

HEALTH SELECT COMMISSION

Date and Time:- Thursday 2 October 2025 at 5.00 p.m.

Venue:- Rotherham Town Hall, The Crofts, Moorgate Street, Rotherham. S60 2TH

Membership:- Councillors Keenan (Chair), Yasseen (Vice-Chair), Adair, Ahmed, Baum-Dixon, Bennett-Sylvester, Brent, Clarke, Duncan, Garnett, Harper, Havard, Knight, Reynolds, Tarmey, Thorp, Fisher and Harrison.

Co-opted Member David Gill representing Rotherham Speak Up.

This meeting will be webcast live and will be available to view [via the Council's website](#). The items which will be discussed are described on the agenda below and there are reports attached which give more details.

Rotherham Council advocates openness and transparency as part of its democratic processes.

Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

AGENDA

1. Apologies for Absence

To receive the apologies of any Member who is unable to attend the meeting.

2. Minutes of the previous meeting held on 31 July 2025 (Pages 5 - 21)

To consider and approve the minutes of the previous meeting held on 31 July 2025 as a true and correct record of the proceedings and to be signed by the Chair.

3. Declarations of Interest

To receive declarations of interest from Members in respect of items listed on the agenda.

4. Questions from members of the public and the press

To receive questions relating to items of business on the agenda from

members of the public or press who are present at the meeting.

5. Exclusion of the Press and Public

To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

For Discussion/Decision:-

6. Physical Activity for Health (Sport England) (Pages 23 - 66)

This item is to receive a report and presentation providing an update in relation to how the Moving Rotherham Partnership is using grant funding secured to improve health across the borough through physical activity.

7. TRFT Annual Report (Pages 67 - 228)

This item is to receive a the TRFT Annual Report and a supporting presentation which highlights areas of particular interest for the Health Select Commission, and to assist it to identify areas of TRFT's work that it would like to consider in more detail.

8. Safeguarding Adults Board Strategic Plan 2025-2028 (Pages 229 - 252)

This item is to receive a report and presentation in relation to the Safeguarding Adults Board Strategic Plan 2025-2028, in order to assist the Commission to identify aspects it may wish to consider in more detail during that period.

This item had previously been considered by the Improving Lives Select Commission, and was brought under the Health Select Commission's remit under changes to the constitution in the 2025/26 municipal year.

9. Health Select Commission Work Programme - 2024/25 (Pages 253 - 254)

To consider the Health Select Commission's work programme for 2024/25.

For Information/Monitoring:-

To receive and note the contents of any reports routinely submitted to the Health Select Commission for information and awareness.

10. South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee (Pages 255 - 260)

To receive and consider the minutes and recommendations of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee.

11. Adult Social Care Local Account 'How Did We Do?' (Pages 261 - 300)

This item is to ensure that the Health Select Commission are sighted on the contents of the Adult Social Care 'How Did We Do?' Local Account.

12. Health and Wellbeing Strategy (Pages 301 - 337)

This item it to ensure that the Health Select Commission are sighted on the Health and Wellbeing Strategy.

13. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.



JOHN EDWARDS,
Chief Executive.

**The next meeting of the Health Select Commission
will be held on Thursday 20 November 2025
commencing at 5.00 p.m.
in Rotherham Town Hall.**

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HEALTH SELECT COMMISSION
Thursday 31 July 2025

Present:- Councillor Keenan (in the Chair); Councillors Yasseen, Ahmed, Bennett-Sylvester, Brent, Clarke, Duncan, Garnett, Harper, Havard, Knight, Thorp and Fisher.

Apologies for absence:- Apologies were received from Adair and Baum-Dixon.

The webcast of the Council Meeting can be viewed at:-

<https://rotherham.public-i.tv/core/portal/home>

11. MINUTES OF THE PREVIOUS MEETING HELD ON 26 JUNE 2025

Resolved:-

That the minutes of the meeting held on 26 June 2025 were approved as a true and correct record of the proceedings.

12. DECLARATIONS OF INTEREST

The following declarations of interest were made:-

Member	Agenda Item	Interest Type	Nature of Interest
Councillor Ahmed	Agenda Item 6 – ADASS (Association of Directors of Adult Social Services) Peer Review Report	Disclosable Pecuniary Interest	Employment in commissioned provided of Adult Social Care Services

13. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or press.

14. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

15. ADASS PEER REVIEW REPORT

The Chair welcomed Councillor Baker-Rogers, Cabinet Member for Adult

Care and Health, and Dania Pritchard, Assurance Lead, Professional Practice to the meeting and invited them to introduce the report and presentation.

The Cabinet Member for Adult Care and Health explained that in January 2025, Rotherham Council's Adult Social Care (ASC) Service undertook a significant step in its journey of continuous improvement by commissioning a peer review from the Association of Directors of Adult Social Services (ADASS). This initiative was driven by a desire to gain external assurance on the effectiveness of its service delivery and to ensure that the needs of residents were being met in a compassionate, efficient, and person-centred manner.

The review was conducted over three days and was framed around the Care Quality Commission's (CQC) assurance framework. Specifically, the review focused on three of the four key themes: working with people, providing support, and leadership. The fourth theme, ensuring safety, had already been addressed through a separate peer review by the Rotherham Safeguarding Adults Board earlier in the year.

To carry out the review, ADASS engaged in a comprehensive process that included the audit of 12 case files, interviews, and discussions with approximately 150 individuals including council staff, partner organisations, and people with lived experience along with a thorough examination of submitted evidence. In total, the Peer Review Team spent around 200 hours engaging with the council, both on-site and through document analysis, to build a detailed understanding of the service's strengths and areas for development.

The findings of the review were both affirming and constructive. ADASS identified ten key messages that painted a largely positive picture of Rotherham's adult social care landscape. There was clear evidence of strong political and corporate leadership, which instilled confidence in the service's ability to deliver high-quality care. Relationships with external partners were described as robust and impactful, with numerous examples of effective collaboration that directly benefited service users.

The Assurance Lead, Professional Practice indicated that one of the most encouraging observations was the growing adoption of person-centred and strengths-based approaches. These practices were becoming increasingly embedded in day-to-day operations, reflecting a cultural shift towards empowering individuals and recognising their capabilities. Staff across the service spoke positively about the learning and development opportunities available to them, highlighting the council's investment in professional growth and workforce sustainability.

The review also noted that the council had established robust systems for quality assurance, performance monitoring, and risk management. Providers reported feeling well-supported through a model of 'high challenge, high support' which fostered accountability while encouraging

innovation. At the time of the review, there were no delays in the commissioning of home care services, and there was adequate capacity within supported living arrangements—both indicators of a well-functioning care infrastructure.

Despite the strengths identified, the review did not shy away from identifying areas where further progress was needed. ADASS recommended that the Council place greater emphasis on articulating the outcomes and experiences of service users, moving beyond process metrics to understand the real-world impact of care interventions.

Recruitment challenges remained, which included some use of agency staff and whilst efforts to reduce agency reliance were acknowledged, continued focus was advised to address those challenges. Additionally, the voice of people with lived experience needed to be more deeply embedded, not only in strategic planning but also in everyday service delivery.

The Peer Review Team also encouraged the council to celebrate its successes more visibly. They observed that while innovative and effective work was taking place, it was not always recognised or shared widely enough. This presented an opportunity to boost morale, foster pride, and build public confidence in the service.

Safeguarding processes were found to be proactive, with risks and outcomes considered early in the intervention. The Council's market position statement supported a whole-market approach to shaping the independent care sector, ensuring that services were responsive to the needs of Rotherham people and bridged identified gaps. The relationship between commissioning and quality teams was described as strong and collaborative, contributing to the delivery of high-quality community care services.

Feedback from individuals with lived experience was overwhelmingly positive. The Peer Review Team met with six distinct groups, including people with learning disabilities and those experiencing mental health challenges, who shared how the services had positively impacted their lives. The Safeguarding Adults Board was also commended for its effective partnerships and coordinated approach to protecting vulnerable residents.

Leadership within the Adult Social Care service was consistently praised. Senior leaders were visible, stable, and approachable, and the Principal Social Worker maintained a productive relationship with the Strategic Director, enabling meaningful influence and collaboration. Career development pathways were well-established, with opportunities such as apprenticeships, advanced practitioner roles, and structured support for newly qualified social workers. The service demonstrated a clear willingness to innovate, learn, and adapt which were qualities that gave the Peer Review Team confidence in its future trajectory.

In response to the review, the Council developed a comprehensive improvement plan aligned with the CQC assurance framework. This plan included targeted actions across all four themes, even though the peer review had only focused on three. The plan outlined six recommendations under 'working with people' four under 'providing support' three under 'ensuring safety' and four under 'leadership'. These actions were scheduled for completion by spring 2026 and were to be monitored through the Council's monthly Adult Social Care Regulatory Assurance Board.

Importantly, many of the improvements identified in the review were already underway prior to the ADASS visit, reflecting the Council's proactive approach to service development. The timing of the review also aligned with preparations for the CQC inspection, which took place in July 2025. Although the results of the inspection were not yet available, they were expected by late autumn, and the service intended to report the findings to the Health Select Commission following receipt.

The Cabinet Member for Adult Care and Health commented that they felt the report reflected an incredibly positive picture in terms of the provision of Council services for adult social care and health. They believed that the service was committed, had a workforce that was proud to work for Rotherham Council and was very compassionate and caring to the residents they served. They also noted that the report reflected that the service wanted to move forward in terms of the technologies used to improve ways of working.

The Chair thanked The Cabinet Member for Adult Care and Health and the Assurance Lead, Professional Practice for the comprehensive report and invited questions and comments from Members.

Councillor Fisher commented that they like the idea about doing more to celebrate success and achievements. They wanted to understand how the Council intended to address this going forward.

The Assurance Lead, Professional Practice advised that the Council had already begun implementing initiatives to celebrate success. Two whole-service events were held annually, which focussed on sharing best practice and celebrating achievements. A new initiative called 'Time to Shine' was introduced to highlight impactful stories from staff, which showcased the difference their work made to individuals. These stories were shared with consent, often including photographs. Weekly Senior Management Team meetings featured examples of strong equality, diversity, and inclusion practice. Staff achievements were also recognised through corporate awards and external accolades such as the South Yorkshire Teaching Partnership Awards. Additionally, informal "coffee and cake" sessions were being organised for staff involved in the CQC inspection to reflect and celebrate their contributions.

Councillor Fisher also felt that it was difficult to identify from the report which specific parts of the service were attributed to the strengths and recommendations it contained. They wanted to know if it was possible for this to be clarified in order to allow the Health Select Commission to identify any pockets of concern where it might want to do further scrutiny work or seek further assurances.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that the peer review was conducted at a macro level and assessed the service's delivery of requirements under the Health and Social Care Act more broadly, whilst it did drill into some specifics.

They proposed consolidating findings from the LGA (Local Government Association), ADASS, and CQC reviews once published into a single overarching update of the service's improvement journey to bring to a future Health Select Commission meeting to provide clarity and facilitate further scrutiny.

Councillor Garnett wanted to know more about the three stage test in safeguarding and wanted to understand what systems were in place to ensure the consistent application of the test and whether there were any identified patterns or gaps in how the test was applied across various parts of the service.

The Assurance Lead, Professional Practice advised that the Council had recently strengthened the application of the three-stage test. While a detailed explanation was deferred, it was confirmed that feedback from the ADASS review led to reflection by the Safeguarding Adults Board. In response to a specific case file audit, the board commissioned a Mental Capacity Act coaching support programme to strengthen practice. Officers committed to providing a written response with more detail on the three-stage test.

Councillor Garnett also wanted to understand what steps were being taken to improve staff understanding and application of the Mental Capacity Act and whether there were mechanisms in place to audit decisions made under the Act to ensure compliance and best practise.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that staff development included reflective practice through one-to-one discussions at practitioner level and bespoke training. Routine audits were conducted to assess decision-making under the Act, and findings were used to inform further training and development. The council emphasised the importance of equipping staff with the best information to make informed decisions as part of its training and development offer.

Councillor Havard wanted to know what strategies were in place to address gaps in commissioning and procurement, given the mention within the report of the need to develop tactical commissioning

approaches, direct payments limiting options for support and more work needed to commission a more diverse range of options and more work to map and understand the full range of preventative support available in the community. They also wanted to know what strategies were in place to address any identified gaps in the market, particularly in light of the anticipated procurement changes, and how the Council used strategic insights to inform commissioning and procurement activities. They were particularly interested in whether any specific areas such as learning disabilities, micro enterprises, or carer services had been identified for further development.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that the Council conducted annual market sustainability assessments in order to be clear about the needs that the Council had for its residents now and in the future and then proactively worked with the market in terms of making sure we can meet those needs now in the medium to long term. Tactical commissioning ensured quality and diversity in service options, including direct payments and support for unpaid carers. Strategic insights informed procurement, and flexible purchasing systems were used to maintain standards with appropriate governance in place to ensure quality assurance and maintain an appropriate suite of options.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer highlighted that direct payments and self-directed support was incredibly important in terms of making sure that people had as much power and control as possible over the services that they want to and do receive as part of Adult Social Care. They added that specific areas such as learning disabilities, autism, and support for unpaid carers had been targeted for development and that the Council also worked closely with the voluntary and community sector to co-produce and co-design services. They referred to information previously shared with the Health Select Commission around flexible purchasing systems use in Adult Social Care and how that delivered quality and sufficiency of care in a timely manner. They also explained that the Council worked with providers to stimulate them in terms of coming into Rotherham but also supporting the evolution of the provider base to make sure it remained appropriate to need locally and that would continue to be reflected in the market position statement.

Councillor Havard requested further reassurance regarding how the Council planned to manage procurement changes without disrupting service provision.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer confirmed that whilst amended procurement regulations were now in place procurement changes would be implemented gradually to avoid disruption. Internal processes were being reviewed to ensure compliance with new regulations, and the focus remained on maintaining high standards of care and support for residents.

Councillor Clarke asked officers to elaborate on the recruitment challenges Adult Social Care faced.

The Assurance Lead, Professional Practice explained that recruitment challenges were an acknowledged national trend. Agency staff were used primarily to address recruitment challenges around specific projects, such as reducing wait times for Care Act assessments. The Council had developed a recruitment microsite to focus on attracting newly qualified social workers, whilst apprenticeship programmes and collaborative work with the South Yorkshire Teaching Partnership were used to grow internal capacity and support future workforce development.

Councillor Clarke commented that they would welcome an invitation to any awards ceremony for Adult Social Care staff to show support for those delivering vital front line services. The Chair echoed that request.

Councillor Thorp noted concern about over-reliance on phone and internet support within the report. They wanted to know how the Council intended to address that.

The Assurance Lead, Professional Practice reassured Councillor Thorp that face-to-face support remained available, but acknowledged that some individuals felt underserved by digital channels. The Council had implemented digital inclusion strategies, including support at libraries and free Wi-Fi in community centres. Officers clarified that the feedback reflected individual experiences based on a limited sample and emphasises that face-to-face assessments were still in place.

Councillor Thorp also wanted to understand what was meant by 'zero delays in home care' and 'good capacity for supported living for some people'.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that 'zero delays' referred to a specific point in time and was subject to change based on demand. The 'some people' referred to indicated that supported living capacity was sufficient for certain needs, but matching individual preferences could still result in delays. The Council continued to refine its care and assessment planning to ensure appropriate service matching.

Councillor Yasseen reflected that overall, the review had been positive and the explanations provided regarding how improvements would be taken forward had demonstrated reflection and direction in terms of next steps. They queried whether there was a thematic contrast between strengths and areas for improvement identified in the report as they had noted that the identified strengths focused on internal organisational aspects, while areas for improvement related more to service users' experiences.

The Assurance Lead, Professional Practice responded that the feedback was balanced but also reflected a moment in time. They acknowledged the need to promote and expand the mechanisms for embedding lived experience into service design, such as SMS surveys and “How Did We Do” feedback cards, and QR codes.

The Cabinet Member for Adult Care and Health added that user voice was incredibly important and the service did want to hear about people’s experiences, thoughts, and suggestions. We do want to hear what people think.

Whilst ideally, the service wanted users to a positive experience, it also wanted to capture feedback and experiences, whatever they were as a vehicle for continual improvement which was why expanding the means of gathering feedback was so important.

Councillor Yasseen also wanted to understand what the safeguarding three stage test actually was in practice.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that the test was a legislative framework used to determine whether a safeguarding referral should be made. Practitioners conducted initial screenings, and if thresholds were not met, alternative routes such as contract compliance or social worker reviews were pursued. Officers offered to provide a more detailed explanation in a future safeguarding report if that would be helpful to Members.

Councillor Yasseen reflected that the transition from children’s to adult services remained a challenge. They acknowledged that there had been improvements over time, but queried what more was being done to improve the transition.

The Assurance Lead, Professional Practice referred to the Preparing for Adulthood pathway, which aimed to ensure timely support for young people approaching 18. Officers acknowledged historical challenges but highlighted recent improvements in early planning and lifetime needs assessments. The council remained committed to strengthening this area further building on the improvements already achieved.

Councillor Havard wanted to understand how Adult Social Care services could be more closely aligned with the Carer’s Strategy.

The Assurance Lead, Professional Practice explained that the Council worked closely with the Rotherham Carers Network and had appointed Carers Link Officers within Adult Contact Teams. These officers supported carers and ensured alignment between peer review feedback and strategic priorities. The strategic lead for carers participated in the monthly regulatory assurance board to maintain focus and coordination.

The Assistant Director of Strategic Commissioning and Health Select

Commission Link Officer added that alignment was incredibly important for the Council. There had been significant investment in ensuring clarity around the carer offer and recognising the value and contribution of unpaid carers to the overall wellbeing of Rotherham residents. The focus was on being clear about priorities, informed by lived experience and embedding that in the overall service approach which was enhanced by the appointment of the Carers Link Officers.

Councillor Fisher queried the budget implications of using agency staff to address recruitment challenges.

The Assistant Director of Strategic Commissioning and Health Select Commission Link Officer explained that agency staff usage was managed within the council's financial framework. It was primarily used to maintain safe staffing thresholds within in-house services and to support transformational projects. Budgetary allowances were made on a case-by-case basis to ensure sustainability and compliance.

Resolved:-

That the Health Select Commission:

1. Noted the findings of the Peer Review of Adult Social Care and the subsequent improvement programme.
2. Requested that more specific detail be provided regarding which parts of the service the identified strengths and areas for improvement related to in order for consideration to be given to the need for further scrutiny around particular areas of provision.
3. Requested that 'Time to Shine' information or information from similar initiatives be shared with the Health Select Commission at regular intervals so that the Commission was sighted on the services success and achievements and the ways in which they were celebrated.
4. Agreed that Adult Social Care would provide a consolidated report encompassing the service's improvement journey in the context of the LGA, ADASS and CQC reports at an appropriate point in the future following the publication of the latter.
5. Agreed that the service would provide a written explanation of the application of the three stage test in safeguarding to aid Members' understanding of this issue.

16. HEALTHWATCH ROTHERHAM ANNUAL REPORT

The Chair welcomed Kym Gleeson, Healthwatch Rotherham Manager to the meeting and invited them to introduce the annual report.

The Healthwatch Rotherham Manager acknowledged the recent government announcement signalling the intention to terminate the Healthwatch model by amending the Health and Social Care Act and transfer its statutory functions to the DHSC (Department for Health and Social Care). This development raised concerns about the future of statutory independence, service continuity, and the long-term mission to amplify patient voices and address health inequalities. Despite the uncertainty and lack of a clear transitional plan from commissioners, Healthwatch remained committed to safeguarding Rotherham's independent voice and working with strategic partners to protect transitional areas.

The Chair responded by commending Healthwatch Rotherham for its outstanding work over the years, acknowledging its role in bringing critical issues to light and representing the voice of the community with dedication and effectiveness.

The Healthwatch Rotherham Manager described that during 2024–2025, Healthwatch Rotherham had undertaken a wide range of impactful activities aimed at amplifying the voices of local residents and improving health and social care services. During the year, Healthwatch engaged with over 1000 individuals who shared their experiences of health and social care, highlighting both successes and areas needing improvement. The organisation supported more than 10,000 people by providing guidance on accessing NHS dentists, understanding mental health services, and navigating the healthcare system.

Outreach efforts included 126 sessions reaching over 4,000 individuals, and targeted health information was delivered to more than 250 people through “Let’s Talk” sessions on topics such as smoking, vaping, and digital support.

Healthwatch’s digital presence extended its reach to over 40,000 people via social media, enabling access to health information beyond traditional methods.

Behind every statistic lay a personal story, and Healthwatch focused on preserving dignity, empowerment, and equity in care. Five focus reports were published during the year, each based on direct community feedback. These reports addressed issues such as misaligned appointment times with public transport timetabling, the need for real-time travel information, and calls for more evening and weekend services. Following the transport report, local bus operators and NHS schedulers revised timetables and added stops.

People with Autism and those with learning disabilities advocated for routine health checks, sensory-friendly waiting areas, easy-read materials, health passports, and staff training in compassionate communication.

Refugee communities highlighted inconsistent interpreter availability, lack

of continuity between trusts, and limited cultural competency among staff, requesting more translation support and tailored mental health outreach. People experiencing homelessness called for mobile clinics, fast-track dental referrals, addiction and mental health support at shelters, and digital inclusion initiatives.

Healthwatch also engaged with 445 young people who expressed confusion about where to seek mental health support. In response, the organisation created and distributed a young persons' mental health directory, available both online and in print. The Young Persons Report was selected to feature in the Director of Public Health's annual report, demonstrating its broader value to services and the council.

Continued engagement with the neurodiverse community led to the co-production of an Accessible Information Standard style card to address the lack of reasonable adjustments in care. The easy-read communication card was embedded into practice, enabling clearer healthcare conversations. These efforts translated into tangible changes.

Healthwatch's regional collaboration with counterparts in Sheffield, Doncaster, and Barnsley facilitated county-wide issue identification and coordinated action. Its presence on the Place Board and partnership with Citizens Advice ensured that Rotherham residents' experiences influenced regional planning and service improvements.

Through targeted projects, Healthwatch transformed lived experiences into actionable insights, co-designed solutions with service providers, and maintained a consistent stream of community feedback to sustain change.

Personal stories were central to Healthwatch's approach. Alina's blog, detailing her journey as a refugee navigating inconsistent NHS care, prompted South Yorkshire ICB (Integrated Care Board) to invite her to present at a full board meeting and arrange for her story to be filmed.

When veterans requested a portable health passport, Healthwatch collaborated with the Rotherham Foundation Trust and the veterans themselves to co-design an A5 document that captured individual adjustment preferences, empowering veterans during appointments. Healthwatch's sustained engagement led to measurable improvements, including redesigned waiting areas and simplified referral pathways.

Monthly "What We Heard" insights and "Let's Talk" sessions expanded community reach by over a third compared to the previous year. The organisation deliberately sought out underrepresented voices and translated their experiences into clear, targeted recommendations. Its information and signposting service supported over 10,000 people with reliable guidance on navigating the NHS, registering with GPs, and raising concerns about care. The website hosted mental health resources and Easy Read materials to promote independence and self-advocacy. Healthwatch also supported the development of a comprehensive Easy

Read section with BSL (British Sign Language) tools in collaboration with the local ICB (Integrated Care Board) and the Rotherham NHS Foundation Trust.

Volunteers played a vital role in Healthwatch's work. Eight volunteers, including third-year medical and psychology students from the University of Sheffield, contributed 511 hours. Their involvement in enter-and-view visits and co-delivery of sessions provided them with meaningful patient interactions, which they described as invaluable and transformative for their future practice.

Looking ahead, Healthwatch planned three focus areas based on feedback from the past year: understanding digital and non-digital access challenges, supporting people with addiction and recovery, and exploring social care experiences. The latter was a new area of focus, informed by liaison with the Strategic Director of Adult Social Care, Housing and Public Health and participation in the ADASS peer review, including a mystery shopping exercise that identified front-door challenges and led to staff training.

The Healthwatch Rotherham Manager concluded with a respectful request for continued support to sustain independent patient voice's central role in shaping future services, especially in light of the proposed termination of the Healthwatch model.

The Chair thanked the Healthwatch Rotherham Manager for the detailed report and invited questions and comments from Members.

Councillor Brent asked king whether Healthwatch had worked in areas related to sexual health, sexuality, and gender identity, particularly in support of young people.

The Healthwatch Rotherham Manager responded that Healthwatch had actively worked with Rainbow in Wath, engaging with various groups including a transgender group. They had provided reassurance following changes in gender classification arising from the recent ruling and liaised with health partners to ensure compassionate care.

Councillor Brent appreciated the response and noted that the information would be useful for the Corporate Parenting Partnership Board. They also reflected the difficulties some members had experienced when reading the ADASS Peer Review Report and highlighted the importance of easy-read materials for those who needed them. They queried whether the library of easy-read materials created by Healthwatch might be lost and how the generation of further easy read materials might be sustained in its absence.

The Healthwatch Rotherham Manager explained that engagement with neurodiverse communities had revealed a lack of easy-read materials, prompting Healthwatch to champion their development. They had collaborated with Rotherham Hospital to pilot easy-read letters for

younger patients and were advocating for broader adoption across South Yorkshire, but agreed that this was a source of concern.

Councillor Harper asked about the health outcomes Healthwatch hoped to achieve through initiatives like the mystery shopper exercise, particularly for those receiving home care.

The Healthwatch Rotherham Manager explained that Healthwatch aimed to understand how recipients and providers of care packages felt about their experiences, including social contact and emotional wellbeing. She emphasised the importance of listening to lived experience to inform service design and expressed hope that the ICB would continue to commission independent voices.

Councillor Harper responded by expressing concern about Healthwatch's future and asked whether the organisation could continue in some form.

The Healthwatch Rotherham Manager clarified that Healthwatch was being abolished due to national policy changes and would cease to exist. They noted that the current funding was expected to last until March 2027, but uncertainty could lead to staff departures prior to that time.

Councillor Duncan reiterated the importance of independent patient voice in shaping services and driving improvements and transformation, and asked how scrutiny could support the transition from Healthwatch any new means of capturing patients voice that may be established.

The Healthwatch Rotherham Manager shared that Healthwatch's strategic board was preparing a lobbying effort to retain an independent patient voice in Rotherham and encouraged Members of the committee to support that if they were at all able.

Councillor Garnett queries how effectively public feedback was being integrated into decision-making and whether there were examples of service changes resulting from Healthwatch's work.

The Healthwatch Rotherham Manager provided several examples, including making GP surgeries more dementia-friendly and working with Rotherham Hospital's audiology department to reduce waiting times for hearing aids by establishing outreach clinics. She noted that many more examples were included in the report.

Councillor Clarke asked whether the decision to abolish Healthwatch was solely financially motivated and whether commissioners were resisting to the proposed change.

The Healthwatch Rotherham Manager responded that they understood that commissioners had received no prior information about the proposals and learned about the decision through announcements made in the media, which they felt was regrettable.

Councillor David Fisher asked about the young persons' directory and whether Healthwatch could measure its success.

The Healthwatch Rotherham Manager confirmed that the directory was a living tool and that QR codes had been distributed to schools and colleges for easy access. They were unable to provide data at that time, but agreed to provide this through the Governance Advisor at a later stage.

Councillor Yasseen praised Healthwatch's role in amplifying resident voices and noted the importance of its independent perspective, whilst noting the non-political nature of scrutiny work. They wanted to understand how Healthwatch had been able to increase resident engagement by 33% despite limited staffing.

The Healthwatch Rotherham Manager advised that the Healthwatch Rotherham team consisted of only 3.6 full-time equivalent staff and credited the increase to the addition of a dedicated information and signposting officer which had freed up time for the engagement officer to undertake additional outreach work. They also attributed the success to the team's passion and versatility.

Councillor Paul Thorp was impressed that Healthwatch had been able deliver so much with a limited budget and expressed hope that efforts could be made to preserve its work. Councillor Havard echoed Councillor Thorp's sentiment, noting Healthwatch's consistent presence at carers' forums.

The Chair referred to the Health Hub item discussed at the previous Health Select Commission meeting and asked whether Healthwatch had identified service gaps in services that could be addressed in phase two of the project.

The Healthwatch Rotherham Manager advocated for the inclusion of secondary care services in the Health Hub due to accessibility challenges in the hospital setting.

The Healthwatch Rotherham Manager concluded by extending and invitation to a health fair at Rotherham Minster on 11 September 2025, encouraged them to attend if they could and share details of the event with Rotherham communities to maximise reach.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the Healthwatch Annual Report.
2. Agreed to identify, with the assistance of Healthwatch's insights, potential health services that could be incorporated in

considerations for Phase 2 of the Health Hub Development to share with relevant Council services.

3. Requested that Healthwatch and relevant Officers consider how patient voice might best be represented going forward and how scrutiny can support that.
4. Requested that Healthwatch and relevant Officers consider how an easy-read document library including health literature might be sustained in the absence of Healthwatch.
5. Agreed to receive data relating to engagement and impact of the Young Person's Directory from Healthwatch at a later stage. The specific timeline for this was to be confirmed.

17. YORKSHIRE CANCER RESEARCH WHITE ROSE REPORT UPDATE

The Chair invited Councillor Clarke to provide an overview and update in relation to the Yorkshire Cancer Research White Rose Report launch event that they had attended on 3 July 2025, on behalf of the Health Select Commission.

Councillor Clarke advised that the event had taken place at the Wellbeing Research Centre in Attercliffe, where Yorkshire Cancer Research showcased their impactful work and facilities. The report, which was launched by SYMCA (South Yorkshire Mayoral Combined Authority) Mayor, Oliver Coppard, was described as deeply sobering, and reflected clear challenges in Cancer prevention and treatment within the region.

Councillor Clarke explained that in Rotherham, 36 people were diagnosed with cancer and 15 died from it each week. Alarming, half of all cancers in the area were diagnosed at stage three or four and despite Yorkshire representing 8% of the UK population's cancer diagnoses, the region received less than 5% of national research funding with seven out of thirteen areas in Yorkshire that had cancer incidence rates above the national average, and nine that had higher mortality rates.

Councillor Clarke also highlighted the impact of health inequalities around Cancer, noting that language and cultural barriers within minority communities often delayed diagnoses. For example, 16% of people from ethnic minority groups and 15% of Black and Asian individuals needed to consult a professional five or more times before receiving a diagnosis, compared to 8% of the white population.

Councillor Clark advised agreed to share the report in full and the Rotherham specific statistics that they had obtained with members via the Commission's Governance Advisor.

Resolved:-

That the Health Select Commission:

1. Noted the contents of the update provided.
2. Agreed to consider how the information provided might inform scrutiny regarding the fourth lung clinic at Rotherham Hospital scheduled to take place during the Commission's March 2026 public meeting.

18. HEALTH SELECT COMMISSION WORK PROGRAMME - 2025-2026

The Chair invited questions and comments from members regarding the Health Select Commission's Work Programme as detailed within the agenda pack.

Councillor Yasseen raised a sensitive issue involving the death of a young child at the local hospital trust, which had been subject of a previous report to the Commission and further scrutiny. Councillor Yassen suggested that it may be prudent to consider whether the findings from a further investigation that had been conducted warranted further consideration by the Health Select Commission.

It was agreed that Councillor Yasseen would provide relevant background information regarding the Health Select Commission's past involvement to the Chair and Governance Advisor to facilitate considerations regarding the appropriate response in the circumstances.

Councillor Harper queried the absence of the nitrous oxide abuse 'item for scheduling' which had been listed on the work programme supplied at the previous Health Select Commission meeting, but which no longer featured in the version included within the agenda pack.

The Governance Advisor explained that following discussions with Councillor Clarke, who had initially brought the issue to the Commission's attention, the Health Select Commission Chair and the Head of Democratic Services, it was agreed that Rotherham Safer Together Partnership represented a more appropriate vehicle via which to address that issue due to it involving issues around anti-social behaviour and criminal justice in addition to health concerns due to the membership of that partnership.

The Chair noted that despite the realignment of the issue, it remained the case that the Health Select Commission would be kept informed in relation to any discussions and proposed action following the matter being considered by the Rotherham Safer Together Partnership.

Resolved:-

That the Health Select Commission:

1. Approved the work programme.
2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

19. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

The meeting of the South Yorkshire, Derbyshire, and Nottinghamshire Joint Health Overview and Scrutiny Committee (JHOSC) had taken place on 23 June 2025. Members were reminded to submit comments, queries, or questions for forthcoming JHOSC agenda items so that these could be discussed or debated during the meeting next meeting, following publication of the agenda.

Members' attention was drawn to two items from the 23 June agenda: IVF treatment and gluten-free prescribing, which were discussed at length. Consultations regarding both topics had been launched by the Integrated Care Board, details of which were due to be shared with Health Select Commission members, whom the Chair encouraged to share information about those consultations within their communities to promote engagement and gather a broad range of views.

The Chair detailed that discussions at JHOSC had secured lengthier and more representative consultation arrangements than had originally been proposed in both cases.

20. URGENT BUSINESS

No urgent business was formally raised by the Chair during the meeting. However, the Chair reminded members of the information provided by Kym Gleeson regarding the Healthwatch Health Fair event at Rotherham Minster on Thursday 11 September 2025 from 11.00 am until 14.00 pm and encouraged members to attend if possible.

Also, with the Chair's permission, Councillor Garnett advised Members about a public panel event that had been scheduled for Wednesday 6 August 2025 in person and online at Rotherham Hospital between 6.00 and 7.00 pm. The panel aimed to gather input on improving the hospital discharge process. Councillor Garnett agreed to provide details to the Governance Advisor to share with Health Select Commission members should they wish to attend.

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Public Report
Health Select Commission

Committee Name and Date of Committee Meeting

Health Select Commission – 02 October 2025

Report Title

Physical Activity for Health (Sport England)

Is this a Key Decision and has it been included on the Forward Plan?

No

Strategic Director Approving Submission of the Report

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)

Gilly Brenner, Consultant in Public Health
gilly.brenner@rotherham.gov.uk

Ward(s) Affected

Borough-Wide

Report Summary

The Moving Rotherham partnership is delivering a Sport England Place Expansion Programme development grant, awarded to Rotherham Council in April 2025. This has increased capacity to work together to embed physical activity as part of everyday life and tackle health inequalities across the borough. An update was requested on delivery of this grant. An action plan has been developed which tracks delivery of partner activity. The learning and evaluation of this will be collated to inform an application for further funding for a main award in Spring 2026.

Recommendations

That the Health Select Commission:

1. Note the Sport England Place Expansion Programme as a facilitator of wider activity work led and coordinated through the Moving Rotherham partnership to embed physical activity as part of everyday lives.
2. Members consider the opportunity to champion the Moving Rotherham ambition within their wards and communities, promoting and identifying opportunities for residents to engage in physical activity and supporting collaboration across sectors.

List of Appendices Included

Appendix 1 Moving Rotherham Action Plan 2025-26

Background Papers

[Cabinet item 131 Monday 17 March 2025, 10.00 a.m. - Rotherham Council](#)

Consideration by any other Council Committee, Scrutiny or Advisory Panel
Cabinet – 17 March 2025

Council Approval Required
No

Exempt from the Press and Public
No

Physical Activity for Health (Sport England)

1. Background

- 1.1 There is strong evidence that regular physical activity can significantly reduce the risk and impact of long-term health conditions and support positive mental health for people of all ages. The Chief Medical Officer's Physical Activity Guidelines note that: *"If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat."*
- 1.2 But physical activity is not just a health issue. It brings people together to enjoy shared activities and contributes to building strong communities whilst supporting the economy to grow. Using the UK Treasury methodology, researchers have estimated that Parkrun contributes £667 million annually to the UK economy, primarily through significant improvements in participants' physical and mental health and life satisfaction.
- 1.3 Rotherham was chosen by Sport England as a Place Expansion Programme area based on the high levels of physical inactivity in the borough and also on the strength of the existing Moving Rotherham partnership and our readiness to work together as a system to tackle this.
- 1.4 A Cabinet paper was presented in March 2025 setting out the proposals for spend of the £455K Sport England Place Expansion Programme development award for Rotherham. This paper provides some further detail on the delivery to date of that award, expected future delivery and timescales for further investment, all within the context of the wider Moving Rotherham partnership.

2. Key Issues

- 2.1 Appendix 1 contains the Moving Rotherham Partnership Action Plan 2025-26 which is aligned against five strategic aims designed to deliver a successful Sport England development award and application for further main award funding in March 2026.
- 2.2 **Aim A** focuses on strategy and coordination. The grant has been used to create two Council officer posts supporting programme management and data and evaluation. These new officers have worked to develop the action plan and pull together data and research to inform the planning and future evaluation of new delivery. A new governance structure has been implemented, with the Moving Rotherham Board providing overall assurance and a Moving Rotherham Systems Leaders Group overseeing operational delivery of the plan. A much broader Big Active Network is being developed for wide-ranging partners to remain connected and inspired to work towards the aims of the partnership. Communication and resource sharing with these three groups will be supported by a new extranet resource. Moving Rotherham partners are actively involved in learning from other areas and best practice to ensure our plans are informed by findings and research from elsewhere.

- 2.3 **Aim B** seeks to increase physical activity levels in the borough, supporting those who do some activity, to become more active. As part of this work, mapping is being coordinated to better understand the breadth of opportunities that exist in the borough to enable signposting and support, and to raise awareness and use of the existing Activity Finder webtool on the Rotherhive website. Further work will be needed to refresh a public-facing Moving Rotherham website and develop a public communications / marketing plan to raise the profile of the Moving Rotherham branding.
- 2.4 Further training is planned to ensure front-line workers, such as those in the NHS, feel confident and have the knowledge and skills to talk to people about the benefits and opportunities of doing more physical activity and to champion its importance. Further resources will be hosted on the extranet site.
- 2.5 **Aim C** focuses on decreasing inactivity by supporting people who are currently inactive to start moving more and identification of barriers. Flux Rotherham have been grant funded through the Sport England development award to deliver an Active Outdoors project in priority neighbourhoods to better understand the barriers to being active, with a particular focus on the outdoors. We have heard from residents that they enjoy spending time outdoors and see benefits to their wellbeing. We would like to enhance these opportunities and remove barriers to embedding active time outdoors into daily lives.
- 2.6 There are a range of actions being led by the Council's Culture, Sport and Tourism service relating to sport and leisure facility improvements in the borough and with insight from Playing Pitch Strategy findings and including regeneration works in parks, including the splash park at Clifton Park and new facilities at Rother Valley and Thrybergh Country Parks.
- 2.7 We have worked with South Yorkshire Mayoral Combined Authority colleagues to influence and contribute to the newly launched South Yorkshire Walking, Wheeling and Cycling Strategy, so that reaching local shops, amenities, schools and work as part of our everyday lives can be active and safe for all
- 2.8 Yorkshire Sport Foundation and Flux Rotherham will be leading community consultation in identified priority neighbourhoods where Sport England identified lower levels of physical activity, initially in: Masbrough and Bradgate, Greasbrough and Wingfield, East Dene and Herringthorpe, and Rawmarsh. Consultation in these areas will ensure the lived experience of residents informs how we can support changes to local communities that facilitate them to be more active in their daily lives. This might include changes to the local environment, offering training to voluntary and community sector partners, or working with organisations in the area to increase opportunities to be active. For some changes we will be able to consider options for resource from the Sport England main award funding or other identified funding sources. Learning from these neighbourhoods will inform wider plans for the borough.

- 2.9 **Aim D** seeks to reduce inequalities and has included the development of an Inclusive Activity Network to champion opportunities to improve physical activity options for people with disabilities or long-term health conditions. A workshop has already been held with speakers and contributions from those with lived experience, supporting a solution-focused approach to removing barriers to physical activity opportunities. Further workshops are planned to continue this work with partners.
- 2.10 Data shows that people with disabilities or long-term health conditions are far more likely to be inactive and yet could see significant health gains from being active. 'Every Move Counts' is a pilot being delivered by health coaches based at Rotherham Connect Healthcare to provide support to develop personalised activity plans for people with long-term health conditions. This could range from support into specialist level 4 exercise classes tailored to their health condition, or more general community-based activity including walking or gardening, but focused on enjoyable activity that can be sustained long-term. Collaborative work is planned with GP practices to commit to Active Practice principles and support both staff and patients to be motivated and given opportunities to be more active.
- 2.11 **Aim E** is focused on providing positive experiences for children and young people. This work will build on the successes of the Children's Capital of Culture, including the school-baton relay and Uplift event. Further consultation work with children and young people will seek to better understand the best opportunities for increasing activity levels. This was to be led by a Council-hosted post but will now be supported by colleagues at Yorkshire Sport Foundation.

3. Options considered and recommended proposal

- 3.1 This paper provides an update on the progress of the delivery of the Sport England Place Expansion Programme development award from March 2025. Health Select Commission are requested to note progress to date and the intention to apply for a main award in March 2026.

4. Consultation on proposal

- 4.1 As noted in the action plan and section 2 of this report, significant amounts of the Moving Rotherham plan include further consultation and engagement. This is the approach required by Sport England to ensure the main award is based on insight from communities.
- 4.2 Engagement activity will take a variety of forms including focus groups, interviews and surveys with residents to capture local voices and lived experience. Creative engagement activities in green spaces across Ferham, Bradgate, Greasbrough and Rawmarsh, is currently being delivered by Flux and further engagement activity linked into voluntary and community sector organisations is being led by Yorkshire Sport Foundation in priority neighbourhoods. Further engagement through the Moving Rotherham Zone was undertaken at the Rotherham Show. Additional engagement with

children, young people and families will be facilitated through schools, youth groups and voluntary sector organisations.

