony Buckham, Non-Executive Director and Vice Chair	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
[1] Paul Buckley, Interim Director of Strategy and Planning (from 03 Sept 2020)	110 - 115	0	0	0	42.5 - 45	155 - 160	65 - 70	0	0	0	27.5 - 30	95 - 100
Sandi Carman, Assistant Chief Executive	115 - 120	0	0	0	47.5 - 50	160 - 165	110 - 115	0	0	0	27.5 - 30	140 - 145
Anne Gibbs, Director of Strategy and Planning (to 13 Dec 2021)	105 - 110	0	0	0	17.5 - 20	125 - 130	135 - 140	0	0	0	37.5 - 40	175 - 180
Mark Gwilliam, Director of Human Resources and Staff Development	180 - 185	0	0	0	67.5 - 70	245 - 250	175 - 180	0	0	0	32.5 - 35	205 - 210
Michael Harper, Chief Operating Officer	145 - 150	0	0	0	52.5 - 55	200 - 205	140 - 145	0	0	0	52.5 - 55	195 - 200
[2] Jennifer Hill, Medical Director (Operations)	190 - 195	0	0	0	422.5 - 425	610 - 615	185 - 190	0	0	0	177.5 - 180	360 - 365
David Hughes, Medical Director (Development) (to 31 Jan 2022)	150 - 155	0	0	0	-	150 - 155	175 - 180	0	0	0	42.5 - 45	220 - 225
Annette Laban, Chair (from 1 Jan 2021) / Non-Executive Director (to 31 Dec 2020)	55 - 60	0	0	0	-	55 - 60	25 - 30	0	0	0	-	25 - 30
Kirsten Major, Chief Executive	235 - 240	0	0	0	75 - 77.5	310 - 315	225 - 230	0	0	0	60 - 62.5	290 - 295
Chris Morley, Chief Nurse	155 - 160	0	0	0	70 - 72.5	225 - 230	150 - 155	0	0	0	35 - 37.5	185 - 190
Chris Newman, Non-Executive Director	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
John O'Kane, Non-Executive Director	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Tony Pedder, Chair (to 31 Dec 2020)	-	0	0	0	-		40 - 45	0	0	0	-	40 - 45
Julie Phelan, Comms & Marketing Director	120 - 125	0	0	0	47.5 - 50	170 - 175	115 - 120	0	0	0	30 - 32.5	150 - 155
Maggie Porteous, Non-Executive Director (from 01 May 2021)	10 - 15	0	0	0	-	10 - 15	-	0	0	0	-	-
Neil Priestley, Chief Finance Officer	195 - 200	0	0	0	-	195 - 200	190 - 195	0	0	0	-	190 - 195
[3] Rosamond Roughton, Non-Executive Director	10 - 15	0	0	0	-	10 - 15	-	0	0	0	-	-
Toni Schwarz, Non-Executive Director (from 01 May 2021)	10 - 15	0	0	0	-	10 - 15	-	0	0	0	-	-
Martin Temple, Non-Executive Director	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20
Shiella Wright, Non-Executive Director	15 - 20	0	0	0	-	15 - 20	15 - 20	0	0	0	-	15 - 20

Notes on Table 1

1 Paul Buckley's total remuneration (£65k - £70k) in 2020/21 reflects the amount that relates to his role of Interim Director of Strategy and Planning only, the role being effective from 03 September 2020.

2 Jennifer Hill was appointed to the Executive Director position of Medical Director (Operations) from 1 December 2020 following undertaking the role on an interim basis and attending Board meetings as a Participating Director from 1 February 2020. Jennifer Hill's salary in 2020/21 is inclusive of an amount of £87k remuneration in respect of clinical duties undertaken in her role prior to her appointment to the substantive position of Medical Director (Operations).

3 Rosamond Roughton chose not to receive remuneration for her Non-Executive role while being employed as a senior civil servant. From 1 June 2021 Rosamond has received remuneration for her Non-Executive role at the Trust.

Pension related benefits have been calculated using the HRMC method advised by NHSI in the Annual Reporting Manual.

Table 1 subject to audit.

Table 2: Total pension benefits*

	Real increase in pension at pension age (£' 000)	Real increase in pension lump sum at pension age (£' 000)	Total Accrued pension at pension age @ 31.03.22 (£' 000)	Lump sum at pension age related to accrued pension at 31.03.22 (£' 000)	CETV @ 31.03.21 (£' 000)	Real Change in CETV (£' 000)	CETV @ 31.03.22 (£' 000)
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	(£,000)	(£,000)	(£,000)
Paul Buckley, Interim Director of Strategy and Planning	2.5 – 5	2.5 – 5	40 – 45	85 - 90	678	45	743
Sandi Carman, Assistant Chief Executive	2.5 – 5	0 - 2.5	45 – 50	90 - 95	785	47	853
Anne Gibbs, Director of Strategy and Planning (until 13 December 2021)	0 – 2.5	0 - 2.5	50 – 55	100 - 105	807	27	842
Mark Gwilliam, Director of Human Resources and Staff Development	2.5 – 5	0 - 2.5	45 – 50	90 - 95	858	74	962
Michael Harper, Chief Operating Officer	2.5 – 5	0 – 2.5	45 – 50	85 - 90	635	40	698
Jennifer Hill, Medical Director (Operations)	20 – 22.5	47.5 -50	85 – 90	215 - 220	1,450	449	1,944
David Hughes, Medical Director (until 31 January 2022)	0 – 2.5	0 - 2.5	45 – 50	125 - 130	1,179	0	0
Kirsten Major, Chief Executive	5 – 7.5	0 - 2.5	75 – 80	145 - 150	1,211	74	1,325
Chris Morley, Chief Nurse	2.5 – 5	2.5 – 5	70 – 75	175 - 180	1,302	76	1,408
Julie Phelan, Communications and Marketing Director	2.5 – 5	0 - 2.5	45 – 50	95 - 100	858	52	932

Notes on Table 2

The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholders pension scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2021/22 and whose membership was active at 31 March 2022. CETV (Cash Equivalent Transfer Value) is the value of a member's pension fund at 31 March if he/she were to transfer that pension fund on that date. Benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud Judgement and the Guaranteed Minimum Pension (GMP) Judgement.

Table 2 subject to audit.

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Hutton Report disclosure

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. For 2021/22, these ratios are set out in the table below.

Prior year comparatives (2020/21 and 2019/20) are set out in respect of median pay only and are expressed as a multiple of basic pay only, in line with mandated reporting requirements.

The banded remuneration of the highest paid director in the organisation (the Chief Executive) in the financial year 2021/22 was £237,500 (2020/21, £227,500). This is a change between years of 3 per cent.

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

In making decisions about the level of remuneration awarded to any individual director, the Trust takes steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS foundation trusts, and that this rate enables the Trust to attract and retain senior managers with the necessary abilities to lead and develop the Trust's activities fully for the benefit of patients. As such, when appointing to this highest paid director position of Chief Executive, due regard was given to remuneration benchmarking data, market conditions, and the individual's level of experience.

For employees of the Trust as a whole, the range of remuneration (comprising basic pay and additional elements of pay) in 2021/22 was from £0[4] to £396,000. For 2020/21 the range was from £0 to £340,000.

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2.35 per cent. The percentage change in respect of the highest paid director is 3 per cent. No remuneration is made in respect of performance pay and bonuses.

The average pay calculation above is performed with reference to elements of pay other than basic salary and is reflective of work undertaken and paid in 2021/22 and in 2020/21. Basic salary increases are applied on the same percentage basis to employees and to directors alike, and are therefore not differential; The remuneration

[4] Employees on zero hour contracts or whose tenure of employment with the Trust ended soon after the start of the financial year and on an Agenda for Change (AfC) Band 2 pay scale will be included in this lowest remuneration banding. The annual remuneration of a member of staff paid at the bottom of the AfC Band 2 pay scale working 37.5 hours a week is equivalent to £18,546.

of the highest paid director has increased by an amount that was consistent with the annual pay award made to staff on Agenda for Change terms and conditions of service.

One employee received remuneration in excess of the highest paid director in 2021/22 and in 2020/21.

Fair pay multiple 2021/22

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. This reporting metric is new in year. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce. Previous years' published ratios based on the now superseded 2021/22 reporting requirements are set out in the table entitled Fair Pay Multiple Prior Years (2020/21 and 2019/20).

Table 3 - Fair pay multiple 2021/22*

2021/2022*	25th percentile	Median	75th percentile
Salary component of pay (Basic pay)	£19,918	£27,780	£39,027
Total pay and benefits excluding pension benefits	£21,976	£31,262	£42,515
Total pay and benefits excluding pension benefits; pay ratio to highest paid director (based on mid-point banded remuneration, £237.5k)	10.81	7.60	5.59

Fair pay multiple prior years (2020/21 and 2019/20)

Information for prior years (based on the Median Salary component of basic pay only) is set out below.

Table 4 - Fair pay multiple prior years*

	2020/21	2019/20
Band of highest paid director's total remuneration (midpoint banded remuneration in multiples of £5k)	£227.5k	£222.5k
Median total remuneration	£28,346	£25,512
Ratio	8.03	8.72

There are no significant changes in the ratios between the current and prior financial years which is reflective of the Trust's equitable pay / remuneration policy. As mentioned, the remuneration of the highest paid director has increases by an amount that is consistent with the annual pay award made to staff on Agenda for Change terms and conditions of service.

*Tables subject to audit

Remuneration report signed by the Chief Executive in capacity as Accounting Officer

Kirsten Major

21 June 2022

Staff Report

The colleagues and volunteers of Sheffield Teaching Hospitals NHS Foundation Trust are the reason for our continued success and have been vital to the delivery of our services and the care and support we provide to our patients as well as the ongoing response to the Covid-19 pandemic and planning for service recovery.

Our 18,500 plus workforce is vital to ensuring we continue to deliver high quality care, and over the last year they have shown immense flexibility, dedication, and commitment to work above and beyond the requirements of their individual roles to care for and support our patients. Without them we would not be able to deliver the standard of care, or offer the range of clinical services, that we do.

Through continued commitment to deliver our People Strategy, we are dedicated to ensuring that Sheffield Teaching Hospitals is a brilliant and personal place for our colleagues to work. Focused on 10 workstreams, this strategy allows us to provide our colleagues with the best opportunities to put patients first. We have continued to work with our PROUD values and to embed these into the Trust's ethos. The PROUD values are:

- Patient first - Ensure that the people we serve are at the heart of all we do;
- Respectful - Be kind, respectful to everyone and value diversity;
- Ownership - Celebrate our successes, learn continuously and ensure we improve;
- Unity - Work in partnership and value the roles of others; and
- Deliver - Be efficient, effective and accountable for our actions.

This year we have undertaken a wide-ranging consultation exercise to create a set of PROUD Behaviours to underpin our PROUD Values. There was a total of 6,845 interactions as part of the consultation, through a wide variety of methods including surveys, focus groups, fora, meetings, networks, plus using existing data sources (eg NHS staff survey, People Pulse, patient complaints and compliments). Monitoring data was collected and reviewed throughout to seek input from a diverse range of patients and staff across different roles, directorates, and protected characteristics. This led to targeted work to seek views from groups where representation was low. The data were analysed and themed around PROUD values into behaviours that people expect to see and behaviours they don't expect to see. The behavioural framework is being refined before final sign off and approval at the Board of Directors meeting in May 2022, with a launch week planned in June

2022 to communicate and commence implementation of PROUD Behaviours throughout the Trust. Our PROUD values and behaviours underpin the way in which we all work and deliver the best service at all times. We strive to achieve exceptional engagement and leadership, ultimately delivering the best for our patients.

We have continued to prioritise our People Strategy work programmes and review of national publications such as the NHS People Plan, in light of the continued impact of the pandemic to ensure we continue to support teams and staff to help them do the best they can. The current People Strategy expires at the end of 2022 so discussions are underway to plan and execute a consultation exercise to create the next People Strategy for the Trust from 2023 onwards. We continue to recognise the great work that individuals and teams carry out via our annual Thank You Awards, our Long Service Awards and at local department level. This year, in recognition of the ongoing hard work during the pandemic, the Board of Directors have awarded an additional thank you gesture of £200 to each member of staff which was much appreciated by colleagues and we have introduced the High Five thank you app so that our staff have an easy means to say thank you to their teams and colleagues. We have continued to expand our reward programme for colleagues, which includes many salary sacrifice options and staff discounts. This year we have also continued to strengthen our relationship with Sheffield Credit Union enabling colleagues to both save and have loans via salary deductions.

In November 2021 we were once again finalists in the national Employee Benefits Awards, an award which is open to all sectors.

Working with our staff

Statement on approach to staff experience and engagement

We recognise that in order to deliver consistently high-quality clinical services it is important to have colleagues who feel valued and cared for and who are willing to go over and above.

The Trust is committed to involving colleagues in decision-making, engaging them on key developments and keeping them informed of change across the organisation.

We use a range of well-established communications channels to ensure that all colleagues are aware of both internal and external developments that may affect the Trust. These include a regular briefing from the Chief Executive which this year has continued online and a weekly email bulletin to all colleagues, as well as using our social media feeds. Our intranet pages provide access for colleagues to Trust policies, guidance and online resources. In addition, we have the external Vivup

portal which holds wellbeing information and information on the full range of staff benefits and discounts which staff can access from everywhere.

The Trust has a well-established Partnership Forum where management and union representatives meet to discuss Trust-wide workforce issues. Through this forum, policies and procedures are formally agreed and wider views sought on a broad range of subjects that may affect colleagues, including formal consultation on areas of organisational change.

We recently received the results of our 2021 Staff Survey and are actively reviewing this feedback to identify themes that we can address with our colleagues to improve their experience at work. More detail is included later in this report and our full survey results are available electronically from the following link.

The Trust's Freedom to Speak up Guardians, supported by the Freedom to Speak up Operational and Steering Groups, has focused on expanding our support infrastructure for employees wishing to raise concerns. The Trust has published a new Freedom to Speak up policy which supports an open and transparent culture where staff can feel supported and confident that they will be listened to and that learning will take place.

The Trust currently has three Freedom to Speak up Guardians supported by a number of Freedom to Speak up Advocates from across the organisation. Their contact details can be found on the Human Resources intranet page and are publicised on posters across the organisation. There is also a dedicated email address for staff to use to raise concerns.

Regular communication bulletins, including profiles of Guardians and Advocates, have been issued to increase awareness of these roles across the Trust, as well as the provision of online training for both staff and managers on the importance of speaking up and how to deal with concerns raised.

This year we have introduced more ways to ensure staff have a voice through the introduction of the National Quarterly Pulse surveys in April 2021, July 2021 and January 2022.

National Staff Survey

Each year the Trust undertakes a census survey as part of the National Staff Survey. This annual survey provides an opportunity to give feedback and provides a valuable measure of staff experience.

The Trust is benchmarked in the acute and acute and community trusts group.

Fig: Response rate to the NHS Staff Survey: Staff involvement

2021		2020	
Trust	National Average	Trust	National Average
38%	48%	42%	49%

From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replace the 10 indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Scores for each indicator, together with that of the survey benchmarking group (acute and acute and community trusts group) are presented below:

Fig: 2021 Staff survey results

	2021	
	Trust	Benchmark group
We are compassionate and inclusive	7.2	7.2
We are recognised and rewarded	5.8	5.8
We each have a voice that counts	6.7	6.7
We are safe and healthy	5.9	5.9
We are always learning	5.2	5.2
We work flexibly	5.8	5.9
We are a team	6.5	6.6
Staff engagement	6.7	6.8
Morale	5.8	5.7

2019 and 2020

Scores for each indicator, together with that of the survey benchmarking group (acute and acute and community trusts group) are presented below:

Fig: 2019 and 2020 Staff survey results

	2020		2019	
	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.3	9.1	9.2	9.2
Health and wellbeing	6.1	6.1	6.0	6.0
Immediate managers	6.9	6.8	6.9	6.9
Morale	6.4	6.2	6.3	6.2
Quality of care	7.5	7.5	7.4	7.5
Safe environment – bullying and harassment	8.5	8.1	8.4	8.2
Safe environment – violence	9.5	9.5	9.5	9.5
Safety culture	6.9	6.8	6.9	6.8
Staff engagement	7.0	7.0	7.1	7.1
Team working	6.3	6.5	6.5	6.7

For the 2021 NHS Staff Survey the Trust scored above average for Acute and Acute and Community Trusts for one of the themes:

- Morale

Average for five themes:

- We are compassionate and inclusive;
- We are recognised and rewarded;
- We each have a voice that counts;
- We are safe and healthy; and
- We are always learning.

Below average for:

- We work flexibly;
- We are a team; and
- Staff engagement.

The highest score overall achieved was for the theme *'We are compassionate and inclusive'* (7.2) and the lowest was for the theme *'We are always learning'* (5.2), albeit this was average for our benchmarking group.

The Staff Survey results will be used to update directorate action plans and, at a Trust level, the implementation of the seven themes of the People Promise and Staff Engagement and Morale will be used to continue to improve colleagues' experience.

Our key corporate priorities for the Staff Survey in the coming year are:

- To align the People Promise Staff Survey themes through review of our People Strategy;
- Engaging staff in development of recovery plans and continued promotion of the staff wellbeing support;
- Improvement of the response rate through a planned approach to ensure staff have time to complete the survey and the use of iPads;
- To particularly address '*We work flexibly*' through the development of flexible rostering, '*We are a team*', '*Staff engagement*' and '*We each have a voice that counts*' through the implementation of a Listening Strategy and though implementation of the Trust-level action plan which is further supported by directorate survey action plans.

The implementation of the Trust-level action plan will be via the Human Resources Strategy Group and the Human Resources and Organisational Development Committee of the Board of Directors. Progress with implementing directorate survey action plans will be monitored through directorate performance reviews.

Equality, diversity and inclusion

The Trust aims to create a diverse and inclusive workforce that attracts and engages talented individuals from all backgrounds. We will celebrate diversity and promote a culture of inclusion. Our vision is to have a workforce that fully reflects the communities we serve and a workplace culture in which everyone feels valued and is treated with fairness and respect.

We are achieving our vision by:

- Developing robust ways to manage performance and ensuring that all areas embed equality, diversity and inclusion (EDI) best practice;
- Ensuring there is visible leadership of EDI, that people are leading by example and that we achieve what we say we will within the deadlines agreed;
- Building strong community connections and networks so that our activity is informed by conversations with local people and partners;
- Embedding a zero-tolerance approach to any form of discrimination, bullying, harassment and victimisation and bringing people together to create a social movement for change;
- Building the EDI capability of every member of staff so that we are all confident to challenge when we witness language or behaviour that doesn't fit with the Trust's PROUD values;
- Using positive action to build a diverse workforce, ensuring access to opportunities for current colleagues, supporting our staff network groups and ensuring that we support our disabled colleagues with reasonable adjustments; and
- Embedding an effective way of measuring and evaluating what we are achieving and what impact we are having across the organisation.

As well as EDI being a 'golden thread' throughout our People Strategy, we have a specific workstream entitled 'Promoting and valuing difference'. This workstream is leading the programme of work to achieve our vision which is overseen by our Equality, diversity and inclusion (EDI) Board. The EDI Board provides oversight to, and governance of, the Trust's strategic approach to meeting its legislative, moral and social duties, including those within the Equality Act 2010, the Human Rights Act 1998, the NHS Equality Delivery System and the national NHS Workplace Race and Disability Equality Standards.

With a diverse and broad membership, including senior leaders, the EDI Board reports to the Trust Executive Group and oversees any EDI work carried out in respect of workforce, patients and service delivery.

Over the past 12 months, we have made significant progress on EDI through a collaborative approach working across the whole Trust and with our partners and communities. Some of our achievements are listed below:

- Establishment of our EDI Team, with a Head of EDI and two EDI Manager posts being created;
- Development of our new EDI Strategy that clearly communicates our key priority areas and the action we plan to take;
- Supporting our staff network groups to develop and grow;
- Achieving an overall improvement in our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) performance. Establishing realistic but challenging action plans;
- Developing a Diversity and Inclusion Calendar and agreeing key dates to be marked by the Trust on an annual basis;
- Establishing a Reciprocal Mentoring Programme where senior leaders and staff network group members are paired to share experiences and support each other;
- Launched our representative recruitment panels approach to ensure ethnicity and gender representation throughout the recruitment process;
- Developed a Race Equality Charter as part of our partnership working with the Sheffield Accountable Care Partnership, in response to the Covid-19 pandemic and its spotlight on race inequality;
- Launched a new rapid equality impact assessment process with guidance and training to ensure we fully understand the implications of what we propose and do;
- Developed an EDI performance dashboard with key indicators covering patient, staff and operational EDI;
- Supported our colleagues and protected them from harm through the Covid-19 pandemic by developing and implementing the Individual Staff Impact Assessment process;
- Commitment to the development of a personalised programme of training for our Board of Directors and Governors;
- Developed and delivered Trans and Gender Diversity training to challenge myths and misconceptions and promote a culture of inclusion and respect; and
- Procured a series of e-learning resources to increase the capability and confidence of colleagues in terms of EDI.