5. Timetable and Accountability for Implementing this Decision

- 5.1 Delivery of the Sport England development award began in April 2025 on receipt of the funding following Cabinet approval in March. Key milestones are being tracked through the Moving Rotherham Action Plan 2025-26 and assurance monitored by quarterly Moving Rotherham Board meetings.
- 5.2 Key activity over the next 6 months includes:
- Ongoing delivery of the 'Every Move Counts' Active Hub for people with long-term conditions
 - Neighbourhood engagement activity delivered by Yorkshire Sport Foundation (by December 25)
 - Development of a branding toolkit and roll out of extranet resource for partners (Autumn 25)
 - Further development of the Inclusive Physical Activity Network including further workshops (January 2026)
 - Collation of community insight and thematic analysis and data evaluation to support main award bid writing (February 2026)
 - Submission of Sport England main award (April 2026)

6. Financial and Procurement Advice and Implications

- 6.1 There are no direct procurement implications arising from the recommendations in this report. Expenditure with 3rd party organisations arising from the grant or other identified funding sources will be subject to the Council's Financial and Procurement Procedure Rules and relevant applicable legislation (Procurement Act 2023, Provider Selection Regime (Healthcare Services), Public Contract Regulations 2015 (as amended)) subject to the route to market identified in partnership with the Procurement Team.

7. Legal Advice and Implications

- 7.1 No new legal implications. All arrangements detailed in previous March Cabinet paper.

8. Human Resources Advice and Implications

- 8.1 No new HR implications. All arrangements detailed in previous March Cabinet paper.

9. Implications for Children and Young People and Vulnerable Adults

- 9.1 No new children and young people or vulnerable adult implications. All arrangements detailed in previous March Cabinet paper.

10. Equalities and Human Rights Advice and Implications

- 10.1 No new equalities or human rights implications. All arrangements detailed in previous March Cabinet paper.

11. Implications for CO₂ Emissions and Climate Change

- 11.1 No new emissions or climate change implications. All arrangements detailed in previous March Cabinet paper.

12. Implications for Partners

- 12.1 No new partner implications. All arrangements detailed in previous March Cabinet paper.

13. Risks and Mitigation

- 13.1 The most significant risk is the tight timescale for delivery prior to submission of a bid for the further main award funding. This risk is being mitigated through careful project management by the new project manager and reporting of the action plan to the Moving Rotherham Board. Sport England have assured the Council that their timescales for submission of the main award are flexible, so the risk is only delay to implementation, not further funding.

Accountable Officer(s)

Emily Parry-Harries, Director of Public Health

Approvals obtained on behalf of:

	Name	Date
Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Named officer	Click here to enter a date.
Assistant Director of Legal Services (Monitoring Officer)	Named officer	Click here to enter a date.
Assistant Director of Human Resources (if appropriate)		Click here to enter a date.
Head of Human Resources (if appropriate)		Click here to enter a date.
The Strategic Director with responsibility for this report	Ian Spicer, Strategic Director of Adult Care, Housing and Public Health	16/09/25
Consultation undertaken with the relevant Cabinet Member	Cabinet Member for Adult Social Care and Health - Councillor Baker- Rogers	15/09/25

Report Author: Gilly Brenner, Consultant in Public Health
gilly.brenner@rotherham.gov.uk

This report is published on the Council's [website](#).

MOVING ROTHERHAM PARTNERSHIP – ACTION PLAN 2025-26

People in Rotherham are proud to live in and contribute to stronger, thriving communities by engaging with physical activity or sport.

The Moving Rotherham Partnership will: *plan, promote and co-ordinate programmes that encourage physical activity or sport to be an everyday part of people's lives.*

Ambition: *For Rotherham to become a more physically active borough, improving health & wellbeing outcomes for all.*

This workplan is aligned against five strategic aims designed to deliver a successful Sport England development award and application for further main award funding by March 2026. Each aim is underpinned by key priorities which support delivery of the aim and focus the activity and operational delivery and monitoring of the plan. Each numbered action within the key priorities details the responsible lead, timescale and anticipated output.

Five Strategic Aims:

- A. Strategy and coordination** - deliver the development award and seek further main award Sport England bid by March 2026
- B. Increase physical activity across the borough** (moving from a bit active to more active)
- C. Decrease inactivity and identify barriers to engagement** (moving from inactive to active)
- D. Tackle inequality and identify areas for development to enable equitable opportunities for all**
- E. Provide positive physical opportunities for children and young people across the borough**

A. Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026	B. Increase physical activity across the borough (moving from a bit active to more active)	C. Decrease inactivity and identify barriers to engagement (moving from inactive to active)	D. Tackle inequality and identify areas for development to enable equitable opportunities for all	E. Provide positive physical activities opportunities for children and young people across the borough
<ol style="list-style-type: none"> Action plan: Continue to develop a shared vision and action plan with accountability and support for stakeholders Data: Improve the availability and use of local data on physical activity to support targeting, monitoring and evaluation Place Expansion: Ensure delivery, monitoring and evaluation are tracked and progressed to align with Sport England development award submissions and application for main award. Leadership: Establish working groups and provider networks to support systems working across place. Best practice: Consider best practice and research to identify local opportunities to develop policy or system change. 	<ol style="list-style-type: none"> Making every contact count (MECC): Develop skills and knowledge in relation to physical activity across all organisations and services, so that conversations with local people about being active happen as often as possible. Information: Improve the availability of information on physical activity opportunities, including increasing content and use of Rotherham activity finder Comms and marketing: Use front-line workers, targeted and mass communication to change perceptions, attitudes and social norms around physical activity and awareness of benefits amongst the wider population 	<ol style="list-style-type: none"> Improving the physical ‘environment’: Identify and consider scope to improve environments that enable activity, whether this is outdoors in green spaces, town centres and local streets, or within schools, colleges and workplaces. Working with communities: Supporting and engaging with local communities to sustain their projects through training and support with process and policies Active travel: Collaborate with transport colleagues and other stakeholders on the new South Yorkshire Walking, Wheeling and Cycling Strategy and Rotherham local infrastructure and delivery plans 	<ol style="list-style-type: none"> Inclusion: Strengthen the physical activity offer to adults with long term health conditions or disabilities Testing new things: Deliver targeted test pilots in innovative inclusive ways of working to provide wider opportunities to increase physical activity - including projects with communities, workplaces and wider system change 	<ol style="list-style-type: none"> Schools: Support schools to integrate and promote physical activity opportunities and the benefits CYP engagement: Coordinate wider opportunities to develop learning and understanding of what physical opportunities children and young people would like to engage with. CCoC legacy: Identify possible opportunities to increase awareness of physical activity opportunities across the borough building on Children’s Capital of Culture and legacy programme

Ref	Action		Timescale						Lead (support)	Output	Notes		
			2025/6				2026/7					Focus Area	
			Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Q1 Apr-Jun	Q2 Jul-Sep					
Focus Area Key:		Active Champions – Develop skills and knowledge in relation to physical activity across all organisations and services, so that conversations with local people about being active happen as often as possible.											
		Active Environments – Help create environments that enable physical activity, whether this is outdoors in green spaces, town centres and local streets, or within schools, colleges and workplaces.											
		Active Communities – Bringing people together through physical activity has huge potential in helping communities thrive and become vibrant places to live.											
		Active Communications – A Rotherham-wide “social movement” campaign and communication plan, helping to make being active in Rotherham something that everybody does, whether this is taking a few extra steps to open the door to a carer, or running a marathon, and everything in-between!											
A	Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026												
1	Continue to develop a shared vision and action plan with accountability and support for stakeholders												
1.1	Maintain quarterly Moving Rotherham Board meetings with representation from senior officers.	x	x	x	x	x	x				Director of Public Health	Maintain a strategic overview	Quarterly meetings chaired by Director of Public Health
1.2	Review and adapt existing boards and planning groups to ensure they best suit delivery of the partnership	x				x					Moving Rotherham Programme Manager	Appropriate representation and governance arrangements	MR Board MR Systems Leaders Group MR Big Active Network
1.3	Maintain partner awareness and buy-in to the action plan and progress through updates to boards and planning groups such as: <ul style="list-style-type: none">- Health & Wellbeing Board- Moving Rotherham Board- Moving Rotherham Systems Leaders Group- Moving Rotherham Big Active Network- Cultural Partnership Board	x	x	x	x	x	x				Public Health Consultant - Healthy Communities (Moving Rotherham Programme Manager)	Update papers presented.	Meeting date scheduled for: HWb Board: March 2025 MR Board – quarterly MR Systems Leaders Group – bimonthly MR Big Active Network – annual and regular comms Y&H COI – quarterly

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	<ul style="list-style-type: none">- Creative Health Board- Prevention and Health Inequalities Group- Yorkshire & Humber Public Health Community of Interest physical activity group														Cultural Partnership Board – quarterly Creative Health Board – as required Prevention and Health Inequalities Group – as required
1.4	Review progress against the action plan and strategy to be reported back at bimonthly and quarterly meetings	x	x	x	x	x	X					Moving Rotherham Programme Manager	Action plan updated and assurance of output monitoring.		
1.5	Conduct a scoping exercise to look at the wider successful system / policy change delivery at UK level to identify areas for future development	X	X	X	X	X	X					Moving Rotherham Programme Manager	Gain an insight of successful system change to inform choices for test pilots and main award bid	Ongoing, including learning from Local Delivery Pilots	
A	Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026														
2	Improve the availability and use of local data on physical activity to support targeting, monitoring and evaluation														
2.1	Use the MR Systems Leaders Group to facilitate regular information sharing and problem-solving sessions and improve coordination between partners	x	x	x	x	x	x					Moving Rotherham Programme Manager	Agenda regular network sharing item		

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2.2	Collate partner data to improve availability and range of local and national physical activity data	x	x	x	x	x	x					Moving Rotherham Research and Evaluation Officer (Yorkshire Sport Foundation Data Analyst)	Expanded range of available local and national data to describe physical activity levels, barriers, facilitators, impacts and outcomes.	Include BeWell@Work data if available, Make Space for Us and Moving in Nature engagement insight.
2.3	Create a dashboard to monitor physical impact and outcomes of MR action plan. * Continued development of dashboard	x	x	x								Moving Rotherham Research and Evaluation Officer (Moving Rotherham Programme Manager)	Dashboard developed and reported to MR Board and MR Systems Leaders Group	Include all sections from plan including physical activity levels, training, comms stats, environmental conditions (green space / leisure facilities etc), community engagement / insight, active travel, health conditions and active hub insight, schools, cyp insight and CCoC.
2.4	Create data system or needs assessment to better collate quantitative and qualitative data on physical activity levels, barriers, facilitators, impacts and outcomes across the borough and in different communities.	x	x	x	x	x	X					Moving Rotherham Research and Evaluation Officer	Data system developed to capture and share insight to inform targeting of activity / actions and main award bid submission	Evaluation framework in development
A	Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026													
3	Ensure delivery, monitoring and evaluation are tracked and progressed to align with Sport England development award submissions and application for main award.													
3.1	Maintain regular contact with the Sport England lead to ensure that all deadlines for compliance and bid paperwork are	x	x	x	x	x	X					Moving Rotherham Programme	Successful delivery of development stage and successful bid	6-month report due: 1/10/25

	met within Sport England guidance and timeframes *Submit 6-monthly evaluation and learning report to Sport England									Manager (Sports England Place Relationships Manager)	application for main award	12-month report due: 01/04/26	
3.2	Work collaboratively with partners to ensure that the action plan is reviewed using the NELP System Maturity Matrix to identify strengths and weaknesses and inform development * Attend SE NELP sessions and support on submission of the SMM			x		x				Moving Rotherham Programme Manager (Moving Rotherham Research and Evaluation Officer)	NELP strengths and weaknesses identified and inform action plan *NELP SMM submission completed	NELP submission request expected in October	
3.3	Review previous Theory of Change to inform dashboard and reflect progress of action plan implementation prior to main award bid submission		x	x	x					Moving Rotherham Programme Manager (Moving Rotherham Research and Evaluation Officer)	Work with MR SL Group to re-do TOC	Page 30	
3.4	* Develop an Equality Impact Assessment as part of community engagement plans, and agree this with Sport England Strategic Lead and Place Relationship Manager	x				x				Moving Rotherham Programme Manager	EIA agreed		Review again for 6-month report (1 st Oct)
3.5	* Updated risk register highlighting the fraud, bribery and corruption risks with delivery of the project especially around any test and learn elements	x				x				Moving Rotherham Programme Manager	Risk register updated		Review again for 6-month report (1 st Oct)
A	Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026												
4	Establish working groups and provider networks to support systems working across place. (See also A1.2 and A1.3)												

4.1	Review and re-establish the Big Active Conversation group, through a new Big Active Network enabling wider partner involvement and updates across the system * Plan and deliver follow up session to 2023's Big Active Conversation session	x	x								Moving Rotherham Programme Manager (Yorkshire Sport Foundation Development Manager)	Online network established with broad spectrum of members who can communicate and receive updates * Follow up session arranged	
4.2	Work collaboratively with partners to identify capacity, resources and ways of working with potential for growth. To inform the key target areas for test pilots and main award bid	x	x	x	x	x	x				Moving Rotherham Programme Manager	Key priorities and data to inform the next stage of the bid	
4.3	Work with MR Systems Leaders Group to deliver * 6 x themed and facilitated networking sessions per year		x	x	x						Moving Rotherham Programme Manager (MR SL Group)	* 6 sessions supporting networking and learning delivered	Session 1: Inclusive activity 15/07/25 Moving Rotherham System Leaders Session 1: 25/9/25 Ripple Effect Mapping
A	Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026												
5	Consider best practice and research to identify local opportunities to develop policy or system change.												
5.1	Attend regular Local Delivery Provider (LDP) and National Evaluation & Learning Partnerships (NELP) events to ensure action plan, test pilots and the main award bid submission are developed with the most up to date good practice	x	x	x	x	x	x				Moving Rotherham Programme Manager	Effective models of best practice inform local plans and delivery to achieve the best impact.	LDP Meeting Date: 8/7/25 NELP Meeting Date: 21/7/25, 5/8/25, 7/8/25, 14/8/25, 3/7/25
B	Increase physical activity across the borough (moving from a bit active to more active)												
6	Develop skills and knowledge in relation to physical activity across all organisations and services, so that conversations with local people about being active happen as often as possible.												

6.1	Making Every Contact Count (MECC) training offer delivered to front-line workers – including social prescribers - in a range of professions to increase awareness of benefits of physical activity and confidence in having conversations										Moving Rotherham Programme Manager Yorkshire Sport Foundation Development Manager	Number of people attending training Training outcomes	Session previously delivered to TRFT by Yorkshire Sport Foundation Development Manager (Rotherham). Investigating options to further roll out in other settings.
B Increase physical activity across the borough (moving from a bit active to more active)													
7 Improve the availability of information on physical activity opportunities, including increasing content and use of Rotherham activity finder													
7.1	Conduct an audit of existing physical activity opportunities across the borough	x	x	x	x	x	X				Moving Rotherham Research and Evaluation Officer (Moving Rotherham Programme Manager, Active Hub, YSF)	Increased understanding of available opportunities in Rotherham communities	Meeting 9 th July Initial mapping exercise completed.
7.2	Improve the quality and accessibility of the Activity Finder, increasing the number and types of activity providers listed.	x	x	x	x	x	x				Moving Rotherham Programme Manager (Yorkshire Foundation Web Specialist, YSF)	To create a more comprehensive database of physical activity opportunities across Rotherham	Opportunity to raise profile of finder through Big Active Network and extranet.
7.3	Improve access to online information about physical activity in Rotherham by identifying requirements and re-designing Moving Rotherham website.	x	x	x	x	x	x				Moving Rotherham Programme Manager (Strategic Partnerships)	To create a more accessible source of physical activity information in Rotherham	As part of comms / marketing work programme.

											Manager, marketing/ comms support)		
7.4	* Development of webpages dedicated to PA training for HCP's integrated into MR website or available in short-term via MR Big Active network										Public Health Specialist in Physical Activity (Yorkshire Sport Foundation Development Manager (Rotherham))	Information resource for clinicians in Rotherham	Include information on the MR extranet site
7.5	Promote the Council's existing discount schemes such as for Rothercard to increase physical activity across the borough. With a particular focus on Wath which has a low uptake of Rothercard in the Leisure centre.			x	x	x	x				Moving Rotherham Programme Manager (marketing / comms support, Places for People Contracts Manager)	Increased participation in physical activity	Opportunity to work with Places Leisure and neighbourhoods team.
B	Increase physical activity across the borough (moving from a bit active to more active)												
8	Use front-line workers, targeted and mass communication to change perceptions, attitudes and social norms around physical activity and awareness of benefits amongst the wider population												
8.1	Develop brand / communications guide for use and dissemination of Moving Rotherham logo and comms	x	x	x	x	x	X				Moving Rotherham Programme Manager (Strategic Partnerships Manager, marketing/ comms support)	Increased Moving Rotherham brand awareness and physical activity communications	Brief sent out to five designers, deadline of 14th Sept for applications to be reviewed 15 th Sept by Strategic Partnerships Manager, Moving Rotherham Programme Manager and RMBC Communications and

															Marketing Manager in Regeneration and Environment from corporate comms.
8.2	Deliver * 2 x Moving Rotherham new starter awareness sessions per year (open to all partner organisations) to partners taking up use of Moving Rotherham comms and branding			x	x							Moving Rotherham Programme Manager (Strategic Partnerships Manager, marketing/ comms support)	Consistent and quality assured Moving Rotherham brand usage in the borough	To be incorporated into comms/marketing plan.	
8.3	Identify successful mass communication campaigns resulting in behaviour change and improvements in physical activity and identify any current communications	x	x	x								Moving Rotherham Programme Manager (Strategic Partnerships Manager, marketing/ comms support)	Increased knowledge to inform the choice of communication methods	Consider social influencers in this and high-profile people across the borough and wide range to include RUFC, Titans but other models, 'This girl can' type campaign. Meeting taken place with other comms leads from SY, work progressing to look at lessons learnt from other LDP's i.e. Doncaster and if any mass campaigns can be delivered at a SY level supported by SYMCA.	
8.4	Complete an audit on what resources and costs would be required to deliver a successful mass communication	x	x	x								Moving Rotherham Programme	Identified priorities for mass messaging for main award bid	Support offered from RUCT	

	campaign for a range of cohort audience segments											Manager (Strategic Partnerships Manager, marketing/ comms support)		To work with corporate comms team to replicate ways of working for CCoC.
8.5	Develop a communication plan to disseminate the new physical activity platform/s and benefits of physical activity to partners and general public across the borough * Consistent Moving Rotherham theme/messaging to run across community events such as Rotherham Show 4 x per year		x	x	x	x	x					Moving Rotherham Programme Manager (Strategic Partnerships Manager, marketing/ comms support)	Consistent and quality assured Moving Rotherham brand usage and comms in the borough	Support offered from RUCT. Marketing brief shared with corporate comms team to feed into comms/marketing project. Branding in place for Rotherham Show.
8.6	Ambition to continue to host elite sport events and large-scale participatory events raising profile of physical activity in Rotherham eg Wentworth 10K				x	x	x					Head of Sport, Leisure and Strategic Partnerships	Ongoing work re Tour de Britain and other events eg Wentworth cycle race and 10K	This action will be implemented once the new branding and communication plan is in place
C	Decrease inactivity and identify barriers to engagement (moving from inactive to active)													
9	Identify and consider scope to improve environments that enable activity, whether this is outdoors in green spaces, town centres and local streets, or within schools, colleges and workplaces.													
9.1	Use Active Outdoors creative engagement project to identify barriers in community open green and blue space or public realm and suggest opportunities for improvement that would lead to increase in activity levels	x	x	x								Director of Flux	Outputs: 15 different activities in each of the 3 green spaces (minimum of 45 activities) Minimum of 300 people engaged and consulted. Outcomes:	A series of practical workshops and consultation activity in identified green spaces (minimum of 3). Direct planning and delivery with community partners

											End of Project Report	Test and learn ideas with a range of target audiences Show case at Rotherham Show 2025 and other community events. Attend Place Expansion – Rotherham steering groups (Project lead) Contribute to share and learn sessions in partnership with community facilitation project Align with evaluation post Produce a report at the end of the project with learnings and recommendations Insights gathered on physical activity barriers
9.2	Audit the current collaboration with the employers, including BeWell@work and other initiatives	x	x	x							Moving Rotherham Programme Manager (RMBC Public Health Practitioner)	Gain an insight into the existing networks and opportunities with workplaces Healthy Hospital Team at TRFT linked in (Healthy Hospitals Programme Manager). Further opportunities to be sought with other employers.
9.3	Play Streets applications to be made available for residents from 2026						x				Strategic Partnerships Manager	Increased physical activity in communities and community cohesion Ongoing work with Members to identify support.

9.4	Rotherham's Playing Pitch Strategy (PPS) to be finalised Oct/Nov, approval from full cabinet end of year/beginning of new year.			x	x						Strategic Partnerships Manager	Better understanding of standards of Rotherham's sports facilities linking into the local plan for housing developments	Strategy commissioned and awaiting publication.
9.5	Improve facilities through Rotherham 2025 Tennis Plan										Head of Sport, Leisure and Strategic Partnerships (Rotherham Tennis Network Group)	Improvements to tennis facilities in the borough	
9.6	Football facilities development plan linking into the Home Advantage fund and Play Zones Linking the Playing Pitch Strategy to the Local Football Facilities Plan (LFFP)										Head of Sport, Leisure and Strategic Partnerships (Football Subgroup)	Improvements to football facilities in the borough	
9.7	Develop and action plan to cover maintenance / improvement of Council-owned facilities eg Herringthorpe running track										Head of Sport, Leisure and Strategic Partnerships	A long-term plan for sustainability of current facilities	
9.8	Commitment from Places Leisure to explore the role of leisure centres in driving physical activity and removing barriers for local communities.					x	x				Places for People Contracts Manager	Increased physical activity opportunities in community settings	Open Data link with Yorkshire Sport Foundation Data Analyst. Continued good engagement and seeking opportunities eg sponsorship of Rotherham 10K.
9.9	Voluntary Action Rotherham to support development of Community Hubs as active places - Volunteer Coordination				x	x	x				VAR Director of Services (Projects)	Increased physical activity opportunities in community settings	Meeting scheduled to discuss volunteering opportunities.

										VAR Volunteering and Group Support Manager Yorkshire Sport Foundation Development Manager (Rotherham)		
9.10	Age UK Rotherham to further embed physical activity opportunities into community activity for older people				x	x	x			Age UK Rotherham Manager, Partnerships and Projects	Increased physical activity opportunities for older people	
9.11	YSF to support and promote physical activities in care homes across all relevant delivery programs available				x	x	x			RMBC Senior Public Health Practitioner Yorkshire Sport Foundation Development Manager (Rotherham)		YSF Training of Physical Activity plus S Yorks Network Some additional work required to map and coordinate activity.
9.12	Action to cover the significant improvements to green space in the borough eg. splash park, playground upgrades, Thrybergh Country Park, Rother Valley Country Park, Chesterfield Canal etc.		x	x	x	x	x			Head of Sport, Leisure and Strategic Partnerships	Improved green space and play facilities in the borough	Splash Park launched. Other improvement works ongoing.
C	Decrease inactivity and identify barriers to engagement (moving from inactive to active)											
10	Supporting and engaging with local communities to sustain their projects through training and support with process and policies											

10.1	Use data and mapping to identify target MSOAs for development phase where physical activity levels are lowest and opportunities to increase (*Assessment of MSOA areas based on data and local insight) * Up to 4 x MSOA areas to be identified for support	x	x							Moving Rotherham Programme Manager (Yorkshire Sport Foundation Development Manager (Rotherham), YSF, Director of Flux, Moving Rotherham Research and Evaluation Officer)		Areas chosen from Sport England full list: Rawmarsh South, Greasbrough, Thryburgh & Hooton Roberts, Kimberworth Park, East Herringthorpe, Eastwood & East Dene, Masbrough & Bradgate, Rotherham Central & Maltby East (Hellaby)
10.2	* Hold 2 collaborative sessions to gain and share learning with LDP or other local Place Expansion areas		x			x				Moving Rotherham Programme Manager (Yorkshire Sport Foundation Development Manager (Rotherham), YSF)	* 2 collaborative sessions	Session 1: 8/7/25 - Bradford, Essex & Doncaster Session 2: 16/9/25 - Doncaster
10.3	*Hold 2 community stakeholder workshops and use other techniques (surveys and focus groups, with at least 1 survey and 1consultation session per MSOA) to get * baseline of current community activity levels, physical activity opportunities and uptake of these in target MSOAs		x	x						Yorkshire Sport Foundation Development Manager (Rotherham) (YSF, Moving Rotherham Research and	* 2 workshops held * Consultation as per bid * Baseline data collected	Sessions in planning stages by YSF.

											Evaluation Officer)		
10.4	*Hold 2 co-production workshops in target MSOAs to identify gaps and opportunities for physical activity in the target areas and engage with community to understand how best to work together to overcome these			x							Yorkshire Sport Foundation Development Manager (Rotherham) (YSF)	Data to inform future opportunities for test pilots and main award bid	Sessions in planning stages by YSF.
10.5	* Develop an action plan for support to describe the MSOA community needs identified and how these can be supported in the main award bid.				x						Yorkshire Sport Foundation Development Manager (Rotherham)(YSF)	Plan to describe identified needs for MSOAs and co-produced potential solutions for main award bid.	Work coordinated by YSF.
10.6	*Hold 2 share and learn sessions to share findings locally on engagement with communities and outdoor active project				x						Yorkshire Sport Foundation Development Manager (Rotherham) (Moving Rotherham Programme Manager, Moving Rotherham Research and Evaluation Officer, Director of Flux)	Use findings to influence future strategic direction, actions, test pilots and main award bid	To be planned following engagement sessions.
10.7	Support local community groups with funding, training and development to provide self-sustaining activity opportunities			x	x	x	x				Yorkshire Sport Foundation Development		These will dependent upon the community consultation results

	* Use investment from a variety of sources to support delivery										Manager (Rotherham)		
10.8	Community activity providers to consider how to expand their offer and diversify their demographic to ensure accessibility to a wider range of people and communities based on the initial consultation results and further findings						x				Community Sports Clubs/ Governing Body reps	Change in demographic uptake of provision Increase in uptake of provision Change in provision to meet community preference	To be identified through the Moving Rotherham System Leaders Steering Group
C	Decrease inactivity and identify barriers to engagement (moving from inactive to active)												
11	Collaborate with transport colleagues and other stakeholders on the South Yorkshire Walking, Wheeling and Cycling Strategy and Rotherham local infrastructure and delivery plans												
11.1	Collaboration between Council Transport team, Public Health and wider partners to ensure alignment of strategic aims of SY and local active travel plans with MR partnership	x	x	x	x	x	x				Moving Rotherham Programme Manager RMBC Engagement Officer	Ensure active travel plays a role in increasing physical activity levels	Attend LWWCIP meetings Dates: 6/6/25, 21/7/25
11.2	Identify any areas of potential from the Active Travel engagement that could be pursued in the test pilots or inform main award bid	x	x	x	x	x	x				RMBC Engagement Officer	Use engagement insight to develop and improve active travel 'hardware' and 'software'	
11.3	Collaboration between Council Transport team and Public Health to monitor and evaluate and consider 'software' support in Rotherham, including ModeShift stars, Living Streets, Journey Matters Cycle Hub etc.	x	x	x	x	x	x				Senior Transport Planner RMBC Planning, Active Travel and Living Streets Coordinator)	Use insight from delivery to inform future plans	

D	Tackle inequality and identify areas for development to enable equitable opportunities for all													
12	Strengthen the physical activity offer to adults with long term health conditions or disabilities													
12.1	Implement and begin delivery on the Active Hub model utilising key partners and using behaviour change as a focus. * Recruit and induct 3 x Health Coaches * Target 75 sessions individual coaching sessions per week (once in post) * Capture feedback from patients that informs physical activity opportunities that are currently not available	x	x	x	x	x	x				Public Health Specialist in Physical Activity (Connect)	Model of delivery agreed using insight Staff recruited and delivery of model Data monitoring agreed	‘Every Move Counts’ referrals are being received. 3 Health Coaches recruited. Information shared with GPs via PLT and clinical directors. Links with secondary care being explored for specific conditions. Data collection agreed.	
12.2	Increased awareness of the benefits of physical activity on long term conditions. * 3 x community health events (i.e. supporting MSK Community Awareness Day)	x	x	x	x						Public Health Specialist in Physical Activity (Connect, Healthy Hospitals Team)	Increased knowledge of clinicians, vol sector and general public on the benefits of physical activity		Connect attended Rotherham Show 6/9/20
12.3	Track and monitor base line and outcome data for the Active Hub to inform ongoing delivery and main award bid	x	x	x	x	x	x				Moving Rotherham Research and Evaluation Officer (Public Health Specialist in Physical Activity, Connect, Moving Rotherham	Quantitative and qualitative data case studies to shape future focus areas and the main award bid.		

											Programme Manager)		
12.4	* 6 training sessions to be delivered to health care professionals to increase awareness of benefits of physical activity to health outcomes	x	x	x	x	x	x				Public Health Specialist in Physical Activity (Connect)	Track number of clinicians trained	Opportunities for training NCPs, inc. GPs are being explored e.g. using PLT or existing meetings to deliver sessions. YSF delivering PA training to stop smoking advisors.
12.5	* Wider sharing of Active Medicine by new offer via the Active Partnerships network	x	x	x	x	x	x				Yorkshire Sport Foundation Development (Public Health Specialist in Physical Activity)		More info to come following Physical Activity Clinical Champions training changes.
12.6	* Up to 5 GP practices signed up for Active Practice Charter with a view to sharing learning and increasing numbers of participants	x	x	x	x	x	x				Public Health Specialist in Physical Activity (Connect)	5 GP Practices signed up to the Active Practice Charter	Connect to survey GP practices to understand what they are already doing, to inform targeted support offered to encourage sign up.
12.7	* Initial consultation of workforce skills as per work with CIMSPA in Sheffield and Doncaster				x	x	x				Public Health Specialist in Physical Activity (Yorkshire Sport Foundation Development Manager (Rotherham), Connect)		Skills Board to maximise work force opportunities

12.8	Establish an inclusive physical activity network, working collaboratively to develop an action plan to improve the physical activity offer to people with disabilities.				x	x	x				Public Health Specialist in Physical Activity (Yorkshire Sport Foundation Development Officer for Doncaster and Rotherham)	A wider physical activity offers for people with disabilities. Increased collaboration across delivery providers & reduction in siloed working. Potential tests pilots for more inclusive working	Network established following successful event in July. Next steps being considered inc. a possible training package to develop leadership for this agenda. Network linked via extranet site.
D	Tackle inequality and identify areas for development to enable equitable opportunities for all												
13	Deliver targeted test pilots in innovative inclusive ways of working to provide wider opportunities to increase physical activity – including projects with communities, workplaces and wider system change												
13.1	Oversee, monitor and ensure evaluation for test pilots as agreed for development award bid: 1) Community engagement and co-production (see section C10) 2) Active Outdoors project (see section C10) 3) Active Hub (see section D12) 4) Comms and marketing improvements (see section B8) 5) Training roll-out (see section B6 and D12)	x	x	x	x						Moving Rotherham Programme Manager (Moving Rotherham Research and Evaluation Officer)	Projects are coherent without duplication and contribute to evidence for main award bid	Ongoing coordination
13.2	Identify, agree evaluation data collection and monitor delivery of additional potential test pilots which contribute to priorities of action plan	x	x	x							Moving Rotherham Programme Manager (Moving	Potential pilots during the development award phase which can be upscaled in the main bid	Under development.

											Rotherham Research and Evaluation Officer)		
13.3	Placeholder for further actions regarding test and learn pilots as developed.												
E	Provide positive physical opportunities for children and young people across the borough												
14	Support schools to integrate and promote physical activity opportunities and the benefits												
14.1	Develop current understanding of physical activity offers in schools including PE, embedded in curriculum (eg daily mile), lunch and after school clubs		x	x	x						New CYP officer (Moving Rotherham Programme Manager, School Games Coordinator)	Clear understanding of the current physical activity offer within schools across the borough	Delays to post recruitment, plan to deliver this work being finalised.
14.2	Continue to develop school sports partnership offers, especially targeting least active CYP, including School Games	x	x	x	x	x	x				School Games Coordinator (new CYP officer)	To identify opportunities for the full bid on where further developments in partnerships can increase physical activity across CYP	Successful School Games held in June. Further coordination work planned.
14.3	Host schools CPD or conference event annually to increase awareness and profile of physical activity opportunities in Rotherham				x						School Games Coordinator (new CYP officer)	Schools conference	Plan to present at the Head Teachers Conference January 26
14.4	Explore opportunities to work with Family Hubs and home educated families to identify opportunities to develop system change and change long term habits		x	x	x	x	x				New CYP officer (Moving Rotherham Programme Manager)	Data to enable further system-change in the main award bid	Work plan to include possible link to Bradford CAS and Rotherham Family Help

14.5	Explore opportunities to increase physical activity in Early Years settings eg nurseries and community play groups		x	x	x	x	x					New CYP officer (Moving Rotherham Programme Manager)	Data to enable further system-change in the main award bid	Work plan to consider pre-school age children and settings.
14.6	Monitor and seek engagement data from delivery of Holiday Activity Fund sessions		x	x	x							New CYP officer (Moving Rotherham Programme Manager)	Data to enable further system-change in the main award bid	
E	Provide positive physical opportunities for children and young people across the borough													
15	Coordinate wider opportunities to develop learning and understanding of what physical opportunities children and young people would like to engage with.													
15.1	Coordinate insight gathering from a range of CYP activity providers and Moving Rotherham partners and projects including active outdoors project and community engagement work	x	x	x								New CYP officer (Moving Rotherham Research and Evaluation Officer)	Data and insight on CYP relating to physical activity levels, barriers and facilitators	Work plan to include links to RUCT, sports clubs, school survey findings and VAR groups
15.2	Develop a positive relationship with the Rotherham Youth Cabinet to support this year's focus on health and wellbeing.	x	x	x	x	x	x					Moving Rotherham Programme Manager (New CYP officer)	CYP engagement and contribution to Moving Rotherham partnership	Work plan to consider pilot project with RUCT on sugary drinks and physical activity
E	Provide positive physical opportunities for children and young people across the borough													
16	Identify possible opportunities to increase awareness of physical activity opportunities across the borough building on Children's Capital of Culture 2025 festival year and legacy programme													
16.1	Identify existing and new opportunities for physical activities and the benefits of large-scale promotion across the borough e.g. CCoC school baton relay	x	x	x	x	x	x					Head of Sport, Leisure and Strategic Partnerships	Increased opportunities to raise awareness of joy of physical activity	Very successful school baton relay. Data and photos to feed into further work.

										(New CYP officer, Strategic Partnerships Manager, Moving Rotherham Programme Manager)		
16.2	Deliver Uplift Festival to offer new physical activity opportunities and raise profile of urban sports including skateboarding, BMX, street dance etc		x			x				Yorkshire Sport Foundation Children & Young Peoples Manager (Creative Programming & Events Manager)	High profile opportunity to engage cyp in urban sports Data on attendance	Uplift festival delivered, evaluation report to feed data and findings into wider engagement findings.
16.3	Deliver Moving Rotherham zone activities at Rotherham Show to raise awareness and provide opportunities to engage in physical activity		x							Head of Sport, Leisure and Strategic Partnerships	Increased opportunity for mass participation and raised awareness of local providers and opportunities	Rotherham Show Sept 25 included Moving Rotherham Zone.
16.3	Agree a schedule of events to increase physical activity and awareness across the borough working in collaboration with the Cultural Partnership Board and Culture Sports and Tourism service events team	x	x	x	x	x	x			Head of Sport, Leisure and Strategic Partnerships (Strategic Partnerships Manager, Moving Rotherham Programme Manager)	Increased participation and consultation data Better understanding of physical activity benefits to change social norms	Sheffield Olympic Park Event, Rotherham Show, 10K, with Sheff or South Yorkshire, School Games, Walking Festival, Children's Capital of Culture, Play Streets, Tennis Festival, Rotherham Show

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MOVING ROTHERHAM

Physical Activity for Health
(Sport England)

Health Select Commission
2nd October 2025

Gilly Brenner, Consultant in Public Health,
Rotherham Council

“Embedding physical activity
into everyday life”

Why Rotherham? Why Now ?

Sport England Investment in Rotherham – Driving Change Together

- **Rotherham faces some of the poorest health outcomes in England.**
High levels of inactivity, long-term illness, and health inequality continue to impact our communities.
- **Sport England has identified Rotherham as a priority area for investment**, based on readiness, national data and need.
- **This is a collaborative opportunity** – to co-design solutions **with our communities**, putting local people at the heart of change.

Ambition:

➡ *For Rotherham to become a more physically active borough, improving health and wellbeing outcomes for all.*



What is Moving Rotherham?

- ▶ Partnership with Sport England and local organisations.
- ▶ Whole-system approach: physical activity integrated into everyday life - health, planning, regeneration, transport, community.
- ▶ Vision: “To make physical activity an everyday part of life in Rotherham.
- ▶ Aligned with:

Rotherham Health & Wellbeing Strategy
NHS Long Term Plan (prevention)
DCMS “Get Active” Strategy (2023–2030).

Our Priorities



A. Strategy and coordination. Deliver the development award and seek further main award Sport England bid by March 2026

1. **Action plan:** Continue to develop a shared vision and action plan with accountability and support for stakeholders
2. **Data:** Improve the availability and use of local data on physical activity to support targeting, monitoring and evaluation
3. **Place Expansion:** Ensure delivery, monitoring and evaluation are tracked and progressed to align with Sport England development award submissions and application for main award.
4. **Leadership:** Establish working groups and provider networks to support systems working across place.
5. **Best practice:** Consider best practice and research to identify local opportunities to develop policy or system change.

5 strategic aims 2025-26 action plan

- ▶ **Shared vision across partners and the borough**
- ▶ Shared plan with partner contributions
- ▶ Data, evidence and engagement under-pinning
- ▶ Growing systems leadership

B. Increase physical activity across the borough (moving from a bit active to more active)

6. **Making every contact count (MECC):** Develop skills and knowledge in relation to physical activity across all organisations and services, so that conversations with local people about being active happen as often as possible.
7. **Information:** Improve the availability of information on physical activity opportunities, including increasing content and use of Rotherham activity finder
8. **Comms and marketing:** Use front-line workers, targeted and mass communication to change perceptions, attitudes and social norms around physical activity and awareness of benefits amongst the wider population

- ▶ **Increasing levels of physical activity – doing more!**
- ▶ Everyone talking about being active and skilled and confident to do so
- ▶ Readily available information – activity finder and resources for partners via Extranet site
- ▶ Comms and marketing being developed

C. Decrease inactivity
and identify barriers to
engagement
(moving from inactive
to active)

9. **Improving the physical 'environment'**: Identify and consider scope to improve environments that enable activity, whether this is outdoors in green spaces, town centres and local streets, or within schools, colleges and workplaces.

10. **Working with communities**: Supporting and engaging with local communities to sustain their projects through training and support with process and policies

11. **Active travel**: Collaborate with transport colleagues and other stakeholders on the new South Yorkshire Walking, Wheeling and Cycling Strategy and Rotherham local infrastructure and delivery plans

- ▶ **Decreasing levels of inactivity – getting people started moving**
- ▶ Changing the environment in which we live, work and play
- ▶ Flux engagement project focused on green spaces
- ▶ Working with communities to build on strengths and opportunities
- ▶ Linking to active travel and school streets and play streets

D. Tackle inequality and identify areas for development to enable equitable opportunities for all

12. **Inclusion:** Strengthen the physical activity offer to adults with long term health conditions or disabilities

13. **Testing new things:** Deliver targeted test pilots in innovative inclusive ways of working to provide wider opportunities to increase physical activity - including projects with communities, workplaces and wider system change

- ▶ **Tackling inequality in activity levels**
- ▶ Inclusive physical activity strand and network
- ▶ Inclusive activity event
- ▶ Every Move Counts physical activity referral programme (Active Hub through Connect)
- ▶ Testing new things

E. Provide positive physical activities opportunities for children and young people across the borough

14. **Schools:** Support schools to integrate and promote physical activity opportunities and the benefits
15. **CYP engagement:** Coordinate wider opportunities to develop learning and understanding of what physical opportunities children and young people would like to engage with.
16. **CCoC legacy:** Identify possible opportunities to increase awareness of physical activity opportunities across the borough building on Children's Capital of Culture and legacy programme

- ▶ **Supporting children and young people to stay active and enjoy being active**
- ▶ Work with schools – school baton relay and school games
- ▶ Legacy of engagement and events from Children's Capital of Culture
- ▶ Family focus / multi-generational activity

Progress so far

- ▶ 'Every Move Counts' health coaches in place, referrals flowing.
- ▶ Community test pilots launched with YSF and engagement underway.
- ▶ Creative engagement in green spaces (Ferham, Bradgate, Greasbrough, Rawmarsh).
- ▶ Inclusive Activity seminar delivered.
- ▶ Branding toolkit, comms plan and Extranet in development.
- ▶ Refreshed governance with Board and Terms of Reference in place.





Risks and Challenges

- ▶ Tight timelines – full main award submission due April 2026.
- ▶ Sustaining partner engagement – requires consistent collaboration.
- ▶ Community expectations – must be managed carefully.

Timetable

- ▶ 2025: Ongoing consultation, training, communications & system change.
- ▶ Quarterly: Action Plan reviewed and updated.
- ▶ April 2026: Final Main Bid submission to Sport England.



The Rotherham NHS Foundation Trust
***Annual Report
and Accounts
2024/25***

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2024-25

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



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Welcome from the Chair

Last year, I noted how in my first months as Chair of The Rotherham NHS Foundation Trust, I was struck by the overwhelming dedication from both clinical and non-clinical staff who were working hard to meet significant operational challenges. Over the past year, I have had the opportunity and privilege to discover more of the fantastic work happening across Rotherham, and meet the colleagues driving new ways of working and developments forward. I have been inspired by the determination our staff have for improving services, patient and staff experience, and helping to reduce health inequalities in Rotherham.

The ambition and drive of colleagues across the Trust has been recognised with our refreshed five-year strategy which stretches our ambitions further. In the past year, we have also launched our Digital Strategy and People and Culture Strategy. These each set out objectives and milestones for the coming years. We are also setting our sights on achieving Teaching Hospital status, recognising the fantastic education offer we provide in Rotherham. I look forward to seeing how we continue to develop our ambitions over the next 12 months.

Throughout the year, we have continued to work collaboratively across the region with the development of the South Yorkshire Pathology service, as well as further strengthening the Trust's partnership with Barnsley Hospital NHS Foundation Trust. I am pleased with the positive developments and improvements to patient care that are underway due to this partnership, which will deliver great benefits to the communities of both towns.

As Chair, I would like to thank our Council of Governors for holding us to account, representing the public and helping ensure we provide the best possible care. I would like to thank Gavin Rimmer who served as our Lead Governor for many years until the end of his term in May 2024, and welcome Geoff Berry to the position.

Finally, I would like to welcome Shirley Congdon who joined the Board as a Non-Executive Director and Andrew Mondon who joined as Associate Non-Executive Director, as well as extending my thanks to Zlakha Ahmed who came to the end of her term.

Best wishes,



Dr Mike Richmond
Chair







Performance Overview 2024/25

A brief history and statutory background

The Rotherham NHS Foundation Trust (TRFT) was established on 1 June 2005 pursuant to Section 6 of the Health and Social Care (Community Health and Social Care) Act 2003. We are regulated by NHS England and operate as a membership-based, public benefit corporation, with the Care Quality Commission (CQC) regulating the quality of the services we provide.

Prior to achieving Foundation Trust status in 2005, the organisation operated as Rotherham General Hospital NHS Trust. In 2011, we integrated Rotherham Community Health Services, becoming a combined provider of both acute and community services across Rotherham, Doncaster and Barnsley.

Activities of The Rotherham NHS Foundation Trust

The Trust is registered with the Care Quality Commission to provide the following regulated activities:

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

We deliver care across multiple sites, with the majority of our acute services based at the Moorgate Road site. Additional services are delivered from Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre, and New Street Health Centre in Barnsley.

As at 31 March 2025, the Trust employed over 5,000 dedicated staff across its acute and community services, supporting a population of over 270,000 across South Yorkshire.

Following a comprehensive restructure the Trust now operates through a Care Group structure comprising:

- Care Group 1 – includes Medicine and Urgent and Emergency Care
- Care Group 2 – includes Surgery, Anaesthetics & Theatres
- Care Group 3 – includes Family Health and Clinical Support Services
- Care Group 4 – includes Community and Diagnostic Services

Supporting these Care Groups are corporate services including Health Informatics, Estates and Facilities, Strategy, Planning and Performance, Workforce, and Finance, each led by an Executive Director.

Rotherham continues to experience higher-than-average levels of deprivation, with over 50,400 residents living in deprived areas. Health inequality remains a significant challenge, and improving equitable access to care for all our communities remains a core ambition. Our population is older than the national average, predominantly White British, with around 60,000 residents from minority ethnic groups.

System and Partnership Working

During 2024/25, the Trust has continued to strengthen system collaboration across South Yorkshire, remaining a core member of the Acute Federation.

Our strategic partnership with Barnsley Hospital NHS Foundation Trust has developed further, with the Joint Strategic Partnership Group continuing to provide oversight of the joint work programme. This includes quarterly meetings of both organisations' Chairs, Joint Chief Executive, Managing Directors, Non-Executive Directors, and the Joint Director of Corporate Affairs.

The Joint Delivery Group, made up of Executive team members from both organisations, has continued to progress the delivery of our partnership ambitions.

This year we built on previous progress in:

- Governance structures
- Major collaborative programmes
- Smaller-scale improvement projects

Following the successful implementation of a joint gastroenterology service, we have expanded clinical collaboration into additional service areas, including developing a joint approach to our haematology service. Further opportunities for shared learning, mutual support, and sustainability of critical services continue to be explored.

The Joint Leadership Development Programme, initiated last year, has matured significantly, embedding a shared leadership culture across both Trusts. We also further embedded joint roles where appropriate, including the continued joint appointments at Chief Executive, Director of Corporate Affairs, Head of Procurement level, and Director of Communications.

We continue to host NHS Graduate Management Trainees across both organisations, offering a unique blended experience which is highly valued by NHS England.

Looking ahead, we are committed to deepening our collaboration across clinical and non-clinical areas where it provides clear benefits for our patients, staff, and populations.

Our Purpose

We remain incredibly proud of our achievements during 2024/25 and are determined to continue our improvement journey.

'Our New Journey Together' outlines our Strategic Ambitions through to 2027, providing a clear roadmap through the changing health and care landscape.

Key Issues, Opportunities and Risks

Delivering high-quality care remains our foremost priority.

The Board of Directors and Senior Leaders continue to monitor key risks and challenges that could impact the achievement of our Strategic Ambitions through the monthly Board Assurance Framework process.

Key risks and challenges identified during the year, and into 2025/26, include:

- Risk of not embedding quality care due to resource, capacity, and capability challenges, potentially leading to poor clinical outcomes and patient experience
- Risk of slow progress on system-wide service reconfiguration, impacting the delivery of seamless end-to-end patient care
- Risk of insufficient influence at the Rotherham PLACE level, potentially limiting our ability to reduce health inequalities
- Risk of deteriorating operational performance and financial constraints impacting patient access and experience
- Risk of sustaining service delivery in line with national and system requirements due to ongoing financial pressures

These risks are described in detail in the Annual Governance Statement.

Performance Analysis – Statement from the Chief Executive

During 2024/25, the Trust has operated in a highly challenging environment, shaped by increasing demand for our services and national workforce pressures across key clinical areas. Despite these challenges, our teams have remained dedicated to delivering safe, effective care for our patients.

Performance across the Trust continues to be closely monitored through a comprehensive Integrated Performance Report (IPR), structured around the domains of quality, workforce, operational delivery, and financial performance. The IPR is discussed monthly at the Board, following detailed scrutiny by Board Committees. This year, we have enhanced our reporting with greater use of Statistical Process Control (SPC) analysis, providing clearer insights into trends, variation, and areas requiring action.

Care Group Performance meetings and monthly Executive-led reviews of corporate functions have strengthened our focus on accountability and improvement across all areas. We have continued to develop our live performance reporting and business intelligence functions to enable operational teams to access real-time data, supporting timely decision-making and improvement initiatives.

Following the national move back to the four-hour urgent and emergency care standard in 2023/24, the Trust has continued to work to embed new ways of working to support timely access to emergency care. Improving performance against the national 78% target has required ongoing focus across urgent care pathways, operational processes, workforce planning, and patient experience. While significant progress has been made, we recognise that further work is required to embed new models of care and ensure sustainable delivery of the standard across all areas.

Operational pressures during 2024/25 were exacerbated by periods of exceptionally high demand, particularly over the winter months. The Trust implemented a comprehensive Winter Plan, modelling anticipated pressures across critical care, acute, and community services and identifying the actions required to respond. Partners from across the borough actively engaged with the plan, ensuring a coordinated system-wide response to managing pressures and maintaining patient safety.

We continue to work closely with health and social care partners in Rotherham to prevent avoidable hospital admissions and reduce unnecessary lengths of stay, helping to optimise patient flow across the health and care system. The national move to use the Emergency Care Dataset (ECDS) to record Same Day Emergency Care activity will further support benchmarking and improvement opportunities throughout 2025/26.

In parallel with the focus on urgent care, significant progress has been made in elective recovery. During 2024/25, colleagues worked hard to increase elective activity levels towards 103% of 2019/20 volumes, in line with the requirements of the South Yorkshire Integrated Care Board. Despite workforce pressures, particularly within anaesthetic teams and theatres, and the challenges associated with sustained high demand, the Trust has successfully increased activity levels towards pre-pandemic volumes, particularly in the second half of the year following targeted investment. As a result, we have eliminated patients waiting more than 65 weeks by the end of the financial year, meeting our strategic ambition.

Looking ahead to 2025/26, we remain committed to improving patient access, further embedding improvements in urgent and elective care, supporting our workforce, and working in partnership across the system to deliver high-quality, sustainable services. I would like to extend my sincere thanks to all our colleagues for their hard work, resilience, and unwavering commitment to our patients and communities throughout another challenging year.

Performance Analysis for 2024/25: Summary of performance against key healthcare targets

Emergency Access

Over the past year, demand for emergency care has continued to rise, with an 8% increase in attendances compared to 2023/24. This growth was most evident in the winter months and was driven by a 4% rise in ambulance arrivals and a 10% increase in walk-in patients, particularly among the 36–45 age group (up 15%) and those aged 75+ (up 10%).

During 2024/25, the Trust has worked closely with partners to improve urgent and emergency care delivery, particularly against the national 4-hour standard. Building on the reset work undertaken in 2023/24, the Trust implemented a number of operational changes designed to streamline patient flow and decision-making at the front door. Performance against the 4-hour target improved from the previous year, rising from 62.9% in March 2024 to 65.5% by March 2025, reducing the gap towards the national ambition of 78%. The Trust moved from 2nd to 1st quartile nationally this year for Type 1 A&E attendances, ranking 29th out of 118 acute and integrated providers.



Ambulance handovers within 30 minutes remained a key area of focus, with sustained improvements resulting in a 36% reduction in handovers >60 minutes compared to 2023/24.

Same Day Emergency Care (SDEC) and Community Urgent Care

The expanded Same Day Emergency Care Unit played a critical role in reducing admission pressures, particularly early in the year, delivering a 40% increase in SDEC activity compared to the previous year. Unfortunately, as pressures increased into winter the need to utilise SDEC to accommodate patients overnight became unavoidable and this reduced again. The Trust is now progressing the development of a standalone SDEC Unit to support sustainable improvement moving forwards.

The Trust also worked closely with system partners to strengthen community-based alternatives to admission, contributing to a reduction in avoidable admissions and improvements in discharge timeliness.

Elective Care and Referral to Treatment (RTT)

Despite ongoing workforce challenges, the Trust made significant strides in stabilising and reducing elective waiting lists. At the end of 2024/25, the Trust reduced the overall waiting list from approximately 33,000 patients in August 2024, where it peaked, to around 31,000, reversing the growth seen in previous years. This sustained focus on reducing long waits and improving access to care has led to a 4.2% reduction in the overall elective waiting list from April 2024 to March 2025.

Simultaneously, the Trust has delivered a 4.9% improvement in RTT performance, moving from 59.8% in March 2024 to 64.7% by March 2025, which now places the organisation in the first national quartile. The Trust is currently ranked 30th out of 123 acute and integrated providers, reflecting significant trust-wide improvement and performance.

While the number of patients waiting over 52 weeks peaked at 902 in January 2025, this was reduced to 790 by March 2025, placing the Trust in the second quartile nationally for 52-week waits, with further plans in place to drive this figure down in early 2025/26. Specialty-level interventions in ENT, Orthopaedics, Gynaecology, Gastroenterology, and Ophthalmology led to targeted improvements in RTT performance.

Cancer Waiting Times

The Trust continued its positive trajectory in cancer performance during 2024/25, exceeding national expectations. Against the Faster Diagnosis Standard (target 77% by March 2025), the Trust achieved 80.9% by March 2025 underpinned by the centralisation of cancer services, which enabled enhanced coordination and a stronger focus on patient pathways.

Performance against the 62-day standard also improved, with 77.9% of patients treated within the timeframe in March 2025, again exceeding the national expectations of 70%. The number of patients waiting over 62 days reduced month-on-month, moving the Trust closer to achieving sustainable compliance.

The Trust also achieved the 31-Day General Treatment Standard of 96% in 7 months during 2024/25, with performance of 100% delivered in March 2025.

Diagnostics

Diagnostic performance remained strong, with the Trust consistently delivering the constitutional DM01 standard throughout 2024/25. Investment in imaging, endoscopy, and cardiac physiology services enabled the Trust to sustain high levels of activity, ending at 0.59% exceeding the national standard of less than 5% waiting over 6 weeks, despite the addition of Endoscopy surveillance patients to the active waiting list in September 2024.

This achievement reflects the continued efforts of our diagnostic teams to deliver timely care, while also providing mutual aid to neighbouring Trusts. The Trust remains one of the top-performing organisations nationally, consistently benchmarking in the top decile.

Community Services

The Trust's community teams continued to deliver high-quality services despite increased demand. The Transfer of Care Hub matured significantly, helping to further integrate discharge planning and improve flow.

The virtual ward has expanded its role in supporting both discharge and admission avoidance, enabling more acutely unwell patients to be safely cared for at home. Despite workforce-related limits on growth, patient outcomes and feedback remain positive. Ongoing work as part of the Community Services Review is assessing demand and future scaling options.

Performance against the Urgent Community Response standard remained stable at 74%, with a renewed emphasis placed on workforce flexibility to respond to surges in demand. This is above the national standard for Urgent Community Response services which is to assess, treat, and support at least 70% of patients referred within two hours.

Looking Ahead to 2025/26

Following the progress achieved during 2024/25, the Trust has set ambitious plans for 2025/26, with a continued focus on urgent care improvement and elective recovery.

Key priorities for 2025/26 include:

- Deliver the national 78% 4-hour Emergency Access standard by embedding new front-door processes, further expanding ambulatory care pathways, and working with system partners to reduce hospital demand.
- Reducing the overall elective waiting list further to ensure no more than 1% of patients have been waiting longer than 52 weeks for treatment, with a strong emphasis on improving productivity across outpatient, diagnostic, and theatre services.
- Achieving sustainable compliance with the 62-day Cancer Waiting Time Standard, targeting a consistent performance of 75% or higher.
- Sustaining delivery of the Faster Diagnosis Standard through pathway redesign and further development of diagnostic pathways.
- Maintaining diagnostic excellence, ensuring the Trust remains in the top decile nationally for DM01 compliance.
- Enhancing community services by expanding Virtual Ward capacity to 80 patients, improving community response times, and continuing the integration of community urgent care services into the wider urgent and emergency care pathway.
- Embedding productivity gains across all clinical services, in line with the South Yorkshire Acute Federation's productivity metrics and GIRFT Further Faster guidance.
- System Collaboration, working closely with partners across Rotherham Place to deliver improvements in flow, prevent admissions, and support timely, safe discharges.

Through these initiatives, the Trust aims to continue delivering tangible improvements for patients and communities, building a more resilient, efficient, and responsive health service for Rotherham.

Digital and Technology

This year, the Trust has continued to advance its digital transformation agenda, guided by strategic themes of creating Reliable, Intuitive, Informative, Integrated, Innovative, and Helpful systems across our Digital, Data, Technology, and People domains. Our efforts have focused on enhancing patient care, supporting clinical efficiency, and fostering system-wide integration. Building on this, our internal SEPIA shared record and operational reporting solution achieved full integration with the Yorkshire and Humber Care Record, providing real-time access to patient information across multiple NHS providers. Furthermore, the successful live implementation of GPConnect now pulls real-time medication and allergy information directly into hospital patient records, significantly enhancing patient safety by eradicating data transcription errors and reducing time for medicines reconciliation.

Innovation has been a prominent feature of our work. We launched a UK-first chatbot-facilitated radiology booking system with primary care and the NHSapp. This, alongside automated Waiting List Validation and eMeet and Greet referral notifications, is already demonstrating a 10-15% reduction in patient calls and was shortlisted for a national HSJ award. Internally, we, an innovative GenAI knowledge chatbot designed to assist staff in quickly accessing information from policies and procedures, and have commenced pilots exploring Generative AI for UECC activity summarisers and auto-code generators. We also started trialled Ambient AI technology in clinical areas and advanced our smart hospital solution, now actively tracking hundreds of assets using RFID, Bluetooth, and WiFi.

Operational efficiencies and enhanced patient pathways were realised through the successful implementation of fully digital processes for the Same Day Emergency Care (SDEC) pathway, aligning with national standards and ensuring compliance with Emergency Care Data Set v4 submissions. The Trust's Integrated Performance Reporting (IPR) tool was updated, leveraging Statistical Process Control for improved data presentation. In our Contact Centre, an automated OpenSource eRS Referral



Downloader solution has significantly improved efficiency in processing GP referrals. Our technological infrastructure has been substantially strengthened, including an upgrade to our internet connections, the formal closure of major WiFi and Telephony upgrade projects and updates to secure our MediTech EPR infrastructure. Preparations are well underway for a transition to the national NHS 365 teams environment, promising enhanced collaboration tools, with N365 Phase 1 completed and planning for subsequent phases underway.

Data Excellence, Cybersecurity, and People Development

We have continued to strengthen our cybersecurity measures robustly, implementing multi-factor authentication across all mail accounts, conducting a thorough review of firewall rules, and rolling out a programme of cyber awareness training, including targeted training around phishing. A privileged remote access solution is also being urgently implemented to secure 3rd party remote access. This unwavering commitment to data security was validated by achieving Substantial Assurance for our Data Security and Protection Toolkit from Internal Audit for the fifth consecutive year.

Our clinical coding team has consistently met Freeze and Flex deadlines and made substantial progress in data quality, with 91% of spells now fully coded electronically, supporting effective decision-making and financial improvement efforts. The Trust is now also operationally connected to the Federated Data Platform, and a process has been established for extracting Ethnicity and other Inequalities data into a single unified repository.

Empowering our workforce has been critical to this digital journey. The Trust's Data Essentials programme has been instrumental in enhancing data literacy across the organisation, providing education on data storytelling and SPC charts. This commitment to upskilling was notably recognised as we became the first in Yorkshire and Humber to receive Level 2 accreditation from the Digital Skills Development Network.

Health inequalities

Health inequalities are unjust and avoidable differences in people's health across the population and between specific groups. The causes of health inequalities are complex but research has shown that the main drivers of health inequalities are social determinants; the environments people live in, access to employment and the kind of start they had in life. Inequalities are also driven by the ways in which health services are designed, delivered, and by the quality of clinical care received. The NHS plays a role in both mitigating against the impact of the wider determinants and in reducing healthcare-based inequalities. Addressing health inequalities will improve the quality of clinical care, patient outcomes and safety.

Population needs of Rotherham

Over the last decade the Rotherham population has increased by 4% to approximately 269,000 of which 51% are female. Three quarters of the population are of working age (between 16 and 67). The 2021 Census data shows that 91% of the population are white, 4% Pakistani, 1% African and remaining 4% are of other ethnic backgrounds.

Over a third of the Rotherham population live within the 20% most deprived areas in England and around 22% of children live in low-income families. Over one in five of our households (23%) are workless compared to the England average of 13%. In addition, 32% of the Rotherham working age population have long term illness, 7% above the England average.

The benefits claimant count has not yet returned to pre-pandemic levels in any area and the post pandemic cost of living crisis and change in economy has resulted in more people in work who are also experiencing poverty. The gross disposable household income gap between Rotherham and England has widened over time. Hourly individual earnings in Rotherham are £16.27, which is £2.50 lower than the English average. Women in Rotherham have consistently lower rates of employment compared to men, often on lower pay rates. A fifth of our pensioners were estimated to be living in poverty in 2020.

Overall, the health of our population is poorer than the England average. In Rotherham, the life expectancy at birth for women is 80.9 years and 77.8 years for men, compared to 83.0 and 79.1 years respectively in England. Life expectancy is 9.9 years lower for men and 9.5 years lower for women in the most deprived areas of Rotherham than in the least deprived areas, and the latest data shows this gap is widening. The average healthy life expectancy for a children born in Rotherham in 2023 is around 56 years, which is significantly lower by six years than that for England. This indicates that a child born today would be expected to live in good health without developing illnesses up to approximately 56 years of age: twelve years earlier than expected state retirement age. Working people in Rotherham live shorter lives and endure a greater proportion of their lives in ill health when compared to the national average.

Smoking is the leading cause of preventable disease and premature mortality in Rotherham, and despite significant reductions over the past decade, a higher proportion of Rotherham adults smoke (14%) than in England, and this leads to high rates of hospital admissions directly caused by smoking. Alcohol consumption is also higher than average, with a third of the population drinking at a level that puts their health at risk (over 14 units per week). Rotherham has higher alcohol-related admissions rates than England. Low levels of physical activity in the borough are also contributing to poor long-term health outcomes. Mental health is a concern for the population too, with more than one in five people estimated to suffer from anxiety or depression.

Our Response to Health Inequalities as a System Leader

We assert that it is unacceptable that there are those in our community who suffer poorer health and health outcomes because of their status, socioeconomic background or demographic characteristics. The Trust plan for health inequalities looks to address issues of need, access, experience and outcome experienced by our population. There are six components to this:

- Understanding our population and patient needs better through data and engagement.
- Providing equity of access to our services
- Providing tailored, patient-centred care which is adapted for individual needs
- Building prevention into our pathways
- Supporting our staff to live healthy lives
- Providing leadership to improve the lives of our communities

Under this plan, some of our successes and work in progress include:

Substantial developments behind the scenes in our ability to draw socioeconomic and demographic information into our regular reporting processes in a consistent way. This development is allowing us to highlight and address any gaps in our knowledge about our patients and to use information to support a range of initiatives to target inequity. There are regular discussions tabled at the Trust Executive Team and Board on health inequalities, and a new suite of health inequalities reporting tools are currently in development.

With tobacco use being one of the major causes of health inequality in Rotherham, the Trust's role in supporting patients to stop smoking is critical. Over 2024/25, we had nearly 3,000 conversations with inpatients about smoking cessation, prescribed nicotine replacement therapy for 1,350 and referred nearly 1,000 people to our community stop smoking services to help them give up for good.

Helping patients to be fit for surgery is also an important way to reduce inequalities in access, experience of healthcare and outcomes. Our work to improve access to digital weight management tools has provided support for patients referred for surgery has helped them achieve a healthy weight in advance of their intervention. Our initial evaluation data shows that patients referred through our secondary care pathways lost more weight than the equivalent programme in general practice.

Over the past year, we have devoted much time to staff training and development on health inequalities. In addition to a programme of lunchtime lectures on inequalities, prevention and early intervention and behavioural approaches to health improvement, we continue to deliver and develop our Enhanced Making Every Contact Count training, open to all staff to develop expertise on health inequalities and the tools available to tackle them, including health coaching, advice and signposting, for example to our comprehensive Rotherhive website.

The Trust has also invested in placing bespoke care navigation support in many of our pathways to support improved access for patients, and to enhance care processes. We currently have social prescribers supporting the wider needs of our emergency department attenders; care navigators to facilitate and support the experience of our cancer patients; a veteran

support role and roles to support vulnerable patients in maternity and children's services.

In terms of the health inequalities experienced by our staff, we are providing a range of services including health checks, smoking cessation support, counselling and signposting. We have also launched the staff health and wellbeing programme, to undertake a thorough needs assessment for our staff and will be developing further targeted interventions to build on the support already available.

Environmental Sustainability and Net Zero

The Trust remains committed to delivering on the NHS Net Zero ambition.

Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below.

The trust is currently refreshing the Green Plan, and will shortly ask the Board to approve a plan for 2025-27. It will set out how we will address the environmental impact of our activities, aiming for:

- An 80% reduction in carbon emissions from on-site sources by 2032
- A further 5% reduction in general waste from 2020 levels
- A 25% reduction in patient service mileage from 2020 levels through increased community-based care
- Elimination of single-use plastics
- A 10% reduction in water consumption by 2025

Progress continues across all workstreams, with sustainability embedded into our estate planning, clinical service design, and operational delivery.

The Trust has seen mixed progress in this area in 2024/25. The trust's carbon emissions from utilities peaked at 8,437 CO2e in 2021-22, and have fallen by almost a quarter since then to 6,482 CO2e. Having fallen initially, water consumption at the trust has increased by around 3% since 2020-21.

General and clinical waste both increased substantially during the Covid-19, and clinical waste has fallen from its peak, including a 3% reduction from 2023/24 to 2024/25.

The Trust has recognised the need to strengthen its governance of sustainability issues. We have appointed the Managing Director as the Executive Sponsor of the workstream. He will chair a new Sustainability Group, with the Director of Estates and Facilities as the operational lead.

Regular progress updates on the metrics against the Green Plan will be provided to the Executive Team and the Finance and Performance Committee.

Environmental risks are considered as part of the corporate risk register, which is reported to the board at each of its meetings. Heatwave and severe weather plans are in place, and we ensure timely warnings are issued to key operational staff where necessary. Strategic suppliers are coordinated during high-risk periods to maintain service continuity. Sustainability requirements are also embedded in capital investment decisions to mitigate future climate risks and rising energy costs.

Going Concern Disclosure

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

Preparation of the Report

The annual report has been prepared on the same group basis as the annual accounts.

Conclusion

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

R. Jenkins

Dr Richard Jenkins

Chief Executive

26 June 2025





Accountability Report

Director's Report

The Board of Directors: Roles and Responsibilities

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

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

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

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

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

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

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

Composition of the Board

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

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

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

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

During the reporting period the Board has engaged with and completed a programme of facilitated Board development.

Non-Executive Directors		
Name and position	Background	Total number of board meetings attended
Dr Mike Richmond Chair	<p>Mike joined the Trust as Chair in January 2024. Mike is an experienced physician and leader. An anaesthetist by background, he has held many senior roles in healthcare organisations both nationally and internationally in the Middle East and Bermuda. Most recently, Mike was a Non-Executive Director with the Bermuda Health Council and was also Chief Executive and President of Bermuda hospitals Board.</p> <p>Mike was Chair of the Board of Directors, Council of Governors, Board Nominations and Remuneration Committee and the Governor Nomination and Remuneration Committee.</p> <p>Terms of office 01.01.2024 to 31.12.2026</p>	11/11
Heather Craven Non-Executive Director & Senior Independent Director	<p>Heather joined the Trust as a Non- Executive Director in February 2017. Heather is a Chartered Accountant and has spent the majority of her career working in the private sector as Finance Director for FTSE and AIM listed companies across a wide spectrum of industries both in the UK and overseas.</p> <p>Since 2006, Heather has helped a number of organisations via interim and consultancy roles to identify operational, commercial and financial issues and weaknesses delivering solutions to resolve.</p> <p>Heather is the Senior Independent Director, a member, Vice Chair of the Quality Committee (until January 2025), member of the Audit and Risk Committee, Vice Chair of the Nominations and Remuneration Committee, Chair of the Charitable Funds Committee, and member of Finance and Performance Committee (from January 2025).</p> <p>Heather also Chairs the Organ Donation Committee.</p> <p>Terms of office 17.02.2017 to 16.02.2020 17.02.2020 to 28.02.2023 01.03.2023 to 31.03.2025 01.04.2025 to 30.09.2025</p>	10/11
Rumit Shah Non-Executive Director	<p>Rumit joined the Trust as a Non-Executive Director in January 2020.</p> <p>Rumit is currently a full-time practicing General Practitioner in Hatfield, Doncaster. Rumit is a graduate of the University of Sheffield and his commitment to the NHS spans over 38 years during which time he has been engaged in various capacities including the Local Medical committees (LMC), Primary Care Groups, Primary Care Trusts in addition to being a Clinical Director of East Doncaster Primary Care Network. Rumit is the Chair of the Doncaster LMC.</p> <p>Rumit has been a GP Appraiser, sat on the National Clinical Assessment Service (NCAS) assessing General Practice, a GP member on the Area Prescribing Committee and the Scheduled Drug Monitoring Sub- Committee of Doncaster.</p> <p>Rumit is Chair of the People and Culture Committee, and a member of the Audit and Risk Committee and Nominations and Remuneration Committee.</p> <p>Terms of office 01.01.2020 to 31.12.2021 01.01.2022 to 31.12.2024 01.01.2025 to 31.12.2025</p>	9/11

Non-Executive Directors		
Name and position	Background	Total number of board meetings attended
Kamran Malik Non-Executive Director & Vice Chair	<p>Kamran Malik joined the Trust as an Associate NED in April 2021 and was subsequently appointed as a substantive NED from 11 September 2021.</p> <p>Kamran is a finance professional focusing on business transformation through a coaching approach to people and culture change. He qualified as a Chartered Accountant with KPMG, worked overseas with TNT in senior finance roles, was a Finance Director for a start-up before joining the Royal Mail. During his 20 years at the Royal Mail, he further expanded his business acumen by undertaking various senior leadership roles and professional qualifications including Risk Management, Regulatory Compliance, Procurement, Business and Personal Coaching and as a Director of Cost Transformation.</p> <p>Kamran is the Chair of the Audit and Risk Committee, a member of the Finance and Performance Committee and a member of the Nomination and Remuneration Committee.</p> <p>Terms of Office Associate NED: April 2021 to September 2021 NED :11.09.2021 to 10.09.2024 11.09.2024 to 10.09.2027</p> <p>Kamran was appointed Interim Chair from 01 September 2023 to 31 December 2023</p>	9/11
Martin Temple Non-Executive Director	<p>Martin Temple is an experienced chair and non-executive director with a background in large-scale manufacturing, business services, public sector, regulatory organisations, academia and the health sector.</p> <p>Through his chairmanship of the Health and Safety Executive and having served for nine years on the Board of Sheffield Teaching Hospitals NHS Foundation Trust he has direct experience of the health sector.</p> <p>He has also acted as an Independent Chair for a number of reviews for several governments covering design and the built environment, government business support and health and safety.</p> <p>Martin is the Chair of the Finance and Performance Committee and a member of the People and Culture Committee and Nominations and Remuneration Committee.</p> <p>Term of Office 01.10.2022 – 30.09.2025</p>	9/11
Hannah Watson Non-Executive Director	<p>Hannah joined the Board in August 2023. Hannah is a career HR professional focussed on leading change and has experience in both private and public sector organisations, nationally and internationally. Hannah is currently a Director working part-time in a large government department. Hannah brings experience of navigating challenges at scale within a complex political framework which she combines with volunteering as a school governor in a large high school in addition to leading people change within commercial organisations.</p> <p>Hannah is a member of the Finance and Performance Committee (until January 2025), Vice Chair of the People and Culture Committee, member of the Quality Committee (from January 2025) and member of the Nomination and Remuneration Committee.</p> <p>Term of office 17.08.2023 – 16.08.2026</p>	9/11

Non-Executive Directors		
Name and position	Background	Total number of board meetings attended
Julia Burrows Non-Executive Director	<p>Julia brings valuable experience from senior roles in local government, academia and the NHS. She recently retired from her role as Executive Director of Public Health and Communities at Barnsley Council.</p> <p>Julia initially trained and midwife in the 1990's. She was appointed as an Honorary Professor at Sheffield Hallam University in November 2023 and is a long standing honorary senior lecturer at the University of Sheffield. Her academic interests include public health, law and medical ethics. Julia is also a Fellow of the Faculty of Public Health.</p> <p>Julia is interested in compassionate and responsible leadership and the importance of a culture where all staff and patients feel valued and listened to. Her commitment to social justice and addressing inequalities is what drives her.</p> <p>Julia is Chair of the Quality Committee, a member of the Charitable Funds Committee and a member of the Nomination and Remuneration Committee.</p> <p>Term of Office 01.10.2023 – 30.09.2026</p>	11/11
Shirley Congdon Non-Executive Director	<p>Shirley was delighted and honoured to join the Trust as a Non-Executive Director in November 2024. She has had a long and successful career in the health and care sector and higher education and is currently the Vice-Chancellor of the University of Bradford. With a professional background in Nursing, she is committed to both advancing the quality of patient care and supporting the Trust to understand how best to enhance staff wellbeing and engagement. Shirley has led the University to be first in England for Social Mobility.</p> <p>Shirley has served on the Governing Body of Bradford District Care Trust as a Stakeholder Governor and works closely with NHS Trusts in West Yorkshire. She is a member of the Health and Wellbeing Board and is involved in many population health research programmes and initiatives as well as having significant experience of workforce planning and education and training.</p> <p>Shirley is a member of the Quality Committee, People and Culture Committee, Charitable Funds Committee, and Nomination and Remuneration Committee.</p> <p>Term of Office 01.11.2024 to 31.10.2027</p>	5/5

Non-Executive Directors		
Name and position	Background	Total number of board meetings attended
Andrew Mondon Associate Non-Executive Director	<p>Andrew is a Chartered Accountant, having qualified within an audit background. He has worked in a service environment for several large organisations, including significant experience of providing outsourced government contracts in defence, education and employability.</p> <p>Having recently completed a five-year period as the Chief Finance Officer at Change Grow Live, a national charity that helps tens of thousands of people each day to make a difference in their lives, Andrew is now moving to a portfolio of roles, which includes the Trustee of an education charity that supports individuals to develop their potential through vocational training, where Andrew is chair of the Finance and Audit Committee.</p> <p>Previously, Andrew worked as a Finance Director in a skills and employability provider, which offered a wide range of apprenticeships and a variety of employability solutions aimed at providing individuals with the skills needed to gain and improve employment.</p> <p>Andrew has also consistently driven change aimed at improving delivery at the frontline and is committed to playing a part in improving the lives of others.</p> <p>Term of Office 01.11.2024 to 31.10.2025</p>	4/5
Zlakhah Ahmed Associate Non-Executive Director	<p>Zlakhah Ahmed has nearly 40 years' experience of working, leading, managing and overseeing the development work within Black and minority communities.</p> <p>She set up the Apna Haq organisation which supports BME women and girls in Rotherham who have been subjected to domestic and sexual violence.</p> <p>Zlakhah was involved in drafting the NICE domestic violence guidance published in 2013. She was awarded an MBE for services to women's rights and community cohesion in 2014.</p> <p>Term of office 01.10.2022 – 30.09.2023 01.10.23 – 30.09.24</p>	4/4



Executive Directors		
Name and position	Background	Total number of board meetings attended
Dr Richard Jenkins, Chief Executive	<p>Richard joined the Trust on 10 February 2020 as Interim Chief Executive on a joint basis with Barnsley Hospital NHS Foundation Trust where he serves as the Chief Executive. He has previously been the Medical Director for two NHS provider organisations.</p> <p>He has practised medicine for over 28 years since graduating from the University of Sheffield in 1991 with an intercalated degree in virology in addition to his medical degree.</p> <p>Richard was a trainee doctor in South Yorkshire before he became a Consultant in 2002, specialising in diabetes and endocrinology.</p> <p>Richard became the substantive Joint Chief Executive between the Trust and Barnsley Hospitals NHS Foundation Trust in September 2022.</p>	11/11
Bob Kirton, Managing Director	<p>Bob Kirton joined the Trust on 6 January 2025.</p> <p>Bob was previously Managing Director of Barnsley Hospital NHS Foundation Trust, where he has held a number of other director roles, including Director of Strategy and Chief Delivery Officer. Prior to this, he had a successful career in retail. He has a BA in History from Leicester University and an MSc in Strategy and Leadership in Healthcare from Bradford University. Bob also completed the Aspiring CEO programme in 2022.</p>	3/3
Michael Wright, Managing Director	<p>Michael joined the Trust initially as Interim Deputy Chief Executive in February 2020 becoming substantive from November 2020. Michael became the Managing Director during 2023.</p> <p>Michael has extensive experience across both the NHS and Department for Work and Pensions. He has been a Turnaround Director at Liverpool University Hospitals NHS Foundation Trust and the Director of Finance at Barnsley Hospital NHS Foundation Trust.</p> <p>Michael left the Trust on 5 January 2025 to take up the Managing Director role at Barnsley Hospital NHS Foundation Trust.</p>	8/8
Steve Hackett, Director of Finance	<p>Steve joined the Trust as Director of Finance in July 2021. He has worked in the NHS since 1990 having previously worked for local acute Trusts, NHS England and Primary Care Trusts in the area. Steve qualified as a Certified Accountant in 1997 and has worked as a Director of Finance in the NHS since 2001, with recent roles at Chesterfield Royal Hospital NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).</p>	11/11
Daniel Hartley, Director of People	<p>Daniel joined the Trust in June 2023 as Director of People.</p> <p>Daniel previously worked as the Regional Director of Workforce and OD for NHS England across the North East and Yorkshire. He has over 20 years of HR, organisational development and workforce experience and has held a number of senior leadership roles across large public sector organisations.</p>	7/11

Executive Directors		
Name and position	Background	Total number of board meetings attended
Helen Dobson, Chief Nurse	<p>Helen was appointed as Interim Chief Nurse in October 2021 and subsequently appointed to the substantive Chief Nurse role in April 2022.</p> <p>Helen previously worked at Sheffield Children's NHS Foundation Trust specialising in Paediatric Critical Care and has a significant educational background, including being a Lecturer/ Practitioner at the University of Sheffield and leading national educational groups. Helen joined The Rotherham NHS Foundation Trust in November 2015 as Head of Nursing for our Surgical Division and was appointed Deputy Chief Nurse in February 2017.</p>	10/11
Sally Kilgariff, Chief Operating Officer	<p>Sally became the Chief Operating Officer in May 2022 after being the Deputy Chief Operating Officer and Director of Operations since November 2018.</p> <p>Sally has extensive experience within the NHS and started her career with a placement in Rotherham Hospital whilst at University. She began working for the Trust in 2001. Sally has held various managerial roles including Deputy Chief Operating Officer at Doncaster and Bassetlaw Hospital NHS Foundation Trust. She has completed a BSc (Hons) in Business and Technology and an MSc in Health Service Management and Leadership. She completed the first cohort of the Aspiring Chief Operating Officer Programme run by NHSE in 2019.</p>	11/11
Jo Beahan Medical Director	<p>Jo joined the Trust in December 2022 as Medical Director having previously been Deputy Medical Director at Barnsley Hospital NHS Foundation Trust.</p> <p>Jo graduated from the University of Sheffield in 1995 and has worked in a number of acute trusts in South Yorkshire. She has worked as an Emergency Medicine Consultant since 2008. She is a CQC Specialist Advisor for the CQC Urgent and Emergency Care.</p>	10/11

Directors' Register of Interests

All Board members are required to declare any company directorships and any other significant interests which may conflict with their management responsibilities. Any such declarations are reviewed and published on the Trust website and has been completed for the relevant reporting period. Registers are available from the Director of Corporate Affairs (Company Secretary) at the address below:

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

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid, verified invoice, whichever is later. As can be seen in the table below, during 2024/25 the Trust paid 94.83% by number and 85.18% by value of all of its total bills within the 30-day target.

The total amount of liability to pay interest which accrued by virtue of the Trust failing to pay invoices within the 30-day period, and the total amount of interest actually paid in discharge of such liability by the Trust during 2024/25 was £295.36.

	Number	Value £000's
NON NHS		
Total Bills Paid in Year	51,815	122,879
Total Bills Paid Within Target	49,302	106,128
Percentage of Bills Paid in Target	95.15%	86.37%
NHS		
Total Bills Paid in Year	1,736	19,166
Total Bills Paid Within Target	1,480	14,870
Percentage of Bills Paid in Target	85.25%	77.59%
Total		
Total Bills Paid in Year	53,551	142,045
Total Bills Paid Within Target	50,782	120,998
Percentage of Bills Paid in Target	94.83%	85.18%

Information on fees and charging

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

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

As required by Section 43(3A) of the NHS Act 2006, an NHS Foundation Trust must provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England.

The Rotherham NHS Foundation Trust has not received any income which was not for the purposes of the health service in England during 2024-25.

NHS England Well-Led Framework

The Trust continues to keep its corporate governance arrangements under review to ensure the standards set out in the NHS England well-led framework continues to be met.

The Trust commissioned an external Well Led Review in 2024/25, which was carried out by the Advancing Quality Alliance (Aqua). The results of have been shared with the board. An action plan is being developed to support further improvements in the trust's leadership, and will be reported to a board meeting in public in 2025/26.



Statutory Committees of the Board

Audit and Risk Committee (Statutory Committee)

The Trust Audit and Risk Committee is a Statutory Committee formally constituted as a Committee of the Board and comprises three Non-Executive Directors. The Audit and Risk Committee is chaired by Kamran Malik and membership comprises two additional Non-Executive Directors, Rumit Shah and Heather Craven. From November 2024, Andrew Mondon, Associate Non-Executive Director, also attends the Committee. Standing attendees to the Audit and Risk Committee include the Director of Finance, Chief Nurse and Director of Corporate Affairs. Representatives from both Internal and External Audit are also in attendance.

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

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

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

- Approved the Internal Audit Plan for 2024-25
- Approved the Anti-Fraud Annual Work Plan for 2024-25
- Reviewed the Board Assurance Framework and Trust wide Risk Register
- Monitored responses by management to the recommendations made by Internal Audit through associated reviews
- Received assurance in relation to the improvement plan to strengthen the Trust's processes for managing litigation and inquests in addition to actions as a result of litigation
- Maintained oversight of the Trust's schedule of outstanding debt and the schedule of losses and compensations
- Maintained oversight of the Tender Waivers
- Reviewed the work of External Audit
- Reviewed the work and findings from Anti-Fraud
- Reviewed the 2024-25 Financial Statements seeking assurance they are appropriately compiled on a going concern basis
- Reviewed the Trust's Standing Financial Instructions and Standing Orders in addition to Scheme of Delegation and Matters Reserved for the Board
- Received assurance in relation to cyber security
- Received the Register of Interests
- Reviewed the Annual Report and Accounts (2023-24)
- Received the Annual Review of Standards of Business Conduct
- Received the Annual Report from the Freedom to Speak Up Guardian
- Reviewed the position in relation to Risk Management and the Trust's Risk Register.