Further information about the Trust's EDI objectives can be found on our website via this link.

Staff health and wellbeing

The Trust had a well-established Employee Assistance Programme provided by Vivup, prior to the pandemic which has continued to be available 24 hours a day, seven days a week to provide colleagues with support whenever they need it. Vivup also provides a range of self-help Cognitive Behavioural Therapy (CBT) guides, an app to help manage stress and podcasts to support colleagues with their wellbeing.

We have continued to provide Covid-19 testing for all colleagues and their families and to utilise the Covid-19 Absence Reporting System which provided a daily picture of Covid-19 absence and the impact on service, and allowed the Trust to support colleagues to return to work quickly and safely following either a negative test or the end of their isolation period.

Many of our colleagues continued to work from home during this year and the Trust developed and implemented a Homeworking Policy which provides guidance for managers and colleagues and incorporates a risk assessment of the homeworking environment.

We have now also undertaken a programme of Covid-19 vaccinations for all front-line colleagues as well as the annual flu vaccinations programme.

In recognition of the importance of staff wellbeing and the need to support staff recovery, this year we have introduced wellbeing conversations into appraisal and are in the process of training Wellbeing Champions across the Trust to support more regular conversations and enable them to signpost colleagues appropriately.

We have continued to promote the NHS people wellbeing offer, for example Access to Headspace / Unmind, and developed our own offer through the recommencement of Schwartz rounds in some directorates and the establishment of a Carers Forum for staff. In recognition that the pandemic has also impacted on staff families we have also introduced access to telephone counselling for family members over 16 years of age.

Thanks to the continued support of Sheffield Hospitals Charity, we have been able to increase the wellbeing support during the last year to include:

- Creating and maintaining over 60 calm rooms across the Trust to provide a quiet space for staff to rest and reflect;
- Increased psychological support for teams; and
- More training in Mental Health First Aid.

During 2021 there has also been more training on wellbeing topics available for staff via the South Yorkshire ICS and support for staff with long Covid provided as well as additional trauma treatment.

We have also continued to provide access to the staff physiotherapy service and encouraged colleagues to keep active through the introduction of a second online fitness platform which is particularly important for colleagues working at home.

Staff health and safety and incident management

The Trust's People Strategy commits us to ensuring that we identify and proactively manage the risks to the health, safety, and wellbeing of our staff to prevent harm and promote long term health.

Once again, a significant impact on the health and safety of our staff this year has been the management of Covid-19. In the second year of this pandemic, we have built on our work relating to the assessment and mitigation of risks to our staff including:

- Updating guidance on the management of vulnerable staff groups and enabling them to return to work safely;
- Establishing a ventilation safety steering group; and
- Expanding the use of FFP3 masks and increasing the numbers of staff who are fit tested.

We have increased the frequency of the Safety and Risk Committee and Safety and Risk Forum from bi-monthly to monthly to provide a timelier response to issues. The committee receives and reviews reports relating to staff health and safety covering incident data, risk assessments, guidance documents and deep dives on issues identified.

The table below shows the number of incidents reported over the last three years involving staff (including bank / agency), members of the public, students and contractors. In addition to monitoring incident data centrally, it is monitored at directorate level via formal governance management processes and on a newly introduced central electronic dashboard.

Fig: Incidents involving staff, members of the public, students and contractors

Total number of incidents by work group			
	2019/2020	2020/2021	2021/2022
Accident/incident involving member of staff	2135	1901	2005
Accident/incident involving member of agency staff	32	14	25
Accident/incident involving contractor	44	42	43
Accident/incident affecting member of public	308	194	313
Accident/incident involving student	42	25	50

Oversight of staff health and safety is via the Safety and Risk Committee chaired by the Medical Director (Operations) and an annual report to the Quality Committee (formerly Healthcare Governance Committee).

Staff analysis

Staff numbers

Fig: Average number of persons employed (contracted whole time equivalent basis)

	2021/22			2020/21		
	Permanent	Other	Total	Permanent	Other	Total
Medical and Dental staff	2,014	34	2,048	1,940	36	1,976
Administration and Estates staff	3,206	165	3,371	3,142	65	3,207
Healthcare Assistants and other Support staff	1,621	208	1,829	1,645	232	1,877
Nursing, Midwifery and Health Visiting staff	5,946	103	6,049	5,936	110	6,046
Scientific, Therapeutic and Technical staff	2,741	24	2,765	2,684	16	2,700
Healthcare Science staff	157	-	157	151	-	151
Total average numbers	15,685	534	16,219	15,498	459	15,957

Figures subject to audit

Staff turnover

Data for staff turnover at the Trust is published by NHS Digital within NHS Workforce Statistics and can be accessed via the following link.

Gender of staff

On 31 March 2022, the Trust Board of Directors had 16 voting members, nine male and seven female. Women represent 65.9 per cent of senior staff at band eight and above.

The current Trust headcount at 31 March 2022 was 18,316. Female employees comprised 76.5 per cent of the workforce and 23.5 per cent were male.

It became mandatory for public sector organisations with over 250 employees to report annually on their Gender Pay Gap. Analysis for 2021 indicates that for our Trust there is an average hourly pay gap in favour of men of 21.45 per cent, which is a 0.15 per cent deterioration on data for 2020 (21.3 per cent). This pay gap is

largely accounted for by a combination of a higher proportion of female colleagues in Agenda for Chance (AfC) pay bands one to four, and higher numbers of male colleagues in senior medical (consultant) posts. High level actions in place to address this gap are detailed below.

Removing the Gender Pay Gap

The Trust is committed to ensuring an equitable workforce and although the pay gap compares favourably to some other organisations, we continue to work towards achieving the following actions:

- Continue to deliver on our People Strategy which prioritises equality, diversity and inclusion. For 2022 this will include a review and refresh of our Equality, Diversity and Inclusion Policy alongside a review and refresh of our Recruitment and Selection Policy and the introduction of new Recruitment and Selection training for our recruiting managers. The Trust has strengthened the resource within our EDI Team, and has developed our new EDI Strategy;
- There are already initiatives in place at the Trust to support the career path of women in Medicine, for example the Health Education England (HEE) funded SuppoRTT programme which provides funding to medical and dental employees returning from prolonged absence from work, such as those returning to work from caring responsibilities. Existing links with Sheffield Women in Medicine (SWIM) which a number of our female medical and dental colleagues support. There are also several key champions of this work within our workforce, such as our Medical Director (Operations), Deputy Director of Medical Education and Chief Registrar. In addition, the Organisational Development Directorate have established, and continue to develop, a Trust Women's Staff Network Group;
- Work on attracting and recruiting men into the organisation particularly focused on Agenda for Change (AfC) pay bands one to four (facilities roles) to create a more gender balanced workforce. For example, through the work the HR team are continuing to do with the Department of Work and Pensions / Job Centre plus to identify unemployed applicants with access to employment opportunities;
- Promotion of the wide breadth of career opportunities available across all roles and professions, within the Trust / NHS through our role as an anchor institution working with schools;
- Raise awareness of shared parental leave entitlements and flexible working opportunities for all, including establishment of our Homeworking Policy and review and refresh of our Flexible Working Policy;

- Continue to provide career development opportunities for all colleagues, including mentoring and coaching and continued development of our leadership and management development framework (LEAD); and
- Ongoing work on diverse recruitment panels (including the gender make up of panels), and the reciprocal mentoring programme should also have a positive impact although these programmes have a broader EDI focus.

In addition to the above ongoing actions we intend to undertake the following work in partnership between our HR Department and EDI Team:

- Undertake a deep dive of the Gender Pay Gap data to identify themes and trends to inform further possible work;
- Consider turnover rates and exit information by gender; and
- Review the findings of the deep dive with our Women's Staff Network Group to develop the themes and actions for future work in this area.

Information on the Trust's gender pay gap can be found on the Cabinet Office website.

Staff sickness absence data

Data for average sick days per full time equivalent (FTE) provided by the Department of Health and Social Care is published by NHS Digital can be accessed here.

The Trust's data can be found on the table below.

Fig: Staff sickness absence data

Average FTE 2021	Adjusted FTE days lost	Average sick days per FTE	FTE – days available	FTE – days lost to sickness absence
15,588	182,264	11.7	5,689,654	295,672

Staff costs

Fig: Analysis of staff costs

	2021/22 Permanent £000	Other £000	Total £000	2020/21 Total £000
Salaries and wages	626,148	16,598	642,746	622,147
Social security costs	57,427	-	57,427	53,472
Apprenticeship levy	3,029	-	3,029	2,852
Employer's contributions to NHS Pensions Scheme	105,150	-	105,150	100,295
Pension cost – others	424	-	424	405
Agency / contract staff	-	7,137	7,137	7,188
Total	**792,178**	**23,735**	**815,913**	**786,359**

Notes: The above figure of £815,913k is net of the amount of £1,107k (2020/21 £926k) in respect of capitalised salary costs included in fixed asset additions in the Accounts (notes 8.1 and 9.1).

Figure subject to audit

Exit packages

The table below outlines the total number of exit packages agreed during the year.

Fig: Compensation scheme - exit packages

Staff exit packages	2021/22			2020/21		
Exit package cost band (including any special payment element)	Number of Compulsory redundancies	Number of other departures agreed (non-compulsory)	Total number of exit packages by cost band	Number of Compulsory redundancies	Number of Other departures agreed (non-compulsory)	Total number of exit packages by cost band
< £10,000	0	1	1	0	0	0
£10,001 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
Total number by type	1	1	2	0	0	0
Total resource cost (£000)	60	6	66	0	0	0

Notes: Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this table are the full costs of departures agreed in the year. Where Sheffield Teaching Hospitals NHS Foundation Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Trust has agreed one compulsory redundancy in year (£60k), for which costs have been recognised in the accounts. HM Treasury approval was not relevant to this agreement.

The non-compulsory redundancy relates to one case and was settled in the sum of £6k, representing a contractual payment in lieu of notice.

Trade union facility time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of trade union facility time within their organisation.

Fig: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
50	46.8

Fig: Percentage of time spent on facility time

Percentage of time	Number of employees
0	15
1 – 50	31
51 – 99	1
100	3

Fig: Percentage of total pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	Figures
Total cost of facility time	£97,492.19
Total pay bill	£815,913,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.014%

Fig: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 808.22 hours / 6444.98 hours	Per cent
Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours x 100	7.6%

Off payroll engagements

The Trust has identified 45 off-payroll engagements remunerated at more than £245 per day during 2021/22. Of these 45 engagements, 27 of these were in post at 31 March 2022.

During the year there were 35 engagements identified which were new for 2021/22. Of these new engagements, all were assessed as within the scope of IR35. In all cases, assurances / appropriate actions have been taken to ensure the appropriate declaration of income tax and national insurance are made to HMRC.

A total of 21 individuals have been deemed Board members and / or senior officials with significant financial responsibility during 2021/22, all of which were on-payroll engagements.

Fig: Highly paid off-payroll engagements as of 31 March 2022, for more than £245 per day or greater

Number of existing engagements as of 31 March 2022	27
Of which	
Number that have existed for less than one year at time of reporting	21
Number that have existed for between one year and two years at time of reporting	5
Number that have existed for between two years and three years at time of reporting	0
Number that have existed for between three years and four years at time of reporting	0
Number that have existed for between for four or more years at time of reporting	1

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

Number of off-payroll workers engaged during the year ended 31 March 2022	45
Of which	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	45
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	6
Of which: number of engagements that saw a change to IR35 status following review	0

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

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

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements	21

Code of Governance Report

Council of Governors

The Council of Governors advises the Trust on how best to meet the needs of patients and the wider community we serve. It has a number of statutory duties, including holding the Non-Executive Directors to account for the performance of the Board of Directors and representing the interests of Trust Members and members of the public.

The Council of Governors works with the Board of Directors to shape the Trust's future strategy and is responsible for providing feedback from the Membership and stakeholders on proposed strategic developments. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance through formal council meetings.

Comprised of elected and nominated Governors, as detailed below, the Council of Governors has decision-making powers defined by statute. These powers are outlined in the Trust's constitution and principally refer to the appointment, removal and remuneration of the Trust Chair and Non-Executive Directors; the appointment and removal of the Trust's external auditors; the approval of the appointment of the Chief Executive; and receiving the Trust's annual accounts, any report of the auditor on the accounts and the Annual Report.

While the Council of Governors is responsible for holding the Board, and in particular, the Non-Executive Directors, to account and ensuring that it is acting in a way that means that the Trust will meet its obligations, it continues to remain the responsibility of the Board of Directors to oversee the running of the Trust.

The Council of Governors discharges its statutory responsibilities through a combination of formal Council meetings, standing committees and working groups.

During 2021/22 arrangements were put in place to ensure that members of the Council of Governors remained informed and engaged in Trust business during Covid-19 social distancing restrictions, and in line with provisions within the Standing Orders of the Council of Governors, the Council was able to conduct all its business by video conferencing.

A record of attendance by individual Governors at formal meetings of the Council of Governors is presented in the following tables. These tables outline membership of the Council of Governors during 2021/22.

Composition of the Council of Governors 2021/22

At 31 March 2022 there were 33 seats on the Council of Governors - 13 to represent public Members, seven to represent patients, six to represent staff Members and seven seats for Governors nominated by partner organisations. There are three vacant seats on the Council of Governors for nominated partner governors.

Fig: Council of Governors membership and attendance 2021/22

	Elected / Re-elected from	Attendance (actual / possible)
Patient Governors		
George Chia	1 July 2021	4 from 6
Michelle Cook	1 July 2021	2 from 4
Martin Hodgson	1 July 2019	6 from 6
Steve Jones	1 November 2020	3 from 6
Kath Parker (to 30 June 2021)	1 July 2018	2 from 2
Harold Sharpe	1 December 2019	4 from 6
Shirley Sherwood	1 November 2020	4 from 6
Fiona Tatton	1 July 2019	2 from 6
Public Governors		
Mick Ashman	1 July 2019	2 from 6
Steve Banks	1 July 2019	6 from 6
Georgina Bishop	1 November 2020	3 from 6
Paul Dore	1 July 2021	4 from 4
Joyce Justice (to 30 June 2021)	1 July 2018	0 from 2
Kaye Meegan	1 November 2020	1 from 6
Ian Merriman	1 July 2021	4 /from 6
Brendan Molloy (to 30 June 2021)	1 July 2018	2 from 2
Lewis Noble	1 July 2021	3 from 6
Jane Pratt	1 November 2020	4 from 6
Sheila Reynolds	1 November 2020	5 from 5
Joe Saverimoutou	1 July 2021	6 from 6
Chris Sterry	1 July 2019	5 from 6
Sue Taylor	1 July 2019	5 from 6
Mark Wilcox	1 July 2021	4 from 4

Staff Governors		
Paulette Afflick-Anderson	1 November 2020	6 from 6
Irene Mabbott	1 July 2021	6 from 6
Liz Puddy	1 November 2020	3 from 6
Cressida Ridge	1 November 2020	2 from 6
Jess Sheehan	1 July 2021	0 from/ 4
Pete Tanker (to 30 June 2021)	1 July 2018	1 from 2
Emma Warrander	1 November 2020	4 from 6

Appointed Governors	Appointed	
Angela Foulkes, Sheffield College	10 December 2018	1 from 6
David Warwicker, Sheffield CCG	30 March 2020	3 from 6

Attendance is recorded for four general Council of Governors' meetings and two extraordinary Council of Governors' meetings held by videoconference during 2021/22. The two extraordinary meetings were held on 15 April 2021, to approve the appointment of two Non-Executive Directors and the re-appointment of a Non-Executive Director, and 26 July 2021, to receive the report of the External Auditors.

Governors are required to declare interests which are relevant and material to the business of the Trust.

The Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee of the Council of Governors makes recommendations to the Council on the appointment and remuneration of the Chair and Non-Executive Directors and considers and contributes to their appraisals.

At a meeting of the Council of Governors held on 14 December 2021 the Council of Governors approved the Committee's recommendation to reappoint Chris Newman, Non-Executive Director for a second term of office.

The Nomination and Remuneration Committee was also convened during the latter part of 2021/22 to commence the process to recruit a Non-Executive Director position to succeed Martin Temple whose current term of office comes to end on 30 June 2022. Martin's one-year extended term of office was approved by the Council of Governors to provide stability and continuity of Non-Executive Director oversight during the pandemic and was made under a provision within the Trust's constitution allowing extension of a Non-Executive Directors' tenure past two full terms in exceptional circumstances.

This same provision within the Trust's constitution supported the Committee's recommendation to the March 2022 Council of Governors in respect of reappointing John O'Kane for a one-year extended term of office. To take effect from 1 October 2022 this will, again, provide stability on the Board of Directors and continuity of oversight in the context of significant changes in the NHS financial regime and uncertainty regarding the future financial framework.

As reported in our Annual Report for 2020/21, the outcome of a recruitment process concluded in April 2021 led to recommendations from the Committee being approved at an extraordinary meeting of the Council of Governors to appoint both Maggie Porteous and Toni Schwarz as Non-Executive Directors. Maggie and Toni took up their positions on the Board of Directors from 1 May 2021.

Remuneration of Non-Executive Directors and the Chair

The Council of Governors did not change the amount of remuneration paid to the Non-Executive Directors or the Chair during 2021/22.

Governor elections held within the reporting period

Council of Governor elections took place between May and June 2021 with the results declared on 25 June 2021. Nominations were sought for nine seats across seven constituencies.

Sixteen nominations were received from members who wished to stand for election, including five current Governors seeking re-election.

Five constituencies were contested: South West Sheffield (public), Sheffield West (public), the patient constituency and staff constituency of Nurses and Midwives.

All elections were held in accordance with the election rules set out in our constitution. Turnout in the contested seats was as follows:

- South West Sheffield (Public) – 19.5 per cent;
- Sheffield West (Public) – 13.2 per cent;
- Patients – 19.2 per cent; and
- Nurses and Midwives (Staff) – 10.2 per cent.

Four new Governors and five re-elected Governors started their terms of office on 1 July 2021.

In the event of an elected Governor's seat falling vacant for any reason before the end of a term of office it shall be filled by the second placed candidate in the last election held for that seat.

Lead Governor

In line with the Foundation Trust Code of Governance, the Council of Governors elects one of the Public / Patient Governors to be Lead Governor. This is to act as the main point of contact for NHS Improvement (NHSI) should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.

In 2021 a formal nomination process for the position of Lead Governor was held, through which Patient Governor, Martin Hodgson, was appointed as Lead Governor.

Strengthening links between the Board and Governors and Members

The Board of Directors is committed to working collaboratively with the Council of Governors. Executive and Non-Executive Directors value the role and contribution of Governors and work openly and transparently with the Council.

Although not all members of the Council of Governors, Directors attend Council meetings and listen and respond to Governors' views. The Chair of the Board of Directors also chairs the Council of Governors, providing a link between the two.

To strengthen the relationship further, the Chair and Non-Executive Directors are invited to attend the quarterly Governors' Forum meetings.

Governors observe the Board of Directors' meetings held in public and are invited to meet monthly with the Chair to review and discuss items debated by the Board in its private session. Governors are invited to observe committees of the Board of Directors to support them in fulfilling their statutory duty of holding the Board of Directors to account and assist in their assessment of the performance of Non-Executive Directors.

Directors also attended the Annual Members' Meeting which was held virtually on 23 September 2021.

Fig: Attendance by Directors at Council of Governors meetings

Name		Attendance (actual / possible)
Annette Laban	Chair	6 from 6
David Black	Medical Director (Development)	1 from 1
Paul Buckley	Interim Director of Strategy and Planning	3 from 5
Anne Gibbs (to 13 Dec 2021) [a]	Director of Strategy and Planning	0 from 4
Mark Gwilliam	Director of HR and Staff Development	5 from 5
Michael Harper	Chief Operating Officer	4 from 5
Jennifer Hill	Medical Director (Operations)	4 from 5
David Hughes (to 31 Jan 2022)	Medical Director (Development)	3 from 4
Kirsten Major	Chief Executive	5 from 5
Chris Morley	Chief Nurse	5 from 5
Tony Buckham	Non-Executive Director (Vice Chair)	4 from 5
Chris Newman	Non-Executive Director	1 from 5
Neil Priestley	Chief Finance Officer	5 from 5
John O' Kane	Non-Executive Director	3 from 5
Maggie Porteous	Non-Executive Director	5 from 5
Rosamond Roughton	Non-Executive Director	4 from 5
Toni Schwarz	Non-Executive Director	4 from 5
Martin Temple	Non-Executive Director	4 from 5
Shiella Wright	Non-Executive Director	4 from 5

[a] Long-term absence precluded attendance at Board of Directors' meetings

There has also been continued focus on involving the Council of Governors in key developments and issues impacting the Trust. Governors attend monthly Governors' Board Briefing meetings, quarterly finance briefings and bi-annual updates from the Director of Human Resources and Staff Development.

Individual Governors also attend a range of Trust Committees including:

- Patient Experience Committee;
- Infection, Prevention and Control Committee;
- Mental Health Committee;
- Psychology Board;
- Patient-Led Assessments of the Care Environment (PLACE);
- Clinical Effectiveness Committee;
- Equality, Diversity and Inclusion (EDI) Board;
- End of Life Care Group;
- PROUD Forum;
- Food Management Group;
- Emergency Planning Operational Group;
- Patient First Group;
- Pharmacy Board;

- Quality Board; and
- Nutrition Steering Group.

During the Covid-19 pandemic, presentations for Governors from staff regarding Trust services and Governors' visits to departments around the Trust were paused.

Membership

The Trust considers its Membership to be a valuable asset, which helps guide its work and the decisions it makes, while also holding the organisation to account and ensuring we adhere to NHS values. It is one of the ways the Trust communicates with patients, the public and staff.

The Trust has four Membership categories:

- Patients: anyone aged 12 years or over who has been a patient of the Trust;
- Public: residents of Sheffield 12 years or over;
- Public Outside Sheffield: residents of England and Wales, outside Sheffield, aged 12 years or over; and
- Staff: employees contracted to work for the Trust for at least one year.

As in previous years, all Members were invited to our Annual Members' Meeting. Due to Covid-19 social distancing requirements this was held virtually.

Fig: Membership breakdown at 31 March 2022

Constituency	Sub-constituency	Number of members
Patient Membership		**3,271**
Public Membership	North Sheffield	1,948
	Sheffield South East	2,140
	Sheffield South West	1,852
	West Sheffield	1,976
	Outside Sheffield	522
	Sub-total	**12,231**
Staff Membership	(sub divided into sub-constituencies listed):	**18,079**
	Medical and Dental	
	Nursing and Midwifery	
	Allied Health Professionals, Scientists and Technicians	
	Administration, Management and Clerical	
	Ancillary, Works and Maintenance Staff	
	Primary and Community Services Staff	
	Total membership	**33,581**

Meetings of the Board of Directors and its committees

The Board of Directors is the decision-making body for strategic direction and the overall allocation of resources. It delegates decision making for the operational running of the Trust to the Trust Executive Group. The Board takes decisions consistent with the approved strategy.

The Board's role is to promote the success of the organisation so as to maximise the benefits for the Members of the Trust as a whole and for the public. It does this by:

- Formulating strategy;
- Ensuring accountability by holding the organisation to account for the delivery of that strategy and through seeking assurance that systems of control are robust and reliable;
- Shaping a positive culture for the Board and the organisation; and
- Promoting effective dialogue with the local communities we serve.

The Board of Directors delegates decision-making for the operational running of the Trust to the Trust Executive Group in accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Trust's Standing Orders set out matters which are reserved for the Board of Directors to decide. These relate to regulation and control, appointments, strategic and business planning and policy development, direct operational decisions, financial and performance reporting arrangements, audit arrangements and investment decisions.

Meetings of the Board of Directors are held in public, although part of the meeting is held in private to deal with matters of a confidential nature. The agenda and papers for the section of the meeting held in public are published on the Trust's website.

Due to Covid-19 social distancing requirements in place throughout 2021/22, the Board of Directors has held its meetings virtually. To maintain transparency and accountability to the public, the Board invited members of the Council of Governors, as representatives of our Foundation Trust membership and our partner organisations, to observe these virtual meetings via video link or voice only conference. This invitation now extends to members of the public.

As part of a continued improvement focus on Board leadership and development, a review of Board meetings architecture was undertaken during 2021/22. This formal review of the operation of the Board of Directors reflected on the business continuity arrangements for Board-level governance and assurance adopted during the Trust's

emergency response to the Covid-19 pandemic, noting that this had supported streamlined decision-making while providing appropriate levels of Board assurance.

Following this review, proposals were agreed to move to scheduling Board of Directors meetings held in public on a bi-monthly basis (every two months), supported by the continued routine monthly focus on performance and assurance through its committee structure. This has been implemented from October 2021. In the months where no session of the Board is held in public a Strategy, Board Development or Masterclass session is scheduled.

Membership of the Board of Directors is detailed earlier in this report. The following table presents the attendance records of individuals at Board meetings held during 2021/22.

Fig: Attendance by Board of Directors meetings held in public during 2021/22

Name		Attendance (actual / possible)
Annette Laban	Chair	8 from 8
David Black	Medical Director (from 1 February 2022)	1 from 1
Tony Buckham	Non-Executive Director (Vice Chair)	8 from 8
Paul Buckley	Interim Director of Strategy and Planning	7 from 8
Sandi Carman	Assistant Chief Executive	8 from 8
Anne Gibbs[a]	Director of Strategy and Planning (to 13 December 2021)	0 from 6
Mark Gwilliam	Director of Human Resources and Staff Development	8 from 8
Michael Harper	Chief Operating Officer	8 from 8
Jennifer Hill	Medical Director (Operations)	8 from 8
David Hughes	Medical Director (Development) (to 31 January 2022)	7 from 7
Kirsten Major	Chief Executive	8 from 8
Chris Morley	Chief Nurse	8 from 8
Chris Newman	Non-Executive Director	3 from 8
John O'Kane	Non-Executive Director	7 from 8
Julie Phelan	Communications and Marketing Director	8 from 8
Maggie Porteous	Non-Executive Director (from 1 May 2021)	7 from 7
Neil Priestley	Chief Finance Officer	8 from 8
Rosamond Roughton	Non-Executive Director	7 from 8
Toni Schwarz	Non-Executive Director (from 1 May 2021)	7 from 7
Martin Temple	Non-Executive Director	8 from 8
Shiella Wright	Non-Executive Director	7 from 8

[a] Long-term absence precluded attendance at Board of Directors' meetings

The Board has established a committee structure with each of its standing committees chaired by a Non-Executive Director. This Board committee structure includes the statutory committees of Audit, Board of Directors' Nomination and Remuneration and Quality, as well as Finance and Performance and Human Resources and Organisational Development.

More detail of the Board's committee structure and the role of its committees is outlined within the Annual Governance Statement.

Audit Committee

The Audit Committee is appointed by the Board of Directors and its terms of reference state that its membership comprises of four Non-Executive Directors. One of these members is required to have recent and relevant financial experience and this requirement is fulfilled through the Committee Chair, John O'Kane.

Fig: Member attendance at meetings of the Audit Committee 2021/22

NED membership	Attendances (actual / possible)
John O'Kane, Chair	5 from 5
Rosamond Roughton	5 from 5
Toni Schwarz	1 from 5
Shiella Wright	1 from 5

Other Non-Executive Directors, who chair other Board committees, have a standing invitation to attend meetings of the Audit Committee.

Meetings of the Audit Committee are attended by senior representatives of the Trust's internal and external auditors, the local counter fraud specialist, as well as the Chief Finance Officer and Assistant Chief Executive. The Chief Executive and the Trust Chair are invited to attend the meeting at which the annual accounts are presented.

The Committee provides the Board of Directors with an independent and objective review of the effectiveness of the system of internal control (both financial and non-financial). It is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek information it requires from staff to fulfil its functions.

The Audit Committee is responsible for agreeing and reviewing the annual work plans for independent external and internal audit services, counter fraud services and commissioning independent audit work from other bodies as required.

The Trust's internal audit service is provided by 360 Assurance, a consortium principally serving a number of foundation trusts and clinical commissioning groups in the region. Through detailed testing of the Trust's internal control systems, this service fulfils a key role in the Trust's assurance processes.

Local counter fraud provision is commissioned from 360 Assurance. The local counter fraud specialist supports the Trust to create an anti-fraud culture, to deter, prevent and detect fraud, investigating suspicions as they arise and seeking to apply appropriate sanction and redress in respect of any monies obtained through fraud.

The Audit Committee is responsible for making a recommendation to the Council of Governors in respect of the appointment and approval of the Trust's external auditors.

At the meeting of the Council of Governors held in July 2021, the Chief Finance Officer presented a recommendation supported by the Audit Committee that KPMG be appointed as the Trust's external auditors. This followed the end of the previous contract with Mazars LLP, which had been extended in duration as far as contract terms permitted.

In approving the recommendation from the Audit Committee to appoint KPMG as the new external audit provider, the Council of Governors noted the procurement process adopted and the impact on the tender process of the changing public sector audit market, together with fee benchmarking data. This base audit fee had been considered by the Audit Committee.

KPMG were appointed by the Council of Governors for a three-year initial period, commencing with the 2021/22 audit cycle and subject to annual reappointment, with an option to extend for a further two years.

The statutory audit fee for the 2021/22 audit was £187,000 plus VAT.

The Committee routinely receives external audit progress reports, including technical updates on key emerging issues / developments. KPMG provides its services within the Code of Audit Practice. The Audit Committee has delegated authority from the Board of Directors to commission additional services whilst complying with independence rules as defined by Auditor Guidance Note 01 (AGN01).

There has been no provision of non-audit services by the external auditor during the financial year 2021/22.

The provision of non-audit services by the external auditor would include any work relating to the assurance report on the Trust's annual Quality Report. On 24 December 2021, NHSE/I issued guidance confirming measures to reduce the burden of reporting to manage the Covid-19 pandemic in light of the challenges placed across the NHS due to growth of the Omicron variant. These included confirmation

that quality reports are not required within 2021/22 annual reports and that there is no requirement to obtain quality reports assurance.

Principal areas of review and significant issues considered by the Audit Committee during 2021/22

The following section outlines key matters considered by the Committee, reflecting key duties / areas of responsibility set out by its terms of reference.

Internal control and risk management

- Reviewing the Integrated Risk and Assurance Report (IRAR) on behalf of (October 2021) or in advance of presentation to the Board of Directors (July 2021 and January 2022) and overseeing the implementation of IRAR standard operating processes, incorporating a programme of deep-dive reviews through the Board committee structure;
- Receiving to note, in March 2022, an update on the development of Principal Risks to be entered onto the 2021/22 IRAR and the plans to introduce a new higher level risk report to provide increased oversight of extreme-level risks;
- Reviewing the annual financial statements, with particular focus given to major areas of judgement and any changes in accounting policies (January 2022) and the Board's determination that the 2021/22 annual accounts be prepared on a Going Concern basis. This followed consideration of the planned financial position for 2022/23;
- Receiving the Register of Interests Annual Report (July 2021);
- Receiving the annual update on the Trust's insurance arrangements for 2021/22 (July 2021);
- Considering, in advance of discussion with the Board of Directors, recommendations relating to the operation of the Board of Directors and its underpinning committee architecture (July 2021);
- Noting proposals to undertake a review of the effectiveness of the Board and its committees (October 2021) and implementing, as part of this, its own committee effectiveness review;
- Undertaking a review of areas of self-assessed non-compliance with provisions within the NHS Foundation Trust Code of Governance (July 2021); and
- informed by its oversight of the Trust's systems of integrated governance, reviewing the adequacy of all risk and control related disclosure statements within the Trust's Annual Report (specifically, the Annual Governance Statement).

Internal audit

- Agreeing at the start of the year the internal audit plan 2021/22, taking into account risk assessment work undertaken by 360 Assurance and with the Trust Executive Group, and informed by Public Sector Internal Audit Standards;
- Through the course of the year, routinely receiving findings from individual reviews within the internal audit work plan, including reviews focused on patient safety (serious incidents and never events), accessible information standard, payroll, Covid-19 vaccination programme, cyber security, patient experience, estates procurement, directorate risk management and use of Lorenzo electronic prescribing and medicines administration (EPMA). Monitoring management's responsiveness to internal audit recommendations and providing oversight of follow up completion rates;
- Approving in-year timing changes to the internal audit plan 2021/22 to reflect the significant and ongoing operational impact on the Trust of the Covid-19 pandemic;
- Receiving in June 2022 the Internal Audit Annual Report for 2021/22, including the Head of Internal Audit Opinion 2021/22, noting that the report provided a moderate assurance opinion on the Trust's system of internal controls; and
- Undertaking an annual review of the effectiveness of the internal audit function against a set of performance measures / standards including benchmarked costs (July 2021).

Local counter fraud

- Overseeing progress against the annual fraud, bribery and corruption risk assessment and work plan through consideration of routine progress reports from the anti-crime specialist and receiving in June 2022 the Counter Fraud Annual Report 2021/22; and
- Giving consideration to current progress against the Trust's 2021 Counter Fraud Functional Standard Return, including new requirements regarding assessment and management of fraud risks.

External audit

- Agreeing the 2021/22 Audit Plan in March 2022, setting out an analysis of the external auditor's assessment of significant audit risks, the proposed elements of the financial statements audit and its reporting timetable and other matters;
- Receiving technical updates highlighting key developments in the health sector, relevant accounting and auditing developments as well as benchmarking reports; and

- Agreeing, in July 2021, a recommendation to the Council of Governors in respect of the appointment of a new external audit provider, as noted earlier in this section of the report.

The Chief Executive, as the Trust's Accounting Officer, is responsible for the preparation of the financial statements prior to them being audited by the external auditors. These responsibilities are detailed within the statement of Accounting Officer's responsibilities and in the Independent Auditor's report.

The Audit Committee gives full consideration to any significant risks and areas of audit focus raised in the external audit plan. In 2021/22 the four areas of audit focus related to management override of controls, risk of fraud in revenue recognition, expenditure recognition and valuation of land and buildings.

In each of these areas, the Committee has been able to place reliance on work undertaken by the external auditors, KPMG, as part of the work that they have undertaken to enable them to develop their audit opinion.

Compliance with NHS Foundation Trust Code of Governance

The Trust continues to seek to comply with the NHS Foundation Trust Code of Governance (the Code) which is issued to assist NHS foundation trust boards develop their governance arrangements in line with best practice.

The Code operates on a 'comply or explain' basis and foundation trusts are required to report on how they apply the Code within their Annual Report. While there is a requirement to adhere to main principles of the Code, so long as reasons for any deviation from individual code provisions are explained and that alternative arrangements reflect the main principles of the Code, non-compliance is permitted.

Compliance with the Code

The Board considers the Trust compliant with main principles of the NHS Foundation Trust Code of Governance.

Details of how the Trust has applied the Code principles and complied with its provisions are set out in relevant sections of this Annual Report. In seeking to continually develop its governance arrangements, where action has been identified to further strengthen compliance against a Code provision this has also been described.

The disclosures required by the Code in relation to the roles and activities of the Board of Directors, its statutory committees and the Council of Governors and Membership are outlined earlier in this Accountability Section.

Required statements of disclosure relating to the functioning of the Board Nomination and Remuneration Committee are contained within the Remuneration Report.

A review of compliance against individual code provisions has been undertaken. Explanations for areas of non-compliance are outlined here:

B.6.2 *Evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years.*

While an independent review has not been commissioned to the Code's suggested timeline, planning is currently in place to commission an external review during 2022/23. The scheduling of this review has taken into account work to refresh the Trust's corporate strategy and the publication of '*Making a Difference – the next chapter 2022-27*'.

On an annual basis the Board undertakes an effectiveness review which aligns to the eight key lines of enquiry (KLoE) of the well-led framework and covers the scope

of the operation of the Board of Directors and its Committees. This ensures that the Board of Directors is using the well-led framework as a key instrument to critically evaluate its own performance to feed into continuous development of the Trust's leadership and governance arrangements.

Additionally, during 2021/22 the Trust commissioned an independent Trust-wide governance review to identify good practice and provide a view on areas for improvement. This followed the Care Quality Commission (CQC) inspection of Maternity Services in March 2021 which suggested that there were some weaknesses in systems to continually monitor and improve the quality and safety of services.

The Good Governance Institute (GGI) undertook assessment work between January and March 2022 which focused on the Trust's quality governance arrangements considering a selection of the CQC well-led key lines of enquiry (KLoEs). Findings from this review will facilitate continuous improvement of our quality governance arrangements to support the delivery of excellent care for patients.

Outcomes from both this and our recent CQC well-led inspection will be used to develop and implement a robust action plan for oversight at Board level focused on the continuous development of leadership and governance arrangements. Undertaking a developmental review against the well-led framework will form part of the CQC action plan.

B.7.4 *Non-Executive Directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 Act provisions relating to the removal of a director.*

The Standing Orders for the practice and procedure of the Board of Directors set out the term of office for the Chair and the Non-Executive Directors. These are reviewed regularly and it has been agreed to maintain the term of office at four years, rather than the three years as recommended in the Code.

Non-Executive Director appointments and reappointments made by the Council of Governors are made with four-year terms of office. The Board of Directors and the Council of Governors agree that this provides the Board with additional stability and continuity without compromising independence.

Arrangements are in place for a review of independence to be undertaken routinely as part of each second term re-appointment and a statement is made within the Annual Report by the Board of Directors with regard to each Non-Executive Director's independence.

Due regard was also given to determining independence in respect of the appointment of Annette Laban as Trust Chair on the basis of length of previous Non-

Executive Director tenure. On recommending the appointment to the Council of Governors, its Nomination and Remuneration Committee confirmed that it was satisfied through testing at interview and triangulation with feedback sought from members of the Board of Directors that Annette was independent in character and judgement. As previously agreed by Governors at a Governors' Forum meeting held on 27 February 2020 and noted at the Council of Governors' Nomination and Remuneration Committee held on 18 May 2020 any future appointment of an existing Non-Executive Director will be for one term of office.

D.2.3 *The Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a Non-Executive*.

The Council of Governors has not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors but the Trust participates in NHS Providers remuneration surveys and other industry benchmarking exercises. This benchmarking data is used by the Council of Governors Nomination and Remuneration Committee when making recommendations to the Council of Governors in relation to the remuneration of the Chair and the Non-Executive Directors. In guiding consideration, reference is also made to NHSE/I's publication 'Structure for Chair and NED remuneration in NHS Trusts and NHS Foundation Trusts'.

Regulatory ratings

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; and
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from one to four, where four 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

NHS Improvement has reviewed the Trust's performance and information available to it and placed the Trust in Segment 2. This segmentation information is the Trust's position as at March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Accountability Report signed by the Chief Executive
in capacity as Accounting Officer

Kirsten Major
Chief Executive
21 June 2022

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Sheffield Teaching Hospitals 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 Teaching Hospitals 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 Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

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

Signed

Kirsten Major
Chief Executive
21 June 2022

Annual Governance Statement 2021/22

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching Hospitals 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 Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the Annual Report and accounts.

Capacity to handle risk

The Board of Directors is responsible for reviewing the effectiveness of the system of internal control and for ensuring that the Trust has effective systems and structures in place for managing all types of risk that threaten the Trust's ability to meet its aims and objectives, and the achievement of its values.

To support an integrated approach to risk management the Trust's Framework for Risk Management defines the structures and processes in place to identify, manage and eliminate or reduce risks to a tolerable level. It clarifies accountability arrangements for the management of risk within the Trust from Board to Ward, setting out the responsibility of Executive Directors and Senior Managers in respect of leadership in risk management and confirms the role that all staff within the organisation have in relation to responsibility for the identification and reporting of risks and incidents.

Operational responsibility for risk management sits within clinical and corporate directorates. Each directorate is required to have processes in place by which risks are identified, assessed and managed at a local level, and escalated as required in accordance with the Trust's policy framework. The Trust's Quality Governance Arrangements Policy and Framework for Delivery document describes the local quality governance structures, systems and processes that clinical directorates and corporate departments need to have in place to manage risk.

The committee structure of the Board of Directors provides assurance on, and challenge to, the Trust's risk management process. Each chaired by a Non-Executive Director to enhance independent scrutiny, these committees are the key structures in ensuring quality, safety and management of risk, and provide the mechanism for managing and monitoring risk throughout the Trust and for assurance reporting to the Trust Board of Directors. Executive Directors provide leadership on the management of key areas of risk commensurate with their roles and are represented across the Board committee structure.

The Trust Executive Group (TEG) is responsible for the implementation of risk management and related assurance mechanisms. Individual Executive Directors are responsible for overseeing a programme of risk management activities in their areas of responsibility and the Trust Executive brings together the corporate, workforce, clinical, information, research, reputational and governance risk agendas.

With delegated authority from the Board of Directors, the Audit Committee has overall responsibility for integrated governance, risk management and internal control. It oversees the system of internal control and governance and overall assurance process associated with managing risk to ensure that risks to the delivery of the Trust's services are identified and addressed. During 2021/22 strategic risks have been reported to the Board of Directors and the Audit Committee via the Integrated Risk and Assurance Report (IRAR).