The Audit and Risk Committee met on a total of six times with the following attendance by the Committee members:

Kamran Malik attended a total of 6 out of 6 meetings

Rumit Shah attended a total of 5 out of 6 meetings

Heather Craven attended a total of 5 out of 6 meetings

Andrew Mondon attended a total of 1 out of 1 meeting

Nominations and Remuneration Committee (Statutory)

The Trust has a Joint Nominations and Remuneration Committee with responsibility for the appointment and remuneration of Executive Directors. Responsibility for the appointment of Non-Executive Directors lies with the Council of Governor's Nomination and Remuneration Committee. Both are chaired by the Trust Chair.

The Nomination and Remuneration Committee met on five occasions during the reporting period.

Mike Richmond attended a total of 5 out of 5 meetings

Julia Burrows attended a total of 5 out of 5 meetings

Martin Temple attended a total of 3 out of 5 meetings

Hannah Watson attended a total of 2 out of 5 meetings

Shirley Congdon attended a total of 4 out of 4 meetings

Kamran Malik attended a total of 3 out of 5 meetings

Rumit Shah attended a total of 5 out of 5 meetings

Heather Craven attended a total of 3 out of 5 meetings

Andrew Mondon attended a total of 4 out of 4 meetings



Remuneration Report

Annual Statement on Remuneration

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

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

I am pleased to present the Remuneration Report of the financial year 2024-25 on behalf of The Rotherham NHS Foundation Trust Nominations and Remuneration Committee. As delegated by the Board of Directors, the Remuneration Committee has primary regard to the remuneration and terms of service of Executive Directors. The remuneration of Non-Executive Directors is dealt with by the Remuneration Committee established by the Council of Governors.

Major decisions taken on senior managers' remuneration 2024-25

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

During 2024-25 the Nominations and Remuneration Committee continued to utilise annual benchmarked data provided by NHS Providers as the pay and reward framework upon which to base Executive salary awards. For the period 2024-25 the Nominations and Remuneration Committee took into account the Executive Remuneration Framework whilst being mindful to ensure that levels of remuneration were sufficient to attract, retain and motivate directors with the skills and experience required by the Trust. The Trust was mindful not to pay more than necessary for this. In line with national guidance the Executive Directors were awarded a 5% cost of living pay award for the financial year 2024-25.



Dr Mike Richmond

Chair of the Trust's Nominations and Remuneration Committee
26 June 2025

Senior Managers Remuneration Policy

The Remuneration Policy for Executive Directors was updated during 2019-20 and remained in place for the period 2024-25. The aims of the pay and reward framework are to;

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

Executive Directors

During the reporting period 2024-25, Executive Director remuneration was set at an appropriate level to recognise the significant responsibilities of Executive Directors in similar sized Foundation Trusts. The future policy table below illustrates the commitment to ensuring pay is considered in line with value for money and the national context.

Component of Pay	Links to short and long-term strategic goals	How the Trust operates this in practice	Maximum potential value of the component	Performance measures
Base salary	Proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work	The Nomination & Remuneration Committee reviews the following in setting the remuneration: <ul style="list-style-type: none"> • Roles, responsibilities and accountabilities • Skills, experience and performance • Pay awards across the Trust • Local and national market conditions • Advice from NHS England if applicable • Benchmarking 	There is no prescribed limit but senior managers are not treated more favourably than other staff.	The Chief Executive and Executive Directors participate in annual performance reviews undertaken by the Chair and Chief Executive respectively. Individual agreed objectives are agreed and any performance issues are managed through the Trust's Policies relating to performance.
Pension related benefit		The Trust operates the standard NHS Pension scheme which is open to all eligible.	The Pension scheme is open to Directors who are subject to the Scheme rules	Not applicable
Bonus	The Trust does not have any bonus arrangements in place.			
On-call Payments	Executive Directors do not receive on call payments but participate in the Strategic on call rota.			
Benefits	The Trust operates a number of salary sacrifice schemes including a lease car scheme, child care vouchers which are open to all members of staff.			
Travel Expenses	Appropriate travel expenses are remunerated for business mileage.			

Directors with a Total Remuneration Greater than £150,000

In circumstances where our very senior managers are paid more than £150,000, the Nomination and Remuneration Committee has taken steps to assure itself that the pay was commensurate with market conditions, the responsibilities and duties of the role in addition to ensuring it is regularly reviewed to ensure the Trust is receiving value-for-money. This is achieved by the Committee carrying out a regular benchmarking review.

Service Contract Obligations

All senior managers are subject to substantive employment contracts which do not have a length of appointment stipulated. The Executive Directors and Chief Executive have permanent employment contracts with appropriate notice periods in line with current employment law practice. The following table illustrates the service contracts in place during the reporting period for Executive Directors.

Name	Date of Contract	Term	Notice Period
Dr Richard Jenkins	February 2020 - Interim September 2022 - substantive	Open ended	6 months
Michael Wright	February 2020 Interim November 2020 – December 2024 substantive	Open ended	6 months
Bob Kirton	January 2025 -	Open ended	6 months
Steve Hackett	July 2021 -	Open ended	6 months
Daniel Hartley	June 2023 -	Open ended	6 months
Helen Dobson	October 2021 – Interim December 2021 -	Open ended	6 months
Sally Kilgariff	May 2022 -	Open ended	6 months
Dr Jo Beahan	December 2022 -	Open ended	6 months

Service Contract Obligations

Policy on Payment for Loss of Office - subject to audit

In the event of early termination, there is no entitlement to any additional remuneration. During the reporting period 2024-25 no senior manager received payment for loss of office.

Diversity and Inclusion

The Board is committed to ensuring that there is an appropriate balance of skills, knowledge and experience. All appointments to the Board are subject to rigorous and transparent processes with careful consideration being given to age, race, disability, sexual orientation, marital or civil partnership status, religion or non-belief.

Statement of Consideration of Employment Conditions Elsewhere in the Trust

In determining the pay and conditions of employment for Executive Directors, the Nominations and Remuneration Committee take account of national pay awards for medical and non-medical staff groups that are subject to Agenda for Change or national Medical and Dental Terms and Conditions in addition to reviewing national benchmarked data to determine appropriate remuneration for Executive Directors.

Directors' Remuneration Report and Pension Entitlements – subject to audit

The following information is required by Paragraph 4 – 16 inclusive of Part 3 of Schedule 8 to the Regulations, or where required by the NHS FT Code of Governance. These disclosures outline the remuneration figures for Senior Managers made up of a single remuneration figure for each senior manager who served during the year in tabular form as shown below. This Single Total Figure table reports salary and benefits related to the period in office. Pension Benefits are affected by pension inflation in year and salary increases in year. See Table B Pensions, for further details.

Single Total Figure Table		Period 01/04/24 to 31/03/25				Period 01/04/23 to 31/03/24						
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance- Related Bonuses (bands of £5000)	Long-Term Performance- Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance- Related Bonuses (bands of £5000)	Long-Term Performance- Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
	45 - 50	5	0	0	0	45 - 50	10 - 15	0	0	0	0	10 - 15
Dr M Richmond, Chairman	10 - 15	0	0	0	0	10 - 15	25 - 30	0	0	0	0	25 - 30
Mr K Malik, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mrs H Craven, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Dr R Shah, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mr M Temple, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Ms J Burrows, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
Mrs H Watson, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
Professor S Congdon, Non-Executive Director (1 November 2024 to 31 March 2025)	5 - 10	0	0	0	0	5 - 10	0	0	0	0	0	0
Mr A Mondon, Non-Executive Director (1 November 2024 to 31 March 2025)	0 - 5	0	0	0	0	0 - 5	0					0
Mrs Z Ahmed, Non-Executive Director (1 April 2024 to 30 September 2024)	0 - 5	0	0	0	0	0 - 5	5 - 10	0	0	0	0	5 - 10
Dr R Jenkins, Chief Executive	140 - 145	0	0	0	0	140 - 145	135 - 140	2	0	0	0	135 - 140
Mr M Wright, Managing Director (1 April 2024 to 5 January 2025)	125 - 130	2	0	0	30 - 32.5	155 - 160	155 - 160	11	0	0	0	155 - 160
Mr R Kirton, Managing Director (6 January 2025 to 31 March 2025)	35 - 40	3	0	0	55 - 57.5	90 - 95						
Mr S Hackett, Director of Finance	160 - 165	0	0	0	65 - 67.5	225 - 230	150 - 155	4	0	0	0	150 - 155
Mr D Hartley, Director of People	145 - 150	22	0	0	37.5 - 40	185 - 190	115 - 120	18	0	0	35 - 37.5	150 - 155
Dr J Beahan, Medical Director	200 - 205	14	0	0	52.5 - 55	255 - 260	185 - 190	14	0	0	322.5 - 325	510 - 515
Mrs H Dobson, Chief Nurse	135 - 140	9	0	0	0	135 - 140	135 - 140	8	0	0	0	135 - 140
Mrs S Kilgariff, Chief Operating Officer	140 - 145	14	0	0	37.5 - 40	180 - 185	130 - 135	15	0	0	0	135 - 140

Mr R Jenkins is the joint Chief Executive at both Barnsley NHS Foundation Trust and Rotherham NHS Foundation Trust. Mr R Jenkins works at the Trust on a 0.5 Full Time Equivalent basis. Based on his full remuneration across both Trusts, his salary and fees would fall within the band of 285K and 290K.

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

	Number in Office		Number receiving expenses	
	2024/25	2023/24	2024/25	2023/24
Governors	25	21	2	1
Directors (including the Chair and non-executives)	18	19	3	3

Directors and Governors Expenses

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

Expenses shown in hundreds £00s	2024/25 £00	2023/24 £00
Aggregate sum of expenses paid to Governors	5	2
Aggregate sum of expenses paid to Directors	19	7
Total	24	9

Name and title	Real increase during the reporting year in pension at pension age (bands of £2,500) £000	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at 31 March 2025 ^a (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Real increase in Cash Equivalent Transfer Value (for period in post) £000	Employer's contribution to stakeholder pension £000
Dr R Jenkins, Chief Executive	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	2,316	0	(2,502)	NA
Mr M Wright, Deputy Chief Executive (1 April 2024 to 5 January 2025)	0.0 - 2.5	0.0 - 2.5	40.0 - 45.0	0.0 - 5.0	652	744	21	NA
Mr R Kilton, Managing Director (6 January 2025 to 31 March 2025)	0.0 - 2.5	0.0 - 2.5	45.0 - 50.0	0.0 - 5.0	670	771	8	NA
Mr S Hackett, Director of Finance	2.5 - 5.0	2.5 - 5.0	65.0 - 70.0	175.0 - 180.0	1,308	1,491	74	NA
Mr D Hartley, Director of People (1 June 2023 to 31 March 2024)	2.5 - 5.0	0.0 - 2.5	25.0 - 30.0	0.0 - 5.0	300	360	23	NA
Dr J Beahan, Medical Director	2.5 - 5.0	0.0 - 2.5	70.0 - 75.0	190.0 - 195.0	1,482	1,667	62	NA
Mrs H Dobson, Chief Nurse	0.0 - 2.5	0.0 - 2.5	60.0 - 65.0	155.0 - 160.0	1,380	121	(1,368)	NA
Mrs S Kilgariff, Chief Operating Officer	2.5 - 5.0	0.0 - 2.5	40.0 - 45.0	105.0 - 110.0	793	898	35	NA

A) Pension Benefits – Subject to audit

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

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

* The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Further details can be found in the Annual Accounts at note 1.2.

Cash Equivalent Transfer Values (CETV)

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

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

(1) These senior managers of the Trust are affected by the Public Sector Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Staff costs

	2024/25			2023/24		
	Permanent £000	Other* £000	Total £000	Permanent £000	Other* £000	Total £000
Salaries and wages**	192,368	10,211	202,579	181,834	8,941	190,775
Social security costs	20,615	-	20,615	18,489	-	18,489
Apprenticeship levy	957	-	957	937	-	937
Employer's contributions to NHS pensions***	38,675	-	38,675	31,252	-	31,252
Pension cost - other	119	-	119	78	-	78
Temporary Staff - External Bank	-	14,331	14,331	-	13,641	13,641
Temporary staff - agency/contract**	-	1,318	1,318	-	3,037	3,037
Total gross staff costs	252,734	25,860	278,594	232,590	25,619	258,209
<i>Of which:</i>						
<i>Costs capitalised as part of assets</i>	<i>297</i>	<i>320</i>	<i>617</i>	<i>363</i>	<i>450</i>	<i>813</i>
<i>Research and Development staffing costs</i>	<i>563</i>	<i>-</i>	<i>563</i>	<i>485</i>	<i>-</i>	<i>485</i>
<i>Redundancy Costs</i>	<i>39</i>	<i>-</i>	<i>39</i>	<i>128</i>	<i>-</i>	<i>128</i>
	251,835	25,540	277,375	231,614	25,169	256,783

Staff Costs – subject to audit

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

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

*** Employers pension contributions increased by 9.4% in 2024/25 and by 6.3% in 2023/24

Staff Exit Packages –Subject to audit

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

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

Exit costs in this note are the full costs of departures agreed in the year. Where The Rotherham NHS FT has agreed early retirements, the additional costs are met by The Rotherham NHS FT and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.3.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
<£10,000	0	0	0	0	0	0
£10,000 - £25,000	2	0	0	1	2	1
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	1	0	0	0	1
Total number of exit packages by type	2	1	0	1	2	2
Total resource cost £000s	39	128	0	11	39	139

Analysis of non-compulsory departure payments

During the 2024/25 financial year there were no non-compulsory departures agreed (one in 2023/24). This note reflects packages agreed in year, irrespective of the actual date of accrual or payment.

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

	Number of agreements		Total value of agreements £000s	
	2024/25	2023/24	2024/25	2023/24
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice*	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval**	0	1	0	11
Total	0	1	0	11
<i>of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>

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

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

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

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

Average number of people employed subject to audit

	2024/25			2023/24		
	Permanent No.	Other* No.	Total No.	Permanent No.	Other* No.	Total No.
Medical and dental	512	91	603	490	89	579
Administration and estates	1,039	48	1,087	1,026	48	1,074
Healthcare assistants and other support staff	833	99	932	861	105	966
Nursing, midwifery and health visiting staff	1,228	110	1,338	1,191	110	1,301
Scientific, therapeutic and technical staff	469	17	486	469	16	485
Healthcare Science Staff	61	2	63	109	5	114
	4,142	367	4,509	4,146	373	4,519
Of which:						
Number of employees engaged on Capital projects	5	4	9	7	5	12

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

Fair Pay – Median Pay – Hutton disclosures subject to audit

The Trust is required to disclose the relationship between the total remuneration of the highest paid director in the organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the organisation in the financial year 2024/25 was £197,500 (2023/24: £187,500). This is a change between years of +5.33%, owing to an increase in pay, as is consistent with salary increases over the NHS workforce.

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

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £12,514 to mid-point band £287,500 (2023/24: £10,324 to mid-point band £272,500).

The percentage change in average employee remuneration (based on total for all employees excluding the highest paid director on an annualised basis divided by full time equivalent number of employees) between years is 8.31%. This is based on the average salary in 2024/25 being £41,156 (2023/24: £38,021). The increase is due to the NHS Award of 5.5% and an increase in the proportion of staff paid on higher salary bands. In comparison, the change in average employee remuneration for 2023/24 was -0.47% due to the back dating pay awards.

Four employees received remuneration in excess of the highest paid director in 2024/25.

Of the four individuals who received remuneration in excess of the highest paid director in 2024/25, one is our Chief Executive who works under a shared arrangement for both the Trust and for Barnsley Hospital NHS Foundation Trust. The definition of the highest paid director under the Fair Pay disclosure is defined as the salary paid by the Trust alone. Therefore this person is not classed as the highest paid director because the cost to the Trust is lower than this person's total remuneration.

The other three individuals who received remuneration in excess of the highest paid director in 2024/25 are doctors with specialist skills, which are in high demand due to limited availability.

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

	2024/25	2023/24
Mid-Point of Band of Highest Paid Director's Total (Remuneration £000)	197.5	187.5
% change from previous year	5.33%	
Average annualised salary	41.2	38.0
% change from previous year	8.31%	-0.47

2024/25	25th Percentile	Median	75th Percentile
Salary component of pay	25.7	36.5	45.0
Total pay and benefits excluding pension benefits	25.7	36.5	45.0
Pay and benefits excluding pension: pay ratio for highest paid director	7.68:1	5.41:1	4.39:1

2024/25	25th Percentile	Median	75th Percentile
Salary component of pay	22.9	32.6	42.7
Total pay and benefits excluding pension benefits	22.9	32.6	42.7
Pay and benefits excluding pension: pay ratio for highest paid director	8.20:1	5.76:1	4.39:1

Remuneration Report signed by the Chief Executive



Dr Richard Jenkins
Chief Executive
26 June 2025

Staff report

As at 31 March 2025 we employed 5,032 members of staff, all of whom have a role to play in contributing to the high standard of care in our hospital and community. Further analysis of our staff can be found in the tables below.

Analysis of Staff – Gender

As at end March 2025 the breakdown of Trust employed staff by Gender was as follows:

	Male	Female	Total
Executive Directors	4	3	7
Non-Executive Directors	4	4	8
Employees	893	4124	5017
Total	901	4131	5032

**Headcount based on primary assignments, previously calculated using a count of assignments (roles). Change in calculation required due additional assignment created as per pension draw-down process

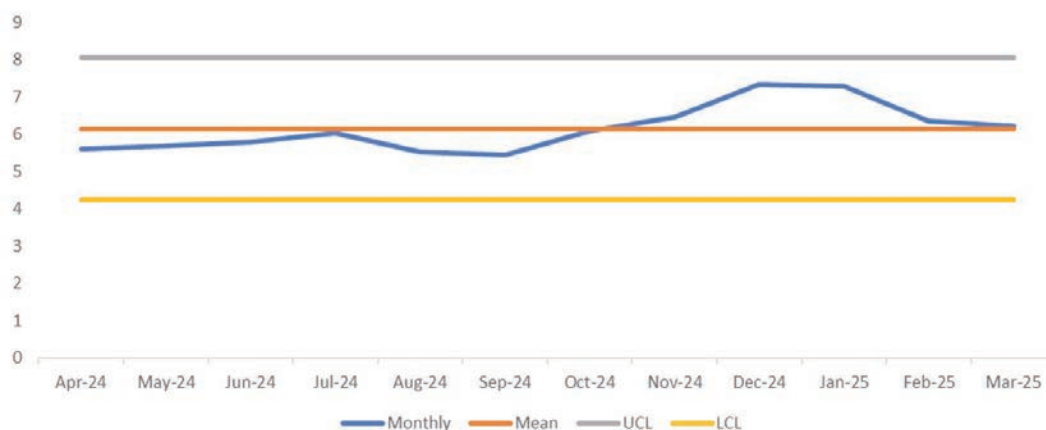
Sickness Absence Data

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

Monthly Sickness Absence

Month	2024-25					2023-24				
	Target	Long Term	Short Term	Monthly	Rolling	Target	Long Term	Short Term	Monthly	Rolling
April	4.80%	3.65%	1.96%	5.60%	5.85%	4.50%	3.05%	1.75%	4.79%	6.38%
May	4.80%	3.80%	1.88%	5.68%	5.91%	4.50%	3.30%	1.59%	4.88%	6.25%
June	4.80%	3.87%	1.94%	5.80%	5.96%	4.50%	3.39%	1.70%	5.09%	6.13%
July	4.80%	4.25%	1.79%	6.04%	5.99%	4.50%	3.89%	1.82%	5.71%	6.00%
August	4.80%	4.10%	1.42%	5.53%	5.94%	4.50%	4.26%	1.81%	6.07%	6.01%
September	4.80%	3.73%	1.71%	5.44%	5.89%	4.50%	3.96%	2.07%	6.03%	5.97%
October	4.80%	3.83%	2.26%	6.09%	5.87%	4.50%	4.13%	2.22%	6.35%	5.90%
November	4.80%	4.18%	2.30%	6.47%	5.89%	4.50%	4.16%	2.13%	6.29%	5.89%
December	4.80%	4.96%	2.37%	7.34%	5.98%	4.50%	3.94%	2.28%	6.21%	5.77%
January	4.80%	4.82%	2.48%	7.29%	6.02%	4.50%	3.89%	2.82%	6.75%	5.79%
February	4.80%	4.14%	2.23%	6.36%	6.04%	4.50%	3.93%	2.31%	6.24%	5.80%
March	4.80%	4.26%	1.95%	6.21%	6.12%	4.50%	3.30%	2.04%	5.33%	5.79%

Sickness Absence %



Data relating to the sickness absence for the Trust is published by NHS Digital and can be accessed here:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

Staff policies and actions applied during the financial year

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

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

Managers at the Trust, with the help of the Occupational Health service provider and the People Team, regularly make workplace modifications for staff that are reasonable and ensure that disabled colleagues can access employment with the Trust, continue in employment with the Trust and seek development and promotion within the Trust. Work is undertaken on a proactive basis, where applicable, with outside agencies including Access to Work. The Trust has a staff "All About Me" passport to facilitate person-centred approach to the management of staff, including reasonable adjustments. The Trust employs an EDI Advisor with experience of supporting disabled people in the workplace, this includes students, applications and members of staff.

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

Alongside the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Gender Pay Gap (GPG), the Trust has continued to develop the EDS during the year to assist in discussions with local partners including local populations and review and improve services and the experience of employment for people with characteristics protected by the Equality Act 2010. Rather than have multiple plans the Trust agreed one overarching EDI action plan which aligns the various EDI workstreams, activities and agreed priorities.

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

The Trust publishes a number of reports and action plans regarding equality and diversity, including the composition of its workforce, its ambitions to advance equality and diversity and its progress with its plans. These are all published on the [EDI section](#) on our website.

In addition to the information regarding Gender Pay Gap published on the Trust website, information is available on the [Gender Pay Gap Gov.UK](#) website

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

The Trust continues to strive for continuous improvement and to prioritise engagement with colleagues, setting high standards, learning from colleague experience, and strengthening partnership working. During the financial year, the Trust has worked with staff side colleagues to develop & review policies, contribute to the new People & Culture Strategy, get involved in an absence improvement workshop, and early engagement with various consultation and organisational change work.

There are many mechanisms through which information is communicated to employees. These include weekly all user e-mails and bulletins, monthly team brief led by the Chief Executive, departmental meetings, monthly senior leader meeting, ad hoc briefings, X (Twitter) and Facebook accounts, personal letters, and electronic pay slip messages and attachments. There is also a direct communication facility available to enable colleagues to ask questions of the Chief Executive (anonymously if desired).

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

The weekly all user e-mails, the intranet and monthly Team Briefs are all used as a means of conveying official information, as appropriate, which is of benefit to colleagues in a social, personal, and developmental way. Examples include reporting on the achievements of colleagues, recognising the learning that is undertaken by colleagues across all clinical and non-clinical services, promoting activities and events taking place, a variety of health-related information and available offers. There are separate pages on the intranet which link to the above support for colleagues particularly in relation to the extensive range of health and wellbeing support as well as offering discounts.

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

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

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

The Trust recognises the continuing challenges that the pandemic placed on all of our colleagues over the last few years; therefore, a key priority for the organisation during 2023/24 was to ensure that all our colleagues felt supported and had every opportunity to access any health and wellbeing

support or service they may require now or in the future. The Trust in response to staff survey feedback and in its ambition to make TRFT a great place to work and to deliver excellent patient care has continued to invest heavily to refurbish wards and clinical areas. It has also delivered a maintenance programme to upgrade and improve many staff rooms, kitchen facilities and changing areas.

The Trust recognises that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This was visibly demonstrated when specific events were arranged for colleagues during June 2024 as part of 'Proud Week' during which a recognition of learning event and a celebration of colleagues with long service were arranged. The week culminated in an evening awards ceremony for colleagues, held at Magna on 14 June 2024 which recognised both individuals and teams who had been nominated for their excellence in delivering or supporting others in providing fantastic care to our patients.

Health & Safety and Occupational Health

During 2023/24, the Trust received its tenth consecutive Gold Award from the Royal Society for the Prevention of Accidents (RoSPA) for preventing accidents on its hospital and community sites. This prestigious award is part of the RoSPA Occupational Health and Safety Awards, recognising organisations that maintain consistently high standards in health and safety. In addition to this achievement, the Trust Health & Safety Team was also honoured with the President's Award, which is given to organisations with 10-14 consecutive Gold Awards, further highlighting their unwavering commitment to safety.

Accident data and RIDDOR-reportable incidents are presented to the Board through the Health & Safety Committee's Annual Report. This comprehensive report includes detailed information on the number and nature of incidents, along with comparative data from previous years to identify any patterns or areas for improvement. In 2024, 17 incidents were reported to the Health and Safety Executive (HSE), a slight decrease of one incident compared to the previous year, which is a testament to the continuous efforts in reducing accidents. No significant incidents or emerging trends were identified during the reporting period, indicating a stable safety environment. The Trust Health & Safety Team monitors all incidents and ensures thorough investigation of all RIDDOR-reportable events, demonstrating their proactive approach in maintaining a safe workplace.

During 2024/25 the Trust continued to contract occupational health through Sheffield Teaching Hospital the contract started on 01 March 2022, staff are now referred online through the Cority system which was implemented in June 2023 and allows managers to refer staff at any time of the day and appointments are booked directly with the individual staff member. The occupational health service continued to deliver quality interventions to employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Supporting the health and wellbeing of all colleagues at the Trust is a key driver. The Head of Health & Safety and members of the People Teams meet regularly with the Head of OH at Sheffield Teaching Hospitals to ensure the organisation receives the service and support it needs. A key area where we work jointly is to ensure that appropriate and timely health surveillance is delivered when requested for small groups of our staff.

Supporting the Health and Wellbeing of colleagues at TRFT is a key priority of the trust. The Health and Wellbeing Team work to deliver an extensive programme of activities to support the wellbeing of colleagues through a holistic approach recognising the needs of different staff groups, departments and individuals. Activities include free gym and swimming sessions, cardiovascular disease checks and complementary therapy massages. The total number of sessions attended was 892 in 24/25. The Health and Wellbeing Team have also formed close working partnerships with various external organisations, including Rotherham United Community Trust, South Yorkshire Housing Association and Connect Healthcare to deliver interventions and activities for colleagues. The team continue to have an extensive focus on menopause awareness and support appreciating the impact that a lack of support can have on the workforce and sickness absence.

Support includes training sessions for managers and teams, a 24/7 helpline manned by specialist menopause clinicians, support groups and café's to share experiences and 20 colleagues who have been trained as menopause champions and advocates who can offer supportive conversations and signposting. The team work in both a preventative and responsive way. Preventative work focuses on delivering activities, such as cardiovascular disease checks, and working with individual teams to prevent health and wellbeing issues arising. Initiatives such as a carer's support group have been developed to respond to the specific needs of TRFT colleagues. The team have also increased the number of Wellbeing Champions to 107 to be able to respond to and support our colleagues through being a point of contact for wellbeing conversations and signposting.

The Wellbeing Team also work on strategic, trust wide projects with the aim of delivering a sustained improvement in the health and wellbeing of colleagues and reducing sickness absence across the Trust. The Health, Wellbeing and Attendance programme is a large scale, transformational programme of work consisting of multiple work streams aiming to address matters such as the health inequalities of our colleagues, ensure core needs are met and improving the way data is used within wellbeing to allow for a focused, targeted approach to initiatives.

Analysis of Staff: Ethnicity of Staff

As at end March 2025 the breakdown of Trust employed staff by ethnicity was as follows:

Ethnicity Group	Total	% Headcount
BME	841	16.71%
Not Stated	55	1.09%
White	4136	82.19%
Grand Total	5032	100.00%

**Headcount based on primary assignments, previously calculated using a count of assignments (roles). Change in calculation required due additional assignment created as per pension draw-down process.

Ethnic Origin	Headcount	% of Workforce
Asian/Asian British: Bangladeshi	8	0.16%
Asian/Asian British: Chinese	17	0.34%
Asian/Asian British: Indian	258	5.13%
Asian/Asian British: Other Asian	68	1.35%
Asian/Asian British: Pakistani	175	3.48%
Black/African/Caribbean/Black British: African	145	2.88%
Black/African/Caribbean/Black British: Caribbean	12	0.24%
Black/African/Caribbean/Black British: Other Black	9	0.18%
Mixed/multiple ethnic groups: Other Mixed	32	0.64%
Mixed/multiple ethnic groups: White and Asian	20	0.40%
Mixed/multiple ethnic groups: White and Black African	14	0.28%
Mixed/multiple ethnic groups: White and Black Caribbean	27	0.54%
Not Disclosed	55	1.09%
Other ethnic group: Any other ethnic group	56	1.11%
White: English/Welsh/Scottish/Northern Irish/British	4032	80.13%
White: Irish	15	0.30%
White: Other White	89	1.77%
Grand Total	5032	100.00%

**Headcount based on primary assignments, previously calculated using a count of assignments (roles). Change in calculation required due additional assignment created as per pension draw-down process

Information on staff turnover

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

NHS staff survey 2024

Staff experience and engagement

NHS staff survey

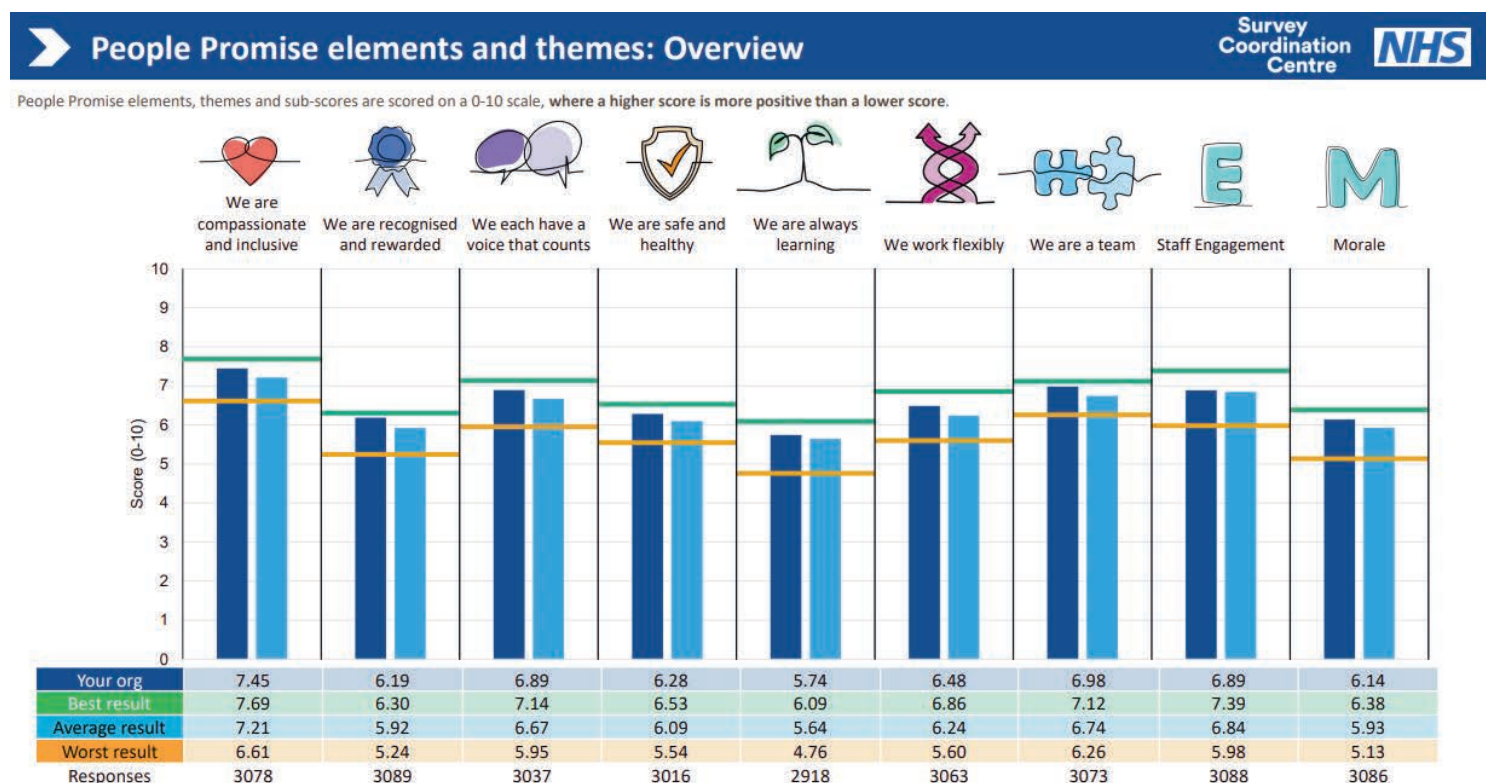
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2024 survey among trust staff was 64% (2023: 67%).

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

Indicators (‘People Promise’ elements and themes)	2024/25		2023/24		2022/23	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.46	7.23	7.53	7.24	7.4	7.2
We are recognised and rewarded	6.19	5.9	6.28	5.94	6.0	5.7
We each have a voice that counts	6.90	6.66	7.01	6.70	6.8	6.6
We are safe and healthy	6.31	6.10	6.25	6.05	6.1	5.9
We are always learning	5.73	5.61	5.94	5.61	5.6	5.4
We work flexibly	6.51	6.23	6.57	6.20	6.2	6.0
We are a team	6.99	6.73	7.07	6.75	6.9	6.6
Staff engagement	6.89	6.81	6.98	6.91	6.7	6.8
Morale	6.16	5.91	6.20	5.91	5.9	5.7

The Trust has deteriorated slightly against all the staff survey domains but has posted its second-best results since the inception of the staff survey and continues to benchmark above the national average for all domains when compared to the peer group.



The 2024/2025 NSS results, although representing a small step down from the previous year, still demonstrate a longer-term trend of improvement. The Trust maintained its quartile positions versus the benchmark Picker group.

NHS Response Rate

The table below highlights the Trust performance in relation to wider NHS organisations.

	2018	2019	2020	2021	2022	2023	2024
Best	71.6%	76.0%	79.8%	79.4%	60.9%	69.5%	70.9%
TRFT	38.5%	48.0%	52.2%	59.7%	61.0%	67.0%	64.40%
Median	43.6%	46.9%	45.4%	51.1%	44.5%	45.8%	48.6%
Worst	24.6%	27.2%	28.1%	36.5%	26.2%	21.4%	29.1%

The Trust had good engagement with the 2024 national staff survey, with 64.40% of colleagues responding to the questionnaire and providing their valuable feedback; this is the second highest return rate the Trust has ever achieved and well above the national average.

Future priorities and targets

Top 5 scores vs Organisation Average	Org	Sample Avg
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	72%	66%
q14c. Not experienced harassment, bullying or abuse from other colleagues	88%	82%
q23a. Received appraisal in the past 12 months	90%	84%
q11a. Organisation takes positive action on health and well-being	61%	55%
q19d. Feedback given on changes made following errors/near misses/incidents	66%	60%

Most improved scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	75%	70%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	69%	65%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	77%	74%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	55%	53%
q12e. Never/rarely worn out at the end of work	21%	19%

Key Areas for Improvement and Future Priorities

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	61%
q23b. Appraisal helped me improve how I do my job	23%	26%
q24b. There are opportunities for me to develop my career in this organisation	51%	54%
q2a. Often/always look forward to going to work	52%	54%
q12c. Never/rarely frustrated by work	20%	22%

Most declined scores	Org 2024	Org 2023
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	60%	65%
q3e. Involved in deciding changes that affect work	52%	56%
q24e. Able to access the right learning and development opportunities when I need to	59%	63%
q24d. Feel supported to develop my potential	57%	61%
q20a. Would feel secure raising concerns about unsafe clinical practice	73%	76%

Top 5 Priorities for 2025/26

Taking on board feedback from the 2024/25 staff survey and the free text comments from colleagues a number of areas have been identified for action during the new financial year. These priorities have been agreed by the Executive team with a lead Executive Director being assigned against each priority area. These will be developed into a branded “We Said, We Did” action plan during April/early May and shared across the Trust in May following the launch of the new People and Culture Strategy.

No.	Area	Lead Director
1	MaST	Director of People
2	Patient Safety Priorities	Chief Nurse & Chief Medical Director
3	Rest, Rehydrate and Refuel	Deputy Chief Nurse and Director of Estates and Facilities
4	Celebrate Our Achievements and the Differences We Make to Patients	Director of Communications
5	Call to Action: Quality Appraisals	All Managers

Monitoring arrangements - future priorities and how they will be measured

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

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

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

Trade Union Facility Time disclosures

Engaging, communicating, and consulting with our employees in partnership with our trade unions and professional bodies has always been core to our service delivery, and we reinforced our commitment to this by formalising protected time for trade union colleagues and staff network leads in our refreshed Partnership Working Policy. We are committed to developing engagement with all employees and maximising the benefits of staff involvement by ensuring that we have robust mechanisms in place with our union colleagues. We recognise that employee involvement and partnership working must take place throughout the organisation, regardless of professional, service, or functional boundaries.

The trust is committed to maximising staff involvement by:

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

It is recognised that good employment relations are an important factor in achieving our objectives and delivering high quality patient care.

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

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

Table 1: Relevant union officials

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

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

Table 2: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent:

a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

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

Table 3: Percentage of pay bill spent on facility time

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

	Figures
Provide the total cost of facility time	£71,459
Provide the total pay bill	£252.73m
Provide the percentage of the total pay bill spent on facility time, calculated as:	0.028%
(total cost of facility time ÷ total pay bill) x 100	

Table 4: Paid trade union activities

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

Time spent on paid trade union activities as a percentage of total paid facility time	2.57
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(Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100
note that this is slightly different to what we are asked to report on gov.uk – they ask for total number of staff (headcount not WTE – this puts us over 5000) and ask for both headcount and employed WTE (12.6) for TU reps.

Table 1. Highly paid off-payroll worker engagements as at 31 March 2025, earning £245 per day or greater	
Number of existing engagements as of 31 March 2025	0
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed between one and two years at time of reporting	0

Consultancy costs during 2024/25 were nil compared to £104k during 2023/24.

Table 2.
All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2025	0
Of which:	
Not subject of off-payroll legislation*	0
Subject to off payroll legislation and determined as in-scope of IR35	0
Subject to off payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 3.
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2025

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
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Countering Fraud, Bribery and Corruption

Since 1 April 2021 the Trust has been required to comply with Government Functional Standard 013: Counter Fraud ('the Functional Standard'). Oversight of compliance with the Functional Standard, and the Trust's response to fraud risk more generally, lies with the Director of Finance and Audit and Risk Committee.

The Trust is required to self-assess against the requirements of the Functional Standards annually by completing and submitting the Trust's Counter Fraud Functional Standard return (CFFSR). This requires prior sign off by the Trust's Director of Finance and the Audit Committee Chair. Within its 2025 return the Trust demonstrated an overall 'Green' rating following the self-assessment.

The Trust has in place a nominated Counter Fraud Specialist (CFS) in place provided by 360 Assurance. The CFS is responsible for carrying out a range of activities to support compliance with the Functional Standard and to respond to fraud risk. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities. Priorities are changed if new threat emerge during the year.

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

Where fraud is identified or reported it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption Policy. During 2024-25, eleven referrals were made to the CFS, an increase on the previous year, demonstrating good awareness and understanding of the Fraud, Bribery and Corruption Policy and related issues.

Council of Governors

The Council of Governors is responsible for making decisions regarding the appointment or removal of the Chair, the Non-Executive Directors and the Trust's auditors; the terms and conditions of office of the Non-Executive Directors in addition to approving the appointment of the Chief Executive. The Council of Governors is also consulted by the Board of Directors and its views taken into consideration when formulating the Trust's forward plans. The Trust has a Council of Governors with a statutory duty to hold our Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

The Council also considers the Trust's annual accounts and the external auditor's report on them. It also represents the interests of members and partnership organisations in the governance of the Trust, regularly feeding back information about the Trust to the constituencies it represents. Other statutory duties of the Council of Governors include providing their views to the Board of Directors on the Trust's strategy, to respond to the Board of Directors when consulted and to undertake functions as requested by the Board of Directors, and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

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

The Council of Governors comprises of 16 elected Public Governors, 5 elected Staff Governors and 7 appointed Partner Governors. All Governors, both elected and appointed, hold office for a term of three years. They are eligible for re-election or re-appointment at the end of that period and serve a maximum of three terms (nine years in total). All elections for public and staff governor positions are conducted under the auspices of Civica, in accordance with the requirements of the Trust's Constitution.

The Council of Governors are scheduled to meet four times during any given year and continued to do so during the financial year 2024-25. During the reporting year, meetings of the Council of Governors continued to be face to face and open to observation by the public. The agenda and meeting papers continue to be made available prior to the meeting on the Trust's website. The sub-committee / group meetings of the Governor Nomination Committee and Member Engagement Group continued to be held virtually.

Elections to the Council of Governors commenced in Quarter Four of 2023-24 and closed in Quarter One of 2024-25.

Members of the Board of Directors (Executive and Non-Executive Directors) have routinely attended the scheduled Council of Governors meetings to ensure that they develop an understanding of the view of Governors and Members.

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

declared interests. Each Governor is required annually to renew their declarations with regard to the Code of Conduct and Register of Interest. The register of governor's interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

Ms Angela Wendzicha, Director of Corporate Affairs

Trust Headquarters
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

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

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

Foundation Trust Membership

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

The Trust has two membership constituencies: a ‘public constituency’ and a ‘staff constituency’.