Staff training and guidance on the management of risk

Mandatory risk management and health and safety awareness training are incorporated within the Trust's induction programme for all new starters. The frequency and level of risk management training is identified through training needs assessments, ensuring that individual members of staff have the relevant training to equip them for their duties and level of responsibility.

Additionally, a range of policies is in place and available to staff via the Trust's intranet which describe the roles and responsibilities in relation to the identification, management and control of risk. Staff are made aware of these policies and are actively encouraged to access them to ensure that they understand their own roles and responsibilities. The Patient and Healthcare Governance Department provides additional support, guidance and expert advice to staff on risk management. The

department assists risk owners in identifying, assessing and managing and reviewing risks. Specifically, it supports all areas of the Trust in the use of the Datix Risk Management System as the electronic Trust-wide Risk Register.

During 2021/22 the Trust developed and piloted a new programme of risk management training to support staff in fulfilling their roles and responsibilities relating to the management of risk in line with the Trust's Framework for Risk Management described below. Risk Management training has been delivered to the Board of Directors, members of triumvirate teams, senior managers and governance leads within directorates, including Maternity Services, and to members of the Trust's Audit and Clinical Effectiveness department. Comprising separate modules, this is being rolled out across the Trust in line with a revised training needs outline registered on PALMS, the Trust's Personal Achievement and Learning Management System.

The Trust takes all opportunities to learn from good practice and has a breadth of mechanisms in place to support this. These range from clinical supervision, reflective practice, peer review work and clinical audit. Learning from root cause analysis investigations and information such as trends in incidents, complaints and claims are used to enhance and improve standards of patient care by feeding into our quality improvement programme. The Trust's incident management policy and Trust-wide action plan guidelines support robust action planning following incident investigations. Reports from healthcare regulators are routinely used to identify learning from significant incidents and events in other healthcare organisations.

The risk and control framework

Framework for risk management

As referred to above, the Trust's Framework for Risk Management describes the Trust's overall risk management process, within which the operation of a Trust-wide Risk Register and governance structure for the cascade and escalation of risk and assurance ensure that risk management is an integral part of clinical, managerial and financial processes across the Trust.

The framework defines the role of all staff in managing risks with associated procedural documents clearly outlining a systematic approach to the identification, evaluation and control of risk, which commences with a structured risk assessment process.

Local risks are reported and entered onto the Trust's Risk Register via directorate governance groups and Trust management committees. The use of a standard assessment tool to identify risks ensures a consistent approach is taken to the evaluation and monitoring of risk across the Trust. Additionally, the use of a grading

matrix of likelihood and consequence to produce a risk score enables risks to be prioritised against other risks on the Risk Register.

A target risk score is assigned to each risk to ensure that risks are controlled within a timely manner and to an acceptable level. The Board of Directors has developed a Risk Appetite Statement that clearly articulates what risks it is willing or unwilling to accept in order to achieve the Trust's strategic aims. This acknowledges that risk is inherent in the provision of healthcare. As a general principle the Trust has a low tolerance for all risks that have the potential to expose patients, staff, visitors and other stakeholders to harm, that compromise the Trust's ability to deliver operational services, that adversely impact the reputation of the Trust, have severe financial consequences or result in non-compliance with law and regulation. The statement then defines tolerances for balancing different elements of risk, including patient safety, reputation, workforce and financial / value for money, based on how much, or little the Trust wishes to commit in terms of risk.

Risk control measures are identified and implemented through action plans to achieve the target level of risk. Oversight of risk management takes place in line with the structure for the cascade and escalation of risk and assurance. These arrangements involve the consideration of all locally approved new and existing risks scored as eight and above by the Trust's Risk Validation Group (RVG). This group reviews each risk to validate the risk score; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan.

Reporting and oversight arrangements are supported through a Safety and Risk Committee. Chaired by the Medical Director (Operations) this committee has responsibility for ensuring robust and effective arrangements are in place for the management and monitoring of matters relating to safety and risk across the Trust. The RVG reports to this committee and through senior-level representation from both corporate and clinical directorates, it considers risk aggregation and onward reporting to TEG of operational risks with a risk score of 15 or more as part of the standing operating procedure for the management of the Integrated Risk and Assurance Report (IRAR). In-year this committee has had oversight of the Trust's Risk Register Improvement Plan.

A well-established Safety and Risk Forum provides a networking, learning and information sharing forum for directorate risk and governance leads. Other specialist groups with specific risk management responsibilities, for example, the Infection Prevention and Control Committee, Radiation Safety Steering Group and Information Governance Committee also support effective risk management.

During 2021/22 the IRAR has formed the mechanism for proactively assessing risk and control at the very highest level and providing assurance that there is effective management of key risks to the delivery of the Trust's strategic aims. Structured around a set of key strategic risks identified and evaluated by TEG, this mechanism

has facilitated review by the Board of Directors of the controls in place to mitigate and manage each risk, and the assurances available to indicate that the controls are effective.

Detailed scrutiny of controls and assurances is performed by a relevant Board Committee. The Quality Committee (formerly Healthcare Governance Committee), Finance and Performance Committee, Human Resources and Organisational Development Committee each has oversight responsibility for those strategic risks that align with the remit of their own terms of reference. Via their Non-Executive Chair, each reports formally to the Board of Directors, to confirm delivery of assurance or escalate matters as necessary. Focus has been maintained during 2021/22 on embedding a programme of deep dive reviews through the Board committee structure and on using conclusions drawn from these to further inform and drive the Board's assurance framework.

The operation of the IRAR has supported the Board of Directors to monitor the ongoing impact of Covid-19 on the delivery of the Trust's strategic aims. Entering 2021/22 the Board acknowledged that the Trust's strategic landscape would continue to be dominated by Covid-19 for some time. As such, a thematic analysis of the Trust's current risk profile, including risks formerly recorded on command structure risk logs led to the development of a set of recalibrated risks to be entered onto the 2021/22 IRAR which fully reflect the strategic impact of Covid-19.

The Covid-19 pandemic is a clear example of a significant event that impacts on the Board's appetite and tolerance of risk. In agreeing arrangements for the management of Covid-19 related risks within the emergency command structure, a formal review of the Risk Appetite Statement was undertaken outside its annual cycle. While acknowledging that the pandemic would result in a heightened risk portfolio across the Trust, after careful consideration it was agreed that there was no need to amend the current risk appetite statement. Repeated reviews were undertaken during the early part of 2021/22 to seek reassurance around the validity of this approach. This then informed a return to the routine annual review schedule for the Risk Appetite Statement.

As was the case during 2020/21, in-year operation of the Trust's risk and control framework responded to the need to support the organisation being run through a full Major Incident Command and Control Structure for periods of time. At these times arrangements for Board assurance and governance were well balanced to maintain robustness of decision making in a fast-moving environment and provide appropriate levels of Board assurance.

Quality governance arrangements

The Trust's quality governance and leadership structure ensures that the quality and safety of care is being routinely monitored across all services. The robust quality performance and risk management processes and associated reporting mechanisms in place to review and challenge performance and variation can be outlined as follows:

- Board oversight of quality issues through the Quality Committee (formerly Healthcare Governance Committee); a formal committee of the Board providing assurance that adequate quality governance structures, processes and controls are in place across the Trust for the continuous monitoring and improvement of safe and effective patient care;
- A clear and embedded framework described within a Quality Governance Arrangements Policy and Framework for Delivery which supports consistency of structures, systems and processes for local governance and risk management arrangements across clinical and corporate directorates;
- Strategic principles approved by the Board within which the structure and process for selecting and overseeing the implementation of annual quality priorities with involvement from patients, staff, Governors and other key stakeholders is implemented. Our current Quality Strategy will be refreshed during 2022 to reframe our aspirations and approach to quality improvement within the context of a new corporate strategy for the Trust;
- Well embedded reporting arrangements to the committee structure of the Board via a supporting framework of Executive-led sub committees and management groups. This involves monthly consideration of an Integrated Performance Report (IPR) presenting RAG rated performance and exception narrative for national and local performance standards at a Trust and directorate level. Reporting arrangements also include quarterly consideration of an Integrated Quality and Safety Report bringing together incidents, claims, inquests, patient feedback, complaints, risk and clinical audit data;
- A deep dive analysis of performance on an agreed specific topic of interest presented to the Board of Directors meeting held in public;
- Open and honest culture of reporting of incidents, risks and hazards promoted by the Board of Directors and supported by structured processes including online reporting systems for incident reporting and the investigation of Serious Incidents; and
- There are also clear and transparent processes for sharing lessons learned following investigation with reports shared at directorate and Trust-wide level through relevant committees and groups. Learning from incidents, complaints, clinical audits, external visits, inspections and accreditations and from patient

feedback is also cascaded from Ward to Board, across clinical and non-clinical areas through the Safety and Risk Forum, the Safety and Risk Committee, Management Board Briefing and the Quality Committee.

Assurance on Care Quality Commission (CQC) compliance

A range of mechanisms is in place to monitor compliance with the CQC's five domains of safe, effective, caring, responsive and well-led. Through the Quality Committee (formerly the Healthcare Governance Committee) the Board of Directors reviews a range of metrics on patient experience, clinical effectiveness and patient safety reported within the quarterly Integrated Quality and Safety Report and the CQC Insights Report which reviews outcome and audit data viewed regularly by the CQC. This Committee also receives a monthly report on CQC compliance and reports the publication of findings from external CQC reviews and CQC national surveys.

The Quality Committee will provide oversight of the Trust's comprehensive action plan to address the findings of the CQC inspection report published on 5 April 2022. The report followed the unannounced inspection of core services between 5 and 7 October 2021 and the well-led review that took place on 9,10 and 11 November 2021.

As noted earlier in the Annual Report, following the inspection the Trust was issued with a Section 29a Warning Notice (S29a) by the CQC which requires improvement to be made by 17 July 2022.

An unannounced inspection of the maternity service had been previously carried out in March 2021 and the October 2021 CQC visit returned to this area.

During this subsequent visit the Trust was unable to satisfactorily evidence that improvement had been made. Our revised improvement approach entails a stronger focus on outcomes, ensuring we have sufficient staffing and leadership in place and seeking support from partners.

The Trust's CQC Action Plan addresses all 'must do' requirements within the report and the findings raised within the Section 29a warning notice by mapping these to 17 outcomes that the Trust wants to see. For each outcome a set of three high-level actions that will have the biggest impact on achieving the outcome have been clearly defined, alongside the metrics which will identify whether the actions have delivered the necessary outcomes. The action plan also incorporates the 11 outstanding actions from the action plan in response to the CQC letter of intent issued in October 2021 immediately following the inspection.

In addition to this action plan, to support work towards achieving the 17 outcomes, the Trust has identified two priority 'must-do' Trust-wide workstreams which will be

driven centrally to support the CQC programme of work. These are embedding Safety Huddles focussing on falls, pressure ulcers, mental capacity, deteriorating patients and mental health and, secondly ensuring that all wards display Information Boards for patients and visitors and a Quality Board for staff.

In parallel to this Trust-level action plan individual service-based action plans have been agreed for Urgent and Emergency Care, Maternity Services and Community Inpatients. The action plan specific to Maternity Services is still required to be submitted monthly following the unannounced inspection visit to the Jessop Wing in March 2021. This action plan will incorporate actions being taken as part of the overarching work on Maternity Improvement.

Fortnightly monitoring of performance against action plan metrics will be undertaken by the Patient and Healthcare Governance department with monthly reporting to the Trust Executive Group and Quality Committee.

In addition to reporting performance against agreed metrics; audits, spot-checks and / mock inspection visits will provide further assurance on both completion of actions and on sustained delivery of outcomes.

Well-led framework

The Board of Directors uses the well-led framework (NHSI, June 2017) as a key instrument to evaluate its own performance critically to feed into continuous development of the Trust's leadership and governance arrangements.

On an annual basis the Board undertakes an effectiveness review which aligns to the eight key lines of enquiry (KLoE) of the well-led framework and covers the scope of the operation of the Board of Directors and its Committees.

The results from this review shape Board and Board Committee development objectives for the coming year. Results from the most recent effectiveness review, carried out in autumn 2021, have been used to inform the workplan for newly established bi-monthly Board Strategy sessions.

Additionally, during 2021/22 the Trust commissioned an independent Trust-wide governance review to identify good practice and provide a view on areas for improvement. This followed the Care Quality Commission (CQC) inspection of Maternity Services in March 2021 which suggested that there were weaknesses in systems to continually monitor and improve the quality and safety of services that offered pertinent learning for the wider organisation.

The Good Governance Institute (GGI) undertook assessment work between January and March 2022 which focused on a selection of the CQC well-led key lines of enquiry (KLoEs) and findings from this review will facilitate continuous improvement

of our healthcare governance arrangements to support the delivery of excellent care for patients.

The Trust received a requires improvement rating following the CQC well-led inspection that took place between the 9 and 11 November 2021. Findings from both this CQC well-led inspection and the independent governance review will be used to implement a robust outcomes-based action plan for oversight at Board level focused on the continuous development of leadership and governance arrangements. Undertaking a developmental review against the NHSI well-led framework during 2022/23 will provide assurance on delivery of these outcomes.

Managing risks to data security

The reporting and management of both data and security risks are supported by ensuring that all employees of the Trust are reminded of their data security responsibilities through education and awareness. Information governance / data security training forms part of mandatory training requirements. Regular reminders and lessons learned from local incident reviews and risk assessments are shared through regular staff communications. Information governance training forms part of our mandatory training requirements.

Information security risks are actively measured and controlled via the Trust's Cyber Security Group which is chaired by the Informatics Director / Senior Information Risk Owner (SIRO). These include risk and control measures relating to system patching, access controls, cyber defences, audit logging, backups, incident management, phishing response and third-party access.

The Cyber Security Group also monitors responses to NHS cyber alerts, security incidents and audits.

A comprehensive and continuous assessment of information security is taken against the requirements of the Data Security and Protection Toolkit and further assurance is provided annually via independent audit and externally conducted penetration tests.

The effectiveness of these measures is reported to the Information Governance Committee. This includes details of any personal data-related serious incidents, the Trust's annual Data Security and Protection Toolkit status and reports of other information governance incidents and audit reviews.

Information governance

There were no serious incidents during this period.

There are robust and effective systems, procedures and practices in place to identify, manage and control information risks. These include how the Trust receives and responds to high severity alerts from NHS Digital Cyber Alert System.

Whilst the Board of Directors is ultimately responsible for information governance, it has delegated authority to the Information Governance Committee which provides assurance to the Quality Committee (formerly Healthcare Governance Committee) and is chaired by the Medical Director (Development), who is also the Trust Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO), is the Informatics Director. The Trust's Head of Information Governance, and his team support both the above roles and, as such is also a registered Caldicott Guardian and the Trust's Data Protection Officer (DPO).

The Information Governance Committee terms of reference bring together all the statutory requirements, standards and best practice in conjunction with the Trust's Information Governance Policy and are used to drive continuous improvement in information governance across the organisation. The development of this policy framework is informed by the results from the Data Security and Protection Toolkit (DSPT) annual assessment and by participation in the Information Governance Committee, the IT Security Group and the Cyber Security Team.

The Trust maintains a suite of information security policies which are published on the Trust Controlled Documents system.

In accordance with the UK Data Protection legislation, the Trust's Data Protection Officer (DPO) overviews the use of Data Protection Impact Assessments (DPIA) to ensure that information governance and data protection risks are fully considered. DPIAs are routinely produced to support changes to systems or processing of personal and sensitive data.

There were no serious incidents relating to information governance classified as level two during 2021/22.

Principal in-year risks

The impact of the Covid-19 pandemic continues to have a significant bearing on the Trust's strategic risk profile. As described above, the Integrated Risk and Assurance Report (IRAR) framework has been the mechanism to effectively support the Board of Directors and its Committees to assess the ongoing impact of Covid-19 on delivery of the Trust's Strategic Aims.

An outline of a number of in-year risks entered onto the IRAR as Principal (Strategic) Risks is given below and also described within the Performance Section of this Annual Report.

Risks to the delivery of best clinical outcomes and providing patient centred care

The Covid-19 pandemic has continued to impact extensively on the Trust during 2021/22. During each successive wave of the pandemic the Trust had identified and managed a number of potential risks associated with the ability to maintain high quality clinical outcomes during periods of challenging operational pressures.

- *Operational pressures and risks to the provision of quality of care*

  A number of different factors associated with the Covid-19 pandemic have contributed to operational pressures across our services during the last 12 months, many of which continue into 2022/23. These include:

  - Staff absence rates remaining high reflecting, not only continued high community prevalence, but also the cumulative impact of pressures both in and outside the workplace on health and wellbeing;
  - The need to adapt care pathways across the organisation to keep patients safe by separating those with the virus from non-Covid-19 patients which had impacted on capacity and service provision;
  - The growing waiting lists and the need to recover activity levels back to pre-Covid-19 levels in order to treat as many patients as possible and reduce waiting times, which before the pandemic were much better than those of our peers. Whilst our position has deteriorated significantly, we maintain a much better than average position. Given the national pressures there is also a much greater level of discussion with respect to mutual aid between organisations to ensure patients are treated in as timely a way as possible; and
  - The significant impact that the pandemic has had on the health and wellbeing of our patients, which as a result, means we are seeing increased demand on our emergency pathways and greater acuity and dependency amongst patients on both our emergency and planned care pathways.

Establishing a full Major Incident Command and Control Structure involving the organisation being run through Bronze, Silver and Gold Command provided a robust and transparent method of mitigating, preparing and responding to the demands of each wave. Through these emergency planning arrangements tactical oversight of the Trust's operational position and response to escalations of operational risks was undertaken at Silver Command level.

Throughout the last year, as a result of capacity constraints and national guidance in response to the Covid-19 pandemic, priority has been given to those patients presenting with the highest clinical risks. Similar to other trusts, this has led to reduced activity and an increase in the numbers of patients waiting for treatment. A Patient Care Recovery Plan is being developed which supports clinical teams to deliver their recovery plans. An organisation wide structure will ensure improvement and transformation is embedded across patient pathways whilst linking into ongoing work around enablers such as supporting the workforce through improved recruitment and retention and ensuring we have the appropriate estates and inpatient bed infrastructure for this programme.

- *Increased rates of nosocomial infection lead to patient and staff harm*

  The highly infectious nature of viral and bacterial infections combined with any failure to implement, or lack of adherence to, infection prevention and control measures could result in high rates of hospital-based transmission and this risk has been increased by the waves of Covid-19 seen during 2021/22.

  In order to mitigate this risk, the Trust has a robust Infection Prevention and Control (IPC) programme and reporting arrangements which were updated during the year to reflect the possible implications of the Omicron variant; a dedicated multidisciplinary IPC Team; and a framework of infection prevention and control policies and guidance for staff to operate within.

  Further work on these controls will continue into 2022/23 with arrangements adjusted where required in response to any future variants or emerging infections.

- *Staffing / skill mix inadequate to provide high quality services*

  Staff absence due to Covid-19 combined with national shortages across key areas of the workforce creating staffing pressures has been a key strategic risk for the Trust during 2021/22 with emphasis placed on this within the CQC report published in April 2022.

  The Trust continues to undertake significant urgent work to address this risk with mitigating actions including:

  - the recruitment of over 500 additional nurses and midwives through national and international initiatives;

- maximising use of bank and agency staffing, as well as creating internal redeployment schemes to support areas with urgent staffing needs;
- continued focus on Covid-19 secure working and staff testing to reduce the risks of staff absence due to Covid-19 infection; and
- integrating workforce planning with the annual business planning cycle to identify and plan for future workforce needs.

- *Risk of failure to address concerns raised by regulators following in-year inspection work.*

  In-year inspections of our services by the CQC have resulted in several areas being identified for significant improvement.

  Following an unannounced inspection of the maternity service in March 2021, the CQC imposed conditions on the Trust's registration and final inspection report issued on 9 June 2021 lowered our rating for maternity services at the Jessop Wing from outstanding to inadequate.

  The Trust was issued with a Section 29a Warning Notice (S29a) by the CQC following a further unannounced inspection of core services in October 2021 and the well-led review that took place in November 2021. The warning notice requires improvement to be made by 17 July 2022.

  To address concerns raised by regulators the Quality Committee will provide oversight of the Trust's comprehensive action plan to address the findings of the CQC inspection report published on 5 April 2022. Actions specific to Maternity Services have been incorporated within the Maternity Improvement Plan developed following the unannounced inspection visit to maternity services at the Jessop Wing in March 2021.

Further work across these mitigations will continue in 2022/23 with regular reviews of progress to determine effectiveness and identify any need for further action on this risk.

Risks to employing caring and cared for staff

- *Staff health and wellbeing and resilience is negatively impacted*

  Due to both the sustained workload of the Covid-19 pandemic and staff shortages due to increased staff absence, the risk of a detrimental impact on staff wellbeing and resilience has increased.

  Several steps are being taken to mitigate this risk. These are also described within the Staff Health and Wellbeing section of the Annual Report and include:

  - Recruitment of additional staff;
  - A well-established Employee Assistance Programme provided by Vivup;

- Introduction of wellbeing conversations into non-medical appraisals;
- Using ICS funding for a post to recruit and train Wellbeing Champions to support more regular conversations with colleagues and enable them to signpost colleagues appropriately;
- Continuing to promote the free Access to Headspace / Unmind through the NHS people offer;
- Creating and maintaining more calm rooms for staff;
- Increasing psychological support for teams;
- Recommencing Schwartz rounds in several directorates, with the aim of extending this Trust wide during 2022/23; and
- Establishing a Carers Forum.

Many of our colleagues continued to work from home during this year and the Trust developed and implemented a Home Working Policy which provides guidance for managers and colleagues and incorporates a risk assessment of the homeworking environment.

We have continued to provide Covid-19 testing for all colleagues and their families and to utilise the Covid-19 Absence Reporting System which provided a daily picture of Covid-19 absence and the impact on service and allowed the Trust to support colleagues to return to work quickly following either a negative test or the end of their isolation period.

We continue to offer a wide range of financial wellbeing support which is becoming increasingly important as more of our staff experience financial pressures

Major risks 2022/23

The Trust's strategic landscape will continue to be dominated by the impact of Covid-19 for some time. As such there will be a need to continue to mitigate all the in-year risks described above.

Major strategic risks not detailed above which will have a continued impact into 2022/23 include:

- Inequalities and variation in care provision impact on provision of responsive, high quality care
- Failure to sustain financial stability due to an inability to predict future income
- Inadequate implementation and embedding of the digital strategy
- Inability to appropriately identify and utilise capital monies in future years
- Ineffective system working

- Impact of reduced placement provision and educational activity on recruiting our future workforce

Strengthening our strategic risk management arrangements

Regulatory and advisory feedback is being used to inform continuous development of the Trust's strategic risk management arrangements and a key outcome identified within the Trust's 2022 CQC Action Plan is that the Trust has effective systems to ensure Board oversight of the management of risk.

This outcome will also address recommendations within both head of internal audit opinion work focused on the sufficiency of oversight of higher-level operational risks logged on the Trust Risk Register and recommendations following the independent Trust-wide Healthcare Governance Review undertaken by the Good Governance Institute.

An internal review of the operation of the Integrated Risk and Assurance Report (IRAR) has taken place and actions identified to refresh the Trust's Framework for Risk Management and implement revised reporting / oversight arrangements for the management of risk. It has been agreed that this will be delivered through the development and adoption of a newly formatted Board Assurance Framework (BAF) incorporating a focus on significant operational risks. The development of the BAF will involve the rearticulation of risks to the delivery of the Trust's Strategic Aims (Strategic Risks).

Delivery of a communication plan for the implementation of these new arrangements will support increased understanding of the Trust's risk reporting and escalation framework and engagement in Ward to Board reporting of risk.

Compliance and validity of the NHS Foundation Trust condition (FT Governance): Corporate Governance Statement

The Board of Directors considers annually the Corporate Governance Statement with a view to confirming compliance with condition FT(4) of the provider licence. To assure validity of this statement, a schedule of evidence of compliance with each element of the declaration is prepared by the Trust Executive Group (TEG) for review by the Board of Directors prior to final approval.

In its review in May 2022 the Board of Directors noted where risks to compliance had been identified though regulatory inspection work undertaken during 2021/22. The statement references the Trust's 2022 CQC action plan as evidence that the Trust has mitigation in place for identified risks.

Engagement with public stakeholders in risk management

The Trust engages public stakeholders in identifying and managing risks which may impact on them in a number of ways:

- As a foundation trust the organisation aims to make best use of its Membership and of its Council of Governors. Through relevant working groups, Governors are kept apprised of proposed changes, including how potential risks to patients will be minimised. We also take opportunities to engage the Council of Governors on key issues and risks by providing regular briefing and feedback sessions and consulting them on the development of our annual Operational Plan;
- Through selection and discussion of quality objectives at a bi-annual meeting of the Quality Board, reporting into the Quality Committee (formerly Healthcare Governance Committee), which incorporates stakeholder membership including staff, Governors, Healthwatch Sheffield and voluntary and community sector representation; and
- The Trust employs a wide range of methods to capture feedback from patients, their families and carers including national and local surveys, social media, complaints, and the Friends and Family Test, acknowledging the value of this feedback as an early warning mechanism within its risk management processes.

Assurance that staffing processes are safe, sustainable and effective

Our staffing governance processes have been developed in line with National Quality Board guidance and recommendations within *Developing Workforce Safeguards*, (NHSI 2018). This is to ensure that the Trust deploys sufficient suitably qualified, competent, skilled and experienced staff, that there is a systematic approach to determine staffing levels and that this reflects current legislation and guidance.

Optimal staffing on our wards and departments is critical to providing safe, high quality care to our patients. We keep staffing levels and skill mix under constant review to ensure that each ward area is staffed according to real-time need and with reference to best practice staffing models. The Trust's Nursing and Midwifery Staffing Escalation Policy clearly defines the dynamic systems and processes that function daily to ensure that any shortfalls in staffing are mitigated. These are further supported by senior oversight provided by daily nurse staffing meetings to consider plans for staffing over the next 24 hours.

The actual and planned staffing levels on all our wards on a shift-by-shift basis are calculated and published on the Trust's website. In line with national guidance, an exception report is presented through the Human Resources and Organisational Development Committee to the Board of Directors setting out those wards where

staffing capacity and capability fall short of the plan, the reasons for the gap and the impact and actions being taken.

Continuous monitoring of patient outcomes and quality indicators inform establishing nurse staffing levels and we use a range of tools to do this including a nursing and midwifery quality dashboard and ward monitoring systems. Twice a year each inpatient clinical area assesses the care needs of patients in their ward / department, using an evidence-based tool to help determine the nurse / midwifery staffing required to provide safe, compassionate and effective care. In nursing the tool is the Safer Nursing Care Tool (SNCT) and in midwifery it is Birthrate+.

Informed further by professional judgement and evaluation of outcome measures, these establishment reviews are reported through the Human Resources and Organisational Development Committee to the Board of Directors. Reviews using SNCT and Birthrate+ are currently underway and will be reported to the Human Resources and Organisational Development Committee during 2022/23.

As part of the Trust's annual business planning cycle, the planning of our workforce identifies staffing pressures, proposed service changes and other factors affecting our workforce provision. In July 2018, the Trust launched its People Strategy; a key element of which is our Workforce Redesign, Innovation and Planning (WRIP) workstream. Through this workstream a suite of workforce planning and redesign tools have been developed and deployed with teams to enable them to identify, plan and address staffing and skill mix issues. These are supported by training and project facilitation. There is a plan to ensure all Directorates undertake workforce planning with a graded system in place to monitor the quality of workforce planning. Any planned workforce redesign or introduction of new roles is the subject of a full quality impact assessment review. Examples of where impact assessment reviews have taken place have included the development of nursing associates and physician associates roles.

Recognising the value of all clinical staff, the Trust regularly undertakes capacity and demand reviews to ensure the sufficiency of staff and has methods of escalation in place should any concerns regarding staffing levels be raised. All identified risks are assessed and logged onto the Trust's Risk Register with mitigations put in place and closely monitored.

Recruiting sufficient numbers of appropriately qualified clinical staff, particularly nursing staff to be able to care for our patients safely, has been identified as a potential strategic risk to the delivery of the Trust's strategic aims. The Integrated Risk and Assurance Report (IRAR) provides a mechanism for operational staffing risks to be escalated to the Board of Directors. During 2021/22, the Trust has continued to see a significant number of international registered nurses recruited and deployed and cohorts of nursing associates qualify and deployed to mitigate this risk.

To support assurance processes with regard to the adequacy of staffing across all staff groups, the Trust has recently established a Workforce Systems Group. Directly accountable to the Trust Executive Group, this task and finish group additionally reports progress to the People Strategy Programme Board through the above referenced WRIP workstream. The purpose of the Workforce Systems Group is to identify and understand the capability, utilisation and limitations of current workforce systems within the Trust, scope systems to meet business and strategic need and identify options for expansion or procurement of systems in line with need. The group is also creating systems to support Board-level assurance of the adequacy of staffing across all staff groups in the Trust to a similar level of maturity to that in place for nursing and midwifery staff.

Compliance statements

Care Quality Commission (CQC) compliance

As a provider of care, the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust has an overall rating of requires improvement.

Following an unannounced inspection of the maternity service on 8 and 9 March 2021, the CQC imposed conditions on the Trust's registration. These included:

- *The provider must implement an effective system to manage and respond to patient risk;*
- *The provider must implement an effective risk and governance system; and*
- *The registered provider must implement an effective system to ensure that medical and midwifery staff have the qualifications, competence, skills and experience to care for and meet the needs of women and babies safely.*

The final inspection report issued on 9 June 2021 lowered our rating for the Jessop Wing maternity service from outstanding to inadequate.

A comprehensive response was provided by the Trust, monitoring of which, has been undertaken through a Maternity Oversight Committee reporting into the Trust Executive Group and providing assurance to the Board of Directors through the Quality Committee.

Following a further CQC inspection in October 2021 which looked at some services and wards at the Royal Hallamshire and Northern General Hospital, as well as one of our community Rehabilitation Units, our previously good rating changed to requires improvement for the Trust overall with the safe domain being rated as inadequate.

The CQC issued a Section 29a Warning Notice (S29a) following this inspection and a well-led review in November 2021, requiring improvements to be made by 17 July 2022.

The Trust's 2022 CQC Action Plan addresses the findings raised within the Section 29a warning notice by mapping these to outcomes that support the delivery of high-quality patient care to be delivered by the 17 July 2022. For each outcome a set of three high-level actions that will have the biggest impact on achieving the outcome have been clearly defined, alongside the metrics which will identify whether the outcomes have been delivered.

Delivery of the action plan which also addresses all 'must do' requirements within the main inspection report will be overseen by the Quality Committee and the Board of Directors to ensure satisfactory progress is being made.

As part of this visit, CQC inspectors returned to the maternity services inspected in March 2021 and actions specific to Maternity Services have been incorporated within the Maternity Improvement Plan. As noted in the earlier section regarding assurance on CQC compliance this visit highlighted continued concerns about the quality of care and evidence of improvement.

On 27 May 2021 the Trust received an improvement notice from the CQC as the enforcing authority for England under IR(ME)R 2017. The improvement notice was issued under the Health and Safety at Work Act 1974 and the Ionising Radiation (Medical Exposure) Regulations 2017.

The CQC found that the Trust had contravened the following regulations at Royal Hallamshire Hospital and Weston Park Cancer Centre:

- *6(5)(a) The employer must establish recommendations concerning referral guidelines for medical exposures, including radiation doses, and ensure that these are available to the referrer; and*
- *6(5)(b) The employer must establish quality assurance programmes for written procedures and written protocols.*

The Trust implemented an action plan to address the findings and the CQC conducted a compliance re-inspection visit on 27 August 2021 where an update against each of the breaches and supporting evidence was reviewed. Following this visit, the CQC wrote to the Trust to confirm it was satisfied that the actions taken address the Improvement Notice schedule and the recommendations made in the report. The CQC declared the Trust as compliant with the Improvement Notice which has now been removed.

In December 2021, the CQC wrote to the Trust requesting information and documentation under Section 64 of the Health and Social Care Act 2008 to review

the quality of care for young people with mental health needs in Sheffield. The Trust responded within the deadline required. Sheffield Children's Hospital, Sheffield Health and Social Care NHS Foundation Trust and the Sheffield CCG also received similar requests.

In response a focussed child and adolescent Mental Health Act Review in Sheffield was undertaken. This review took place on the 25 and 26 April 2022. The principal areas visited included the Accident and Emergency Department and Acute Medical Unit, the two areas where young people subject to the Mental Health Act are most likely to be encountered in the Trust. The outcome report is awaited.

Following the review, Sheffield Children's Hospital, as the lead organisation, will receive within 20 days of the visit the outcome report which will be shared with partner organisations including Sheffield Teaching Hospitals NHS Foundation Trust.

Register of Interests

The Trust has published on its website an up-to-date Register of Interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the *Managing Conflicts of Interest in the NHS* guidance[5] (NHSE, 2018).

This can be accessed from this link.

Arrangements were put in place during 2020/21 to ensure that gifts and donations offered to the Trust in response to Covid-19 were appropriately managed and logged for inclusion on the Register of Interests and these were maintained during 2021/22.

Pension scheme

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

Equality, diversity and inclusion and human rights

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 a dedicated team to drive forward the work on equality, diversity and inclusion. An Equality, Diversity and Inclusion (EDI) Strategy is in place and supported by a comprehensive implementation plan that contains actions to improve

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

practice across employment and service design and delivery. The Trust's EDI Board monitors progress and provides assurance to the Human Resources and Organisational Development Committee, Quality Committee and Trust Board of Directors that the organisation is meeting its obligations under equalities legislation and best practice.

This includes our commitment to meeting our duties under the Equality Act 2010, ensuring compliance with the Accessible Information Standards, implementing the Equality Delivery System 2 and our active and on-going participation in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Assessing the organisation's impact on the environment

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

Emergency preparedness, resilience and response

The Trust has a key role to play in responding to large scale emergencies as well as ensuring it can continue to deliver high quality patient services if a major and / or business continuity incident occurs. Throughout the year the emergency planning team has helped support the leadership of the Covid-19 response, deploying knowledge and experience from previous incidents to ensure that the Trust's response was based on sound emergency planning principles.

In parallel, there were a number of planned and unplanned business continuity events throughout the year. This included planned IT downtime arrangements, periods of significant operational pressure and inclement weather. In each instance a debrief was undertaken which helped identify learning for future events.

The team also continued to develop plans and prepare for other events including, but not limited to, mass casualties, utility and IT failure and City-wide public events. In the likelihood of such an event, the Trust is assured that appropriate plans and systems are in place to maintain services for patients.

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

The following processes are in place to ensure that resources are used economically, efficiently and effectively:

- Development of detailed plans through the annual planning cycle which reflect service and operational requirements, financial targets in respect of income and expenditure and capital investment and incorporate required efficiency savings;
- Monthly monitoring of delivery of the Board-approved financial plan and at Directorate level by the Finance and Performance Committee and via a performance management framework that incorporates Trust Executive Group led directorate reviews;
- Monthly reporting to the Board of Directors via its committees on key performance indicators including finance, efficiency savings, activity, capacity, quality, performance, human resource management and risk. These reports are aggregated from detailed directorate level reports which support active management of resources at operational level;
- As noted above, continued delivery of a robust performance management framework which is critical to the early identification of any variance from operational or financial plans and for ensuring effective corrective action is put in place. In giving particular attention to financially challenged directorates, support is provided internally through the performance management framework with external input as required;
- Monitoring of the use of capital resources against a Board-approved capital plan by the Capital Investment Team which reports quarterly to the Board of Directors;
- New arrangements necessitated by the Covid-19 pandemic, have generated revised national funding arrangements. In particular, control and approval of specific funding for managing the pandemic has been undertaken by the Trust's Gold Command and TEG, as supported by specific groups to review proposals and requirements from directorates;
- The Making it Better (MIB) transformation and improvement programme which aims to deliver the Trust's overall strategy, and in particular, maximise efforts on improvement and transformation to help secure improved quality and sustainable finances in a challenging context. A key element of this programme is the development of information and performance management systems, including use of the national Model Health System and Getting it Right First Time (GIRFT) metrics. This programme is supporting service activity and financial recovery as the Trust emerges from the pandemic;

- A planned, systematic approach to improving organisational effectiveness through the alignment of strategy, people and processes. The Trust's Organisational Development function brings together a number of workstreams including equality, diversity and inclusion activities, service improvement, leadership development and workforce redesign. The department provides capacity, expertise, and development as an enabler to help the organisation continuously improve and support the delivery of transformation;
- The Trust continues to work on programmes designed to build quality improvement and leadership skills and deliver improvements, such as the Flow Coaching Academy (FCA) and Microsystems Coaching Academy (MCA). FCA continues to work at a national level with The Health Foundation and other partners, training coaches from the Trust, as well as from other organisations. Within the Trust coaches work on a range of pathways including redesign of the acute take, sepsis and the deteriorating patient, end of life care, frailty care, renal vascular access and community diagnostics. The MCA programme was paused during the Covid-19 pandemic and restarted in March 2022, with a full cohort and programme of coaches from the Trust, as well as partner organisations in Sheffield;
- The wider use of national and peer benchmarking to ensure best value for money in delivery of services by informing and guiding service redesign, leading to improvements in service quality and patient experience, as well as financial performance;
- Development of service line reporting (SLR) and patient level costing systems to better understand income and expenditure, therefore facilitating improved financial and operational performance. By also feeding into performance management and budget setting, SLR informs the development of action plans to address deviation from directorate financial plans; and
- Assessment of efficiency schemes for their impact on quality as part of a formal quality impact assessment process.

All of these arrangements and initiatives are underpinned by the Trust's Scheme of Reservation and Delegation of Powers approved by the Board of Directors setting out the decisions, authorities and duties delegated to officers of the Trust, and by the Trust's Standing Financial Instructions detailing the financial responsibilities, policies and procedures adopted by the Trust. These are designed to ensure that an organisation's transactions are carried out in accordance with the law, government policy and good practice in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The Board of Directors has gained assurance from the Audit Committee and the Finance and Performance Committee in respect of financial and budgetary management across the organisation. The Audit Committee receives, as standing

items on its agenda, reports regarding losses, special payments and compensations, write-off of bad debts and contingent liabilities.

The Trust also makes use of both internal and external audit functions to support governance arrangements, deliver economic, efficient and effective use of resources and ensure that controls are effective. Internal audit continues to review systems and processes in place during the year and publishes reports detailing specific actions to ensure the economy, efficiency and effectiveness of the use of resources is maintained. The outcome of these reports and the recommendations therein are also graded according to their perceived level of risk to the organisation, therefore assisting prioritisation of management action.

During 2021/22 these have included internal audit reports on patient safety (serious incidents and never events), accessible information standard, payroll, Covid-19 vaccination programme, cyber security, patient experience, estates procurement, directorate risk management and use of Lorenzo electronic prescribing and medicines administration (EPMA). These have all been reported to the Audit Committee.

Assurance around the accuracy of data

Quality of performance information

The Trust's Data Quality Steering Group ensures a continued focus on data quality issues. In setting the direction of the Trust's Data Quality Programme and overseeing its delivery, this group receives regular progress reports from the Data Quality Operational Group and monitors Trust performance against the national Data Quality Maturity Index (DQMI).

The Group promotes whole organisation engagement in good data quality, receives and approves remedial action plans where lapses in data quality have occurred, and monitors action plan progress and effectiveness. Reporting into TEG, the Group undertakes regular reviews of strategic risks associated with data quality and escalates these as necessary.

Reviews of data quality and the accuracy, validity and completeness of Trust performance information are also considered by the Audit Committee through in-year review work undertaken by internal audit. During 2021/22 there has been focus within the internal audit plan on specific areas of data quality including a review of the data quality of HR metrics focused on Trust-wide reporting on appraisals and mandatory training completion.

Programmes to improve data quality

The Trust has a number of programmes in place to improve data quality. These include:

- A well-established Electronic Patient Record and Data Quality Team to support and drive forward a coordinated data quality agenda across the organisation;
- Reporting dashboards to support improvement to data quality, including the Administrative Patient Safety Dashboard;
- Integration of Trust systems trainers within the performance and information function, to support users in learning from errors, and to further improve training to focus on data quality; and
- Continuation of the Administrative Profession Programme which aims to ensure all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

The Trust has strong governance arrangements in place for the management and oversight of elective waiting time data. The Activity Delivery Group meets on a monthly basis to review performance, service themes and data validation. A performance report, supported by operational reports, details the activities underway to ensure that elective waiting time data is accurate. Assurance is provided to the Waiting Times Performance and Caseload Group which also meets monthly to ensure performance is in line with plans and to oversee the caseload management process established to ensure that patients remain safe whilst they are waiting for treatment.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control has been reviewed and modified in the past year. The Trust committee structure provides balance between the three areas of quality,

finance and performance management. Internal audit has been routinely used to clarify issues where assurance is required.

In accordance with NHS internal audit standards, the Head of Internal Audit is required to provide an overall annual opinion statement to the Trust, based upon, and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. This is one component that is taken into account in making this Annual Governance Statement.

The Trust has received a statement from its internal auditors that, based on work undertaken in 2021/22, provides 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.