In order to become a Public Member, the individual must:

- Be at least 16 years of age; and
- Live within one of the trust’s constituency areas (‘Rotherham’ constituency and a ‘Rest of England’ constituency); and
- Not be a member of the staff constituency; and
- Have made an application for membership to the Trust.

In order to be a Staff Member, the individual must:

- Be at least 16 years of age; and
- Be employed by the Trust with a permanent contract or have worked at the Trust for at least 12 months; and
- Have opted in to be a Member of the Trust

At the end of 2024/25 there were 13,366 Members of The Rotherham NHS Foundation Trust (TRFT) as detailed below:

Public	
Rotherham	8,679
Rest of England	1,366
Total Public Members	10,045
Staff	
Staff Members	3,321
Total Membership	13,366



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

	Public	Staff	Total
Age			
0-16	0	0	0
17-21	0	1	1
22-29	21	106	127
30-39	1,034	698	1,732
40-49	1,246	785	2,031
50-59	1,663	956	2,619
60-74	2,585	691	3,276
75+	2,395	26	2,421
Not stated	1,101	58	1,159
Gender			
Unspecified	4	17	21
Male	3,877	513	4,390
Female	6,164	2,791	8,955
Transgender	0	0	0
Ethnicity			
White - English, Welsh, Scottish, Northern Irish, British	3,462	2,191	5,653
White - Irish	13	8	21
White - Gypsy or Irish Traveller	0	0	0
White - Other	13	23	36
Mixed - White and Black Caribbean	2	11	13
Mixed - White and Black African	1	19	20
Mixed - White and Asian	1	9	10
Mixed - Other Mixed	10	4	14
Asian or Asian British - Indian	32	49	81
Asian or Asian British - Pakistani	167	22	189
Asian or Asian British - Bangladeshi	2	2	4
Asian or Asian British - Chinese	5	7	12
Asian or Asian British - Other Asian	23	18	41
Black or Black British - African	25	3	28
Black or Black British - Caribbean	5	0	5
Black or Black British - Other Black	14	2	16
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	65	25	90
Not stated	6,205	928	7,133
Total numbers of Members	10,045	3,321	13,366

As a Foundation Trust, the Trust works closely with its membership and strives to involve and engage members in the Trust's strategic direction through sustained, two-way communication plans and engagement events. The Staff Governors have raised visibility by presenting on the internal 'Team Brief' meeting regularly, as well as holding a lunchtime lecture to promote the role of a Governor and listen to the views of the staff membership. Furthermore, Governors have been actively engaging with Trust members, visitors, staff and patients through our 'Meet your Governor' initiative (previously titled 'Governor Surgery') and through bi-monthly walk-arounds with the Chief Nursing Team to collect feedback to share the learning and insights gained with the relevant departments.

As in previous years, the Trust ensured members and the general public remained informed on relevant matters through media activities and general briefings. The Governors were given material which they were encouraged to circulate amongst their personal and business contacts or social networks and within their constituencies.

During 2024-25 the Council of Governors monitored progress made in relation to the Member Engagement Strategy 2022-2025.

The strategy has two specific objectives, supported by a number of milestones. The objectives are:

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

On behalf of Council of Governors, the Governor Members Engagement Group have been supporting and monitoring the implementation of the milestones. The Group continued to meet during the year to draw up plans and strategies working in collaboration with Trust officers to increase member engagement.

As part of the strategic initiative to enhance member engagement and communication, the Trust has implemented several key measures. These include active participation in community events, conducting bi-monthly walk-arounds with the Chief Nursing team, and attending public panels. Governors have extended their outreach to local schools, colleges, and universities, and established a digital platform to facilitate feedback to governors at any time. Additionally, Governors have undertaken a comprehensive refresh and rebranding of the 'Governor Surgery,' now known as 'Meet your Governors,' to improve visibility and help foster meaningful interactions.

Plans for the future include tailored invitations to events and workshops and information newsletters and publications to keep members fully up to date on Trust activities. The Governor Members Engagement Group will also determine target areas for recruitment for 2025/26 whilst continuing the 2024/25 drive on staff membership.

The Annual Members Meeting (AMM) 2024 was another opportunity the Governors used to meet members and the public, share achievements and challenges from the year and outline future plans. The Annual Members Meeting on 19th September 2024 was held in person for the first time since the Covid-19 pandemic.

In March 2025, elections for the Council of Governors commenced, seeking nominations for six 'Rotherham-wide' Public Governor seats and two Staff Governor seats. Once the election has ended and results declared, the new governors will be introduced to members at the AMM in September. Members have and continue to be able to contact their Governor by sending an e-mail to: rg-h-tr.public.governors@nhs.net indicating the name of the Public Governor they wish to contact in the subject line of the e-mail. In a similar manner staff members are able to contact their Governor by sending an e-mail to: rg-h-tr.staffgovernors@nhs.net also including the name of the governor in the subject line of the e-mail.

Governor Nominations Committee/Non-Executive Director Appointments 2024

The Governor Nomination Committee (The Committee) has responsibility for giving assurance that the independence, skill, diversity and experience of each of the Non-Executive Directors, which includes the Chair, reflects the needs of the Trust through the composition of the Board of Directors to achieve the Trust's objectives and safeguard the quality of care provided. The Committee is chaired by the Trust Chair and comprised of no more than nine Governors (Public, Staff and Partner), including the former Lead Governor, Gavin Rimmer (until May 2024) and the Lead Governor, Geoffrey Berry (from June 2024).

The Committee met on four occasions during 2024-25.

The Chair and Non-Executive Directors' annual appraisal and objective setting process was undertaken early in quarter one of 2024-25.

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

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

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

NHS Foundation Trust Code of Governance

The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. Whilst the Code is issued as best practice advice, some disclosures are required on a 'comply' or 'explain' basis.

The revised Code of Governance for NHS Provider Trusts was published in October 2022 and has been applicable since 01 April 2023.

The Rotherham NHS Foundation Trust has applied the principles of the NHS Foundation Code of Governance on a 'comply' or 'explain' basis. Table 1 below illustrates where the various disclosures can be found in the Annual Report with Section 2 illustrating disclosures on a 'comply' or 'explain' basis.

Table 1.

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
Disclose	A 2.1	<p>The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.</p> <p>Contained within the Directors Report and Annual Governance Statement</p>
Disclose	A 2.3	<p>The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.</p> <p>Contained within the Directors Report and Annual Governance Statement</p>
Disclose	A 2.8	<p>The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.</p> <p>Contained within the Performance Report</p>
Disclose	B 2.6	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:</p> <ul style="list-style-type: none"> • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. <p>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.</p> <p>Within the Directors Report</p>
Disclose	B 2.13	<p>The annual report should give the number of times the board and its committees met, and individual director attendance.</p> <p>Within the Directors Report</p>
Disclose	B 2.17	<p>For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.</p> <p>Within the Directors report</p>

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
Disclose	C 2.5	<p>If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.</p> <p>The Trust did not engage any external consultancies.</p> <p>The Trust's recruitment of a non-executive director and an associate non-executive director was supported by Gatenby Sanderson. The company was also engaged by the Trust to support compliance with Fit and Proper Persons Test framework.</p>
Disclose	C 2.8	<p>The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.</p> <p>Within the Directors Report</p>
Disclose	C 4.2	<p>The board of directors should include in the annual report a description of each director's skills, expertise and experience.</p> <p>Within the Directors Report</p>
Disclose	C 4.7	<p>All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.</p> <p>Within the Directors Report</p>
Disclose	C 4.13	<p>The annual report should describe the work of the nominations committee(s), including:</p> <ul style="list-style-type: none"> • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the Trust's workforce and communities served • the gender balance of senior management <p>Within the Directors Report</p>
Disclose	C 5.15	<p>Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.</p> <p>Within the Directors Report</p>

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
Disclose	D 2.4	<p>The annual report should include:</p> <ul style="list-style-type: none"> the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. <p>Within the Directors Report</p>
Disclose	D 2.6	<p>The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.</p> <p>Within the Directors Report</p>
Disclose	D 2.7	<p>The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.</p> <p>Within the Annual Governance Statement</p>
Disclose	D 2.8	<p>The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.</p> <p>Within the Annual Governance Statement</p>
Disclose	D 2.9	<p>In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.</p> <p>Within the Performance Report</p>
Disclose	E 2.3	<p>Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.</p> <p>Not applicable to this reporting period</p>
Disclose	Appendix B, para 2.3 (not in Schedule A)	<p>The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.</p> <p>Contained within the Governor and Membership Section</p>
Disclose	Appendix B, para 2.14 (not in Schedule A)	<p>The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.</p> <p>Contained within the Governor and Membership Section</p>
Disclose	Appendix B, para 2.15 (not in Schedule A)	<p>The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.</p> <p>Attendance contained within the Governor and Membership</p>

Table 2

Provision	Requirement
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place- based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions. Comply
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five- year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives. Comply
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance. Comply
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered. Comply
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Comply
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action. Comply
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement. Comply
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board. Comply
Section B, 2.1	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role. Comply
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role. Comply

Provision	Requirement
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors. Comply
Section B, 2.4 (NHS Foundation Trusts only)	A foundation trust chair is responsible for ensuring that the board and council work together effectively. Comply
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director. Comply
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent. Comply
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time. Comply
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience. Comply
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee. Comply
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework. Comply
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present. Comply
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation. Comply
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board. Comply

Provision	Requirement
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies. Comply
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer. Comply
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. Comply
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. Comply
Section C, 2.1 (NHS Foundation Trusts only)	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skill and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach. Comply
Section C, 2.2 (NHS Foundation Trusts only)	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non- executive directors, including the chair. Comply
Section C, 2.3 (NHS Foundation Trusts only)	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair. Comply
Section C, 2.4 (NHS Foundation Trusts only)	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors. Comply
Section C, 2.5 (NHS Foundation Trusts only)	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors. Comply

Provision	Requirement
Section C, 2.6 (NHS Foundation Trusts only)	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non- executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel. Comply
Section C, 2.7 (NHS Foundation Trusts only)	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position. Comply
Section C, 3.1 (NHS Foundation Trusts only)	NHS England is responsible for appointing chairs and other non- executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non- executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England. Not applicable
Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and Proper Persons: Directors Comply The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England. Comply
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England. Comply
Section C, 4.4 (NHS Foundation Trusts only)	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re- election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles. Comply
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders. Comply

Provision	Requirement
Section C, 4.6	<p>The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.</p> <p>Comply</p>
Section C, 4.8 (NHS Foundation Trusts only)	<p>Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:</p> <ul style="list-style-type: none"> • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. <p>The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.</p> <p>Comply</p>
Section C, 4.10 (NHS Foundation Trusts only)	<p>In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.</p> <p>Comply</p>
Section C, 4.11	<p>The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.</p> <p>Comply</p>
Section C, 4.12	<p>The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.</p> <p>Comply</p>
Section C, 5.1	<p>All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.</p> <p>Comply</p>
Section C, 5.2	<p>The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.</p> <p>Comply</p>

Provision	Requirement
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust. Comply
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme. Comply
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board. Comply
Section C, 5.6 (NHS Foundation Trusts only)	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. Comply
Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary. Comply
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required. Comply
Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees. Comply
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate. Comply
Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment. Comply

Provision	Requirement
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance. Comply
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles. Comply
Section C, 5.16 (NHS Foundation Trusts only)	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included. Comply
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution. Comply
Section C, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates. Comply
Section C, 2.2	The main roles and responsibilities of the audit committee should include: <ul style="list-style-type: none"> • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities. Comply
Section D, 2.3	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. Comply

Provision	Requirement
Section D, 2.5	<p>Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.</p> <ul style="list-style-type: none"> • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement. <p>Not applicable during the reporting period</p>
Section E, 2.1	<p>Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.</p> <p>Comply</p>
	<p>The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.</p> <p>Comply</p>
Section E, 2.2	<p>Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.</p> <p>Comply</p>
Section E, 2.4	<p>The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.</p> <p>Comply</p>
Section E, 2.5	<p>Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.</p> <p>Not applicable during the reporting period</p>
Section E, 2.7	<p>The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.</p> <p>Comply</p>

Provision	Requirement
Section C, 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. Comply
Section C, 5.7 (NHS Foundation Trusts only)	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors. Comply
Section C, 2.9 (NHS Foundation Trusts only)	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Comply

he provisions listed below require information to be made publicly available, even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request

Provision	Requirement
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. Comply
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the Trust's website. Comply
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust. Comply

NHS England System Oversight Framework

NHS England's System Oversight Framework provides the framework for overseeing providers and identifying potential support needs. NHS organisations are allocated one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- a) Objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (quality of care, access and outcomes, people, preventing ill-health and reducing inequalities, leadership and capability, finance and use of resources, local strategic priorities)
- b) Additional considerations focused on the assessment of system leadership and behaviors, and improvement capability and capacity.

The Rotherham Hospital NHS Foundation Trust was classified by NHS England as being in segment 3 as at 31 March 2025. Current segmentation information is published on the NHE England website (<https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/>)

Statement of the Chief Executive's Responsibilities as the Accounting Officer of The Rotherham NHS Foundation Trust

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

NHS England has given Accounts Directions which require The Rotherham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of [name] NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Signed



Richard Jenkins
Chief Executive
Date: 26 June 2025

Annual Governance Statement

Scope of Responsibility

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

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Rotherham NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Rotherham NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Leadership of the Risk Management Process

The Trust Board of Directors ("the Board") has overall responsibility for providing leadership of the overall governance agenda, including the management of risk within the Trust. The Board is supported by a number of established Committees, namely Quality Committee, People Committee, Finance and Performance Committee and the Audit and Risk Committee. The Board Committees have clear accountabilities and leadership for oversight of risks aligned to them. The Board Committees scrutinised assurances on internal control including review of the Board Assurance Framework and Corporate Risk Register. The Board Assurance Framework reflects assurances on the high level strategic risks the Board have deemed to be the most significant during the reporting period. The minutes of the aforementioned Board Committees have been received by the Trust Board throughout the reporting period providing assurance of the Trust's capacity to handle risks.

As Chief Executive and designated Accounting Officer, I am responsible for the oversight of risk management across all our clinical, organisational and financial activities. Senior leadership is delegated through the Executive Directors and operationally through the Care Groups, Departments and various Committee structures. Responsibility for the operational leadership relating to risk rests with the Director of Corporate Affairs.

Risk Management within the Trust is supported by the Risk Management Policy which provides clarity on the accountability and reporting arrangements for the management of risk within the Trust. The Policy aims to support a positive culture towards the management of risk and ensures we have continued with a consistent approach during the reporting period. All Executive Directors, management teams and all staff have a role in ensuring that our strengthened approach to risk management has been embedded in all aspects of our activities with risk management a core component of senior managers' role descriptions. Our Audit and Risk

Committee provides the opportunity for our Non-Executive Directors to provide objective oversight of our risk management leadership and function.

Equipping Staff to Manage Risk

Managers at all levels of the organisation have a responsibility to identify and manage the risks relevant to their area in addition to promoting a culture whereby proactive reporting enables the early identification of real or perceived risks to patient care, staff and the environment.

Each Care Group and Department maintains risks on the Risk Register with oversight at the relevant Governance meetings. Any risk scoring 15 or above is escalated to the Corporate Risk Register. Over the last year, the Risk Management Committee has reviewed risks scoring 12 and above to ensure that those risks scoring below the threshold for escalating to the Corporate Risk Register are being managed appropriately with suitable and sufficient controls and mitigations in addition to action plans to close any gaps in controls. Risks scoring 15 and above are reviewed at the Risk Management Committee, escalated to the Executive Team Meeting on a weekly basis, the relevant Board Committees, Audit and Risk Committee and Trust Board alongside the Board Assurance Framework.

During the last year, the Trust has continued to recognise the importance of supporting staff through appropriate training and development. Risk Management training is mandatory for all staff and our compliance at the end 31 March 2025 was 80%. The level and frequency is identified through our training needs analysis which ensures that our staff remain fully equipped to carry out their roles and responsibilities with regards risk management. In addition to the mandatory training sessions bespoke sessions have been carried out training an additional 50 members of staff in order to provide further insight and skills in how to identify, assess and manage risks.

Our internal auditors have, throughout the last financial year, reported on our management of the board assurance framework and corporate risk register. They found the Trust's capacity and ability to handle risk was maintained at substantial assurance with no significant recommendations being made.

The Trust learns from good practice through a range of mechanisms including peer reviews, some of which have been conducted as part of our increasing partnership working with Barnsley Hospital NHS Foundation Trust. In addition, the Trust learns through effective performance management, continuing professional development, outcomes from clinical audits, the application of evidence based practice, after action reviews and reflective practice.

Learning from investigations is also an important aspect of the learning culture within the Trust. The Board receives an alternate patient or staff story at its meeting held in public which provides a rich source of information for Board members, in addition the Board carries out a series of Board visits whereby small groups of a combination of executive and non-executive directors visit various clinical and non-clinical areas following which feedback is provided back to the whole Board of any findings of note.

The Risk and Control Framework

The Trust's Risk Management Policy provides the framework for managing risks across the organisation and sets out the specific responsibilities of each Board member, Board Committee, Care Group Management Team, Clinical Governance Leads, Risk owners in addition to the roles and responsibilities of partner organisations in relation to the management of risks. The Risk Management Policy defines the overall governance structure underpinning the framework at Board and Care Group level in addition to detailing the Trust's approach to identification, assessment, management, monitoring and escalation of risk.

Board and Board Committee agendas continue to be structured around comprehensive forward plans that are closely linked to the Trust's statutory and regulatory responsibilities. This ensures the Board and Board Committees are sighted on the Trust's compliance with these responsibilities and can take timely action where risk to compliance arises.

The risk management process begins with a systematic identification of risks that are evaluated, graded and either managed at a local level (with risk control measures identified and implemented to mitigate the potential for harm) or escalated to the Executive Team and Board via the Board Assurance Framework and or Corporate Risk Register.

In order to facilitate consistency throughout the assessment of risks, risks are identified using a standardised approach. Identified risks are analysed using the risk management grading matrix of consequence and likelihood (5x5 matrix), producing a risk score that enables consistent prioritisation within the risk register. The Trust seeks to reduce risks as far as possible, however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Board and Board Committees are aligned to assure that there is independent and strategic focus on both risks and assurance.

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

- Audit and Risk Committee: Reviews, on behalf of the Board the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's ambitions and also ensures effective internal and external audit functions.
- Quality Committee: Provides assurance to the Trust Board and Audit Committee that there are adequate controls in place to monitor the care given to patients using the services provided by the Trust, and ensure that their experience of our services and outcomes are as expected.
- Finance and Performance Committee: Responsible for scrutinising aspects of financial and operational performance as requested by the Board in addition to scrutinising business cases, proposed investment decisions and regular review of contracts with key partners.
- People and Culture Committee: Responsible for providing leadership and oversight for the Trust on workforce issues that support delivery of the Board's approved People ambitions and for monitoring the operational performance of the Trust in people management, recruitment and retention and employee health and wellbeing.

The Board of Directors review, on an annual basis the principles and appetite around the level of risk which the Trust is prepared to accept or not in pursuit of agreed ambitions. These were reviewed and discussed

at the Board's Strategic session in June 2024. The principles focused on quality, partnerships, workforce, finance and value for money, innovation, commercial opportunities, compliance and regulatory in addition to business continuity including Information Governance and Cyber Security.

The Board Assurance Framework sets out the Trusts principal risks to achieving our strategic ambitions and has been scrutinised at the relevant Board Assurance Committees on a monthly basis with continued oversight by the Executive Team and Trust Board on a bi-monthly basis. As at 31 March 2025, the Trust identified, through the BAF the following significant risks to the achievement of its Strategic Ambitions as follows:

- The risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience.
- The risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to ill health and increased health inequalities.
- The risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.
- The risk we do not create and maintain a compassionate and inclusive culture leading to an inability to retain and recruit staff and deliver excellent healthcare for patients.
- The risk we do not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) due to insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.
- The risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.
- The risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2025-26 leading to further financial instability was added to the BAF as a forward looking risk in Quarter 1.

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

Quality Governance

The Quality Committee is one of the Board Assurance Committees and maintains responsibility for the oversight of quality governance, including risks to the quality of clinical care and is built upon the principles described within the well-led domains. The Quality Committee is chaired by a Non-Executive Director and includes within its membership two additional Non-Executive Directors, Medical Director and the Chief Nurse. The Committee annual work plan enables oversight in relation to clinical quality, safety and patient experience.

The Quality Committee oversees progress against our agreed Quality Priorities including a focus on improvements relating to clinical quality to ensure the Trust learns, disseminates and takes appropriate action in respect of reported incidents. The Trust has maintained a positive incident reporting culture evidenced by the increasing number of low/no harm incidents reported through the formal incident reporting route. For those incidents classed as 'serious' there is an established mechanism for review and investigation with the involvement from the Medical Director and or Chief Nurse at the sign off stage.

Work has been ongoing throughout the last financial year to strengthen dissemination of learning from incidents. The Patient Safety Incident Response Framework, a system-based approach to learning from patient safety incidents, has now been fully implemented throughout the Trust. In line with the Foundation Trust Annual Reporting Manual for 2024-25 the Trust has not prepared a Quality Report to be included as part of this Annual Report. However, the Trust has prepared a separate Quality Report which is available on the Trust website.

Compliance with Developing Workforce Safeguards

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

Workforce metrics are monitored through the People and Culture Committee and ultimately Board with staffing levels being reviewed regularly and e-rostering systems in place for nursing staff.

Our people remain intrinsic to what we do and our Board approved People and Culture Strategy contains key objectives to support and enable Care Groups and Corporate Services to develop robust workforce planning strategies.

Information Governance

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

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

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

The Caldicott Guardian and the SIRO review and monitor any serious incidents relating to information governance, data loss, confidentiality and data security. During the reporting period 2024-25, the Trust reported a total of three incidents to the Information Commissioner, The Trust reports against the Data Security and Protection Toolkit on an annual basis. The Trust's Internal Audit Report overall score for 2023-24 as 'Substantial Assurance' and 'Standards Met'.

Public Stakeholders' Involvement in Managing Risk

The Trust is committed to involving the public in all service changes undertaken and that includes risks associated with those changes and there remains a strong desire to work closely with patients, families and carers across the communities we serve.

The Trust provides information and assurance to the public on its performance against its principle risks and objectives in a number of different ways including presentation to the Council of Governors who in turn represent our membership. In addition, the Council of Governors receive regular updates on the status of the Board objectives alongside any proposed changes to services which may impact on our communities. The Trust engages on a regular basis with overview and scrutiny committees ensuring they are kept up-to-date with any changes to our risk profile. Equality Impact Assessments are an integral part of the patient and public engagement and are required for all new business cases and policy development including those relating to employment.

Data Quality and Governance

An integral part of the Trust's performance management system is the assessment of data quality and by improving data quality we will further improve our patient care. The Trust produces a monthly Integrated Performance Report comprising operational, quality, workforce and financial data.

The Trust has a number of policies and protocols which describe the key performance indicator which assists the Trust in determining if they are assured by the data received.

The Trust has robust procedures in place to ensure the quality and accuracy of data which is subjected to periodic audit by our Internal Audit function. Information assurance processes are employed in the production of a monthly integrated performance report which is published as part of the Board papers and available for the public to access.

Provider Licence

From 1 April 2023, a new Provider Licence was issued by NHS England. The Board reviewed compliance with the Provider Licence Section 4 (Governance) at its Board meeting on 11 June 2024 with no risks identified in relation to compliance.

Compliance with the Care Quality Commission Registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission and maintains an up to date statement of purpose.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust continues to have in place processes to ensure that resources are used economically, efficiently and effectively.

Through the annual planning cycle, detailed plans are submitted reflecting the operational and service requirements including the achievement of a financial control total. Monthly performance meetings take place with each Care Group with any issues of escalation reported through the Finance and Performance Committee.

The emphasis of internal audit work is on governance and internal control processes with any scope for improvement being identified through the internal audit reporting mechanisms.

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

- The Board of Directors approved the operational plan
- Monthly reporting and attendance cycle for Care Groups at the Board Committees on key performance indicators relating to quality, activity and recovery.
- Monthly finance reports to the Finance and Performance Committee and Board in addition to weekly reporting to the Executive Team Meeting on key factors that may affect the Trust's financial position.
- The Trust has a robust process for the assessment and approval of business cases to ensure value for money with scrutiny of each business case and business case brief at the Executive Team Meeting and where applicable at the Finance and Performance Committee and Trust Board. In addition, the Trust has a process of reviewing the benefits realisation of previously approved business cases.

Other Compliance Matters

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's Standards of Business Conduct Policy within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Effectiveness

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

During the reporting period, the Board of Directors has continued to meet every month, alternating between a full Board meeting and strategic Board sessions. The Board has received reports on operational performance via

the Integrated Performance Report. The aforementioned report incorporates performance monitoring in respect of key national priorities, regulatory and statutory indicators, quality, patient safety and our people.

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

The Trust works closely with our External Auditors (Forvis Mazars) and Internal Auditors (360 Assurance) who in turn provide an independent and objective opinion to the Audit and Risk Committee. As stated above, my review has been informed by the reviews undertaken by the Internal Audit function, the results of which have been shared throughout the year with the Audit and Risk Committee in accordance with the approved audit plan. During the last reporting period, we have seen a significant improvement in the participation in clinical audit. The Clinical Effectiveness Committee has met on a quarterly basis and reports into our Quality Committee. During the last reporting period we have further strengthened our focus on outcomes from clinical audits as a result of strengthening our team.

During the last financial year, the Audit and Risk Committee received a total of 13 reports relating to mandated, risk based and advisory reviews, the outcomes of which are detailed below:

One 'Substantial Assurance':

- Data Security and Protection Toolkit

Six 'Significant Assurance':

- Board Assurance Framework
- Budget setting, reporting and monitoring
- Establishment control
- Pay expenditure (23/24 plan)
- Safeguarding governance
- Ward to Board risk management (23/24 plan).

Three 'Moderate/Split Assurance':

- Bank and agency controls (23/24 plan) – split significant/moderate
- Cost Improvement Program governance – split significant/limited
- Cyber governance – moderate.

Three 'Limited Assurance':

- Absence management - focus on long-term absences and return to work conversations (23/24 plan)
- Medicine management
- Patient flow.

Two are currently in progress:

- Care Group governance
- Absence management re-audit.

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

The Trust received a statement from the Head of Internal Audit based upon the work undertaken during 2024-25 and the overall opinion is as follows:

I am providing an opinion of **significant** assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

This position reflects the range of audit opinions provided in-year. There were many positive outcomes across our work programme, however we raised limited assurance opinions in three audits; these all represented areas of known risk to the Trust. The Trust's follow up rate of medium and high risks was 76% for the year, and all high-risk actions which fell due in-year were closed on time.

Conclusion

The Board remains committed to continuous improvement to ensure that robust systems continue to be in place to identify and manage risks. In summary, I am assured through the work carried out during the last financial year and through the opinion of our Internal Auditors we have a sound system of internal control designed to meet the Trust's ambitions and that controls are generally being applied consistently. I am pleased to report that at the time of this report, the Trust had no significant internal control issues identified.



Dr Richard Jenkins

Chief Executive

26 June 2025

The Rotherham NHS Foundation Trust
Annual Accounts
for the Year Ended 31 March 2025

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

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of The Rotherham NHS Foundation Trust ('the Trust') for the year ended 31 March 2025 which comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

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

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2024/25 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: health and safety regulations, CQC conditions of registration and data protection regulations.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- inquiring with management and the Audit and Risk Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to the risk of fraud in revenue recognition (which we pinpointed to the cut-off, completeness and valuation assertion), the risk of fraud in expenditure recognition (which we pinpointed to the cut-off and completeness assertion) and significant one-off or unusual transactions.

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

- making enquiries of management, Internal Audit and the Audit and Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- considering identified significant transactions outside the normal course of business;
- testing accounting estimates impacting amounts included in the financial statements;
- testing of transactions in the pre and post year end period to ensure they have been recognised in the right year;
- testing year end receivable to confirm they exist and are recorded at the correct value; and
- reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care.

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

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2024, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2025:

Significant weakness in arrangements	Recommendation
<p>Financial sustainability</p> <p>The Trust's reported outturn against its financial plan was achieved through delivering non recurrent savings and receiving funding which included deficit support funding. Additionally, the Trust has submitted a break-even plan for the next financial year which includes receipt of non-recurrent deficit support funding and does not address the underlying deficit.</p> <p>In our view the Trust's reliance on non-recurrent savings and deficit support funding alongside the underlying deficit are evidence of a significant weakness in the Trust's arrangements for financial sustainability criteria, specifically 'how the body plans to bridge its funding gaps and identifies achievable savings'.</p>	<p>The Trust should continue to develop its Multi Year Financial Improvement Plan to increase the level of recurrent efficiencies that are achievable and should continue to work within the South Yorkshire System to agree sustainable long-term plans that don't rely on non-recurrent deficit support funding.</p> <p>.</p>

Responsibilities of the Accounting Officer

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

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

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2024/25; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of The Rotherham NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.



Daniel Watson, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

One St Peter's Square
Manchester
M2 3DE

26 June 2025



Foreword to the Account

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed:



Name: Dr R Jenkins
Job title: Chief Executive
Date: 26 June 2025



Statement of Financial Position (SOFP)

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	6,743	7,594
Property, plant and equipment	15	167,134	160,604
Right of use assets	18	14,774	17,315
Receivables	22	428	404
Total non-current assets		189,079	185,917
Current assets			
Inventories	21	4,246	5,043
Receivables	22	13,010	10,682
Cash and cash equivalents	23	15,912	12,116
Total current assets		33,168	27,841
Current liabilities			
Trade and other payables	24	(41,836)	(34,104)
Borrowings	26	(4,621)	(4,594)
Provisions	27	(218)	(1,704)
Other liabilities	25	(2,612)	(1,819)
Total current liabilities		(49,287)	(42,221)
Total assets less current liabilities		172,960	171,537
Non-current liabilities			
Borrowings	26	(28,307)	(32,083)
Provisions	27	(1,097)	(1,042)
Total non-current liabilities		(29,404)	(33,125)
Total assets employed		143,556	138,412
Financed by			
Public dividend capital		175,424	169,520
Revaluation reserve		54,755	57,391
Income and expenditure reserve		(86,623)	(88,499)
Total taxpayers' equity		143,556	138,412

Signed:



Name: Dr R Jenkins

Job title: Chief Executive

Date: 26 June 2025

Statement of Comprehensive Income (SOCl)

		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	375,593	335,563
Other operating income	4	32,408	30,328
Operating expenses	7,9	(404,490)	(370,307)
Operating surplus/(deficit) from continuing operations		3,511	(4,416)
Finance income	10	813	1,169
Finance expenses	11	(968)	(1,484)
PDC dividends payable		(4,125)	(3,932)
Net finance costs		(4,280)	(4,247)
Other gains / (losses)	12	9	(3)
Surplus / (deficit) for the year from continuing operations		(760)	(8,666)
Surplus / (deficit) for the year		(760)	(8,666)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(1,709)
Revaluations	17	-	560
Total comprehensive income / (expense) for the period		(760)	(9,815)

NHS organisations are performance monitored against a control total – Note 35 to these accounts provides further information on this.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2025

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2024 - brought forward	169,520	57,391	(88,499)	138,412
Surplus/(deficit) for the year	-	-	(760)	(760)
Other transfers between reserves	-	(2,636)	2,636	-
Public dividend capital received	5,904	-	-	5,904
Taxpayers' equity at 31 March 2025	175,424	54,755	(86,623)	143,556

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2024

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2023 - brought forward	168,059	60,774	(81,196)	147,637
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(871)	(871)
Surplus/(deficit) for the year	-	-	(8,666)	(8,666)
Other transfers between reserves	-	(2,234)	2,234	-
Impairments	-	(1,709)	-	(1,709)
Revaluations	-	560	-	560
Public dividend capital received	1,461	-	-	1,461
Taxpayers' equity at 31 March 2024	169,520	57,391	(88,499)	138,412

Information on Reserves

Public Dividend Capital

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

Revaluation Reserve

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

Formal valuations are conducted every 5 years, with desktop valuations in the interim as required. The Trust's assets were revalued at the 31 March 2023.

An interim revaluation of three leased buildings was undertaken during 2024/25 where the annual lease payments increased during the financial year.

Income and Expenditure Reserve

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

Statement of Cash Flows (SOCF)

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		3,511	(4,416)
Non-cash income and expense:			
Depreciation and amortisation	7.1	14,513	14,124
Net impairments	8	143	2,606
Income recognised in respect of capital donations	4	(76)	-
(Increase) / decrease in receivables and other assets		(2,352)	7,642
(Increase) / decrease in inventories		797	(1,048)
Increase / (decrease) in payables and other liabilities		3,190	(12,689)
Increase / (decrease) in provisions		(1,448)	1,289
Net cash flows from / (used in) operating activities		18,278	7,508
Cash flows from investing activities			
Interest received		813	1,169
Purchase of intangible assets		(618)	(1,068)
Purchase of PPE and investment property		(11,148)	(12,082)
Sales of PPE and investment property		10	11
Net cash flows from / (used in) investing activities		(10,943)	(11,970)
Cash flows from financing activities			
Public dividend capital received		5,904	1,461
Movement on loans from DHSC		(1,250)	(1,250)
Capital element of lease rental payments		(3,138)	(3,076)
Capital element of PFI and other service concession payments		(335)	(300)
Interest on loans		(247)	(278)
Interest paid on lease liability repayments		(225)	(250)
Interest paid on PFI and other service concession obligations		(284)	(280)
PDC dividend (paid) / refunded		(3,964)	(3,805)
Net cash flows from / (used in) financing activities		(3,539)	(7,778)
Increase / (decrease) in cash and cash equivalents		3,796	(12,240)
Cash and cash equivalents at 1 April - brought forward		12,116	24,356
Cash and cash equivalents at 31 March	23	15,912	12,116

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

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

NHS 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 GAM 2024/2025 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting Convention

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

Note 1.2 Going Concern

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

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

Note 1.3 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

1.3.1 Critical Judgements in Applying Accounting Policies

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

Valuation of Buildings

The Department of Health and Social Care (DHSC) guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical calculation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA the Trust, supported by its appointed Valuer (Clark Weightman, since merged and operating as Sanderson Weatherall LLP), has made judgements around alternative sites and required footprint for an MEA build. In determining the MEA, the Trust has to make assumptions that are practically achievable and would meet the service needs of users, but the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust and would not impact on service delivery or the level and volume of service provided. The Trust has no plans to implement any of the theoretical assumptions that underpin the MEA valuation.

Recognition of Leased Asset

Under leasing arrangements involving use of assets, management make judgements in determining when substantially all the significant risks and rewards of ownership of that asset(s) are transferred to the Trust, and as such should be brought onto the Statement of Financial Position.

At 31 March 2025, the Trust had a number of leases which covered buildings used to provide health care services, medical and non-medical equipment and vehicles. Note 18 provides further details.

The Trust leases a number of buildings from NHS Property Services (NHSPS). Whilst the Trust has occupied the majority of these for a substantial number of years, contractual documentation is limited to a one year rolling service level agreement in each case. In assessing the lease term to apply in relation to IFRS 16, the Trust has reviewed future planned service delivery and took a ten year outlook for the purposes of calculating borrowings and Right of Use Asset valuation upon implementation of IFRS16 on 1 April 2022. Based upon this evaluation, the Right of Use Assets held under IFRS 16 with NHSPS (where there are on-going annual rolling leases) are valued at £1.648million.

1.3.2 Sources of Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuation of Property, Plant and Equipment

The Trust has used valuations carried out at 31 March 2025 and 31 March 2024 by its expert independent professional Valuer (Clark Weightman, since merged and operating as Sanderson Weatherall LLP) to determine the value of property. These property valuations and useful lives are based on the Royal Institute of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care.

A full revaluation of the Trust's property and land assets was undertaken at 31 March 2023. The Trust has considered items such as indices movements, deterioration of assets and its further estates plans to support its revaluation. The revaluation resulted in impairment for 2022/23.

In between formal valuations carried out by the Trust's Valuer, consideration will be given to movement in market prices as applicable to the public sector by applying indices to land and building assets as deemed appropriate.

During 2024/25, three of the buildings leased by the Trust had an increase in annual payments in line with their contracts, as such these assets were revalued to ensure that the assets continued to be recognised at a market rent. The revaluations resulted in impairment losses against these assets.

An interim revaluation of the Special Care Baby Unit (SCBU) and leased buildings was carried out at 31 March 2024. This resulted in both revaluation gains and impairment losses, as individual assets went up or down in value, respectively.

Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Adjustments to estimated lives may be made, 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.

The carrying value of assets held by the Trust at 31 March 2025 totalled £167.134million; further details can be found in Note 15.

Note 1.4 Operating Segments

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

Note 1.5 Income (Revenue from Contracts with Customers)

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

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

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

Revenue from NHS Contracts

The main source of income for the Trust is contracts with Commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS Commissioners under the NHS Payment Scheme. The NHS Payment Scheme sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHS Payment Scheme. Aligned Payment Incentives (API) contracts contain both

a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), outpatient procedures, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHS Payment Scheme. Income is earned at NHS Payment Scheme prices based on actual activity. The fixed element includes income for all other services covered by the NHS Payment Scheme assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from Commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the Commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned in elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £500K), an annual fixed payment is received by the provider as determined in the NHS Payment Scheme documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's Commissioners.

The Trust has apportioned income received under API contracts between acute services and community services. This apportionment is based on the actual split received in 2019/20, which has been uplifted each year thereafter based on tariff.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work

and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

Payment terms are standard reflecting cross government principles.

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

Note 1.6 Expenditure on Employee Benefits

1.6.1 Short-Term Employee Benefits

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

1.6.2 Retirement Benefit Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it

agrees to contribute to the fund and effectively places actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for services rendered by employees during the period.

Note 1.7 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, Plant and Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised where:

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

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

1.8.2 Measurement

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

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use, are measured subsequently at their current value in

existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

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

- land and non-specialised buildings - market value for existing use
- specialised buildings - depreciated replacement cost, modern equivalent asset basis

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.8.3 Subsequent Expenditure

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

1.8.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Public Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

1.8.5 Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.8.6 Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.8.7 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued except where 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational

asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8.8 Donated, Government Grant and Other Grant Funded Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8.9 Useful Economic Lives of Property, Plant and Equipment

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

Plant, Property and Equipment	Minimum life (Years)	Maximum life (Years)
Buildings (excluding dwellings)	3	90
Plant and machinery	5	15
Transport equipment	7	9
Information technology	5	20
Furniture and fittings	10	10

Note 1.9 Investment Properties

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

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

The Rotherham NHS Foundation Trust does not hold any investment properties.

Note 1.10 Intangible Assets

1.10.1 Recognition

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

Internally Generated Intangible Assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

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

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

Software

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

1.10.2 Measurement

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

1.10.3 Subsequent Expenditure

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.10.4 Amortisation

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

1.10.5 Useful Economic Life of Intangible Assets

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

Intangible assets	Minimum life (Years)	Maximum life (Years)
Purchased software	2	20

Note 1.11 Revenue Government and Other Grants

Government grants are grants from government bodies other than income from Commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.12 Inventories

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

Note 1.13 Cash and Cash Equivalents

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

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

Note 1.14 Financial Assets and Financial Liabilities

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

1.14.1 Financial Assets At Amortised Cost

Financial assets and financial liabilities 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 cash equivalents, contract and other trade receivables, trade and other payables and obligations under lease arrangements and loans receivables and payables.

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

1.14.2 Financial Assets At Fair Value Through Other Comprehensive Income

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

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

1.14.3 Financial Assets and Financial Liabilities 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.

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

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

1.14.4 Impairment of Financial Assets

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

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

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.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14.5 Financial Liabilities

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

1.14.6 Financial Liabilities At Fair Value Through Profit and Loss

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

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

1.14.7 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly

discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.15.1 The Trust As Lessee

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% was applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to the following leases:

- with a term of 12 months or less

- where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT

Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent Measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.15.2 The Trust As A Lessor

A lessor shall classify each of its leases as an operating or finance lease.

A lease is classified as finance lease when the lease substantially transfers all of the risks and rewards incidental to ownership of an underlying asset. Where substantially all of 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.

Note 1.16 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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the financial cost, the charge for the services (and lifecycle replacement of component of the asset, where applicable).

Initial Measurement

In accordance with, HM Treasury's FReM the underlying assets are recognised as property, plant and equipment, together with an equivalent PFI liability measured in alignment with the principles of IFRS 16.

Subsequent Measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate. The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical Negligence Costs

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust's Accounts.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Early Retirement Provisions

Early retirement provisions are discounted using the HM Treasury's post-employment benefit discount rate of 2.40% (2.450% in 2023/2024) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (4.26% in 2023/2024) for inflation adjusted expected cash flows up to and including 5 years from the Statement of Financial Position date
- A nominal medium-term rate of 4.07% (4.03% in 2023/2024) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- A nominal long-term rate of 4.81% (4.72% in 2023/2024) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date
- A nominal very long-term date of 4.55% (4.40% in 2023/2024) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date

Note 1.18 Contingent Assets and Contingent Liabilities

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

Contingent liabilities are not recognised but are disclosed in the notes.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

Note 1.19 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets and grant funded assets
- charitable funds
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable
- approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets, as set out in the "pre-audit" version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is

based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

Note 1.20 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation Tax

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

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

Note 1.22 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

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

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

Note 1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them.