During 2021/22, 19 internal audit reports have been completed throughout the year. Four high risk findings have been identified from internal audit reports issued in 2021/22 with associated actions agreed to address. These are detailed below:

- A limited assurance report issued following an internal audit of the use of Lorenzo Electronic Prescribing and Medicines Administration identified a high-risk issue in relation to a lack of oversight of compliance with the system and an absence of evidence that reports were reviewed by relevant groups and committees to provide assurance that the EPMA system is being used safely and effectively.

  Action has been taken to address the recommendations within the report which includes reviewing and updating the terms of reference for the Clinical Design Authority, establishing an Electronic Prescribing Steering Group to provide oversight / assurance and an interface with the Medicines Safety Committee.

  Additionally, a Training Needs Analysis has been produced to identify and agree the training needs of staff in using the EPMA system. This includes how training compliance is monitored to ensure staff receive the correct training to use the system safely and effectively. The Electronic Prescribing and Medication Administration Standard Operating Procedure has also been reviewed and updated and includes staff training requirements.

- Patient Experience Internal Audit – a limited assurance opinion was issued on the joined-up approach to reviewing and responding to patient feedback which was due to limited information being shared with the Board of Directors.

  Four high risk actions were agreed as a result of this, three of which have been closed and the fourth is to be addressed as part of the development of the latest Quality Strategy.

- Estates Procurement Internal Audit – this internal audit identified a lack of clarification between the responsibilities of the Estates Directorate and central procurement; lack of a framework from which to select suppliers for minor new works; non-compliance with Standing Financial Instructions, and non-compliance with the Standards of Business Conduct Policy.

  One high risk action was raised in the report which is being jointly addressed by the Estates, Procurement and Finance departments and is still on course to be closed by its agreed completion date within 2022/23.

- Tissue Viability Internal Audit – this re-audit to identify whether the actions from a 2019 Tissue Viability audit were embedded found that while some had improved, others needed further development and raised a high-risk relating to the completion of documentation. This is being addressed through two actions; one to pilot new pressure ulcer risk assessment documentation and the second by using weekly assurance visits / ward compliance audits to monitor compliance.

The Head of Internal Audit opinion statement also references the Trust's strategic risk management arrangements noting that Board oversight of Extreme-Level Risks should be strengthened. Actions in place to address underpin delivery a key outcome identified within the Trust's 2022 CQC Action Plan focused on the Trust having effective systems to ensure Board oversight of the management of risk.

In considering the internal audit statement and on presentation with internal audit reports across the course of the year, members of the Audit Committee have noted Four internal audit reports issued with limited assurance opinions. Recommendations within the reports are welcomed by members of the Trust Executive Group (TEG). Focus continues to be placed on tracking actions against recommendations through reports submitted to the Audit Committee and the reporting arrangements in place across the committee structure supports the escalation of matters between committees. The Audit Committee has noted the end of year position of 86 per cent and while acknowledging the impact of the pandemic and operational pressures faced by directorates identified the need for driving improvement in this area.

Internal audit work has been supplemented by the external audit reports which provide assurance on the Trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources as part of the value for money element of its annual audit work.

The Board of Directors also received assurances on the use of resources from outside agencies including NHS England and NHS Improvement (NHSE/I) and the CQC. NHSE/I require the Trust to self-assess on a monthly basis.

My review is also informed by:

- the Integrated Risk and Assurance Report (IRAR);
- regular executive reporting to the Board of Directors and escalation processes through the Board committees;
- audit reports prepared independently by both the internal and external audit agencies. In particular, the ISA260 Audit Completion Report produced by KPMG, our external auditor;
- the published results of the quarterly performance management processes undertaken by NHSE/I under the Single Oversight Framework including the Trust's quarterly risk ratings and segmentation;
- the Trust's compliance with annual performance indicators published by the Department of Health and Social Care;
- CQC reports on its visits and inspections;
- external visits, inspections, accreditations and peer reviews
- clinical audit reports;
- the draft report from the Trust-wide Healthcare Governance Review undertaken by the Good Governance Institute;
- investigation reports and action plans following serious incidents, learning events and deep dive reviews;
- user feedback such as monitoring of patient experience, complaints and claims;
- national Patient Survey results including the Friends and Family Test; and
- the results of the NHS Staff Survey.

The above measures also ensure that any internal control issues are identified. During 2021/22 significant internal control issues arose in two key areas, namely significant concerns raised by regulators (CQC) following its in-year inspection work; and performance against national operational performance targets.

Conclusion

The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts. This is designed to manage the key organisational objectives and minimise the NHS Foundation Trust's exposure to risk.

I am satisfied that actions are in place to address recommendations for improvement to this system made within internal audit reports issued with a limited assurance

opinion and also to address the findings of recent CQC inspection work and its well-led review and other independent review work undertaken in year.

The Trust continues to review and update the governance assurance processes to further strengthen arrangements to ensure our services are well-led. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

In conclusion I can confirm that there are three significant internal control issues all of which have improvement plans in place to address them as outlined below.

Significant internal control issues

- *Performance against national elective performance targets*

As is the case across the NHS, the Trust has seen waiting lists grow significantly. This has been both as a consequence of the need to suspend a significant amount of clinical activity during early waves of the Covid-19 pandemic.

As a result of this the Trust's performance against NHS constitutional standards has deteriorated and we have failed to meet several key performance indicators as reported within the Analysis of Operational Performance section of the Annual Report.

Throughout the last year, as a result of capacity constraints and national guidance in response to the Covid-19 pandemic, priority has been given to those patients presenting with the highest clinical risks. Similar to other trusts, this has led to reduced activity and an increase in the numbers of patients waiting for treatment.

A Patient Care Recovery Plan is being developed which supports clinical teams to deliver their recovery plans. An organisation wide structure will ensure improvement and transformation is embedded across patient pathways whilst linking into ongoing work around enablers such as supporting the workforce through improved recruitment and retention and ensuring we have the appropriate estates and inpatient bed infrastructure for this programme.

- *Performance against national Urgent and Emergency Care targets*

The pandemic has had a significant impact on the health and wellbeing of our patients, which as a result, means we are seeing increased demand on our emergency pathways and greater acuity and dependency amongst our patients on both our emergency pathways. This has resulted in a significant deterioration in urgent and emergency care waiting time performance impacting on patient safety and experience. The October 2021 core services inspection resulted in an inadequate rating from CQC for Urgent and Emergency Care.

- *Significant concerns raised by regulators following in-year inspection work*

As described above, in-year inspections of our services by the CQC have resulted in several areas being identified for significant improvement.

Following an unannounced inspection of the maternity service in March 2021, the CQC imposed conditions on the Trust's registration and final inspection report issued on 9 June 2021 lowered our rating for maternity services at the Jessop Wing from outstanding to inadequate.

The Trust was issued with a Section 29a Warning Notice (S29a) by the CQC following a further unannounced inspection of core services in October 2021 and the well-led review that took place in November 2021. The warning notice requires improvement to be made by 17 July 2022.

The Quality Committee will provide oversight of the Trust's comprehensive action plan to address the findings of the CQC inspection report published on 5 April 2022. Actions specific to Maternity Services have been incorporated within the Maternity Improvement Plan developed following the unannounced inspection visit to maternity services at the Jessop Wing in March 2021.

Kirsten Major
Chief Executive
21 June 2022

Independent auditor's report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement 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 2022 and of its 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 2021/22.

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 its 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 above conclusions are 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 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 because of the need to achieve control totals delegated to the Trust by NHS Improvement.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual 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 that income outside of the Trust's block contract funding is accounted for in the incorrect financial period 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 did not identify any additional fraud risks.

We 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 infrequent users, and journals posted from cash to rarely used accounts.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Sample testing accrued expenditure transactions as at 31 March 2022, vouching to supporting documentation to corroborate whether those items were accurately recorded in the correct accounting period.
- Sample testing other operating income transactions recognised, vouching to supporting information and documentation to corroborate whether those items were accurately recorded in the correct accounting period.

Identifying and responding to risks of material misstatement related 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 (as required by auditing standards), and discussed with the directors 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 the National Health Service Act 2006 and 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.
- in our opinion the other information has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

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 2021/22. 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 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on pages 97 and 98, 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 its 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.

Our work identified two significant weaknesses in arrangements, both of which relate to governance and improving economy, efficiency and effectiveness.

The first weakness was in relation to the Trust's risk management and governance processes with particular regard as to whether these enabled appropriate risks to service delivery and associated actions to be identified, implemented and monitored appropriately and in a timely manner.

We raised one recommendation to the Trust regarding this significant weakness. This recommendation asked the Trust to consider whether its governance and risk management arrangements are appropriate to enable timely sight of performance issues and the identification, delivery and monitoring of timely actions to enable a positive impact upon service delivery and patient experience.

The second weakness was in regards to the Trust's maternity service where it was confirmed by the Care Quality Commission (CQC) reinspection visit in October and November 2021 that the Trust had not made the planned improvements to its maternity service following the inspection of its services in March 2021.

We raised one recommendation to the Trust regarding this significant weakness. This recommendation asked the Trust to assure itself that its action plan to address the CQC's concerns with regards to

maternity services ensures that robust monitoring processes are in place to enable the measurement of improvements in service delivery in a clear, transparent manner.

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 its 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 its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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 Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP
Chartered Accountants
Manchester

23 June 2022

Financial Accounts 2021-22

Foreword to the accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2022 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, operating as NHS Improvement, has, with the approval of the Secretary of State for Health, directed, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of that Act.

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

Signed

Kirsten Major
Chief Executive
21 June 2022

Statement of comprehensive income for the year ending 31 March 2022

	Note	2021/22 £'000	2020/21 £'000
Income from patient care activities	3.1	1,166,343	1,086,427
Other operating income	3.1	192,597	236,557
Operating expenses from continuing operations	4.1	(1,354,022)	(1,301,215)
OPERATING SURPLUS		**4,918**	**21,769**
Finance Costs:			
Finance income	7.1	231	0
Finance expense - financial liabilities	7.2	(2,705)	(2,804)
Finance income - unwinding of discount on provisions	19	43	32
Public Dividend Capital dividend expense	29	(5,754)	(5,666)
Net Finance Costs		**(8,185)**	**(8,438)**
(Losses) / Gains on disposal of assets		(66)	175
(DEFICIT) / SURPLUS FROM CONTINUING OPERATIONS		**(3,333)**	**13,506**
Other comprehensive income:			
Impairments		(2,515)	193
Revaluation		5,415	3,113
Other reserve movements		0	0
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(433)**	**16,812**

The notes on pages 142 to 177 form part of these accounts.

All income and expenditure is derived from continuing operations, and the (deficit) / surplus is attributable to the owners of the Trust (the Taxpayer).

Statement of financial position

	Note	31 March 2022 £'000	31 March 2021 £'000
Non-current assets:			
Intangible assets	8.1 & 8.2	3,794	4,486
Property, plant and equipment	9.2 & 9.4	434,876	411,094
Investments	11	0	0
Trade and other receivables	13.2	9,141	6,512
Total non-current assets		**447,811**	**422,092**
Current assets:			
Inventories	12.1	14,447	14,113
Trade and other receivables	13.1	29,785	22,705
Current asset investments	14	0	0
Cash	21	217,984	186,253
Total current assets		**262,216**	**223,071**
Current liabilities:			
Trade and other payables	15.1	(192,344)	(139,955)
Borrowings	16.1	(2,367)	(2,479)
Provisions due within one year	19	(6,958)	(5,745)
Other liabilities	17.1	(27,768)	(20,773)
Total current liabilities		**(229,437)**	**(168,952)**
Total assets less current liabilities		**480,590**	**476,211**
Non-current liabilities:			
Borrowings	16.2	(30,267)	(32,616)
Provisions due after one year	19	(5,666)	(3,985)
Other liabilities	17.2	(566)	(2,724)
Total non-current liabilities		**(36,499)**	**(39,325)**
TOTAL ASSETS EMPLOYED		**444,091**	**436,886**
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		361,290	353,652
Revaluation reserve	20	39,204	37,439
Income and expenditure reserve		43,597	45,795
TOTAL TAXPAYERS' EQUITY		**444,091**	**436,886**

The financial statements on pages 137 to 177 were approved by the Board on 13 June 2022 and were signed on behalf of the Board by

Kirsten Major, Chief Executive
Date: 21 June 2022

Statement of changes in Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	Note	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2021		436,886	353,652	37,439	45,795
Deficit for the year		(3,333)			(3,333)
Transfers between reserves	20	0		(1,135)	1,135
Impairments	20	(2,515)		(2,515)	
Revaluation gains on property, plant and equipment	20	5,415		5,415	
Public Dividend Capital received		7,638	7,638		
Other reserve movements		0	0	0	0
Taxpayers' Equity at 31 March 2022		**444,091**	**361,290**	**39,204**	**43,597**
Taxpayers' Equity at 1 April 2020		398,056	331,634	35,179	31,243
Surplus for the year		13,506			13,506
Transfers between reserves	20	0		(1,046)	1,046
Impairments	20	193		193	
Revaluation gains on property, plant and equipment	20	3,113		3,113	
Public Dividend Capital received		22,018	22,018		
Other reserve movements		0	0	0	0
Taxpayers' Equity at 31 March 2021		**436,886**	**353,652**	**37,439**	**45,795**

Statement of Cash Flows

	Note	2021/22 £'000	2020/21 £'000
Cash flows from operating activities			
Operating surplus from continuing operations		4,918	21,769
Non-cash income and expenditure:			
Depreciation and amortisation	4.1	23,858	23,420
Net impairments	4.1	2,974	5,620
Income recognised in respect of capital donations (cash and non-cash)		(386)	(2,095)
(Increase) / decrease in Trade and other Receivables		(9,989)	42,251
(Increase) / decrease in Inventories		(334)	559
Increase in Trade and other Payables		42,294	25,151
Increase in Other Liabilities		4,837	2,634
Increase in Provisions		2,937	3,661
Other movements in operating cashflows		(147)	(218)
Net cash generated from operations		**70,962**	**122,752**
Cash flows from investing activities:			
Interest received		120	28
Purchase of investments		0	0
Proceeds from settlement of investments		0	0
Purchase of intangible assets		(1,469)	(206)
Purchase of Property, Plant and Equipment		(35,340)	(38,302)
Sales of Property, Plant and Equipment		24	158
Receipt of Cash Donations to purchase capital assets		147	218
Net cash generated (used in) investing activities		**(36,518)**	**(38,104)**
Cash flows from financing activities:			
Public Dividend Capital received		7,638	22,018
DHSC Loans repaid		(1,445)	(1,445)
Capital element of finance lease rental payments		(551)	(531)
Capital element of Private Finance Initiative obligations		(463)	(468)
Interest on DHSC loans		(795)	(861)
Interest element of finance lease		(27)	(48)
Interest element of Private Finance Initiative obligations		(1,885)	(1,896)
Public Dividend Capital Dividend paid		(5,556)	(6,248)
Cash flows from other financing activities		371	309
Net cash generated (used in) / generated from financing activities		**(2,713)**	**10,830**
Increase in cash and cash equivalents		**31,731**	**95,478**
Cash and Cash equivalents at 1 April	21	186,253	90,775
Cash and Cash equivalents at 31 March	21	**217,984**	**186,253**

Accounting policies for the year ending 31 March 2022

1. Accounting policies

The Secretary of State for Health/NHS England and NHS Improvement, in exercising the statutory functions conferred on Monitor/NHS England, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2021/22, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) 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 DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation 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.

1.1 Going Concern

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

1.2 Accounting convention

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

1.3 Basis of consolidation

With effect from 1 April 2017, Sheffield Hospitals Charity became an independent charity, rather than being an NHS Charity. The Trust has established that it is not a corporate Trustee of any of its supporting or linked Charities and does not have the power to exercise control so as to obtain economic benefits, meaning consolidation is not appropriate. Additionally the transactions and balances are immaterial in the context of the Trust operations.

The Trust has a number of minor interests (<£500k) in the following entities, none of which are material to the Trust's operations, and are thus not consolidated on the grounds of materiality:

Name	Nature of Relationship
Epaq Systems Ltd	Minor share-holding in low net worth company
Zilico	Minor share-holding in low net worth company
Elaros 24/7 Ltd	Minor share-holding in low net worth company
Better Hygiene Ltd (formerly Wetwash)	Minor share-holding in low net worth company
Medipex Ltd	No return to the Trust
Legacy Park Ltd	No return to the Trust

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

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

• Basis of consolidation/Interests in other entities – see note 1.3. Judged as not having any material impact.

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a potential risk of resulting in a major adjustment to the carrying amounts of assets and liabilities within the next financial year.

• Plant, property and equipment valuations and useful economic lives

The Trust has used valuations carried out at 31 March 2022 by its expert valuers to determine the value of property. These property valuations and useful lives are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health and Social Care. Within the valuations key areas of risk include obsolescence, build rates and modern equivalent asset site assumptions. Further details are provided in paragraph 1.11 and note 9.5 of the accounts.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

• Revenue estimates

Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on agreements with the main commissioning bodies. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so. Further details are provided in paragraph 1.5.

• Estimation of payments for the PFI and service concession assets, including finance costs

The assets and liabilities relating to the PFI scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health and Social Care's financial model as required by the Department of Health and Social Care guidance. The models also provide estimates for interest payable and contingent rent as disclosed in note 18 of the accounts.

• Impairment of receivables

The Trust is required to judge when there is sufficient evidence to impair individual receivables; this is undertaken on the aged profile and class of the receivable. The Trust adopts a prudent policy of increasing the expected credit loss, with the increasing ageing of the receivable. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so. Further details are provided in paragraph 1.24 and note 13.3 of the accounts.

• Provisions

Provisions are a matter of judgement, with a best estimate made based on information available at the time. Once realised, provisions can be different to the original estimate, but not materially so. Further details are provided in paragraph 1.20 and note 19 of the accounts.

1.5 Revenue

In the application of IFRS 15 (Revenue from contracts with customers) a number of practical expedients offered in the Standard have been employed. These are as follows:

- The Trust will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less..
- The Trust is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the 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 NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS for 2020/21 and 2021/22 changed from those in 2019/20, affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21 and 2021/22

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21 and 2021/22, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the 2020/21 year the trust received block funding from its commissioners. For the second half of the 2020/21 and full 2021/22 year, block contract arrangements were agreed at an 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.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

1.6 Employee benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of annual leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement benefit costs NHS pensions

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their activities.

1.11 Property, plant and equipment

1.11.1 Recognition

Property, Plant and Equipment is capitalised if:

- 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 will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably, and either
- the item individually has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Property, plant and equipment assets are also capitalised where they form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

1.11.2 Measurement

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 (with no plan to bring it back into use) are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.11.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-off and charged to operating expenses.

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.

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is set out in note 9.5 to the accounts.

1.12 Intangible assets

1.12.1 Recognition

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

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

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use

- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for Property, Plant and Equipment.

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in note 8.4 to the accounts.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure..

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 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.

1.16.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability 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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.16.2 The Trust as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as a finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

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.

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

1.17 Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as Property, Plant and Equipment at their current value, together with an equivalent PFI finance lease liability.

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

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.17.1 Services received

The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.17.2 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC12 as adapted and interpreted by the FReM and as detailed below. The liability is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the contract to the opening PFI liability for the period, and is charged to “finance costs” within the Statement of Comprehensive Income.

An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract.

The element of the annual unitary payment increase due to cumulative indexation is firstly apportioned to service charges and life cycle costs and the residual amount is treated as contingent rent and is expensed as incurred.

1.17.3 Life cycle replacement

Components of the asset replaced by the operator during the contract (‘life cycle replacement’) are capitalised where they meet the Trust’s criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

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

Where the fair value of the life cycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) cost formula.

In 2021/22 and 2020/21, the Trust received and consumed 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 and consumption 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.

1.19 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.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rates.

Early retirement provisions are discounted using HM Treasury’s pension discount rate of negative 1.30% (2020/21: negative 0.95%) in real terms.

All general provisions are subject to four separate (nominal) discount rates according to the expected timing of cash-flows from the Statement of Financial Position date: :

Period	Period Definition for expected cash flows	2021/22 Nominal Rate (%)	2020/21 Nominal Rate (%)
Short term	Up to and including 5 years	+0.47	-0.02
Medium term	Over 5 years and up to and including 10 years	+0.70	+0.18
Long term	Over 10 years and up to and including 40 years	+0.95	+1.99
Very long term	Exceeding 40 years	+0.66	+1.99

1.21 Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 19, but is not recognised in the Trust's accounts.

1.22 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 as and when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed (in note 24.1), unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed (in note 24.2) where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 Financial assets

Recognition and de-recognition, measurement and classification

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

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices where possible, or by valuation techniques.