However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.24 Losses and Special Payments

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

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Gifts

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

Note 1.26 Transfers of Functions To / From Other NHS Bodies / Local Government Bodies

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

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

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

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

Note 1.27 Early Adoption of Standards, Amendments and Interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/2025.

Note 1.28 Standards, Amendments and Interpretations in Issue But Not Yet Effective Or Adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/2025:

- IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FreM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

- Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. Building assets, including right of use assets where there is a building lease, currently subject to revaluation have a total book value of £132.904million as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £10million at 31 March 2025.

Note 2 Operating Segments

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

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the Board of Directors, including senior professional Non-Executive Directors. The Board of Directors reviews the financial position of the Trust as a whole in its decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

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

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

	Healthcare		Total	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Income	408,001	365,891	408,001	365,891
Retained Earnings / (Accumulated Deficit)	(760)	(8,666)	(760)	(8,666)
Segment net assets	143,556	138,412	143,556	138,412

Note 3 Operating Income From Patient Care Activities

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

Note 3.1 Income From Patient Care Activities (by Nature)

	2024/25	2023/24
	£000	£000
Acute services		
Income from Commissioners under API contracts – variable element*	71,159	60,489
Income from Commissioners under API contracts – fixed element*	230,468	216,610
High cost drugs income from Commissioners	7,217	5,535
Other NHS clinical income	67	80
Community services		
Income from Commissioners under API contracts*	36,302	32,836
Income from other sources (e.g. local Authorities)	9,608	9,281
All services		
National pay award central funding***	748	149
Additional pension contribution central funding**	15,286	9,499
Other clinical income	4,738	1,084
Total income from activities	375,593	335,563

* Aligned payment and incentive contracts are the main form of contracting between NHS providers and their Commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

** Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7% in 2024/25, and 20.6% in 2023/24) and related NHS England funding (9.4% in 2024/25, and 6.3% in 2023/24) have been recognised in these accounts.

*** Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income From Patient Care Activities (By Source)

	2024/25	2023/24
	£000	£000
NHS England	30,951	22,870
Integrated Care Boards	331,109	297,034
Other NHS providers	67	80
Local Authorities	9,388	9,652
Non-NHS: overseas patients (chargeable to patient)	126	158
Injury cost recovery scheme	580	877
Non NHS: other	3,372	4,892
Total income from activities	375,593	335,563

Note 3.3 Overseas Visitors (Relating to Patients Charged Directly By the Provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	126	158
Cash payments received in-year	31	16
Amounts added to provision for impairment of receivables	46	119
Amounts written off in-year	43	-

Note 4 Other Operating Income

	2024/25		2023/24	
	Contract income	Non-contract income	Contract income	Non-contract income
	£000	£000	£000	£000
Research and development	581	-	534	-
Education and training	15,106	700	13,290	592
Non-patient care services to other bodies	9,710		8,402	
Income in respect of employee benefits accounted on a gross basis	3,320		3,530	
Receipt of capital grants and donations and peppercorn leases		76		-
Charitable and other contributions to expenditure		6		63
Revenue from operating leases		471		468
Other income	2,436	2	3,449	-
Total other operating income	31,153	1,255	29,205	1,123
		32,408		30,328

Note 5.1 Additional Information on Contract Revenue (IFRS 15) Recognised in the Period

	2024/25 £000	2023/24 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,819	2,375

Note 5.2 Transaction Price Allocated to Remaining Performance Obligations

At the 31 March 2025, the Trust had no performance obligations that were either partially or fully unsatisfied that it has not accounted for in revenue recognition in year. Therefore, there are no contracts that commenced prior to the period end, with performance obligations outstanding and income not yet recognised.

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

Note 5.3 Income from Activities Arising from Commissioner Requested Services

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

	2024/25 £000	2023/24 £000
Income from services designated as Commissioner requested services	370,855	334,479
Income from services not designated as Commissioner requested services	37,146	31,412
Total	408,001	365,891

Note 5.4 Profits and Losses On Disposal of Property, Plant and Equipment

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

Note 5.5 Fees and Charges

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

In 2024/25 The Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1million. This was also the case during the 2023/24 financial year.

Note 6 Operating Leases (The Rotherham NHS Foundation Trust as Lessor)

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

Note 6.1 Operating Lease Income

The leases held by the Trust relate to various retail facilities provided at the General Hospital site, land used by other healthcare providers, and creche facilities.

	2024/25 £000	2023/24 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	471	468
Total in-year operating lease income	471	468

Note 6.2 Future Lease Receipts

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due in:		
- not later than one year	387	424
- later than one year and not later than two years	349	370
- later than two years and not later than three years	226	346
- later than three years and not later than four years	226	223
- later than four years and not later than five years	226	223
- later than five years	4,901	5,066
Total	6,315	6,652

Note 7.1 Operating Expenses

The following table shows the operating expenses incurred by the Trust during both the 2024/25 and 2023/24 financial years:

	2024/25 £000	2023/24 £000
Purchase of healthcare from NHS and DHSC bodies (*)	7,008	-
Purchase of healthcare from non-NHS and non-DHSC bodies	2,356	1,166
Staff and Executive Directors costs	277,375	256,783
Remuneration of Non-Executive Directors	152	145
Supplies and services - clinical (excluding drugs costs)	31,961	30,218
Supplies and services - general	5,996	5,378
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	24,390	22,453
Inventories written down	61	13
Consultancy costs	-	104
Establishment	2,437	2,626
Premises	16,096	15,503
Transport (including patient travel)	4,389	3,994
Depreciation on property, plant and equipment	13,015	12,858
Amortisation on intangible assets	1,498	1,266
Net impairments	143	2,606
Movement in credit loss allowance: contract receivables / contract assets	124	227
Movement in credit loss allowance: all other receivables and investments	31	9
Change in provisions discount rate(s)	2	(31)
Fees payable to the External Auditor		
audit services- statutory audit (**)	151	145
Internal Audit costs	114	109
Clinical negligence	11,590	10,252
Legal fees	265	452
Insurance	278	257
Research and development	574	490
Education and training	775	1,016
Expenditure on low value leases	-	6
Redundancy	39	128
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	710	687
Losses, ex gratia and special payments	69	74
Other services, for example External Payroll	2,144	668
Other	747	705
Total	404,490	370,307

Note:

* From the 1 April 2024, Pathology Services for The Rotherham NHS Foundation Trust transferred to Sheffield Teaching Hospital under the South Yorkshire and Bassetlaw Pathology Network. As such costs relating to 2024/25 are showing against Purchase of healthcare from NHS and DHSC bodies in the table above, whereas for the 2023/24 financial year these costs were split over the relevant operating expense headings, such as staffing, supplies and services.

** Audit fees are inclusive of VAT.

Note 7.2 Other Auditor Remuneration

No other External Auditor remuneration was paid during the 2024/25 financial year for work over and above the statutory audit fee, nor was there in 2023/24.

Note 7.3 Limitation on Auditor's Liability

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

Note 8 Impairment of Assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	143	(747)
Other	-	3,353
Total net impairments charged to operating surplus / deficit	143	2,606
Impairments charged to the revaluation reserve	-	1,709
Total net impairments	143	4,315

During 2024/25, an interim revaluation was undertaken on three leased building assets where the annual payment increased during the financial year; this led to impairment costs in year totalling £143k.

In 2023/24, an interim revaluation was undertaken on leased building assets and the Special Care Baby Unit, which led to some impairment costs in year. In addition, some impairment previously charged to the Statement of Comprehensive Income was reversed.

Note 9 Employee Benefits

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	202,579	190,775
Social security costs	20,615	18,489
Apprenticeship levy	957	937
Employer's contributions to NHS pensions	38,675	31,252
Pension cost - other	119	78
Temporary staff (including agency)	15,649	16,678
Total staff costs	278,594	258,209
Of which:		
Costs capitalised as part of assets	617	813
Cost attributable to research and development	563	485
Cost of redundancies	39	128

Note 9.1 Retirements Due to Ill-Health

During 2024/25, there were four early retirements from the Trust agreed on the grounds of ill-health (six in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £215k (£1.121million in 2023/24).

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

Note 10 Finance Income

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	813	1,169
Total finance income	813	1,169

Note 11.1 Finance Expenditure

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

	2024/25 £000	2023/24 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	241	272
Interest on lease obligations	225	250
Finance costs on PFI and other service concession arrangements:		
Main finance costs	284	280
Remeasurement of the liability resulting from change in index or rate	201	665
Total interest expense	951	1,467
Unwinding of discount on provisions	17	17
Total finance costs	968	1,484

Note 11.2 The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015

The Late Payment of Commercial debts (Interest) Act 1998 / Public Contract Regulations requires the Trust to disclose its:

- total liability accruing in year under this legislation as a result of late payments
- amounts included within interest payable arising from claims made under this legislation
- compensation paid to cover debt recovery costs under this legislation.

In 2024/25, the Trust paid £295.36 in late payment fees under the above Act. In 2023/24, the Trust paid £298.35 in late payment fees.

Note 12 Other Gains / (Losses)

	2024/25 £000	2023/24 £000
Gains on disposal of assets	10	9
Losses on disposal of assets	(1)	(12)
Total gains / (losses) on disposal of assets	9	(3)
Total other gains / (losses)	9	(3)

Note 13 Discontinued Operations

No services provided by The Rotherham NHS Foundation Trust were discontinued in either the 2024/25 or 2023/24 financial years.

Note 14.1 Intangible Assets – 2024/25

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	17,321	17,321
Additions	647	647
Valuation / gross cost at 31 March 2025	17,968	17,968
Amortisation at 1 April 2024 - brought forward	9,727	9,727
Provided during the year	1,498	1,498
Amortisation at 31 March 2025	11,225	11,225
Net book value at 31 March 2025	6,743	6,743
Net book value at 1 April 2024	7,594	7,594

Note 14.2 Intangible Assets – 2023/24

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2023	21,171	21,171
Additions	1,016	1,016
Reclassifications	276	276
Disposals / derecognition	(5,142)	(5,142)
Valuation / gross cost at 31 March 2024	17,321	17,321
Amortisation at 1 April 2023	13,555	13,555
Provided during the year	1,266	1,266
Reclassifications	48	48
Disposals / derecognition	(5,142)	(5,142)
Amortisation at 31 March 2024	9,727	9,727
Net book value at 31 March 2024	7,594	7,594
Net book value at 1 April 2023	7,616	7,616

Note 15.1 Property, Plant and Equipment – 2024/25

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024 - brought forward	11,000	124,048	480	42,814	245	11,121	399	190,107
Additions	-	5,758	4,890	3,095	-	2,550	-	16,293
Reclassifications	-	-	-	31	-	-	-	31
Disposals / derecognition	-	-	-	(405)	-	-	-	(405)
Valuation/gross cost at 31 March 2025	11,000	129,806	5,370	45,535	245	13,671	399	206,026
Accumulated depreciation at 1 April 2024 - brought forward	-	4,926	-	20,182	198	3,947	250	29,503
Provided during the year	-	5,257	-	2,850	9	1,637	40	9,793
Disposals / derecognition	-	-	-	(404)	-	-	-	(404)
Accumulated depreciation at 31 March 2025	-	10,183	-	22,628	207	5,584	290	38,892
Net book value at 31 March 2025	11,000	119,623	5,370	22,907	38	8,087	109	167,134
Net book value at 1 April 2024	11,000	119,122	480	22,632	47	7,174	149	160,604

Note 15.2 Property, Plant and Equipment – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	11,000	116,447	177	43,221	256	13,101	393	184,595
Additions	-	8,153	303	1,627	17	1,132	6	11,238
Impairments	-	(2,610)	-	-	-	-	-	(2,610)
Reversals of impairments	-	1,621	-	-	-	-	-	1,621
Reclassifications	-	437	-	(726)	-	13	-	(276)
Disposals / derecognition	-	-	-	(1,308)	(28)	(3,125)	-	(4,461)
Valuation/gross cost at 31 March 2024	11,000	124,048	480	42,814	245	11,121	399	190,107
Accumulated depreciation at 1 April 2023	-	47	-	18,517	188	5,719	210	24,681
Provided during the year	-	4,864	-	3,052	37	1,351	40	9,344
Impairments	-	(27)	-	-	-	-	-	(27)
Reclassifications	-	42	-	(92)	-	2	-	(48)
Disposals / derecognition	-	-	-	(1,295)	(27)	(3,125)	-	(4,447)
Accumulated depreciation at 31 March 2024	-	4,926	-	20,182	198	3,947	250	29,503
Net book value at 31 March 2024	11,000	119,122	480	22,632	47	7,174	149	160,604
Net book value at 1 April 2023	11,000	116,400	177	24,704	68	7,382	183	159,914

Note 15.3 Property, Plant and Equipment Financing – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,000	116,944	5,370	15,894	38	8,087	109	157,442
On-SoFP PFI contracts and other service concession arrangements	-	-	-	6,114	-	-	-	6,114
Owned - donated/granted	-	2,679	-	899	-	-	-	3,578
Total net book value at 31 March 2025	11,000	119,623	5,370	22,907	38	8,087	109	167,134

Note 15.4 Property, Plant and Equipment Financing – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,000	116,256	480	15,081	47	7,174	149	150,187
On-SoFP PFI contracts and other service concession arrangements	-	-	-	6,490	-	-	-	6,490
Owned - donated/granted	-	2,866	-	1,061	-	-	-	3,927
Total net book value at 31 March 2024	11,000	119,122	480	22,632	47	7,174	149	160,604

Note 15.5 Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	588	2,589	-	-	-	-	-	3,177
Not subject to an operating lease	10,412	117,034	5,370	22,907	38	8,087	109	163,957
Total net book value at 31 March 2025	11,000	119,623	5,370	22,907	38	8,087	109	167,134

Note 15.6 Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	588	2,589	-	-	-	-	-	3,177
Not subject to an operating lease	10,412	116,533	480	22,632	47	7,174	149	157,427
Total net book value at 31 March 2024	11,000	119,122	480	22,632	47	7,174	149	160,604

Note 16 Donations of Property, Plant and Equipment

The Trust did not receive any donated assets or cash donations for the purchase of assets during 2024/2025 or 2023/2024.

The Trust did re-enter a building lease during the year, where a rental below market value (known as a peppercorn rent) is paid to the lessor.

Note 17 Revaluations of Property, Plant and Equipment

A full 5 yearly cyclical valuation of the Trust's estate was carried out during 2022/23.

Following a full site inspection and review, the Trust's independent qualified valuer, Clark Weightman (since merged and operating as Sanderson Weatherall LLP), issued their report with a valuation date of 31 March 2023; this included all relevant owned land and buildings, it also includes one peppercorn leased building (see Note 18.3).

The report took account of changes in buildings cost indices, location factors and the effect of capital expenditure during the year. The report was completed in accordance with guidance issued by the Royal Institution of Chartered Surveyors ("RICS") and gave an overall valuation of the Trust's estate (including land and buildings) of £127.279million.

A revaluation was undertaken in 2023/24 of buildings used by the Trust which are leased from third parties, as well as a formal valuation of the Special Care Baby Unit (SCBU) which underwent a refurbishment during the year.

During 2024/25, an interim revaluation was undertaken on three of the leased building assets where the lease payment had increased during the financial year. These revaluations resulted in impairment losses totalling £143k, as shown in Note 8.

Note 18 Leases (The Rotherham NHS Foundation Trust as a Lessee)

This note details information about leases for which the Trust is a lessee.

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

Finance leases are recognised on the Trust's Statement of Financial Position as Right Of Use Assets (non-current assets).

Note 18.1 Right of Use Assets – 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	16,261	5,598	17	21,876	17,473
Additions	85	427	15	527	85
Remeasurements of the lease liability	166	162	-	328	159
Impairments	(358)	-	-	(358)	(296)
Reclassifications	-	(31)	-	(31)	-
Disposals / derecognition	-	(103)	-	(103)	-
Valuation/gross cost at 31 March 2025	16,154	6,053	32	22,239	17,421
Accumulated depreciation at 1 April 2024 - brought forward	990	3,556	15	4,561	1,728
Provided during the year	2,098	1,120	4	3,222	2,410
Impairments	(215)	-	-	(215)	(157)
Disposals / derecognition	-	(103)	-	(103)	-
Accumulated depreciation at 31 March 2025	2,873	4,573	19	7,465	3,981
Net book value at 31 March 2025	13,281	1,480	13	14,774	13,440
Net book value at 1 April 2024	15,271	2,042	2	17,315	15,745
Net book value of right of use assets leased from other NHS providers					2,592
Net book value of right of use assets leased from other DHSC group bodies					10,848

Note 18.2 Right of Use Assets – 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies £000
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	21,201	5,598	17	26,816	22,268
Remeasurements of the lease liability	1,158	-	-	1,158	1,158
Impairments	(6,328)	-	-	(6,328)	(6,183)
Revaluations	230	-	-	230	230
Valuation/gross cost at 31 March 2024	16,261	5,598	17	21,876	17,473
Accumulated depreciation at 1 April 2023 - brought forward	1,894	2,450	8	4,352	2,201
Provided during the year	2,401	1,106	7	3,514	2,708
Impairments	(2,975)	-	-	(2,975)	(2,851)
Revaluations	(330)	-	-	(330)	(330)
Accumulated depreciation at 31 March 2024	990	3,556	15	4,561	1,728
Net book value at 31 March 2024	15,271	2,042	2	17,315	15,745
Net book value at 1 April 2023	19,307	3,148	9	22,464	20,067
Net book value of right of use assets leased from other NHS providers					3,160
Net book value of right of use assets leased from other DHSC group bodies					12,585

Note 18.3 – Revaluation of Right of Use Assets

During 2024/25, a revaluation of three leased buildings was undertaken, where the annual lease rental payment increased during the financial year. These leased buildings are used in the delivery of healthcare services.

Overall, this resulted in impairment losses of £143k, taken to the Statement of Comprehensive Income.

For further information regarding the revaluation carried out, please see Note 17.

Note 18.4 – Reconciliation of the Carrying Value of Lease Liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in Note 26.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	16,836	18,754
Lease additions	451	-
Lease liability remeasurements	328	1,158
Interest charge arising in year	225	250
Lease payments (cash outflows)	(3,363)	(3,326)
Carrying value at 31 March	14,477	16,836

Lease payments for short term leases (less than 12 months) or leases of low value (less than £5K) underlying assets are recognised in operating expenditure.

These payments are disclosed in Note 7.1, Operating Expenses. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 – Maturity Analysis of Future Lease Payments at 31 March 2025 and 31 March 2024

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025 £000	31 March 2025 £000	31 March 2024 £000	31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year	3,129	2,542	3,142	2,550
- later than one year and not later than five years	7,039	6,521	8,922	8,235
- later than five years	5,454	5,442	6,086	6,086
Total gross future lease payments	15,622	14,505	18,150	16,871
Finance charges allocated to future periods	(1,145)	(1,115)	(1,314)	(1,287)
Net lease liabilities at 31 March 2025	14,477	13,390	16,836	15,584
Of which:				
Leased from other NHS providers		2,085		2,642
Leased from other DHSC group bodies		11,305		12,942

Note 19 Investment Property

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

Note 20 Disclosure of Interests in Other Entities

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

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

	31 March 2025 £000	31 March 2024 £000
Total incoming resources	245	345
Resources expended	(344)	(243)
Net movement in funds	(99)	102
Total assets	490	601
Total liabilities	(7)	(19)
Total Charitable Funds	483	582
Total funds made up of:		
Restricted /endowment funds	288	310
Unrestricted funds	195	272

The 2024/25 Charitable Funds accounts have not yet been subject to independent review. The 2023/24 Charitable Funds accounts were subject to independent examination and were finalised in November 2024.

Note 21 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	1,508	1,254
Consumables	2,687	3,743
Energy	51	46
Total inventories	4,246	5,043
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £35.137million (2023/24: £31.865million). Write-down of inventories recognised as expenses for the year were £61k (£13k in 2023/24).

Note 22.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	7,532	6,221
Allowance for impaired contract receivables / assets	(909)	(785)
Allowance for other impaired receivables	(98)	(67)
Prepayments (non-PFI)	4,680	4,039
VAT receivable	1,672	984
Other receivables	133	290
Total current receivables	13,010	10,682
Non-current		
Other receivables	428	404
Total non-current receivables	428	404

Note 22.2 Allowances for Credit Losses

	2024/25		2023/24	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	785	67	558	58
New allowances arising	407	56	450	23
Reversals of allowances	(283)	(25)	(223)	(14)
Allowances as at 31 March 2025	909	98	785	67

The in-year movement in credit loss allowance relating to contract receivables / contract assets (£124k) and all other receivables and investments (£31k) are included within total expenditure in the Statement of Comprehensive Income, as shown in Note 7.1.

Note 22.3 Exposure to Credit Risk

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

Note 23.1 Cash and Cash Equivalents Movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents.

Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£000	£000
At 1 April	12,116	24,356
Net change in year	3,796	(12,240)
At 31 March	15,912	12,116
Broken down into:		
Cash at commercial banks and in hand	118	106
Cash with the Government Banking Service	15,794	12,010
Total cash and cash equivalents as in SoFP	15,912	12,116
Total cash and cash equivalents as in SoCF	15,912	12,116

Note 23.2 Third Party Assets Held by the Trust

On occasions, Trusts hold cash and cash equivalents which relate to monies held on behalf of patients or other parties and in which the Trust has no beneficial interest. Where this is the case, this has been excluded from the cash and cash equivalents figure reported in the Accounts.

At 31 March 2025 the Trust did not hold any cash or cash equivalents which relate to monies held on behalf of patients or other parties. At 31 March 2024, the Trust held £254.48 in cash or cash equivalents which relate to monies held on behalf of patients or other parties.

Note 24 Trade and Other Payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	8,141	6,653
Capital payables	9,291	4,117
Accruals	15,863	15,524
Social security costs	2,373	2,342
VAT payables	81	58
Other taxes payable	2,489	2,310
PDC dividend payable	169	8
Pension contributions payable	3,307	3,024
Other payables	122	68
Total current trade and other payables	41,836	34,104
Of which payables from NHS and DHSC group bodies:		
Current	6,011	6,648

The Trust had no non-current payables at 31 March 2025, nor did it at 31 March 2024.

Note 25 Other Liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	2,612	1,819
Total other current liabilities	2,612	1,819

The Trust had no non-current other liabilities at 31 March 2025, nor did it at 31 March 2024.

Note 26.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	1,311	1,317
Lease liabilities	2,954	2,945
Obligations under PFI or other service concession contracts	356	332
Total current borrowings	4,621	4,594
Non-current		
Loans from DHSC	9,000	10,250
Lease liabilities	11,523	13,891
Obligations under PFI or other service concession contracts	7,784	7,942
Total non-current borrowings	28,307	32,083

Note 26.2 Reconciliation of Liabilities Arising from Financing Activities – 2024/25

	Loans from DHSC £000	Lease Liabilities £000	PFI or other service concession schemes £000	Total £000
Carrying value at 1 April 2024	11,567	16,836	8,274	36,677
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(3,138)	(335)	(4,723)
Financing cash flows - payments of interest	(247)	(225)	(284)	(756)
Non-cash movements:				
Additions	-	451	-	451
Lease liability remeasurements	-	328	-	328
Remeasurement of PFI or other service concession liability resulting from change in index or rate			201	201
Application of effective interest rate	241	225	284	750
Carrying value at 31 March 2025	10,311	14,477	8,140	32,928

Note 26.3 Reconciliation of Liabilities Arising from Financing Activities – 2023/24

	Loans from DHSC	Lease Liabilities	PFI or other service concession schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	12,823	18,754	7,038	38,615
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(3,076)	(300)	(4,626)
Financing cash flows - payments of interest	(278)	(250)	(280)	(808)
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023			871	871
Lease liability remeasurements	-	1,158	-	1,158
Remeasurement of PFI or other service concession liability resulting from change in index or rate			665	665
Application of effective interest rate	272	250	280	802
Carrying value at 31 March 2024	11,567	16,836	8,274	36,677

Note 27.1 Provisions for Liabilities and Charges Analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2024	297	411	133	1,905	2,746
Change in the discount rate	1	1	-	(4)	(2)
Arising during the year	34	56	83	11	184
Utilised during the year	(31)	(39)	(13)	(433)	(516)
Reversed unused	(37)	-	(33)	(1,065)	(1,135)
Unwinding of discount	6	11	-	21	38
At 31 March 2025	270	440	170	435	1,315
Expected timing of cash flows:					
- not later than one year	31	39	141	7	218
- later than one year and not later than five years	239	401	29	45	714
- later than five years	-	-	-	383	383
Total	270	440	170	435	1,315

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

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

The Trust has made provision for potential claims that it is aware of; these are shown under “other provisions.”

Note 27.2 Clinical Negligence Liabilities

At 31 March 2025, £63.536million was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (£55.619million at 31 March 2024).

Note 28 Contingent Assets and Liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(23)	(35)
Net value of contingent liabilities	(23)	(35)
Net value of contingent assets	797	-

The Trust has submitted a claim to HMRC for the recovery of VAT on car parking charges following the principles established in the Northumbria Healthcare NHS Foundation Trust case, amounting to £797k (covering the period April 2018 to June 2024). The case considers whether VAT is due on hospital car parking when provided by NHS Trusts.

While this matter has been subject to legal proceedings and found in favour of Northumbria Healthcare NHS Foundation Trust, the final outcome and its implications for the Trust's claim are dependent on the pending judgment of the Supreme Court.

As the outcome of the case remains uncertain, the Trust has elected to defer recognition of these VAT recoveries in the financial statements for the year ending 2024/25. The Trust has continued to pay over VAT relating to car parking income, pending the outcome of the case.

In accordance with IAS 37, no amounts have been recognised in the financial statements for the year ending 2024/25. Any recoveries will be recognised in the financial statements only if and when the legal position is resolved in a manner that confirms the Trust's entitlement to these amounts.

The Trust continues to monitor developments in the case closely and will reassess the accounting treatment of these potential recoveries in future periods.

Note 29 Contractual Capital Commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	119	1,008
Total	119	1,008

The contractual capital commitments shown in the above table relating to 2024/2025 are for works started during the financial year, but not completed at year end.

At the 31 March 2024, the Trust has a number of multi-year schemes, which started in 2023/24 and were completed during 2024/25. The capital commitments at 31 March 2024 were mainly the result of orders being raised during 2023/24 for works planned to be completed during 2024/25.

Note 30 On-SoFP PFI or Other Service Concession Arrangements

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

The project involved significant investment in the hospital's energy infrastructure which transferred the operational and financial risk to a third party with the intention of realising energy consumption reduction and a reduction in carbon emissions. The Contract for the Energy Saving Project commenced 22 November 2021, following an installation period.

Note 30.1 On-SoFP PFI or Other Service Concession Arrangement Obligations

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

	31 March 2025 £000	31 March 2024 £000
Gross PFI or other service concession liabilities	10,495	10,832
Of which liabilities are due:		
- not later than one year	630	613
- later than one year and not later than five years	2,519	2,453
- later than five years	7,346	7,766
Finance charges allocated to future periods	(2,355)	(2,558)
Net PFI or other service concession arrangement obligation:	8,140	8,274
- not later than one year	356	332
- later than one year and not later than five years	1,594	1,493
- later than five years	6,190	6,449

Note 30.2 Total on-SoFP PFI and Other Service Concession Arrangement Commitments

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

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI or other service concession arrangements	23,367	24,580
Of which payments are due:		
- not later than one year	1,402	1,391
- later than one year and not later than five years	5,608	5,566
- later than five years	16,357	17,623

Note 30.3 Analysis of Amounts Payable to Service Concession Operator

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

	2024/25 £000	2023/24 £000
Unitary payment payable to service concession operator	1,329	1,267
Consisting of:		
- interest charge	284	280
- repayment of balance sheet obligation	335	300
- service element and other charges to operating expenditure	710	687
Total amount paid to service concession operator	1,329	1,267

Note 31 Financial Instruments

Note 31.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the Integrated Care Board and the way those Integrated Care Boards 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. The Trust's treasury activity is subject to review by the Trust's Internal Auditors.

Currency Risk

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

Interest Rate Risk

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

Credit Risk

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

Liquidity Risk

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

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Note 31.2 Carrying Values of Financial Assets

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

Carrying Values of Financial Assets as at 31 March 2025

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through profit and loss	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	7,086	-	-	7,086
Cash and cash equivalents	15,912	-	-	15,912
Total at 31 March 2025	22,998	-	-	22,998

Carrying Values of Financial Assets as at 31 March 2024

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through profit and loss	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	6,063	-	-	6,063
Cash and cash equivalents	12,116	-	-	12,116
Total at 31 March 2024	18,179	-	-	18,179

Note 31.3 Carrying Values of Financial Liabilities**Carrying Values of Financial Liabilities as at 31 March 2025**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through profit and loss	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	10,311	-	10,311
Obligations under leases	14,477	-	14,477
Obligations under PFI and other service concession contracts	8,140	-	8,140
Trade and other payables excluding non financial liabilities	31,961	-	31,961
Total at 31 March 2025	64,889	-	64,889

Carrying values of Financial Liabilities as at 31 March 2024

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through profit and loss	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	11,567	-	11,567
Obligations under leases	16,836	-	16,836
Obligations under PFI and other service concession contracts	8,274	-	8,274
Trade and other payables excluding non financial liabilities	27,930	-	27,930
Total at 31 March 2024	64,607	-	64,607

Note 31.4 Maturity of Financial Liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	37,180	33,176
In more than one year but not more than five years	14,597	17,032
In more than five years	17,551	19,445
Total	69,328	69,653

Note 32 Losses and Special Payments

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	1	1
Bad debts and claims abandoned	31	54	11	1
Stores losses and damage to property	12	61	12	13
Total losses	43	115	24	15
Special payments				
Compensation under court order or legally binding arbitration award	6	9	11	55
Ex-gratia payments	19	6	26	6
Special severance payments	-	-	1	11
Total special payments	25	15	38	72
Total losses and special payments	68	130	62	87

Note 33 Gifts

During the 2024/25 financial year, the Trust did not receive any gifts, nor did it in 2023/24.

Note 34 Related Parties

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

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

During the year the Trust entered into transactions with organisations with which key employees/directors of the Trust have some form of relationship. Only those bodies outside the Department of Health and Social Care parent body, are detailed below and are not considered material.

	31 March 2025 Expenditure to Related Party £000	31 March 2025 Income from Related Party £000	31 March 2024 Expenditure to Related Party £000	31 March 2024 Income from Related Party £000
Sheffield Hallam University	25	192	58	11
University of Sheffield	8	13	18	9
Total related party transactions	33	205	76	20

During the 2024/25 financial year, the following transactions were recorded as related parties, where a member of the Board was either related to a person or persons employed by the organisation, is a Trustee or Director of the Board, or a member of the organisation:

- £8k and £25k of expenditure was incurred with the University of Sheffield and Sheffield Hallam University (respectively) for course fees (including medical education).
- Sheffield Hallam University have been awarded funding from Yorkshire Cancer Research to undertake a study, in which they have invited NHS bodies across the region to assist in. The majority of income recognised in the above table represents staffing recharges for time spent assisting in this study.

- £13k of income was received from Sheffield University for course fees.

In 2023/24, £18k and £58k of expenditure was incurred with the University of Sheffield and Sheffield Hallam University (respectively) for course fees (including medical education). Income was received from Sheffield University (£9k) for course fees, and Sheffield Hallam University (£11k) for staff secondments.

The Rotherham NHS Foundation Trust shares key management personnel with Barnsley Hospital NHS Foundation Trust; for more information, please see the Remuneration Report which also forms part of the Annual Report and Accounts for the Trust.

The Trust as Corporate Trustee also has a relationship with The Rotherham Hospital and Community Charity. Income of £245k was received by the Charity during the 2024/25 financial year, (£345k in 2023/24) which was spent on goods and services provided to the Trust, including on staff and patients. The Rotherham Hospital and Community Charity also paid £127k in relation to recharges for management and staff costs (£113k in 2023/24). The accounts of The Rotherham Hospital and Community Charity are made separately, a summary of which can be found at Note 20.

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

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

Note 35 Adjusted Financial Performance

The Trust is monitored by NHS England against its adjusted financial performance; the following table shows the movement from the Total Comprehensive Income / (Expenses) for the Period shown within the Statement of Comprehensive Income to its Adjusted Financial Performance.

	Note	2024/25 £000	2023/24 £000
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(760)	(8,666)
Remove net impairments not scoring to the Departmental expenditure limit		143	2,606
Remove I&E impact of capital grants and donations		674	748
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis		1,571	945
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis		(1,329)	
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis			(348)
Adjusted financial performance surplus / (deficit)		299	(4,715)

Note 36 Events After the Reporting Date

There are no events after the reporting date at the point when these accounts were presented at Trust Board for approval on 26 June 2025.



Review of 2024-25

- Thank you to all our people who have worked hard, together to ensure we continued to deliver safe care to all our patients
- We are proud of the achievements over the last year and we are determined to continue our improvement journey
- We continue to make progress in a number of ways and you will hear more about our progress to date



Research, audit & Innovation

- We recruited 3,237 patients to participate in research
- We reviewed the outcomes of 203 local clinical audits
- The Trust participated in 95% of national clinical audits and 100% national confidential enquiries it was eligible to participate in

Virtual reality (VR) goggles



Orthopaedic robot

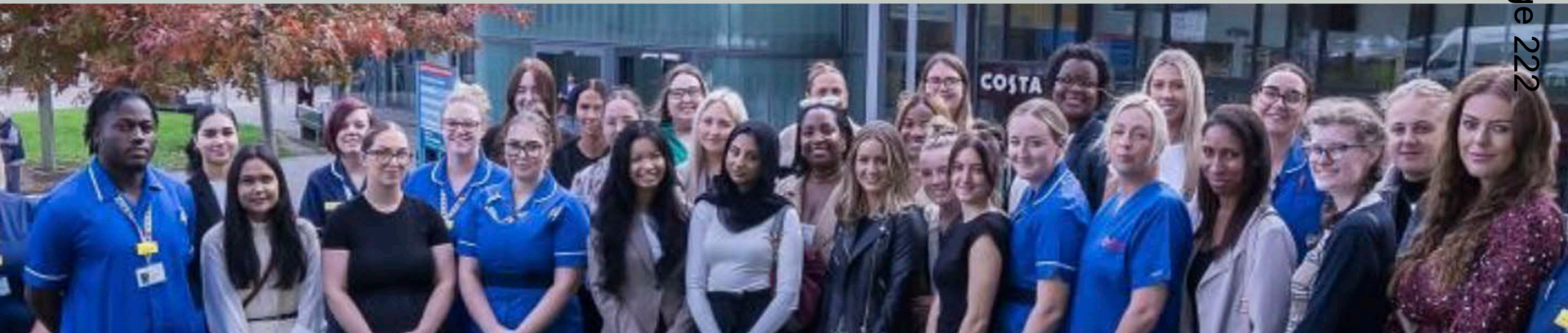


Learning from deaths

- There is minimal delay in registering deaths
- Families are appreciative of the additional step of being contacted by the Medical Examiner's Office
- Medical Examiner rolled out to cover community deaths
- Despite challenges, the service maintained high scrutiny completion rates for TRFT deaths
- 69% of Structured Judgement Reviews were completed in 60 days – an improvement from 57% in 2023/24

Appointments and recruitment

- Joint Director of Midwifery with Barnsley Hospital NHS Foundation Trust
- First Chief AHP (Allied Health Professional) appointed
- Record newly registered nurse intake
- Consistently over-recruited in a number of areas to support winter pressures
- Significant improvements made in retention of the nursing workforce
- Fully recruited to speciality areas of maternity and childrens



Patient experience improvements



This is me
Information to help you support me in hospital

For some people, changes such as moving to an unfamiliar place like hospital can be unsettling and distressing. 'This is me' provides information about the person at the time the document is completed. It can help health and social care staff to build a better understanding of who the person really is, what matters to them and how to care and support them in hospital. It will go with the person as they leave hospital too.

If the person needs further care and support at home, or moves to residential care, this information can contribute to a one-page profile, and to the person's life story information. It is simple to fill in, and complements the information that healthcare professionals will be gathering.

Space for a photograph
(Using a photograph is optional, but it can be really helpful for hospital staff)

Full name _____

What I like to be called _____

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Carer/Care Partner Promise

A Carer/Care Partner is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or addiction cannot cope without their support.

We promise that Carers / Care Partners will:

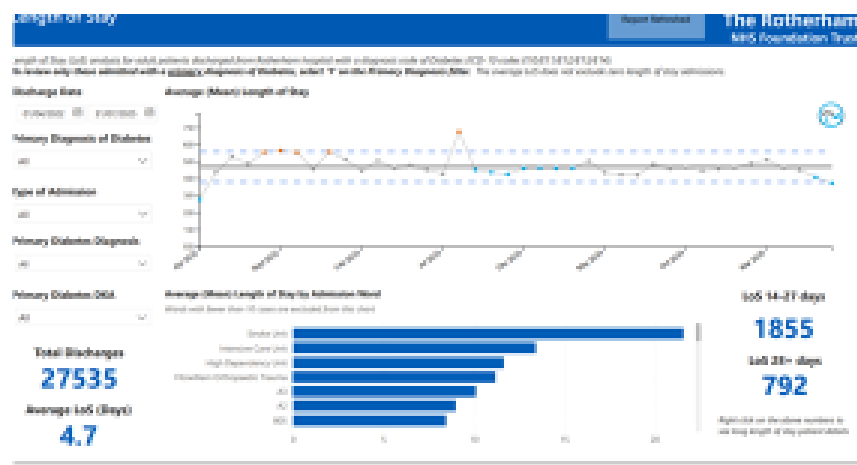
- know your rights
- be identified by staff that know about carers needs
- be welcomed to be with the patient at any time as experts in their care in and out of wards or departments. They are in
- have your caring status recorded on your medical record so that we can get emergency care for your loved one if you are unwell
- be involved in making care decisions with the patient's permission
- be offered a drink on the wards
- be told about parking discounts available
- be able to use a Carer's Passport to write about your needs as a carer
- be encouraged to access a Carer's Assessment
- be given information on community support
- be supported to plan ahead for a crisis such as your loved one becoming unwell
- be involved in planning ahead for the end of life

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Quality Priorities 24/25

- Diabetes Management – All aims and objectives achieved. Priority to continue for a second year
- Acute Pain Management - All aims and objectives achieved. Nominated for a national award.
- Frailty – Partially achieved. Work has continued into 2025 to meet the outstanding objectives.



Emergency access

UECC Performance

Number of Attendances in UECC	
2023/24	2024/25
97,040	104,892



Up by 7,852 attendances this financial year, that's an 8% increase overall this year



Demand for emergency care has continued to grow, with an 8% rise in attendances compared to 2023/24. This increase was most notable in the winter months, with a 4% rise in ambulance arrivals and a 10% increase in walk-in patients. Significant improvement has been progressed despite these challenges:

- **Improved performance:** 4-hour performance rose from 62.9% in March 2024 to 65.5% by March 2025
- **National recognition:** The Trust moved from the 2nd to the 1st quartile nationally for Type 1 A&E attendances, ranking 23rd out of 121 acute and integrated providers
- **Ambulance handover success:** Focused work on ambulance handovers led to a sustained 2.6% reduction in delays over 60 minutes compared to last year



Number of 4-hour breaches in UECC	
2023/24	2024/25
39,426	37,432



The number of 4-hour breaches has reduced by 1,994 following embedding of the 4-hour access standard



Number of Ambulance Handovers - Over 60 minutes (%)	
2023/24	2024/25
7.1%	4.5%







Despite the increase in attendances our Ambulance Handovers >60 minutes reduced by 2.6%

Operational summary

18-week Referral to Treatment (RTT) waiting times

We have delivered significant progress in improving access to elective care over the past year:

-  **Elimination of 65-week waits:** A major milestone that demonstrates our commitment to timely care for patients
-  **Reduction in overall waiting list:** From a peak of approximately 33,000 patients in August 2024 to around 31,000 by March 2025 – a 4.2% reduction despite sustained high demand
-  **Improved RTT performance:** Delivered a 4.9% improvement, placing the Trust 48th out of 154 providers nationally and in the top quartile for RTT performance
-  **Significant reduction in long waits:** Patients waiting over 52 weeks reduced from a peak of 902 in January 2025 to 790 by March; continuing on a downward trajectory

Our focus on operational grip, elective recovery initiatives, and partnership working has resulted in better access, shorter waits, and improved outcomes for patients

Operational summary

Cancer and diagnostic performance

Our teams have delivered an exceptional year of progress in cancer and diagnostic services, ensuring patients are seen and treated faster than ever before.

✓ Cancer waiting times – exceeding national expectations

We have continued on a positive trajectory, consistently outperforming national standards:

- **62-day treatment standard:** 77.9% of patients treated within target, well above the national goal of 70%
- **Faster Diagnosis Standard:** Achieved 80.9% by March 2025, surpassing the target of 77%

This means more patients are receiving quicker diagnoses and treatment, giving them the best possible chance of positive outcomes.

✓ Diagnostics – consistently excellent

- The Trust delivered the DMO1 standard every month, ensuring patients received timely access to diagnostic tests
- Our performance has positioned us as one of the top-performing organisations nationally, reflecting the dedication of our diagnostic teams

Our sustained improvements in cancer and diagnostic services are reducing anxiety for patients, speeding up their care, and improving outcomes, a testament to the hard work and collaboration across clinical, operational, and support teams.

Operational summary

Community performance

Our community teams have had a remarkable year, responding to growing demand while continuing to deliver high-quality care closer to home.