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

1.24.1 Financial assets at amortised cost

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

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

1.24.2 Financial assets at fair value through other comprehensive income

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

1.24.3 Financial assets at fair value through profit and loss

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

1.24.4 Impairment

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

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

Invoiced contract receivables and Non-invoiced contract receivables are largely with other public sector bodies where the risk of credit losses are low and where income and receivable balances are subject to nationally agreed processes and timetables as outlined below. Credit losses on other contract assets, which are not material, are assessed on a case by case basis as relevant and appropriate.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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

1.25 Financial liabilities

Recognition and de-recognition, and measurement

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

1.25.1 Financial liabilities at fair value through profit and loss

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

1.25.2 Other financial liabilities

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

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets) and grant funded assets.
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- approved expenditure on COVID19 capital assets
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.27 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling (the functional currency) at the spot exchange rate on the date of the transaction.

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 27 to the accounts.

1.29 Losses and special payments

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

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

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

1.30 Early adoption of standards, amendments and interpretations

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

1.31 IFRS Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2021/22. These Standards are still subject to HM Treasury FReM adoption.

1.31.1 IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

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

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

Estimated impact on 1 April 2022 statement of financial position	£'000
Additional right of use of assets recognised for existing operating leases	3,477
Additional lease obligations recognised for existing operating leases	(3,384)
Changes to other statement of financial position line items (excluding reserves)	0
Estimated impact on net assets on 1 April 2022	**93**
Estimated in-year impact on 2022/23	
Additional depreciation on right of use assets	(1,363)
Additional finance costs on lease liabilities	(71)
Lease rentals no longer charged to operating expenditure	1,229
Other impacts on income / expenditure	0
Estimated impact on surplus / deficit in 2022/23	**(205)**
Estimated increase in capital additions in 2022/23	**1,916**

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

1.31.2 IFRS 17 Insurance Contracts

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, with adoption by the FReM from 1 April 2023: early adoption is not therefore permitted. The Trust does not expect the adoption of this standard to have a material impact on the Accounts of the Trust.

2. Segmental analysis

The Trust has determined that the Chief Operating decision maker (as defined by IFRS 8: Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

The Board reviews the operating and financial results of the Trust on a monthly basis and considers the position of the Trust as a whole in its decision making process, rather than as individual components which comprise the total, in terms of allocating resources. Consequently the Board of Directors considers that all the Trust's activities fall under the single segment of provision of healthcare, and no further segmental analysis is therefore required..

3. Income

3.1 Operating income from activities: Analysis by nature

	Sub-note	2021/22		2020/21	
		£'000	£'000	£'000	£'000
Operating income from patient care activities					
Block Contract / System Envelope Income			849,659		803,149
High Cost Drugs			180,862		165,662
Other NHS Clinical income not included within COVID-19 block contracts			17,632		15,220
Income re Community Services			70,943		69,781
Private Patient Income			2,741		2,077
Elective Recovery Fund			12,520		0
Additional Pension Contribution	*(1)*		31,986		30,538
Total operating income from patient care activities			**1,166,343**		**1,086,427**
Other operating income					
Research and development			44,538		38,920
Education and training			62,875		58,292
Non-patient care services to other bodies			66,290		55,100
COVID-19 reimbursement & top up funding		10,139		63,709	
COVID-19 consumables donated by DHSC		2,344		11,968	
COVID-19 response: DHSC donated capital equipment		30		1,711	
COVID-19 response: DHSC donated revenue equipment		97		103	
			12,610		77,491
Received from other bodies: Cash donations for capital acquisitions	*(2)*		0		69
Received from NHS Charities: Receipt of grants/donations for capital acquisitions	*(2)*		147		149
Received from other bodies: Receipt of grants/donations for capital acquisitions	*(2)*		209		166
Other	*(2) & (3)*		5,227		5,860
Operating lease income	*Note 3.4*		701		510
Total other operating income			**192,597**		**236,557**
Total Operating Income			**1,358,940**		**1,322,984**

Sub-notes

(1) A revaluation of public sector pensions schemes during 2019/20 resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.

However since April 2019, including 2021/22 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and income has been uplifted to show these contributions to Trust expenses.

(2) Other operating income, with the exception of income received from NHS charities and other bodies, and 'Other' is contract revenue as defined under IFRS15

(3) Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites. The largest individual components relate to the provision of catering and nursery facilities.

3.2 Operating income from activities: Analysis by source

		2021/22	2020/21
		£'000	£'000
Clinical Commissioning Groups and NHS England		1,154,249	1,074,219
NHS Foundation Trusts		43	16
NHS Trusts		0	0
Department of Health and Social Care (DHSC)		0	1
Local Authorities		4,089	4,251
NHS Other		16	2,570
Non NHS: Private patients		2,174	1,280
Non NHS: Overseas patients (non-reciprocal)		564	797
NHS injury scheme (formerly the Road Traffic Act Scheme)		2,440	3,033
Non NHS: Other	(4)	2,768	260
Total operating income from activities by source		**1,166,343**	**1,086,427**

(4) Non NHS Other income from activities comprises income from prescription charges, and income from other Whole Government Accounting Bodies in Scotland, Wales and Ireland.

3.3 Income from Commissioner Related Services

Commissioner Related Services for the year totalled £1,221,272k (2020/21 £1,139,349k). Non Commissioner Related Services were £137,638k (2020/21 £183,635k).

3.4 Operating lease income

	2021/22	2020/21
	£'000	£'000
Rents recognised as income in the period	701	510
Contingent rents recognised as income in the period	0	0
	701	**510**

Future minimum lease payments due	**2021/22**	**2020/21**
	£'000	£'000
Re land		
- not later than one year;	37	37
- later than one year and not later than five years;	150	150
- later than five years.	631	679
Total	**818**	**866**
Re buildings		
- not later than one year;	992	872
- later than one year and not later than five years;	2,307	2,717
- later than five years.	2,883	4,412
Total	**6,182**	**8,001**
Total - all categories		
- not later than one year;	1,029	909
- later than one year and not later than five years;	2,457	2,867
- later than five years.	3,514	5,091
Total	**7,000**	**8,867**

3.5 Overseas Visitors (relating to patients charged directly by the Trust)

	2021/22 £'000	2020/21 £'000
Income recognised in year	564	797
Cash payments received in year (relating to invoices raised in current and previous years)	210	180
Amounts added to provision for impairment of receivables (relating to invoices raised in current and previous years)	498	1,708
Amounts written off in year (relating to invoices raised in current and previous years)	125	254

3.6 Additional Information in contract Revenue (IRFS 15) recognised for the period

	2021/22 £'000	2020/21 £'000
Revenue recognised in the reporting period that was previously included in the contract liability balance (ie release in year of deferred IRFS 15 income)	18,344	8,879

4. Operating expenses

4.1 Operating expenses: Analysis by nature

	Sub-note	2021/22 £'000	2020/21 £'000
Purchase of Healthcare from NHS and DHSC Bodies		11,568	17,213
Purchase of Healthcare from non NHS and DHSC bodies		34,213	17,049
Staff and Executive Directors' costs	Note 5.1	815,913	786,359
Non-Executive Directors' costs		197	166
Drugs costs		199,608	184,842
Supplies and services – clinical		101,299	79,858
Supplies and services - general	(1)	7,706	52,316
Establishment		11,912	9,394
Research and Development		30,544	27,358
Transport		1,154	1,101
Premises		57,338	51,312
Movement in credit loss allowance		751	2,285
Change in provisions discount rate		95	144
Depreciation on property, plant and equipment		21,807	20,924
Amortisation of intangible assets		2,051	2,496
Net Impairments of property, plant and equipment	Note 7.3	2,971	5,581
Net Impairments of intangible assets	Note 7.3	3	39
Operating lease costs	Note 4.3	1,753	1,418
Audit services - statutory audit	Note 4.2	228	58
Other auditor remuneration - audit related assurance purposes - quality report review	Note 4.2	0	0
Clinical negligence		27,702	23,460
Legal fees		2,070	2,383
Consultancy costs		2,741	1,410
Internal audit costs		154	158
Training, courses and conferences		9,015	6,356
Redundancy		66	0
Charges to operating expenditure for on-SoFP for IFRIC 12 Schemes		673	664
Insurance		684	627
Other Services		6,189	2,918
Losses, ex gratia and special payments		106	475
Other		3,511	2,851
Total operating expenses		**1,354,022**	**1,301,215**

Note 4.2 Auditor's liability

	2021/22	2020/21
	£'000	£'000
Limitation on Auditor's liability	1,000	Unlimited

An analysis of the work of the Auditors and the associated fees for the respective work is included above and on page 89 of the Annual Report. Fees and Remuneration above are stated inclusive of VAT.

4.3 Arrangements containing an operating lease - current year expenditure

	2021/22	2020/21
	£'000	£'000
Minimum lease payments	3,098	2,248
Contingent rents	0	0
Less sub-lease payments received	(1,345)	(830)
Total	**1,753**	**1,418**

4.4 Arrangements containing an operating lease - future years' commitments

	2021/22	2020/21
	£'000	£'000
Future minimum lease payments due:		
Within 1 year	2,976	2,261
Between 1 and 5 years	5,415	4,930
After 5 years	661	505
Total	**9,052**	**7,696**

5. Staff costs

5.1 Employee expenses

	Sub-note	2021/22	2020/21
		£'000	£'000
Salaries and wages		642,746	622,147
Social Security Costs		57,427	53,472
Apprenticeship Levy		3,029	2,852
Employer contributions to NHSPA		73,164	69,757
Pension Cost - employer contribution paid by NHSE on providers' behalf	(1)	31,986	30,538
Other pension costs		424	405
Agency / contract staff		7,137	7,188
Total	(2)	**815,913**	**786,359**

(1) A revaluation of public sector pensions schemes during 2019/20 resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019. However, since April 2019, including 2021/22, the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and expenditure has been uplifted to show these contributions to Trust expenses.

(2) The above figure of £815,913k is net of the amount of £1,107k (2020/21 £926k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1).

Further details of staff numbers and costs can be found within the Staff Report on pages 72 to 75 of the Annual Report.

5.2 Early retirements due to ill health

	2021/22	2020/21
	Number	Number
Number of early retirements agreed on the grounds of ill health	11	13
	£'000	£'000
Cost of early retirements agreed on grounds of ill health	693	281

These costs were borne by the NHS Pensions Agency.

6. Performance on payment of debts

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against this code is set out below:

	2021/22	2020/21
	Number	Number
Number of non NHS invoices paid	171,582	180,455
Number of non NHS invoices paid within 30 days	165,710	176,873
Percentage of invoices paid within 30 days	96.58%	98.02%
	£'000	£'000
Value of non NHS invoices paid	480,081	465,606
Value of non NHS invoices paid within 30 days	460,417	453,573
Percentage of invoices paid within 30 days	95.90%	97.42%
Amounts included within Interest Payable (Note 7.2) arising from claims made under the Late Payment of Debts (Interest) Act 1998	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

7. Financing

7.1 Finance income

	2021/22	2020/21
	£'000	£'000
Bank account interest	231	0
Investment interest	0	0
Total	**231**	**0**

No investments have been made during the 2021/22 financial year, given the absence of a positive return.

7.2 Finance costs – interest expense

	2021/22	2020/21
	£'000	£'000
Capital loans from the Department of Health and Social Care	793	860
Finance Lease interest	27	48
Finance Costs in PFI Obligations		
Main Finance Costs	1,026	1,052
Contingent Finance Costs	859	844
Total	**2,705**	**2,946**

7.3 Impairment of assets

	2021/22	2020/21
	£'000	£'000
Loss or damage from normal operations	59	82
Abandonment of assets in course of construction	99	150
Changes in market price	11,331	16,419
Reversal of impairments	(8,515)	(11,031)
Net Impairments charged to operating expenses	**2,974**	**5,620**

8. Intangible non-current assets

8.1 Intangible non-current assets 2021/22

	Total £'000	Intangible assets under construction £'000	Software Licenses £'000
Gross Cost at 1 April 2021	21,097	0	21,097
Additions - purchased / internally generated	1,362	1,149	213
Additions – donated	0	0	0
Impairments charged to operating expenses	(3)	(3)	0
Reclassifications	0	(1,146)	1,146
Disposals	0	0	0
Gross cost at 31 March 2022	**22,456**	**0**	**22,456**
Amortisation at 1 April 2021	16,611	0	16,611
Provided during the year	2,051		2,051
Impairments	0		0
Reversal of Impairments credited to operating expenses	0		0
Reclassification	0		0
Disposals	0		0
Amortisation at 31 March 2022	**18,662**	**0**	**18,662**
Net Book Value at 31 March 2022	**3,794**	**0**	**3,794**

8.2 Intangible non-current assets 2020/21

	Total £'000	Intangible assets under construction £'000	Software Licenses £'000
Gross cost at 1 April 2020	21,174	0	21,174
Additions - purchased / internally generated	147	112	35
Additions – donated	16	16	0
Impairments charged to operating expenses	(39)	(39)	0
Reclassifications	0	(89)	89
Disposals	(201)	0	(201)
Gross cost at 31 March 2021	**21,097**	**0**	**21,097**
Amortisation at 1 April 2020	14,316	0	14,316
Provided during the year	2,496		2,496
Impairments	0		0
Reversal of Impairments credited to operating expenses	0		0
Reclassification	0		0
Disposals	(201)		(201)
Amortisation at 31 March 2021	**16,611**	**0**	**16,611**
Net Book Value at 31 March 2021	**4,486**	**0**	**4,486**

8.3 Analysis of intangible non-current assets

	2021/22	2020/21
	£'000	£'000
Net Book Value		
- Purchased	3,794	4,486
- Donated	0	0
Total 31 March	**3,794**	**4,486**

8.4 Economic life of intangible non-current assets

	Min Life	Max Life
	Years	Years
Software licences	5	8

9. Property, plant and equipment – Non-current assets

9.1 Property, Plant and Equipment 2021/22

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2021	551,171	11,621	327,933	2,093	23,603	147,277	1,225	27,505	9,914
Additions-purchased	45,395	0	1,839	0	37,438	5,071	25	695	327
Additions-leased assets	0	0	0	0	0	0	0	0	0
Additions-donated	209	0	0	0	0	209	0	0	0
Additions-equipment donated from DHSC for COVID-19 response	30	0	0	0	0	30	0	0	0
Additions-assets purchased from cash donations	147	0	0	0	98	49	0	0	0
Impairments charged to operating expenses	(11,427)	(284)	(11,047)	0	(96)	0	0	0	0
Impairments charged to revaluation reserve	(2,517)	0	(2,517)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	8,515	27	8,478	0	10	0	0	0	0
Reversal of impairments credited to revaluation reserve	2	0	2	0	0	0	0	0	0
Reclassifications	0	0	28,066	0	(35,400)	4,376	0	2,275	683
Revaluations	(12,313)	599	(12,912)	0	0	0	0	0	0
Disposals	(8,864)	0	0	0	0	(5,790)	(28)	(1,986)	(1,060)
Cost or valuation at 31 March 2022	**570,348**	**11,963**	**339,842**	**2,093**	**25,653**	**151,222**	**1,222**	**28,489**	**9,864**
Accumulated Depreciation at 1 April 2021	140,077	0	8,531	115	0	100,979	970	23,482	6,000
Provided during the year	21,807	0	9,697	78	0	9,769	57	1,443	763
Impairments charged to operating expenses	59	0	0	0	0	59	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	(19)	0	18	1
Revaluations	(17,728)	0	(17,580)	(148)	0	0	0	0	0
Disposals	(8,864)	0	0	0	0	(5,790)	(28)	(1,986)	(1,060)
Derecognition – COVID equipment returned to DHSC	121					121			
Depreciation at 31 March 2022	**135,472**	**0**	**648**	**45**	**0**	**105,119**	**999**	**22,957**	**5,704**

9.2 Analysis of Property, Plant and Equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
Net book value									
- Purchased at 31 March 2022	392,512	11,276	301,832	1,632	25,653	42,415	223	5,489	3,992
- Finance Leases at 31 March 2022	209	0	0	0	0	171	0	38	0
- PFI at 31 March 2022	14,426	0	14,426	0	0	0	0	0	0
- Gov't. granted/Donated assets at 31 March 2022	26,382	687	22,936	416	0	2,170	0	5	168
- Donated from DHSC re COVID at 31 March 2022	1,347	0	0	0	0	1,347	0	0	0
Total at 31 March 2022	**434,876**	**11,963**	**339,194**	**2,048**	**25,653**	**46,103**	**223**	**5,532**	**4,160**

9.3 Property, Plant and Equipment 2020/21

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2020	518,488	11,187	301,994	2,093	22,803	140,883	1,220	27,767	10,541
Additions - purchased	42,195	88	3,434	0	32,080	6,034	83	245	231
Additions - leased assets	0	0	0	0	0	0	0	0	0
Additions - donated	166	0	0	0	0	166	0	0	0
Additions-equipment donated from DHSC for COVID-19 response	1,711	0	0	0	0	1,711	0	0	0
Additions - assets purchased from cash donations	202	0	4	0	109	85	0	0	4
Impairments charged to operating expenses	(16,530)	0	(16,420)	0	(110)	0	0	0	0
Impairments charged to revaluation reserve	(31)	0	(31)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	11,031	0	11,031	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	224	0	224	0	0	0	0	0	0
Reclassifications	0	0	25,767	0	(31,279)	4,253	0	807	452
Revaluations	2,276	346	1,930	0	0	0	0	0	0
Disposals	(8,561)	0	0	0	0	(5,855)	(78)	(1,314)	(1,314)
Cost or valuation at 31 March 2021	**551,171**	**11,621**	**327,933**	**2,093**	**23,603**	**147,277**	**1,225**	**27,505**	**9,914**
Accumulated Depreciation at 1 April 2020	128,469	0	433	38	0	97,226	987	23,285	6,500
Provided during the year	20,924	0	8,935	77	0	9,526	61	1,511	814
Impairments recognised in operating expenses	82	0	0	0	0	82	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other Revaluations	(837)	0	(837)	0	0	0	0	0	0
Disposals	(8,561)	0	0	0	0	(5,855)	(78)	(1,314)	(1,314)
Depreciation at 31 March 2021	**140,077**	**0**	**8,531**	**115**	**0**	**100,979**	**970**	**23,482**	**6,000**

9.4 Analysis of Property, Plant and Equipment

Netbook value	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information Technology	Furniture and fittings
- Purchased at 31 March 2021	367,455	10,950	283,289	1,577	23,579	40,131	255	3,961	3,713
- Finance leases at 31 March 2021	569	0	0	0	0	514	0	55	0
- PFI at 31 March 2021	13,246	0	13,246	0	0	0	0	0	0
- Government granted/Donated assets at 31 March 2021	28,184	671	22,867	401	24	4,013	0	7	201
- Donated from DHSC re COVID at 31 March 2021	1,640	0	0	0	0	1,640	0	0	0
Total at 31 March 2021	**411,094**	**11,621**	**319,402**	**1,978**	**23,603**	**46,298**	**255**	**4,023**	**3,914**

9.5 Economic life of property, plant and equipment

	Minimum Life (Years)	Maximum Life (Years)
Land	Infinite	Infinite
Buildings excluding dwellings	3	55
Dwellings	25	28
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	10	10

9.6 Non-property valuations

Depreciated historical cost is the basis for determining fair value for the Trust's non-property assets. This is not considered to be materially different from fair value.

9.7 Property valuations

Net book value of assets covered by valuation method	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000
Modern Equivalent Asset (no Alternative Site)	0	0	0
Modern Equivalent Asset (Single Site)	11,963	339,194	0
Market value in existing use	0	0	2,048
Fair value (surplus PPE land and buildings)	0	0	0
Total at 31 March 2022	**11,963**	**339,194**	**2,048**

The Trust undertook a full site revaluation of the land and property estate at 1 April 2018 based on a single site valuation model with its expert advisors, Cushman & Wakefield as members of the Royal Institute of Chartered Surveyors, providing an updated valuation estimation which is compliant with RICS standards. An interim valuation has been undertaken as at 31 March 2022.

10. Non-current assets for sale and assets in disposal groups 2021/22

There were no non-current assets for sale and assets in disposal groups in either financial year.

11. Non-current assets investments

The Trust has holdings in the following companies that are commercially developing intellectual property. The Trust's holdings in these companies carry a minimal value (<£500k) at the Statement of Financial Position date (31 March 2022 and 31 March 2021). None of the entities are material to the Trust's operations, nor classified as subsidiaries, associates or joint ventures under relevant accounting standards.

Companies in which the Trust owns shares	**Shareholding**
Epaq Systems Ltd	43.59%
Elaros 24/7 Ltd	9.80%
Better Hygiene Ltd (Formerly Wetwash Ltd)	5.00%
Zilico ltd	2.99%

Companies limited by guarantee	
Medipex Ltd	Member
Olympic Legacy Park Ltd	Member

12. Inventories

12.1 Inventories by category

	Sub-note	2021/22 £'000	2020/21 £'000
Drugs		6,684	6,119
Energy		252	302
Other (implantable devices, etc.)		7,511	7,692
Total Inventories	**(1)**	**14,447**	**14,113**

12.2 Inventories recognised in expenses

		2021/22 £'000	2020/21 £'000
Inventories recognised in expenses	**(2)**	342,904	335,474
Write down of inventories recognised as an expense		191	554
Total inventories recognised in expenses		**343,095**	**336,028**

(1) Stock counts at 31 March 2022 and 31 March 2021 were either from electronic systems or via a COVID-19 secure physical count in all but two minor areas.

(2) During 2021/22 and 2020/21 the inventory write down includes sums due to expired stock arising from COVID-19 implications.

13. Receivables

13.1 Trade and other receivables falling due within one year

		2021/22 £'000	2020/21 £'000
Contract receivables - NHS and Other DHSC Bodies		21,784	17,050
Contract receivables - Trade and Non DHSC Bodies		7,989	5,793
Contract assets		0	0
Allowance for impaired receivables	**Note 13.3**	(8,499)	(7,965)
Prepayments		6,820	6,116
Interest receivable		111	0
Public Dividend Capital dividend receivable		593	791
VAT receivable		899	672
Clinician Pension Tax Provision reimbursement funding from NHSE		33	0
Other receivables		55	248
Total falling due within one year		**29,785**	**22,705**

13.2 Trade and other receivables falling due after more than one year

		2021/22 £'000	2020/21 £'000
Contract receivables - NHS Injury Scheme		6,655	6,331
Clinician Pension Tax Provision reimbursement funding from NHSE		2,486	181
Total falling due after more than one year		**9,141**	**6,512**
Total Trade and Other Receivables		**38,926**	**29,217**

13.3 Allowances for credit losses (doubtful debts)

	Total £'000	Contract receivables and Contract assets £'000	All other receivables £'000
At 1 April 2021	7,965	7,965	0
New allowances arising	1,701	1,701	0
Reversals of allowances	(950)	(950)	0
Utilisation of allowances	(217)	(217)	0
Total allowance for credit losses at 31 March 2022	**8,499**	**8,499**	**0**
Loss recognised in expenditure	751	751	0

13.4 Credit losses and impairment of receivable

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.

NHS receivables are considered recoverable because the majority of trade is with DHSC or Clinical Commissioning Groups (CCG's) as commissioners for patient care services.

As CCG's are funded by the Government to purchase NHS patient care services, credit scoring is not considered necessary. Similarly, other receivables with related parties are with other Government bodies, so credit scoring is not considered necessary.

The Trust has considered its exposure to potential credit losses in light of the Covid-19 pandemic and does not consider itself exposed to any significantly greater risk; taking this into consideration, its approach to the impairment of receivables remains largely unaltered. .

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.

14. Current asset investments

	2021/22 £'000	**2020/21** £'000
Additions	0	0
Disposals	0	0
Cost or valuation at 31 March	0	0

Current asset investments reflect short-term deposits with the National Loan Fund within the Government Banking Service. No investments have been made during the 2021/22 financial year, given the absence of a positive return.

15. Payables

15.1 Trade and other payables

	2021/22 £'000	2020/21 £'000
Amounts falling due within one year:		
NHS payables	24,323	19,851
Trade payables	40,216	23,483
Trade payables - capital	23,151	13,056
Other payables	10,711	10,200
Accruals	76,677	57,977
Social Security and other taxes	17,266	15,388
Public Dividend Capital payable	0	0
Total current trade and other payables	**192,344**	**139,955**
Amounts falling due after more than one year:		
Total non-current trade and other payables:	0	0
Total non-current trade and other payables	**0**	**0**
Total trade and other payables	**192,344**	**139,955**

15.2 Early retirements and outstanding pension contributions included in payables above

	2021/22 Number	2020/21 Number
- Number of cases involved	0	0
	£'000	£'000
- To buy out the liability for early retirements over 5 years	0	0
Outstanding Pensions Contributions at 31 March	10,425	9,790

16. Borrowings

16.1 Current borrowings

	Sub-note	2021/22 £'000	2020/21 £'000
Capital Loans from the DHSC	(1)	1,463	1,465
Obligations under finance leases		246	551
Obligations under Private Finance Initiative contracts		658	463
Total current borrowings		**2,367**	**2,479**
16.2 Non-current borrowings			
Capital Loans from the DHSC	(1)	14,619	16,064
Obligations under finance leases		141	387
Obligations under Private Finance Initiative contracts		15,507	16,165
Total non-current borrowings		**30,267**	**32,616**
Total borrowings (current and non-current)		**32,634**	**35,095**

(1) On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. This announcement does not affect the DHSC loans above, which are normal course of business loans, rather than interim loans. The long term nature of the loans above therefore does not change.

17. Other liabilities

17.1 Current other liabilities

	2021/22 £'000	2020/21 £'000
Deferred income	27,768	20,773
Total current other liabilities	**27,768**	**20,773**

17.2 Non-current other liabilities

	2021/22 £'000	2020/21 £'000
Deferred income	566	2,724
Total non-current other liabilities	**566**	**2,724**
Total other liabilities (current and non-current)	**28,334**	**23,497**

18. Finance obligations

18.1 Finance lease obligations

	2021/22 £'000	2020/21 £'000
Gross lease liabilities	396	975
of which liabilities are due		
- not later than one year;	253	579
- later than one year and not later than five years;	143	396
- later than five years.	0	0
Finance charges allocated to future periods	(9)	(37)
Net lease liabilities	**387**	**938**
Ageing of net lease liabilities		
- not later than one year;	246	551
- later than one year and not later than five years;	141	387
- later than five years.	0	0
	387	**938**

18.2 Liabilities arising from financing activities

	Total £'000	DHSC Loans £'000	Finance Lease with non-DHSC group counterparty £'000	PFI £'000
Carrying value at 1 April 2021	35,095	17,529	938	16,628
Financing cash flows - principal	(2,459)	(1,445)	(551)	(463)
Financing cash flows - interest	(1,848)	(795)	(27)	(1,026)
Additions	0	0	0	0
Interest charge arising in year	1,846	793	27	1,026
Carrying value at 31 March 2022	**32,634**	**16,082**	**387**	**16,165**

18.3 Private Finance Initiative (PFI) Obligations (on Statement of Financial Position)

	2021/22	2020/21
	£'000	£'000
Gross PFI liabilities	25,130	26,619
of which liabilities are due		
- not later than one year;	1,653	1,489
- later than one year and not later than five years;	6,473	6,580
- later than five years.	17,004	18,550
Finance charges allocated to future periods	(8,965)	(9,991)
Net PFI liabilities	**16,165**	**16,628**
Ageing of PFI liabilities		
- not later than one year;	658	463
- later than one year and not later than five years;	2,946	2,874
- later than five years.	12,561	13,291
	16,165	**16,628**

18.4 Amounts included in operating expenses payable to service concession operator

	2021/22	2020/21
	£'000	£'000
Interest charge	1,026	1,052
Repayment of finance lease liability	463	468
Service element	673	664
Capital lifecycle maintenance	925	865
Contingent rent	859	844
	3,946	**3,893**

18.5 Amounts included in operating expenses in respect of PFI transactions deemed to be in the categories listed below

	2020/21	2020/21
	£'000	£'000
Service element	673	664
Depreciation	243	37
	916	**701**

18.6 Finance charges in respect of PFI transactions

Finance charges in respect of PFI transactions are shown under note 7.2.

18.7 PFI scheme details

Estimated capital value of PFI scheme	£14,426K
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	14 years, 9 months
Contract end date	December 2036

18.8 The Trust is committed to make the following payments for the total service element for on SoFP PFI service concessions for each of the following periods

	2021/22	2020/21
	£'000	£'000
Hadfield Block:		
- Within one year	727	673
- 2nd to 5th years (inclusive)	3,094	2,866
- Later than 5 years	8,941	9,253
	12,762	**12,792**

18.9 Total future payments committed in respect of PFI

	2021/22	2020/21
	£'000	£'000
Hadfield Block:		
- Within one year	4,268	3,946
- 2nd to 5th years (inclusive)	18,166	16,796
- Later than 5 years	52,433	54,167
	74,867	**74,909**

The PFI scheme is a scheme to design, build, finance and maintain a medical ward block on the Northern General Hospital site (Sir Robert Hadfield Block). The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement. .

The unitary charge for the scheme is subject to an annual uplift for future price increases. The operators are responsible for providing a managed maintenance service for the length of the contract, after such time these responsibilities revert to the Trust.

Future unitary charge payments will be uplifted based on actual changes in RPI. In terms of assessing future commitments it is assumed that future indexation will be 2.5% p.a. for all remaining years of the contract.

19. Provisions for liabilities and charges

	Current		Non-Current	
	2021/22	2020/21	2021/22	2020/21
Pensions relating to former staff	222	222	3,097	3,141
Legal claims	521	515	83	178
Agenda For Change	0	0	0	0
Redundancy	60	0	0	0
2019/20 Clinicians' Pension Reimbursement	33	0	2,486	181
Other	6,122	5,008	0	485
	6,958	**5,745**	**5,666**	**3,985**

	2021/22							2020/21
	Total £'000	**Pensions relating to former staff** £'000	**Legal claims** £'000	**Agenda for Change** £'000	**Redundancy** £'000	**2019/20 Clinicians' Pension Reimbursement** £'000	**Other** £'000	**Total** £'000
At 1 April	9,730	3,363	693	0	0	181	5,493	6,101
Change in discount rate	95	95	0	0	0	0	0	144
Arising during the year	6,173	121	360	0	60	2,338	3,294	4,334
Utilised during the year	(435)	(217)	(158)	0	0	0	(60)	(311)
Reversed unused	(2,896)	0	(291)	0	0	0	(2,605)	(506)
Unwinding of discount	(43)	(43)	0	0	0	0	0	(32)
At 31 March	**12,624**	**3,319**	**604**	**0**	**60**	**2,519**	**6,112**	9,730
Expected timing of cashflows								
Within one year	6,958	222	521	0	60	33	6,122	5,745
Between one and five years	1,150	916	83	0	0	151	0	1,750
After five years	4,516	2,181	0	0	0	2,335	0	2,235
	12,624	**3,319**	**604**	**0**	**60**	**2,519**	**6,122**	9,730

Pensions relating to former staff represents the liability relating to staff retiring before April 95 (£460k) and Injury Benefit Liabilities (£2,859k). Injury Benefits 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 discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown. Legal claims relate to:

- Claims brought against the Trust for Employers 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. Costs in excess of £10,000 per case are covered by NHS Resolution and not included above. The provision for such cases totals £295k.
- A number of other legal cases, not being handled by the NHS Resolution, are also recorded under this heading. These total £309k.

Other Provisions

- The Trust has recognised a provision of £626k in respect of potential future pension liabilities which will be charged by the NHS Pensions Agency in respect of final pay controls.
- The Trust has recognised in-year a provision of £1,958k in respect of sundry employment related issues.
- The Trust has recognised a provision of £3,538k in respect of taxation matters which may become payable to HMRC
- £589,366k is included in the provisions of NHS Resolution at 31/03/2022 in respect of clinical negligence liabilities of the Trust (31/3/2021 £390,221k).

20. Revaluation Reserve

	Total Revaluation Reserve £'000	Revaluation Reserve - intangibles £'000	Revaluation Reserve - property, plant and equipment £'000
Revaluation reserve at 1 April 2021	37,439	0	37,439
Transfer by absorption	0	0	0
Impairments	(2,515)	0	(2,515)
Revaluations	5,415	0	5,415
Transfers to other reserves	(1,135)	0	(1,135)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2022	**39,204**	**0**	**39,204**
Revaluation reserve at 1 April 2020	35,179	0	35,179
Transfer by absorption	0	0	0
Impairments	193	0	193
Revaluations	3,113	0	3,113
Transfers to other reserves	(1,046)	0	(1,046)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2021	**37,439**	**0**	**37,439**

21. Cash and cash equivalent

	2021/22 £'000	**2020/21** £'000
At 1 April	186,253	90,775
Net change in year	31,731	95,478
At 31 March	**217,984**	**186,253**
Analysed as cash held:		
- At Commercial Banks and in hand	135	128
- At Government Banking Service	217,849	186,125
Cash and cash equivalents as in the Statement of Financial Position	**217,984**	**186,253**

22. Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position Date were £13.8m (31 March 2021, £7.6m).

The major components of these commitments are as follows:	**Property, Plant & Equipment 2021/22**
	£'000
Scheme:	
Redevelopment / Additional Linear Accelerator Bunkers - Weston Park Hospital	5,940
Chiller Replacement - Firth Wing and Chesterman, Northern General Hospital	1,209
Ward Refurbishment - Royal Hallamshire Hospital	1,126
Gamma Cameras - Royal Hallamshire and Weston Park Hospitals	1,112
B Road Water Proofing - Royal Hallamshire Hospital	941
Picture Archiving and Communication System (PACS)	819
Lift Refurbishment - Weston Park Hospital	574
Other	2,071
Total	**13,792**

The increase in Capital Commitments of £6.2m between financial year ends is mainly driven by Trust capital planning and business case approval timings.

23. Events after the reporting period

There are no other events after the reporting period to highlight.

24. Contingencies

24.1 Contingent liabilities

	2021/22	**2020/21**
	£'000	£'000
Gross value	(119)	(130)
Amounts recoverable	0	0
Net contingent liability	(119)	(130)

Quantified contingencies shown above represent the consequences of losing all current third party legal claim cases currently with NHS Resolution and represent the Trust's excess is relation to such cases, however, the likelihood of losing all cases is considered remote. Note 19 quantifies those cases which have been provided for (£604k) where it is considered more likely that liabilities will crystallize.

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25. Related party transactions

Sheffield Teaching Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sheffield Teaching Hospitals NHS Foundation Trust. Details of Directors' remuneration and pension benefits can be found in the Remuneration Report in the Annual Report. The Declaration of Directors' interests is to be found on page 46 of the Annual Report.

The Department of Health and Social Care is regarded as a related party. During the year Sheffield Teaching Hospitals NHS Foundation 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 including NHSE, Health Education England and NHS Resolution.

In addition, the Trust has had a number of material transactions with other joint enterprises, government departments and other central and local government bodies. Most of these transactions have been with the Department of Education in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises. Income from the University of Sheffield and Sheffield City Council totalled £4,774k and £4,185k respectively.

Expenditure on goods and services was in the sum of £12,801k from the University of Sheffield and £6,517k from Sheffield City Council. At 31 March 2022 £4,319k was owed to the Trust by the University of Sheffield, whilst £8,879k was owed by the Trust.

The Trust considers other NHS Foundation Trusts and NHS bodies to be related parties, as they and the Trust are under the common control of Monitor (NHS Improvement from 1 April 2016), and the Department of Health and Social Care. During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non-clinical support services. Those organisations where the value exceeded £20m include Barnsley CCG, Derby & Derbyshire CCG, Rotherham CCG and Sheffield CCG.

The Trust has considered the list of individuals and entities which have been assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2022. This list was published by the Department of Health and Social Care in May 2022. Of the individuals and entities listed, it has traded in-year with the Leeds Teaching Hospitals NHS Trust. Income received in 2021/22 was in the sum of £256k and expenditure was £8,259k.

Some other entities with whom the Trust trades are considered related parties. These entities are to an extent controlled and / or influenced by certain Non-Executive Directors by the nature of their engagement with that body. Mr Chris Newman, Non-Executive Director, is Dean of the Medical School, University of Sheffield. Toni Schwarz, Non-Executive Director is Dean of the College of Health and Wellbeing Lifesciences, Sheffield Hallam University. As mentioned in the Directors’ Report, a full Register of Directors’ Interests is maintained by the Assistant Chief Executive.

During the year the Trust purchased healthcare from Thornbury Private Hospital in the sum of £2,920k and from Claremont Hospital in the sum of £6,882k. Certain of the Trust's clinical employees have an interest in these companies. Clinical services were provided to these organisations.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely. These governors represent the views of the staff and of the organisations with and for whom they work. This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charity of whom Mr John O'Kane, Non-Executive Director and Mr Chris Morley, Chief Nurse, are trustees. Grants received in the year from this Charity amounted to £1.8m (2020/21 £1.2m).

26. Financial instruments

26.1 Financial assets

Carrying values of financial assets as at 31 March 2022 under IFRS 9	Held at amortised cost £'000	Held at fair value through P&L £'000	Held at fair value through OCI £'000	Total £'000
Receivables excluding non-financial assets	30,584	0	0	30,584
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2022)	217,984	0	0	217,984
Total at 31 March 2022	**248,568**	**0**	**0**	**248,568**

Carrying values of financial assets as at 31 March 2021 under IFRS 9	Held at amortised cost £'000	Held at fair value through P&L £'000	Held at fair value through OCI £'000	Total £'000
Receivables excluding non-financial assets	21,638	0	0	21,638
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2021)	186,253	0	0	186,253
Total at 31 March 2021	**207,891**	**0**	**0**	**207,891**

26.2 Financial liabilities by category

Carrying values of financial liabilities as at 31 March 2022 under IFRS 9	Held at amortised cost £'000	Liabilities at fair value through the SoCI £'000	Total £'000
Borrowings excluding Finance lease and PFI liabilities	16,082		16,082
Finance lease obligations	387		387
Obligations under Private Finance Initiative contracts	16,165		16,165
Trade and other payables excluding non-financial assets	164,368		164,368
Provisions under contract	0		0
Total at 31 March 2022	**197,002**	**0**	**197,002**

Carrying values of financial liabilities as at 31 March 2021 under IFRS 9	Held at amortised cost £'000	Liabilities at fair value through the SoCI £'000	Total £'000
Borrowings excluding Finance lease and PFI liabilities	17,529		17,529
Finance lease obligations	938		938
Obligations under Private Finance Initiative contracts	16,628		16,628
Trade and other payables excluding non-financial assets	114,367		114,367
Provisions under contract	0		0
Total at 31 March 2021	**149,462**	**0**	**149,462**

26.3 Maturity of financial liabilities	2021/22	2020/21
	£'000	£'000
In one year or less	168,681	118,695
In more than one year but not more than five years	14,634	15,527
In more than five years	27,286	30,474
Total	**210,601**	**164,696**

26.4 Fair values of financial assets and liabilities at 31 March 2022

The fair value of the Trust’s financial assets at 31 March 2022 equates to book value. The book value of financial assets and liabilities is shown in notes 26.1 and 26.2.

Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's), and the way the DHSC/CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust has borrowings for capital expenditure, but is subject to affordability as confirmed by the FT Financing Facility. The borrowings are for a maximum remaining period of thirteen years, in line with the associated assets, and interest is charged at 4.80% and 4.59%, fixed for the life of the respective loans. The Trust therefore has low exposure to interest rate fluctuations in this area. The Trust also has borrowings in respect of leasing and its PFI contract which incur fixed interest rates of 4.00% and 6.32% respectively. Exposure to interest rate risk is therefore low as these borrowings are fixed.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the Trade and other receivables note. Owing to the architecture of its financial regime, the Trust does not consider itself to be exposed to any significant greater credit risk as a result of the Covid-19 pandemic.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with Clinical Commissioning Groups, or the Department of Health and Social Care, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks. As with credit risk, the Trust does not consider itself to be exposed to any significant greater liquidity risk as a result of the Covid-19 pandemic.

27. Third party assets

The Trust held £49k at bank and in hand at 31 March 2022 (£20k at 31 March 2021), which related to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts (see note 21).

28. Losses and special payments

	2021/22		2020/21	
	Number	Value £'000	Number	Value £'000
Losses				
Cash Losses	4	0	1	0
Fruitless payments and constructive losses	0	0	0	0
Bad debts and claims abandoned	217	179	320	266
Stores losses (including damage to buildings and property)	5	191	10	557
	226	**370**	**331**	**823**
Special payments				
Extra-contractual payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	1	6	2	29
Special severance payments	0	0	0	0
Ex-gratia payments (including nationally agreed overtime corrective payments)*	44	166	45	2,789
	45	**172**	**47**	**2,818**
Total losses and special payments	**271**	**542**	**378**	**3,641**

No individual items exceeding £300,000 were incurred in either year. These losses are reported on an accruals basis.

* The 2020/21 comparative has been restated in order to comply with reporting requirements in relation to nationally agreed overtime corrective payments.

29. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets, and to pay a dividend based on this rate to HM Treasury. The rate of 3.5% is applied to the Trust's net relevant assets, which are abated by the value of donated assets, any dividend payable or receivable (where appropriate), and by average daily cleared balances held with the Government Banking Service. This resulted in a dividend of £5,754k (2020/21 £5,666k).

For more information please contact :

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