✔ Increased activity across services

We have supported more adults and children than ever before, ensuring timely, accessible care within the community.

✔ Transfer of Care Hub – fully embedded and expanded

The Hub has matured into a key part of patient flow, integrating discharge planning across partners. This has helped patients return home safely and sooner, improving experience and reducing unnecessary delays.

✔ Virtual Ward – expanded role

Played a critical role in supporting early discharge and admission avoidance and enabled patients to receive the right care at home with hospital-level oversight, improving outcomes and patient satisfaction.

✔ Urgent Community Response – exceeding expectations

Maintained the 2-hour response standard at 74%, well above the national average. This rapid response is helping to prevent hospital admissions and provide reassurance to patients and families.

These achievements demonstrate the power of integrated care, improving patient flow, reducing pressure on hospital services, and delivering care where patients want it most: at home and in their community.

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting

Health Select Committee – 2 October 2025

Report Title

Rotherham Safeguarding Adults Strategic Plan 2025 - 2028

Is this a Key Decision and has it been included on the Forward Plan?

No

Strategic Director Approving Submission of the Report

Ian Spicer, Strategic Director of Adult Care, Housing and Public Health

Report Author(s)

Jackie Scantlebury Rotherham Safeguarding Adults Board Manager
01709 254863 or Jackie.scantlebury@rotherham.gov.uk

Ward(s) Affected

Borough-Wide

Report Summary

The Care Act 2014 states that all Safeguarding Adult Boards (SAB) must produce a Strategic Plan outlining how they will achieve their objective of helping and protecting adults at risk of abuse or neglect, and how member organisations will contribute to this..

The 2025 – 2028 Rotherham Safeguarding Adults Board Strategic Plan has been developed through consultation with all members of the Board, including Rotherham Healthwatch and local voluntary organisations.

Recommendations

That the Health Select Committee:

1. Note the development of the 2025 – 2028 Rotherham Safeguarding Adults Board Strategic Plan.
2. Accept the refreshed Strategic Objectives for 2025 – 2028.

List of Appendices Included

Appendix 1 The Rotherham Safeguarding Adults Strategic Plan 2025-28

Background Papers

None

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None

Council Approval Required

No

Exempt from the Press and Public

No

Rotherham Safeguarding Adults Strategic Plan 2025 - 2028

1. Background

1.1 The primary objective of the Rotherham Safeguarding Adults Board (RSAB) is to ensure that local safeguarding arrangements and partnerships act to help and protect adults at risk or experiencing neglect and/or abuse. The RSAB is a multi-agency strategic partnership made up of senior lead officers and nominated safeguarding leads from within adult social services, criminal justice, health, housing, community safety, and voluntary organisations.

1.2 The RSAB has an independent chair who is accountable for the effective delivery of the Board. The Care Act 2014 also specifies that there are three statutory core partners:

1. Local Authority.
2. Integrated Commissioning Board
3. Police

The RSAB is a multi-agency, strategic partnership made up of the three core members alongside:

- Rotherham NHS Foundation Trust
- RDaSH
- South Yorkshire Fire and Rescue
- Probation Service
- Voluntary and Community Sector
- Cabinet member for Adult Care
- Other Council service representatives across housing, community safety and criminal justice
- Children and Young People's Partnership

1.3 The Care Act 2014 requires all Safeguarding Adult Boards (SABs) to produce a strategic plan. The strategic plan is a statement of a SAB's vision, objectives, and agreed-upon strategic priorities for the next three years.

The Strategic Plan informs the public about the SAB's plans and commitment to keeping adults safe.

2. Key Issues

2.1 The Rotherham Safeguarding Adults Board Strategic Plan 2025 -2028 was developed in consultation with all Board members, including the Cabinet Member for Adult Social Care. A development day was held in January 2025 to bring partners together to agree the safeguarding priorities for the next three years. The development session included

workshops to understand what the safeguarding partnership felt were the areas for development, and where, by working together, we could improve services for the people of Rotherham.

The partnership agreed to five new strategic priorities;

Strategic Priority 1

Communication, Engagement and Voice

Improving safeguarding awareness across all citizens, communities, and partner organisations.

- We will work to ensure the citizens of Rotherham are heard by the safeguarding partnership.
- We will work with communities across Rotherham to promote the work of the Board and raise awareness of safeguarding issues.
- We will work to ensure that the voices of seldom-heard people are heard by the Board.

Strategic Priority 2

Prevention and Early Intervention

Developing tools to support practice that promotes open cultures and reduces the risk of abuse and neglect.

- We will continue to work closely with the Rotherham Safeguarding Children's Partnership to build on and develop support for young people in transition.
- We will continue to work with the Safer Rotherham Partnership, partners and communities to protect vulnerable adults including cuckooing, modern day slavery, hate and mate crime and repeat victims of crime to improve reporting and strengthen joint working to tackle crime.
- We will embed a robust Vulnerable Adults Pathway to support people who may be at risk of harm and abuse who do not meet the safeguarding thresholds, but have complex needs.
- We will further strengthen our safeguarding practices relating to neglect, self-neglect and hoarding.

Strategic Priority 3

Leadership and Partnership

To promote effective leadership, partnership working and governance for safeguarding adults, holding partners and agencies to account.

- We will explore the benefits of an Adult Multi Agency Safeguarding Hub.
- We will continue to develop the SAB website to provide timely and accurate information and guidance from across the Partnership for the public and professionals.
- The Board and its partners will continue to work together across the Adult, Children's and Safer Rotherham Partnership Boards.
- Adopting a Think Family approach we will work together across the partnership to fully embed a Think Family approach to safeguarding.

Strategic Priority 4Making Safeguarding Personal

To make sure that safeguarding practice places adults at the centre, and supports them in making their own decisions and outcomes.

- We will review and refresh Making Safeguarding Personal across the safeguarding partnership.
- All work will be done with the “so what?” question in mind. What is the difference we are making.
- We will strengthen our approach to the application of the Mental Capacity Act and use of Advocacy in safeguarding practices.

Strategic Priority 5Learning and Development

To identify and share lessons from reviews and audits to drive practice development and learning.

- Deliver training to staff across the partnership to make sure safeguarding is person-centred and outcome focused.
- Undertake safeguarding adults reviews (SARs) to identify learning, improve practice and prevent similar mistakes from happening again.
- We will develop a SAB multi-agency audit process.
- We will use the professional website page to share the outcomes from learning reviews.

2.2 The Safeguarding Adults Board has four subgroups that sit under the Board and the Executive Group. Membership of the sub-groups includes representatives from across the partnership and each of the groups has a work plan that supports delivery of the strategic plan.

- Safeguarding Adults Review Subgroup
- Policy and Practice subgroup
- Performance and quality Subgroup
- Workforce Development Subgroup

A new subgroup will be developed to bring the customer voice and experience to the Board.

- Voice Subgroup

A business plan will track the progress made on each of the priorities, and the SAB Executive will monitor all actions quarterly.

Safeguarding Adults Review Subgroup ➡	Rotherham Safeguarding Executive Group ➡	Rotherham Safeguarding Adults Board
Policy and Practice Subgroup ➡		
Performance and Quality Subgroup ➡		
Workforce Development Subgroup ➡		
Voice Subgroup ➡		

3. Options considered and recommended proposal

- 3.1 Health Select Commission note the Rotherham Safeguarding Adults Strategic Plan 2025 – 2028

4. Consultation on proposal

- 4.1 The report was presented and signed off by the Rotherham Safeguarding Adults Board on 16 July 2025.

5. Timetable and Accountability for Implementing this Decision

- 5.1 The Safeguarding Adults Board Strategic Plan will be available electronically via the Rotherham Safeguarding Adults Board website, <https://www.rsab.org.uk> from the 1 December 2025.

6. Financial and Procurement Advice and Implications

- 6.1 There are no direct financial implications.

7. Legal Advice and Implications

- 7.1 S43 of the Care Act 2014 sets out the statutory duty of the Council to establish a Safeguarding Adults Board for the borough of Rotherham.

A Safeguarding Adults Board has the objective to help and protect adults in its area who have care and support needs and who are at risk of neglect and/or abuse and unable to protect themselves. A Safeguarding Adults Board may undertake any lawful activity which is necessary and desirable to achieve its objective.

The Care Act 2014 requires all local authorities set up a Safeguarding Adults Board to co-ordinate local work to safeguard adults who need care and support. The Rotherham Safeguarding Adults Board (RSAB) works to protect adults with care and support needs from abuse and neglect. The RSAB must:

- Produce an annual report on the effectiveness of adult safeguarding within their area.
- Produce a strategic plan that sets out the aims of the board.
- Commission Safeguarding Adults Reviews (SAR's) when needed.

The Council has the lead in co-ordinating responsibility for safeguarding, this includes strategic responsibility and establishing multi-agency arrangements to ensure the effectiveness of what the Rotherham Safeguarding Adults Board members do.

8. Human Resources Advice and Implications

- 8.1 There are no direct HR implications.

9. Implications for Children and Young People and Vulnerable Adults

- 9.1 The Rotherham Safeguarding Adults Board is a partnership board and has representation from Children's Services. The Chair of the Children's Partnership was involved with the development of the new Strategic Plan, and the Adults and Children's Partnership will work jointly to deliver cross-cutting themes that are identified.

The strategic plan has identified areas that will benefit from joint partnership working to ensure that safeguarding adults in Rotherham is always improving and developing ways to ensure services are person-centred.

10. Equalities and Human Rights Advice and Implications

- 10.1 This report supports the Council to comply with legal obligations encompassed in the:

- Human Rights Act (1998), to treat everyone equally with fairness dignity and respect with a focus on those who are disadvantaged as a result of disability and
- Equality Act (2010) to legally protect people from discrimination in the wider society.

11. Implications for CO₂ Emissions and Climate Change

- 11.1 The Rotherham Safeguarding Adults Board Strategic Plan 2025-28 will not impact the Council's or area-wide emissions, or otherwise effect progress towards these goals.
- 11.2 The Rotherham Safeguarding Adults Board Strategic Plan 2025-28 does not contain recommendations/proposals that will increase emissions or reduce emissions.

12. Implications for Partners

- 12.1 The Rotherham Safeguarding Adults Strategic Plan 2025-28 has been produced with all partners of the board contributing and agreeing on the final content.
- 12.2 Partners of the board will be asked to share within their own organisations.

13. Risks and Mitigation

- 13.1 The Rotherham Safeguarding Adults Board Strategic Plan 2025-28 has a requirement to be published to ensure the Rotherham Safeguarding Adults Board meets its Statutory Duty under the Care Act 2014

Accountable Officer(s)

Ian Spicer
Strategic Director of Adults, Housing & Public Health
01709 255992, ian.spicer@rotherham.gov.uk

Approvals obtained on behalf of:

	Name	Date
Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Named officer	Click here to enter a date.
Assistant Director of Legal Services (Monitoring Officer)	Named officer	Click here to enter a date.
The Strategic Director with responsibility for this report	Ian Spicer, Strategic Director of Adult Care, Housing and Public Health	18/09/25
Consultation undertaken with the relevant Cabinet Member	Cabinet Member for Adult Social Care and Health – Councillor Baker- Rogers	22/09/25

Jackie Scantlebury Rotherham Safeguarding Adults Board Manager
01709 254863 or Jackie.scantlebury@rotherham.gov.uk
This report is published on the Council's website.

ROTHERHAM SAFEGUARDING ADULTS BOARD STRATEGIC PLAN 2025-28

OUR VISION

Our vision is to make Rotherham a place where adults feel safe, secure, and free from harm and abuse.

Our mission is to promote partnership working and to co-ordinate the effective delivery of safeguarding arrangements across the Borough.

WHO WE ARE

The Rotherham Safeguarding Adults Board (RSAB) is a multi-agency partnership with statutory functions under the Care Act 2014. RSAB's main focus is to ensure that safeguarding arrangements in Rotherham work effectively so that adults at risk can live their lives free from abuse or neglect.

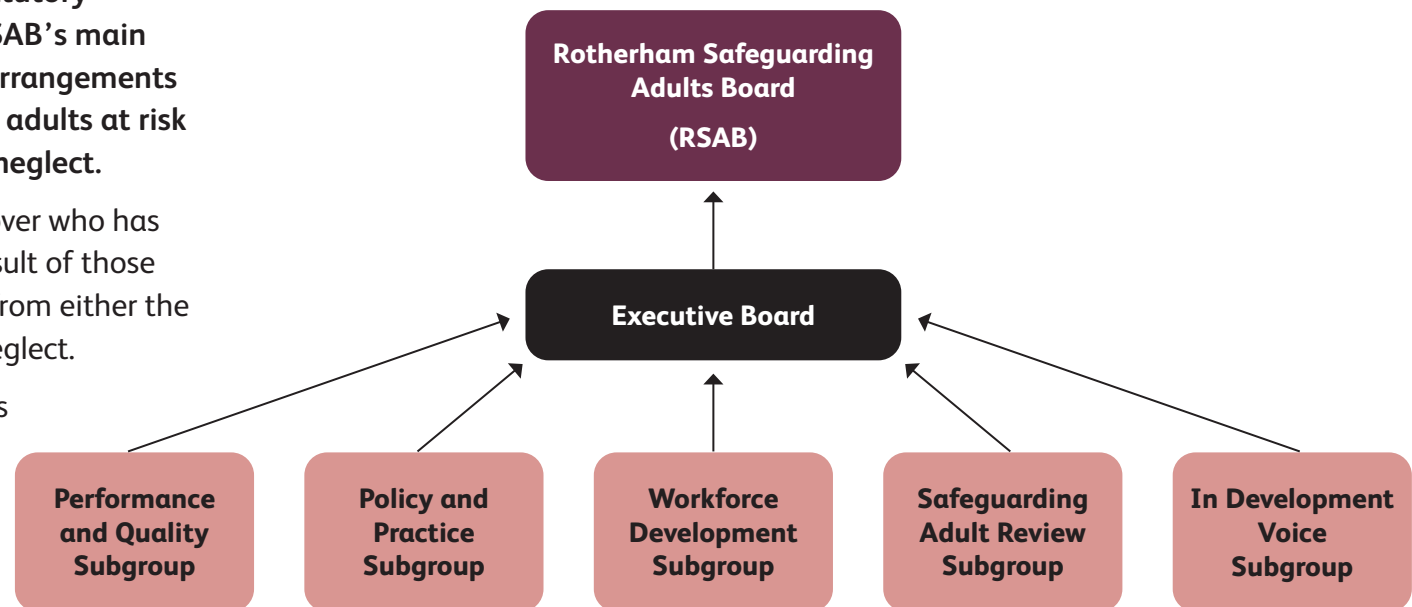
An adult at risk is a person aged 18 or over who has needs for care and support and, as a result of those needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Unpaid carers such as partners, relatives or friends can also get help and support if they are being abused.

In this plan, we will call an adult at risk the 'Adult'.

THE STRUCTURE OF THE SAFEGUARDING ADULTS BOARD

How we will work



OUR STRATEGIC STATEMENT

What we plan to do

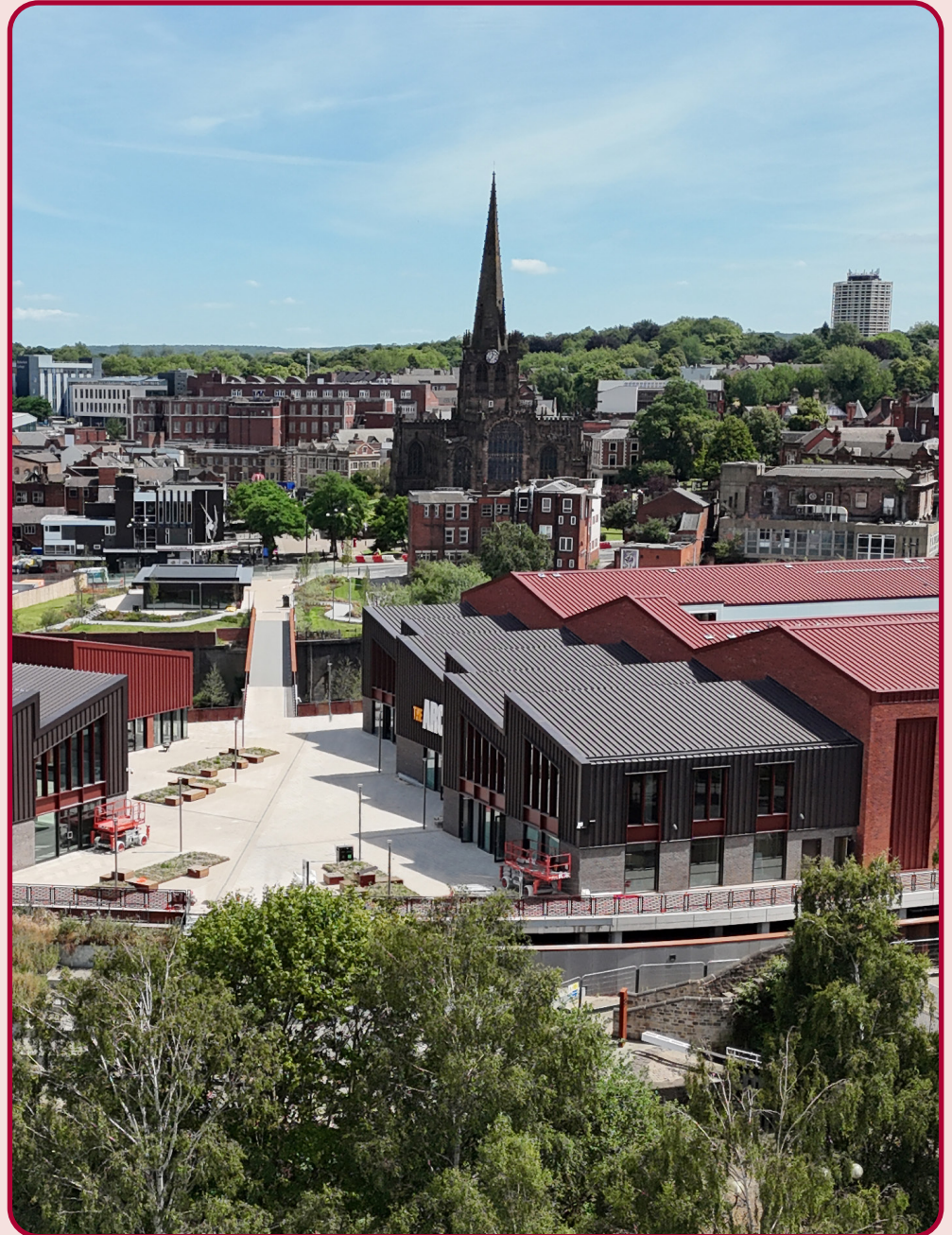
We will work together with partner organisations and people in our communities so that adults can live their best lives with their wellbeing and rights being supported, safe from abuse and neglect.

Our work will follow the six safeguarding principles, which are: **Empowerment; Protection; Proportionality; Prevention; Partnership and Accountability.**

The Rotherham Safeguarding Adults Board has identified five strategic objectives that will ensure we can strengthen the current safeguarding offer for Rotherham residents.

The objectives are;

1. **Communication, Engagement and Voice**
2. **Prevention and Early Intervention**
3. **Leadership and Partnership**
4. **Making Safeguarding Personal**
5. **Learning and Development**





Strategic Objective 1:

Communication,
Engagement,
and Voice



Improving safeguarding awareness across all residents, communities, and partner organisations.

- We will work to ensure the residents of Rotherham are heard by the safeguarding partnership.
 - We will work closely with advocacy organisations/providers to ensure the voice of those they work with are heard by the RSAB.
 - We will use videos featuring experts by experience to tell the safeguarding story.
- We will work with communities across Rotherham to promote the work of the RSAB and raise awareness of safeguarding issues.
 - The annual Safeguarding Awareness Week will provide opportunities to interact with the public and the workforce of Rotherham.
- We will develop easy-read safeguarding guides, co-produced with the Rotherham Adults Social Care Always Listening (RASCALS) Co-production Board.
- We will work to ensure that the voices of seldom heard people are heard by the RSAB. We will establish a customer voice subgroup including RASCALS, Healthwatch and Advocacy to support this aim.
 - People from minoritised groups.
 - People at risk of homelessness.
 - People with drug and alcohol issues.



Strategic Objective 2:

Prevention and Early Intervention



Developing tools to support practice that promotes open cultures and reduces the risk of abuse and neglect.

- We will continue to work closely with the Rotherham Safeguarding Children's Partnership to build on and develop support for young people in transition.
- There will be a focus on Transitional Safeguarding, working with the Principal Social Workers to promote strong working arrangements.
- We will continue to work with the Safer Rotherham Partnership, partners and communities to protect vulnerable adults from issues that include cuckooing, modern-day slavery, hate and mate crime and repeat victims of crime to improve reporting and strengthen joint working to tackle crime.
- We will form a task and finish group to look at protecting vulnerable adults in Rotherham.
- We will use our findings to develop an awareness campaign to inform the public.
- We will embed a robust Vulnerable Adults Pathway to support people who may be at risk of harm and abuse who do not meet the safeguarding thresholds, but who have complex needs.
- We will embed a vulnerable adults pathway based around putting people at the heart of the process.
- We will further embed the Community Multi Agency Risk Assessment Conference (CMARAC), Vulnerable Adults Risk Management Meeting (VARMM) and Vulnerable Adults Panel (VAP).
- We will enhance our partnership approach to supporting complex vulnerable people
- We will develop a suite of information, referral criteria and access routes to support CMARAC, VARMM and VAP.
- We will further strengthen our safeguarding practices relating to neglect, self-neglect and hoarding.
- We will ensure the Self-neglect and hoarding policy is embedded in safeguarding practice
- We will develop a self-neglect pathway that is easy to navigate
- We will work with people who are at risk of neglect, self-neglect and hoarding to prevent significant harm from occurring
- We will ensure learning from Safeguarding Adult Reviews and reviews is shared across the partnership to strengthen practice
- We will develop a partnership approach to supporting neglect



Strategic Objective 3: Leadership and Partnership



Promote effective leadership, partnership working and governance for safeguarding adults, which hold partners and agencies to account.

- We will explore the benefits of an Adult Multi-Agency Safeguarding Hub.
 - We will work to look at co-location and develop protocols for effective referrals.
 - Further strengthen our adult social care front door to include agencies, which will strengthen our multi-agency response to safeguarding.
- We will continue to develop the RSAB website to provide timely and accurate information and guidance from across the Partnership for the public and professionals.
 - We will work with all partners to ensure the RSAB website is providing quality and useful information.
 - We will update and maintain the RSAB website.
- The RSAB and its partners will continue to work together across the Adult, Children's and Safer Rotherham Partnership Boards.
 - We will explore the benefit of a Learning Hub to share good practice and learning relating to Safeguarding Adult Reviews, Domestic Abuse Related Death Reviews and Children's Serious Case Reviews.
 - We will arrange an annual joint safeguarding conference to share work and learning.
 - We will continue to hold a Safeguarding Partners Self-Assessment every two years.
- Adopting a Think Family approach, we will work together across the partnership to fully embed a "Think Family" approach to safeguarding.



Strategic Objective 4:

Making Safeguarding Personal



Ensure that safeguarding practice places the adult at the centre of everything we do and supports them in making their own decisions and outcomes.

- We will review and refresh Making Safeguarding Personal across the safeguarding partnership.
 - We will undertake a Making Safeguarding Personal audit using the Local Government Association toolkit.
- All work will be done with the “so what?” question in mind to understand the difference we are making.
 - Safeguarding will ensure that achievable and proportionate person-centred outcomes are agreed with the person.

- We will strengthen our approach to the application of the Mental Capacity Act and use of Advocacy in safeguarding practices.
 - We will seek assurance through auditing of practice that the legal requirements for completing mental capacity assessments are adhered to in safeguarding.
 - We will seek assurance through auditing practice that advocacy is being used to support adults who require support and captures the voice of the person within their safeguarding experiences.
 - We will develop a suite of information around Deprivation of Liberty information that will inform the RSAB.



Strategic Objective 5:

Learning and Development



Identify and share learning to drive practice development and improvement.

- Deliver training to staff across the partnership to make sure safeguarding is person-centred and outcome-focused.
 - Commission a 3-year training package to ensure the workforce is appropriately skilled.
 - We will ensure training evaluation is robust and consider using mystery shoppers to provide feedback.
- Undertake Safeguarding Adults Reviews (SARs) to identify learning, improve practice and prevent similar mistakes from happening again.
 - Embed the Multi-agency Learning Review process.
 - Use thematic reviews to gain learning from Safeguarding.
 - Embed learning from single-agency reviews.
- We will develop a RSAB multi-agency audit process.
 - We will agree an audit tool and schedule a diary of audits each year.
 - We will develop a methodology for partner agencies reporting into the RSAB on audits relevant to safeguarding.
- We will use the professional website page to share the outcomes from learning reviews.
 - We will develop easy-read guides, 7-minute briefings and videos to share learning to ensure it influences and shapes practice.

HOW ARE WE GOING TO DO THIS?

We will continue to work with our partners to make sure that by 2028 these priorities are achieved. We will develop an action plan that will be monitored by the Safeguarding Adults Board Executive Group and reported to the RSAB for assurance.

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HEALTH SELECT COMMITTEE

02 OCTOBER 2025

Rotherham Safeguarding Adults Board

Strategic Plan 2025 – 2028

Moira Wilson RSAB Independent Chair

STRATEGIC PLAN 2025 -2028 REFRESH

- January 2025 – Development Session with all Safeguarding Partners
- March 2025 – First Draft plan – 5 new Strategic Objectives to Rotherham Safeguarding Adults Board
- June 2025 – Revised Draft Plan – to Rotherham Safeguarding Adults Board
- June 2025 - All Board Members agree on the new Strategic Objectives
- September 2025 – Refreshed report presented to Adult Social Care Senior Leadership Team

RSAB NEW PRIORITIES

Strategic Objective 1 – Communication, Engagement, and Voice

Improving safeguarding awareness across all residents, communities, and partner organisations.

- We will work to ensure the residents of Rotherham are heard by the safeguarding partnership.
- We will work with communities across Rotherham to promote the work of the RSAB and raise awareness of safeguarding issues.
- We will work to ensure that the voices of seldom-heard people are heard by the RSAB. We will establish a Customer Voice subgroup to include RASCALs, Healthwatch, and Advocacy to support this aim.

RSAB NEW PRIORITIES

Strategic Objective 2 – Prevention and Early Intervention

Developing tools to support practice that promotes open cultures and reduces the risk of abuse and neglect.

- We will continue to work closely with the Rotherham Partnership to build on and develop support for young people in transition.
- We will continue to work with the Safer Rotherham Partnership, partners, and communities to protect vulnerable adults from issues that include cuckooing, modern-day slavery, hate and mate crime, and repeat victims of crime to improve reporting and strengthen joint working to tackle crime.
- We will embed a robust Vulnerable Adults Pathway to support people who may be at risk of harm and abuse who do not meet the safeguarding threshold, but who have complex needs.
- We will further strengthen our safeguarding practices relating to neglect, self-neglect and hoarding.

RSAB NEW PRIORITIES

Strategic Objective 3 Leadership and Partnership

Promote effective leadership, partnership working and governance for safeguarding adults, which hold partners and agencies to account.

- We will explore the benefits of an Adult Multi-Agency Safeguarding Hub.
- We will continue to develop the RSAB website to promote timely and accurate information and guidance from across the Partnership for the public and professionals
- The RSAB and its partners will continue to work together across the Adult, Children's and Safer Rotherham Partnership Boards.

RSAB NEW PRIORITIES

Strategic Objective 4 – Making Safeguarding Personal

Ensure that safeguarding practice places the adult at the centre of everything we do and supports them in making their own decisions and outcomes

- We will review and refresh Making Safeguarding Personal across the safeguarding partnership.
- All work will be done with the “so what?” question in mind to understand the difference we are making.
- We will strengthen our approach to the application of the Mental Capacity Act and use of Advocacy in safeguarding practices

RSAB NEW PRIORITIES

Strategic Objective 5 – Learning and Development

Identify and share learning to drive practice development and improvement

- Deliver training to staff across the partnership to make sure safeguarding is person-centred and outcome-focused.
- Undertake Safeguarding Adult Reviews (SARs) to identify learning, improve practice and prevent similar mistakes from happening again.
- We will develop a RSAB multi-agency audit process.
- We will use the professional website page to share the outcomes from learning reviews.

RECOMMENDATION

The Rotherham Safeguarding Adults Board requests that the Health Select Committee:

1. Note the development of the 2025 – 2028 Rotherham Safeguarding Adults Board Strategic Plan.
2. Accept the refreshed Strategic Objectives for 2025 – 2028.

Health Select Commission – Work Programme 2025-2026**Chair: Cllr Keenan****Vice-Chair: Cllr Yasseen****Governance Advisor: Kerry Grinsill-Clinton****Link Officer: Emily Parry-Harries**

The following principles were endorsed by OSMB at its meeting of 5 July 2023 as criteria to long/short list each of the commission's respective priorities:

Establish as a starting point:

- What are the key issues?
- What is the desired outcome?

Agree principles for longlisting:

- Can scrutiny add value or influence?
- Is this being looked at elsewhere?
- Is this a priority for the council or community?

Developing a consistent shortlisting criteria e.g.

- T: Time: is it the tight time, enough resources?
- O: Others: is this duplicating the work of another body?
- P: Performance: can scrutiny make a difference
- I: Interest: what is the interest to the public?
- C: Contribution to the corporate plan

Meeting Date	Responsible Officer	Agenda Item
26-Jun-25	Jayne Metcalfe, Cllr Baker-Rogers Simon Moss, Gilly Brenner and Cllr Williams Governance Advisor	Adult Contact Team Referral Pathway (Adult Social Care) Health Hub Nominate Representative to Health, Safety and Welfare Panel
31-Jul-25	Dania Pritchard, Cllr Baker-Rogers Kym Gleeson Cllr Clarke	ADASS Peer Review Healthwatch Annual Report Yorkshire Cancer Research White Rose Report Update
12-Sep-25	Governance Advisor	Access to Contraception Evidence Gathering Session
16-Sep-25	Governance Advisor, Cllr Keenan	Menopause Workshop
23-Sep-25	Governance Advisor	Access to Contraception Evidence Gathering Session
02-Oct-25	Gilly Brenner, Cllr Baker-Rogers Bob Kirton, Helen Dobson Jackie Scantlebury, Cllr Baker-Rogers Dania Pritchard, Cllr Baker-Rogers Alex Hawley, Cllr Baker-Rogers	Physical Activity for Health (Sport England) TRFT Annual Report Rotherham Safeguarding Adults Board Strategic Plan 2025–2028 How Did We Do - Adult Social Care Local Account (For Information Only) Rotherham Health and Wellbeing Strategy 2025-2030 (For Information Only)
08-Oct-25	Governance Advisor	Access to Contraception Evidence Gathering Session
20-Nov-25	Holly Smith, Cllr Baker-Rogers Steph Watt, Emily Parry-Harries Jackie Scantlebury, Moira Wilson, Cllr Baker-Rogers Governance Advisor, Cllr Keenan Cllr Baker-Rogers	Mental Health Strategy - Pre-Decision Scrutiny Place Partners Winter Planning Rotherham Safeguarding Adults Board Annual Report Access To Contraception Review Outcome and Recommendations (TBC) Health and Wellbeing Board Annual Report (For Information Only)
28-Nov-25	Jacqueline Clark, Katy Lewis and Joanne Bell	Unpaid Carer's Strategy Workshop
22-Jan-26	Jackie Scantlebury, Moira Wilson, Cllr Baker-Rogers Emily Parry-Harries	Rotherham Safeguarding Adults Board Annual Report Director of Public Health's Annual Report (For Information Only)
26-Mar-26	Liz Howarth, Julia Jessop and Mark Tuckett Bob Kirton	Cancer Alliance Lung Clinic Update SDEC (TRFT) Implementation Update

14-May-26	TBC	NHS 10 Year Plan - Local Implications (To be confirmed)
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Substantive Items for Scheduling

TBC		Armed Forces Covenant - GPs commitments

Reviews for Scheduling

2025/26 municipal year		Access to NHS Dentistry - Review (to follow conclusion of Access to Contraception)

Items to be Considered by Other Means (e.g. off-agenda briefing, workshop etc)

Items for Future Consideration

TBC		Learning Disabilities Update (Castle View)
TBC		Primary Care Network (PCN) Development
TBC		Immunisation Programme Commissioning Changes
Sep-26		Consultation/Co-production enagement with HSC re All Age Autism Strategy Refresh
Early-Mid 2027		All Age Autism Strategy Pre-Decision Scrutiny
TBC		NHS Neighbourhood Health Services (Rotherham approach)
TBC		ERCP Reintroduction at TRFT

**South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and
Scrutiny Committee**

Meeting held 23 July 2025

PRESENT: Councillors Councillor Mick Stowe (Barnsley), Eve Keenan, Councillor Dave Knight (Doncaster), Mary Lea (Substitute Member) and Wright (Substitute Member)

1. WELCOME AND HOUSEKEEPING ARRANGEMENTS

- 1.1 Due to the chair's apologies, nominations for a chair were requested. Councillor Mick Stowe nominated himself, this was seconded by Councillor Mary Lea. No further nominations were made. There were 5 votes in favour of appointing Councillor Mick Stowe, 0 against and 0 abstentions. Councillor Mick Stowe was appointed Chair of the Committee.

2. APOLOGIES FOR ABSENCE

- 2.1 Apologies for absence had been received from Councillors Ruth Milsom (Sheffield City Council) and Mike Robertson (Nottinghamshire County Council). Councillors Mary Lea (Sheffield City Council) and Simon Wright (Nottinghamshire County Council) attended as substitutes.

3. EXCLUSION OF PUBLIC AND PRESS

- 3.1 There were no items of business identified where the public and press may be excluded from the meeting.

4. DECLARATIONS OF INTEREST

- 4.1 There were no declarations of interest.

5. MINUTES OF PREVIOUS MEETING

- 5.1 The minutes of the previous meeting of the Committee held on 10th October 2024 were agreed as a correct record.

6. PUBLIC QUESTIONS AND PETITIONS

- 6.1 No public questions or petitions had been submitted prior to the meeting.
- 6.2 Three people in attendance at the meeting sought to ask a public question. Notice of these requests were received shortly before the start of the meeting, and the Chair of the Committee, Councillor Mick Stowe, agreed to use his discretion for

the questions to be asked.

- 6.3 Doug Wright asked whether the public questions agenda item could be deferred until after the other agenda items had been discussed and why going forward the future committee meetings would only be held in Sheffield.
- 6.4 Councillor Mick Stowe responded that item six was the appropriate time for public questions to be asked and that any questions regarding items on the agenda should be submitted prior to the meeting taking place so the appropriate officers can provide responses. Councillor Mick Stowe also confirmed that a response in writing would be send to Doug Wright in regard to why future meetings were being held solely in Sheffield.
- 6.5 Nora Everitt asked for comments regarding public involvement in changes and proposals to change commissioning arrangements that might affect services.
- 6.6 Councillor Mick Stowe explained that the representative from the Integrated Care Board would respond to these concerns whilst discussing item 7.
- 6.7 Nick Trott's, gastroenterology dietitian specialist, question concerned the Engagement Plans for potential changes to Gluten Free prescribing Guidelines, therefore it would be heard before that item.

7. ICB ORGANISATIONAL CHANGE UPDATE

- 7.1 The report which provided an update on proposed changes to the Integrated Care Board was presented by Gavin Boyle, ICB CEO.
- 7.2 The following information was given in response to questions and comments from Members:
 - Due to the reduction of staff, the ICB will no longer be able to provide oversight of partner organisations. There are ongoing conversations with NHS England as to what they will take on.
 - Internal arrangements will be most seriously affected. The ICB will continue to maintain balance from a commissioning perspective but will not be able to provide oversight nor system management.
 - There is ongoing work for colleagues working in ICB to transition to NHS England to minimise redundancies. Difficult environment but other organisations have also been asked to reduce running costs. Another piece of work needed to let employers more generally know that there will be significant numbers of highly trained people entering the labour market.
 - The delay in consultation will cause difficulties to meet the original timescale of completing the process by the end of the calendar year. The new timescales are currently unknown, discussions are happening between the department of health, the treasury and NHS England. The intelligence is that an agreement will be reached within the next two or three weeks, allowing the consultation to start in September.
 - The closure of Healthwatch was unexpected and the plans involved working even more closely with Healthwatch. More now needs to be put in,

regarding engagement and public involvement given that Healthwatch will be disbanded.

- In the ICBs new form they will be able to commission integrated services. It will also incentivise partnership working. The ICB has faced challenges when putting in bids against the national development programme. The ten-year plan references integrated health organisations, and they would like their place partnerships to become those organisations.
- Currently, a member of the ICB is the place lead for Doncaster and Bassetlaw which includes Bassetlaw hospital. Commissioning for Bassetlaw would be the responsibility of the Nottinghamshire ICB.
- The ICB has done gap analysis. There are things not as strong as would like in the ten-year health plan such as health inequality which the ICB are thinking about.
- The most negative outcome of the exercise is the impact on the people who work the ICB. Managing the transition is a different role and that transition will need careful management.

7.3 **RESOLVED** That the Committee: -

1. Thanks Gavin Boyle for attending and presenting the report.
2. Notes the update provided in the report.

8. **ENGAGEMENT PLANS FOR POTENTIAL CHANGES TO GLUTEN FREE PRESCRIBING GUIDELINES**

8.1 The Chair invited Nick Trott to introduce himself and ask his question.

Nick Trott asked-

1. *Why is option 4 the preferred option as we have been down this before and the rationale and justification is no longer evidence based. Who will be most impacted by this who can't access gluten free foods either financially or geographically. Relying on naturally gluten free food reduces intake of iron and increase bone density loss and increased anaemia. Ultra-processed should not be used as justification for non-prescribing of these foods. This will increase inequality and arguments from Leicester ICB, Isle of Wight ICB and Nottinghamshire ICB where prescriptions have stopped.*

8.2 The report which briefed the Committee on the engagement plans for potential changes to gluten free prescribing guidelines was presented by Dr David Chrichton (ICB Chief Medical Officer), Govinder Bhogal (ICB Programme Director for Medicines Optimisation) and Katy Davison (ICB Deputy Director of Involvement)

8.3 The following information was given in response to questions and comments from Members:

- As time goes on seeing more availability of gluten free products. Whilst big supermarkets have quite a range your local shop might not be as well stocked up. Biggest health inequality is those who don't know that they have it, task to educate and support people before thinking about treatment.

- Gluten is found in many products that isn't obvious. Impossible to avoid gluten completely so education after diagnosis is key element. Focus on educating children to understand that if this is the case what they need to do going forward.
- There is more parity in the pricing of gluten free products, with a wider range and more availability in larger stores. The costs of these products has come down considerably from where it previously was.
- When the ICB was CCG they were looking at those who would be most affected which were, Doncaster and Rotherham. Sheffield had been through a big consultation due to changing their provision. Going forward their needs to be a South Yorkshire wide exercise.
- The ICB works with Coeliac UK as the representative body who can lobby wider than the ICB.
- The changes have the potential to disproportionately affect those on low incomes so work has taken place with food banks as availability of these products at food banks is lower so work is required there.
- In Wales they use a voucher scheme for people being prescribed who can take to place of their choice to get produce that is more readily available and could cost less than a prescription charge. However, if Sheffield used this option they would still be restricted to using the vouchers on bread mixes due to national guidance. York ran a similar scheme, and we can learn from them.
- Young people are the most vulnerable, don't want to see poverty in a family causing young people not to be cared for and is why a blanket no prescribing was not proposed.

8.4 **RESOLVED** That the Committee: -

1. Welcome the ICBs commitment to engage with those impacted and reconsider options
2. Request a further report on the results of the engagement prior to the ICB Governing Body making a final decision.

9. ENGAGEMENT PLANS FOR POTENTIAL CHANGES TO THE IVF POLICY WITH REGARDS COMMISSIONED CYCLES

9.1 The report which briefed the Committee on engagement plans for potential changes to the IVF Policy with regards to commissioned cycles was presented by Lisa Kell (ICB Programme Director for Population Health Commissioning), Katy Davison (ICB Deputy Director of Involvement) and Dr David Chrichton (ICB Chief Medical Officer).

9.2 The following information was given in response to questions and comments from Members:

- The consultation has to involve anyone who is directly affected or who might be affected e.g. any women up to the age of 40. To ensure this doing a broader exercise to get the information out there to give anybody the opportunity to comment. Also do more targeted work with communities who are hesitant to come forward. The Equality Impact Assessment will identify those communities who will be most disproportionately affected health inequalities wise.

- When working with more deprived communities they work with the voluntary sector partners. They have put feelers out as to what groups will be meeting over the next five weeks and beyond to see who they can go out and talk to. 40% of South Yorkshire are deprived.
- Important to have a good mix of communities and individuals across South Yorkshire.
- Legislation says to involve all people affected and their family members so this will also be involved.
- Need to involve those with lived experience as they will understand how traumatic the experience can be. Also parents who have lost children during a natural cycle should be involved as it is another form of trauma.
- When the is brought back to the committee they will be able to share how many individuals this will affect. Baseline figures are 200 with 20%-30% going through a second cycle.

9.3 **RESOLVED** That the Committee: -

1. Welcome the ICB's commitment to extend the proposed engagement periods.
2. Request a further report on the results of the engagement prior to the ICB Governing Body making a final decision.

10. UPDATE ON THE NON-EMERGENCY PATIENT TRANSPORT CHANGES FOLLOWING ROLL-OUT EARLIER THIS YEAR

- 10.1 The report on the update on non-emergency transport changes following roll-out earlier this year was presented by Dr David Chrichton (ICB Chief Medical Officer), Lesley Carver (ICB Urgent and Emergency Care Programme Manager) and Katy Davison (ICB Deputy Director of Involvement).
- 10.2 The board have approved to proceed with the intention to move to a national eligibility criteria for South Yorkshire. This has been in place since the 1st April 2025. West Yorkshire went live on 28th April 2025 and Humber and North Yorkshire went live on 27th May 2025.
- 10.3 The following information was given in response to questions and comments from Members:
 - Those who have mobility problems will still use YAS service in preference as there is a parking issue at the hospital. To get from where front door is and where they park the vehicle.
 - Firefly provide service between Doncaster and Sheffield. The ICB are trying to maximise and utilise Firefly and alternative transport.
 - Healthcare travel cost is a national scheme, some local variation. ICB keen to engage with pre-paid travel pass pilot scheme but it was tied up with financial challenges and they are doing local work independent of that. West Yorkshire are piloting the scheme which is being watched and waiting for the evaluation to come through.
 - Linked into alternative providers for community transport. Being mindful of if there is an increase in community transport how would the provider be able to provide that service with no additional funding. Contract manager having

weekly conversations to keep watch.

- Information regarding how many people have been denied transport under new criteria will be available next week. The information can be provided at a future meeting.
- Sign language and visual aid training should be standard for YAS.
- The impact of introducing the new criteria has not seen an increase in those not attending appointments.
- There is a commitment with YAS to review the new criteria. Want to make sure that the needs of the local population are being captured across the three ICBs.

10.4 **RESOLVED** That the Committee: -

1. Request a further update at a future meeting.

11. WORK PROGRAMME

- 11.1 The report was presented by Emily Standbrook-Shaw (Policy and Improvement Officer, Sheffield City Council).
- 11.2 Emily Standbrook-Shaw advised that they would liaise with Katy Davison and other support officers to establish a timescale for today's agenda items to come back
- 11.3 Emily Standbrook-Shaw confirmed that the actions regarding Thrombectomies and the Mexborough Centre would be chased up.

12. DATE OF NEXT MEETING

- 12.1 It was noted that the next meeting of the Committee will be on a date and time to be confirmed.

HOW DID WE DO?

Adult Social Care Local Account 2024 – 2025

People are safe, healthy and live well



www.rotherham.gov.uk

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FOREWORD

Rotherham Council's Adult Social Care Local Account 2024/25 is how we communicate to our residents and partners about the council's accomplishments in adult social care and outline future priorities for the forthcoming year. It emphasises a "doing with" approach, focusing on enabling individuals to achieve their desired outcomes through a person-centred approach.

I am very pleased to say that in the last year substantial progress has been made towards our vision 'to enable every resident with care and supports needs to live their best lives, with the people they value, close to home and with access to the right support at the right time.' We are passionate about supporting everyone who has care and support needs whatever their personal circumstances and wherever they live in the borough. Over the last 12 months, we have supported more than 5,800 residents to do so. Our achievements include the launch of the new Learning Disabilities and All Age Autism Strategies and the introduction of our co-production board.

For 2025/2026 we have set ambitious new priorities. These include an updated strategy for unpaid carers and the introduction of an online portal that will enable residents to self-triage and self-assess their needs should they wish to. Other exciting initiatives are the investment in new assistive technologies, improving employment opportunities for young people with care and support needs and establishing a new hospital discharge 'Transfer of Care Hub.' These will all be achievements that will help us move closer to achieving our vision for adult social care.

Over the last 12 months, we have made great strides in how we hear and listen to the voices of our residents, using their feedback to shape our offer and hold us to account. We appreciate every experience that is shared with us and want to thank every resident who has done so. Please, continue to share your experience of adult social care with us! Focusing on the voice of our residents is of critical importance. It enables the Council to reflect upon and improve the performance of its services based on lived experience.

As always, over the next year, we will continue to build on our strong partnership working with the voluntary sector, health, police, fire and rescue and different council departments. This will ensure that our high-quality services continue to improve and that residents live their best lives.



Cllr Joanna Baker-Rogers
Cabinet Member for Adult Social
Care and Health



Ian Spicer
Strategic Director of Adult Care,
Housing and Public Health

ADULT SOCIAL CARE

About the Local Account

The Local Account aims to summarise our achievements and celebrate the hard work and dedication from our teams over the last year. The Local Account sets out our priorities for the coming year and highlights where we still need to improve and how we plan to do that.

Adult Social Care

Our ambition is to support our residents to be 'safe, healthy and live well'. To enable this Adult Care contributes to the Council priorities through its focus on supporting residents to live well. This includes priorities to improve mental and physical health, assisting adults to live independently, safe and well with access to quality and affordability of homes for all.



Our vision for Rotherham residents is to:

‘Enable every resident with care and support needs to live their best lives, with the people they value, close to home and with access to the right support at the right time’

To achieve our vision we will ensure that residents have access to:

- The right information, at the right time, to help them make informed choices about their care and support needs.
- Support and services tailored to them, which are focused on the persons strengths, abilities and aspirations.
- Local communities and are enabled to maintain relationships which are the most important to them.
- The right services, at the right time, which enables them to live healthier lives for longer and maximises their independence.

Adult social care has delivered on a range of priorities over the last 12 months and have set a number of key priorities for the coming year to support in achieving our ambition and vision for residents.

ADULT SOCIAL CARE

Our Purpose

Adult social care works with people with care and support needs, their families, friends and unpaid carers to enable them to live independently, safe and well. This includes people who are frail, have disabilities, are neurodiverse or experience mental ill health, provide unpaid care, as well as young people preparing for adulthood.

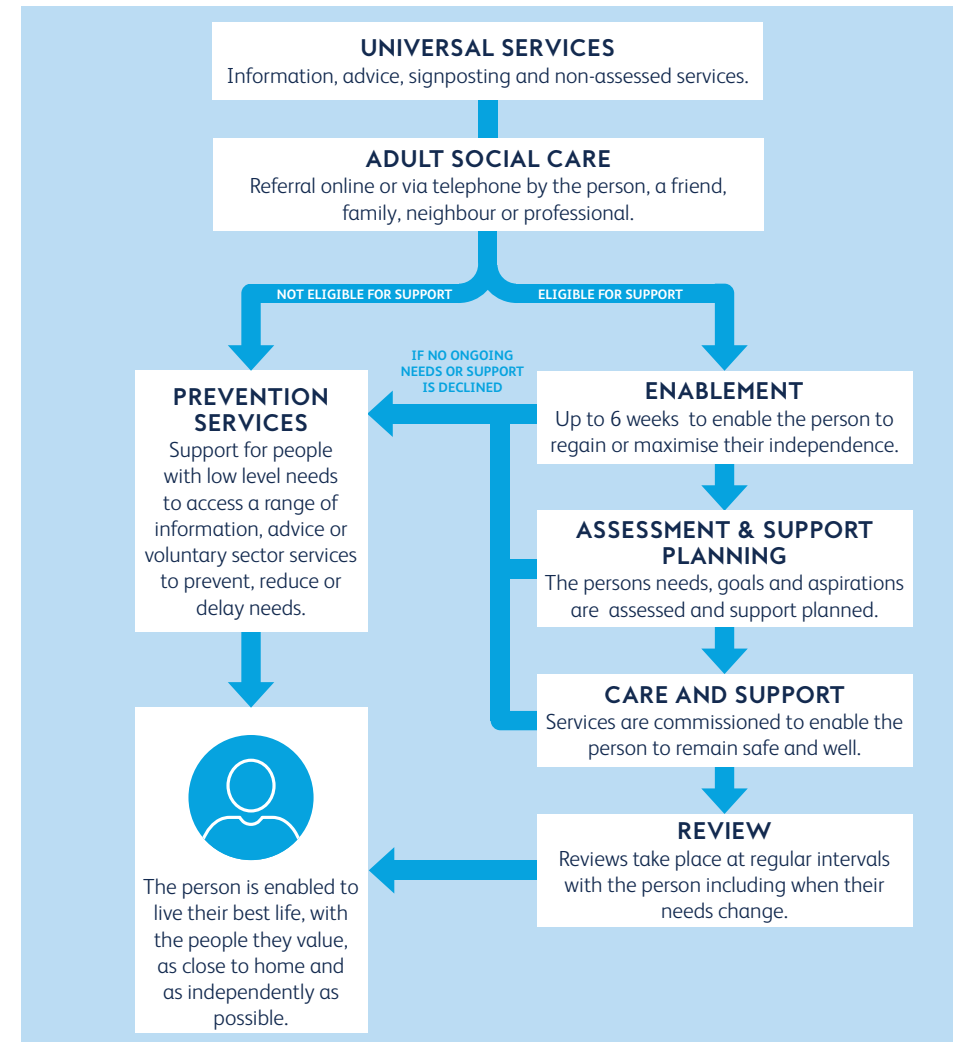
Our approach focuses on 'doing with' and not 'doing to' or 'doing for' people, utilising our resources in the most effective way for people to achieve their personal outcomes. Adopting a person-centred approach acknowledges that fulfilment and independence mean different things to different people, and therefore our interventions need to be proportionate, with a clear understanding of the person, their needs and the outcomes they want to achieve.

Our themes for delivering adult social care are:

- Wellbeing and Independence: enabling people to live their best life.
- Informed Choices: having the right information at the right time.
- Connected to People: support to maintain relationships with people that matter the most to them.
- My Support, My Way: focused on strengths, abilities and cultural needs of the person.

Types of support can include access to preventative services including assistive technology, aids and adaptations, provision of information and advice, targeted support for unpaid carers, short-term intensive support through our enablement services or more long-term support such as home care, access to day opportunities or care provided in care and nursing homes.

Adult Social Care Pathway



SAFEGUARDING ADULTS

Safeguarding is about protecting an adult’s right to live in safety, free from abuse and neglect. The aim of adult safeguarding is to:

- Prevent harm
- Reduce the risk of abuse or neglect for adults with care and support needs
- Stop abuse and neglect wherever possible

The Rotherham Safeguarding Adults Board (RSAB) is a multi-agency partnership which has statutory functions under the Care Act 2014. The focus of the RSAB is to ensure that safeguarding arrangements work effectively so that adults at risk can live their lives free from abuse or neglect. We work together with our partner organisations and people in our communities so that adults can live the best lives they can with their wellbeing and rights being supported, safe from abuse and neglect.

As a Council, we have a Safeguarding Adult Pathway which prevents and protects vulnerable people and ensures we embed ‘Making Safeguarding Personal’ to the person at risk of harm or abuse, this means putting the person at the heart of any safeguarding intervention. Adult social care updated the pathway in April 2025 to further strengthen practice and legal compliance.

Partners offer bespoke services to support vulnerable adults in Rotherham. The ‘Vulnerable Adults Pathway’ is a partnership approach to supporting people with multiple complexities and disadvantages including homelessness, mental illness, drug and alcohol addiction and exploitation and the partners take a person centred and trauma informed approach to everyone. Many of the residents we support do not have eligible needs for care and support, but their health and

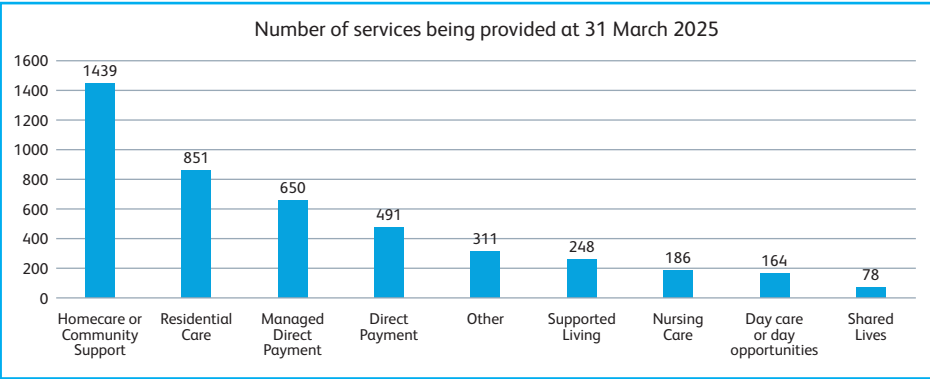
quality of life is severely impacted. The Vulnerable Adults Pathway supports people to regain some control in their life to achieve positive outcomes.

Our work follows the 6 Safeguarding Principles, which are:

Principle	Practice	Making Safeguarding Personal
Empowerment	People are supported and encouraged to make their own decisions and informed consent.	“I am asked what I want as the outcomes from the safeguarding process and this directly inform what happens.”
Prevention	It is better to take action before harm occurs.	“I receive clear and simple information about what abuse is, I know how to recognise the signs, and I know what I can do to seek help.”
Proportionality	The least intrusive response appropriate to the risk presented.	“I am sure that the professionals will work in my interest and they will only get involved as much as is necessary.”
Protection	Support and representation for those in greatest need.	“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”
Partnership	Services offer local solutions through working closely with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”
Accountability	Accountability and transparency in delivering safeguarding.	“I understand the role of everyone involved in my life and so do they.”

SUPPORTING OUR RESIDENTS

During the last 12 months Adult Social Care provided support for 5,801 residents. At the end of March 2025 there were 3,883 residents accessing 4,418 services (meaning some people access multiple services).

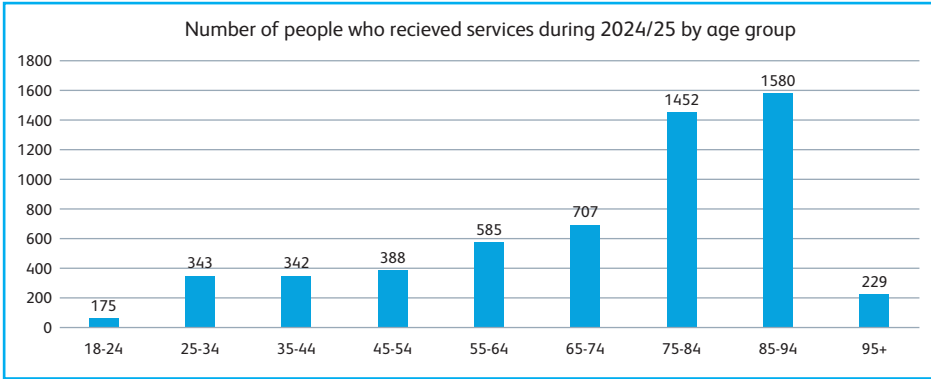


32% of people being supported were aged 18-64 and 68% were aged 65+.

Primary Support Reason	AGE GROUP		ALL
	18-64	65+	
Physical Support	424	1,697	2,121
Learning Disability Support	709	90	798
Mental Health Support	290	145	435
Support with Memory and Cognition	19	261	280
Social Support	74	51	125
Sensory Support	31	25	56
Not yet recorded	17	51	68
Everyone on service at 31 March 2023	1,563	2,320	3,883

During the 2024/25 year, 58% of people receiving support identified as female and 42% identified as male.

Of the 3,883 residents accessing services at the end of March 2025, 51% also received support from an unpaid carer.



Inclusive Communities

There is under-representation of residents from ethnic minority communities who access our services; only 5% of residents which remains low compared to the ethnic minority population rate of 9% in Rotherham. One of our areas of focus is to ensure take up of adult social care from across all our local communities

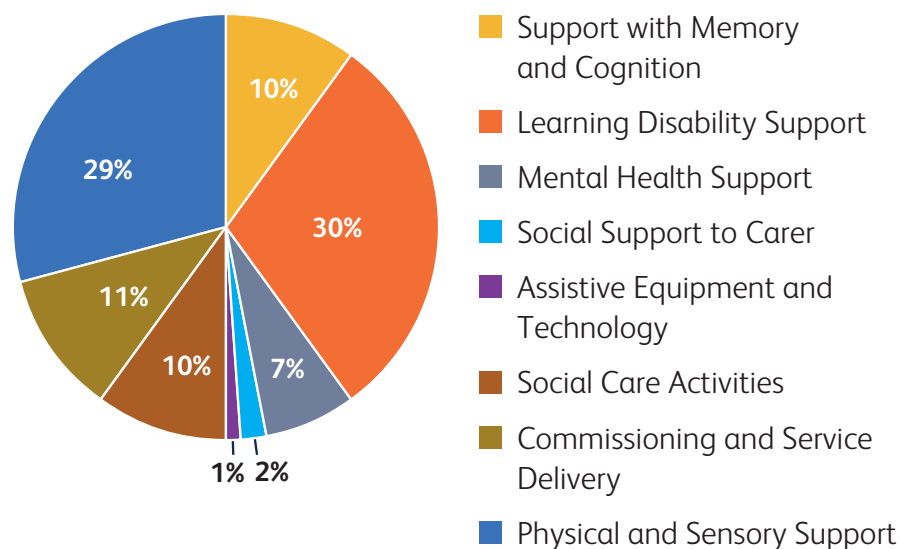
Safeguarding Adults

During the 2024/25 year, 696 people were subject to a new safeguarding enquiry and 864 enquiries were completed. Most enquiries relate to older adults and occur in a person’s own home. At the end of 2024/25, 96.7% of adults involved in a safeguarding enquiry felt their personal outcomes were at least partially or fully met.

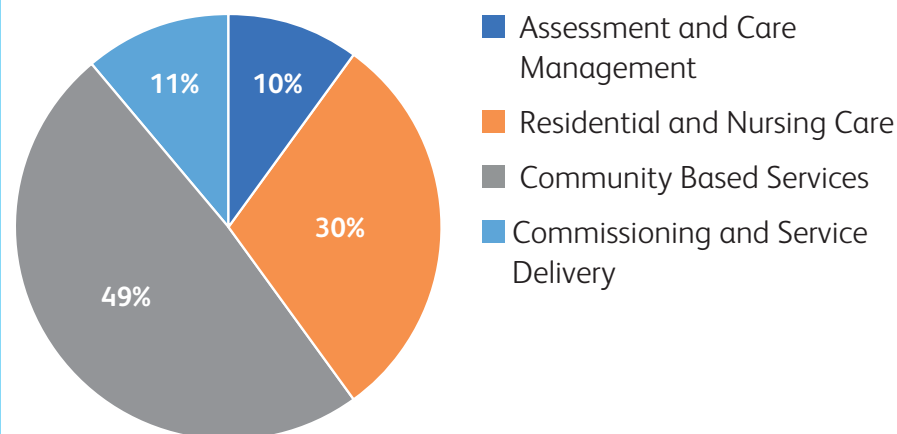
HOW WE USE OUR RESOURCES

Our latest financial data shows Rotherham spent a total of £102.433 million on Adult Care and Support services in 2023/24 (the latest year for which figures are available).

Category of Support



Type of Services



HOW WE PERFORMED

Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. It is used both locally and nationally to help set priorities, measure progress and strengthen transparency and accountability.

The table below shows you our latest published data and how we compare to others across England and the region. Colours have been used to help you to understand these comparisons.

Better or approximately the same as England averages.

Slightly below England average.

Below England average and poor ranking.

	Measure	Rotherham	England	Yorkshire and Humber	Rotherham Rank
1A	Social care-related quality of life score	19.1	19.1	19.3	72
1B	Quality of life of people who use services	0.434	0.417	0.416	n/a
1C	Quality of life of carers	7.1	7.3	7.3	90
1D	Overall satisfaction of people who use services with their care and support	65.4	65.4	66.4	67
1E	Overall satisfaction of carers with social services	41.5	36.7	36.4	46
2A	% of people who received a short-term service, where there was no requirement for further long term support	93.7	79.4	69.7	16
2B	Number of younger adults (aged 18-64), whose long-term support needs are met by admission to residential or nursing care homes, per 100,000 population	28.8	15.2	18.7	147
2C	Number of older adults (aged 65+), whose long-term support needs are met by admission to residential or nursing care homes, per 100,000 population	556.3	566	616.1	78
2D1	% older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	81.4	83.8	83.4	102
2D2	% older people (aged 65+) offered reablement/rehabilitation services after discharge from hospital	2.2	3.0	2.1	95

HOW WE PERFORMED

	Measure	Rotherham	England	Yorkshire and Humber	Rotherham Rank
2E	% adults with a learning disability who live in their own home or with their family	83.7	81.6	82.9	67
3A	% of people who use services who feel they have control over their daily life	77.8	77.6	79.5	81
3B	% of carers who report that they have been involved in discussions about the person they care for	74.3	66.4	67.7	14
3C1	% people who use services who find it easy to find information about support	67.9	67.9	69.0	87
3C2	% carers who find it easy to find information about support	59.5	59.1	59.5	77
3D1a	The proportion of people who use services who receive self-directed support	100	92.2	95.8	1
3D1b	The proportion of carers who receive self-directed support	100	89.7	89.7	1
3D2a	% people who use services who receive direct payments (excludes managed direct payments)	19.5	25.5	25.9	113
3D2b	% carers who receive direct payments (excludes managed direct payments)	69.2	77.4	81.0	113
4A	% of people who use services who feel safe	70.4	71.1	72.7	87
4B	% Safeguarding enquiries where risks were reduced or removed	87.1	91.2	93.6	82
5A1	% people who use services who reported that they had as much social contact as they would like	49.9	45.6	48.5	23
5A2	% carers who reported that they had as much social contact as they would like	26	30.0	32.0	112
6A	% staff in the formal care workforce leaving their role in the past 12 months	17.1	24.8	25.2	18
6B	% adult social care providers rated good or outstanding by CQC	79.2	80.3	77.7	65

OUR ACHIEVEMENTS IN 2024/25

The following tables explain what adult social care achieved in 2023/24 and the impact this had for residents.

Achievement	This means that...
Reviewed and redesigned our public information for young people preparing for adulthood, vulnerable adults and unpaid carers. (ASC Strategy).	Information is easy to understand, accessible and enables a person to make an informed decision about their care needs.
Redesigned the adult social care web pages. (ASC Strategy).	Online information has been improved so that it is easily accessible.
Provided a range of information on direct payments and being a responsible employer. (ASC Strategy).	People receive an employment handbook and guidance to direct payments to help them understand the responsibilities of using a direct payment to meet their care needs.
Implemented a new prevention service which will support both vulnerable adults and young people preparing for adulthood. (ASC Strategy).	People receive care and support earlier to promote independence. The support aims to prevent, reduce, or delay a person's need for formal care and support.
Invested in prevention services in the voluntary sector. (ASC Strategy).	One hundred thousand pounds has been invested in the voluntary sector to provide a range of support services to meet peoples care and support needs.
Reviewed and expanded our out of hours support offer for people in crisis. (ASC Strategy).	People in crisis can access support out of hours to ensure they remain safe.
Implemented a co-production board and other feedback mechanisms to understand how well we are meeting people's needs. (ASC Strategy & Year Ahead Delivery Plan).	People have a voice in how we shape services as well as being able to tell us what we are doing well and how we can further improve.
Strengthened the voice of unpaid carers so that this can be acted on. (ASC Strategy).	Unpaid carers are recognised for what they do, are responded to, and supported in a way that matters to them.

OUR ACHIEVEMENTS IN 2024/25

Achievement	This means that...
Ensured that the voice of the person is central to safeguarding adults through a revised safeguarding pathway and via Rotherham Safeguarding Adults Board work. (ASC Strategy).	Adults can live their best lives with their wellbeing and rights being supported and their personal outcomes being met. Over 97 % of adults felt this was either fully or partially achieved.
Building work has started on Castle View, Canklow which will provide new day opportunities for people with high support needs. (Year Ahead Delivery Plan).	People with complex needs will have access to care closer to home and in a purpose-built environment. It is anticipated the centre would close in mid-2026.
Launched the new Learning Disabilities Strategy which sets out Rotherham's aspirations for people with a learning disability. (Year Ahead Delivery Plan).	People with a learning disability have a strong voice and can make choices that mean they are included, safe and secure, to ensure they have the best life chances.
Launched the new All Age Autism Strategy which sets out aspirations for autistic people living and working in Rotherham. (Year Ahead Delivery Plan).	Autistic people have access to education, employment opportunities and support in their own home. It also means that the right information is available, at the right time, to help make informed choices.

SPOTLIGHT ON SHARED LIVES

Shared Lives is where individuals who need support live with, or regularly visit, a Shared Lives Carer's home. This arrangement goes beyond traditional care settings, fostering genuine relationships and a sense of belonging. It is a testament to the idea that care is not just about meeting physical needs but also about nurturing emotional and social wellbeing.

What makes Shared Lives unique?

- **The impact this has on Carers as well as those being supported**

This is something that benefits the Carer as much as it does the person being supported – for the Shared Lives Carers it is a rewarding and enriching experience!

- **The opportunities Shared Lives provides**

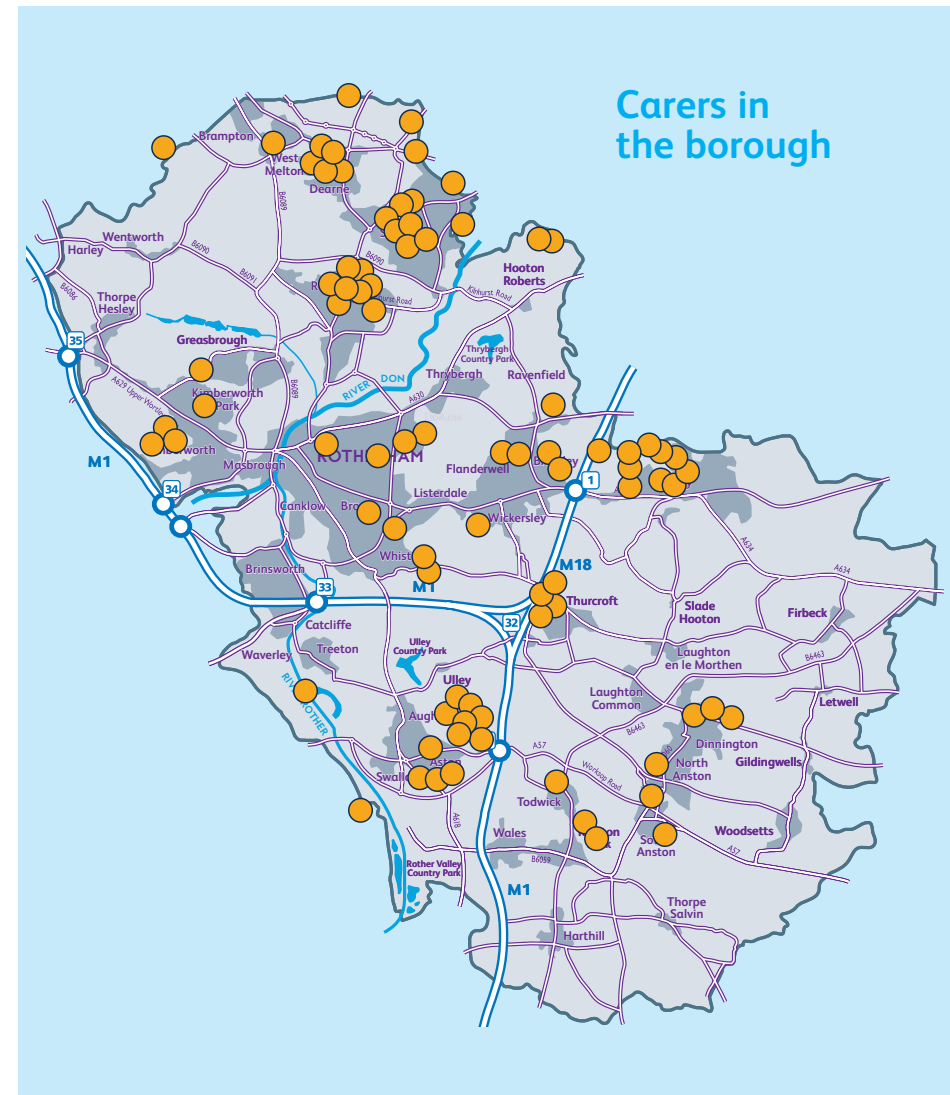
Including building meaningful relationships, developing new skills and participating actively in local communities.

- **The diversity of Carers**

There are 91 Shared Lives carers across the borough which provides a diverse and experienced offer for those being supported. These cover 190 matches and support 91 people.

- **The focus on strong and sustainable relationships**

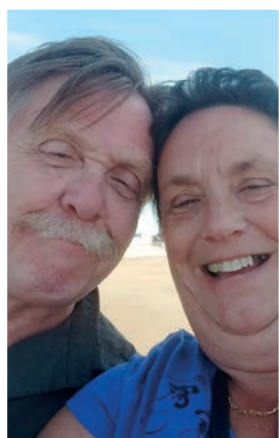
People are matched with Carers who have similar interests, the right skills and community connections for the person being supported. This is a solid foundation for strong relationships.



SPOTLIGHT ON SHARED LIVES

Who is Shared Lives for?

Shared Lives is largely accessed by people with a learning disability but there are opportunities to expand the service to young people transitioning to adulthood, people living with mental ill health including dementia and as respite to provide support to unpaid Carers.



What are Shared Lives proud of?

- The number of Shared Lives carers (pictured here) has doubled in the last 5 years, largely due to word of mouth and the positive impact seen in people's lives.
- The Shared Lives newsletter is made up of contributions from the Shared Lives Community, allowing people to share their stories, stay connected, and learn about local events.
- There are strong relationships with local communities to help those supported to engage actively in their communities including Winthrop Gardens, Rotherham Creative, The Willows School, Rotherham Minister, Rawmarsh Foodbank, and Rotherham Engineering Club.
- Shared Lives Rotherham has participated in a pilot programme with the Department of Health and Social Care to grow the Shared Lives offer. This work has led to an employment opportunity for a person supported by Shared Lives Rotherham as a Shared Lives Ambassador for the north of England!
- Ensuring regular face-to-face contact, check-ins, building a strong community network and expanding social groups, ensures people receive the help they need anytime.
- We are committed to investing in the Shared Lives to support the growth of our Shared Lives offer. Through our investment we can ensure that more individuals have access to the personalised, compassionate care they deserve. We can build stronger, more inclusive communities where everyone can flourish, grow, develop, and prosper.

THE IMPACT OF SHARED LIVES

Hayley, Antony and Andrew

are regular contributors to the newsletter which often features Oakwell Stadium with Antony following his beloved team.

Together they have travelled much of the UK from Cornwall to Scotland. Andrew and Antony are good friends, and Hayley facilitates this friendship.

Hayley's approach ensures they both actively make decisions to be in full control of their lives and have fulfilling experiences.

Sid has dementia and lives in his own home where he is supported by his Shared Lives Carer, Karen, to do the things he loves.

Sid visits his wife in a care home, walks his dog and is part of an engineering club. As a former engineer, Sid has a cherished memory of making a part for the Concorde's engine. Karen arranged a visit to see the Concorde at Manchester Airport, which they both thoroughly enjoyed!

Gracie accessed Shared Lives as a short-term placement but decided to stay after settling in so well.

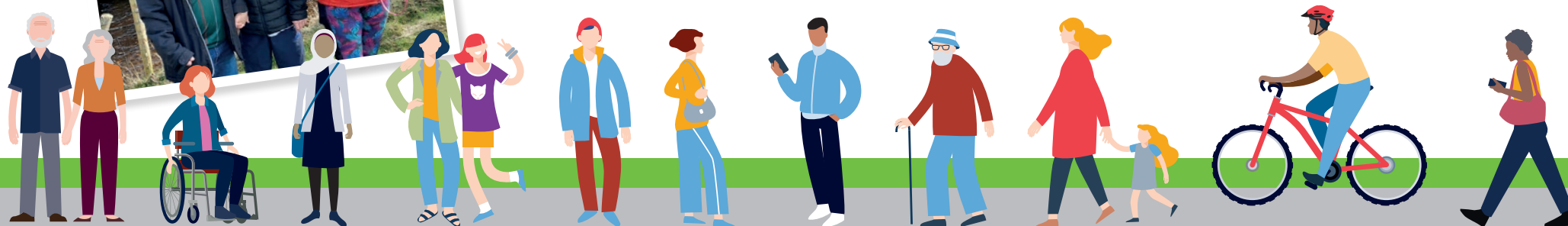
With the support of her Shared Lives Carers, she has helped at a local foodbank which they run, she has learnt sign language, and joined local groups, where she has made many friends and increased her social life.

Gracie is now a Shared Lives Ambassador for Shared Lives Plus covering the North of England – her first paid employment role!

June had lived with Miriam from being a baby until she moved into a supported tenancy last year.

June continues to live a full life with Miriam continuing to provide day support and they still enjoying holidays together.

Miriam's dedication is clear with her now being a registered carer for 50 years!



THE YEAR AHEAD

Looking ahead, we have set several new priorities for delivery in 2025/26.

Priorities	This means that...
Embed the co-production board and other feedback mechanisms to understand how well we are meeting people's needs. (ASC Strategy & Year Ahead Delivery Plan)	People can tell us where we can improve and what we are doing well.
Review the Borough that Cares Strategy and co-produce the updated strategy with unpaid carers.	Unpaid carers can be identified, supported, and have access to the resources they need to maintain their own health and wellbeing, while also balancing their caring responsibilities.
Implement an online adult social care portal for people who wish to self-assess. (ASC Strategy)	People can access information at a time that suits them and interact with Adult Social Care through another communication channel.
Enable people to self-triage and self-assess their needs. (ASC Strategy)	People have control over their care needs by being able to self-triage to find the right support.
Invest in new assistive technologies (AT) and digital solutions supported by an assistive technology strategy. (ASC Strategy)	Assistive technologies and digital solutions will be available to support people to live more independently.
Implement a new transitions assessment process with partners.	Young people preparing for adulthood receive an assessment bespoke for their needs which considers all aspects of their lives.
Improve employment opportunities for young people with care and support needs. (ASC Strategy)	More young people have access to employment, volunteering and internship opportunities as they move into adulthood.
Implement a new hospital discharge 'Transfer of Care Hub' which improves outcomes for residents. (ASC Strategy)	People with new or increased care needs receive the right support to return home or transition to other care settings safely and efficiently.
Implement a redesigned mental health model for social care and work with partners to adopt collaborative community mental health hubs. (ASC Strategy)	People experiencing mental ill health will be supported to regain their independence and live safe and healthy lives.
Seek further opportunities to deliver services collaboratively. (ASC Strategy)	Adult social care will ensure that opportunities to work with partners which improve outcomes for residents adopted.

VOICE OF THE RESIDENT

During 2024/25 we received **450 compliments** compared to **63 formal complaints**. 2024/2025 saw a 50 % increase in compliments compared to the previous year.

"A very special thank you just to let you know your kindness means so much more than words can ever show."

Compliment for Lord Hardy Court

"Thank you for your kindness, support and everything – it means so much."

Compliment for the Integrated Discharge Team Team

"You were so friendly and caring in all your dealings with us. What you didn't know, you went the extra mile to find out. I honestly felt that you approached our case as if you were working on behalf of your own parents."

Compliment for the Localities Team

"I wanted to express my thanks for the excellent help and advice your worker gave to me when requesting support for my mum."

Compliment for the Adult Contact Team (ACT)

"Thank you for arranging funding for the respite...it is really appreciated. Please pass on our sincere thanks."

Compliment for the Learning Disability and Autism Team

"You found out and gave me the explanation for the problems we were subjected to, thanks once again for your help and understanding."

Compliment for the MCA and DoLS Team

Complaints numbers remain consistently low.

In 2024/25 we received 63 compared to 59 in 2023/24 and 55 in 2022/23.

Of the 63 complaints received, 58 (92 %) were satisfied at stage one without further escalation

Three ombudsman investigations were completed in 2024/25, two more than the previous year. Two of these were upheld and one was not upheld.

Complaints appear to be made around two main themes, timeliness of assessments and the outcome of an assessment. The service has implemented additional information to ensure that wait safely whilst awaiting an assessment and invested in additional social work staff so that we can assess people sooner.

In 2024/25, we launched our Adult Social Care appeals process. No appeals were received in 2024/25.

THE BEST WORK OF OUR LIVES

Janet is a lady who has been supported by the Mental Health Enablement Team to improve both her mental and physical wellbeing.

Initially, Janet was struggling with low mental health, managing clutter in her home and self-care, such as eating and drinking properly. She had also been working through a Social Care course but had become so overwhelmed by everything that she was behind and unable to progress.

With the support of her mental health enablement worker, Janet created and began to follow a plan to support her.

Gradually Janet's mental and physical health improved. She sleeps better, has organised her home and cooks and cleans. This has led to her feeling able to catch up with her studies as well as rebuilding her relationship with family members.

Janet says *'You have helped to find my feet in life again. You've helped me get back in control of it all one step at a time, without ever making me feel judged or alone in it. Your energy, kindness and the way you just 'get it' has meant the world to me.'*

Brenda is an older lady who was supported by our hospital and community assessment teams.

Brenda has COPD and was admitted to hospital with shortness of breath and a reduced diet. Upon discharge from hospital Brenda had a care package of 4 calls a day to support with personal care, meal preparation and toileting. However, she was confused and had reduced mobility.

Due to concerns about Brenda's safety at home a short stay in a care home was organised and, during this time, there were significant improvements meaning she needed minimal support and no longer displayed signs of confusion.

Brenda wanted to return home, with a care package in place for ongoing support, where her health continued to improve and she was able to go out in her community independently.

Brenda decided she no longer needed a care package as she had improved so much and was happy with minimal informal support from her daughter.



Sarah is a carer, and a member of the Choir That Cares, who believes that connecting with others, through local groups and social media, has been a lifeline.

Sarah's son has multiple health needs including Spina bifida and Epilepsy and Sarah has been his full-time carer for 18 years.

For Sarah this has had an impact financially and personally and has brought challenges when dealing with professionals and delays when trying to make progress

However, Sarah is proud that she has helped her son attend mainstream school and now college. She explains that family trips are tricky but incredibly satisfying to see how much they mean to her son.

Sarah believes it's vital to recognise the role of carers, paid or unpaid, because so many people rely on them to live full lives. For her, connecting with other carers through groups, such as the Choir That Cares, has helped her realise she's not alone and has opened up new sources of support and friendship.

USEFUL CONTACTS

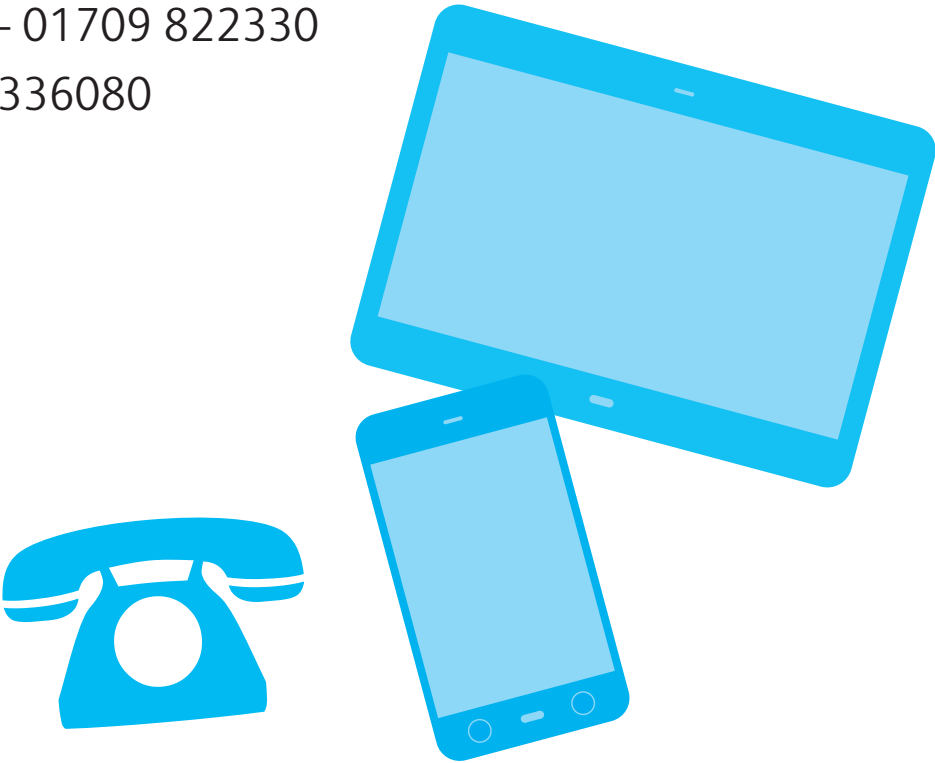
Safeguarding (Customer Contact Team) – **adults** – 01709 822330
Safeguarding (M.A.S.H Team) – **children** – 01709 336080
Mental Health Crisis Team – 0800 652 9571
RDASH Switchboard – 03000 213000

Housing Services – 01709 336009
Reablement Services – 01709 336096
Shared Lives – 01709 334948
Supported Employment – 01709 249600

Age UK Rotherham – 01709 835214
Citizen’s Advice Bureau – 0808 278 7911

Your own important numbers

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HOW DID WE DO?

Adult Social Care Local Account 2024 – 2025

An Easy Read Guide



www.rotherham.gov.uk



About the Local Account



This report will show the good work we did last year. It will also tell you about the hard work from our teams.



We will show you what we will focus on for the next year. We will also say what we need to do better.



This is Ian Spicer the Strategic Director of Adult Care, Housing and Public Health.



This is Councillor Baker-Rogers the Cabinet member for Adult Social Care.

Councillor Baker-Rogers and Ian Spicer's views on the Local Account



The Local Account looks back at the past year. It shows how we have helped people.



We celebrate the good work done and share our plans for the next year. The person is at the centre of everything we do. We aim to help everyone live their best lives.



We want everyone to have a say and be heard.

We are pleased that our Adult Social Care Co-Production Board will help with this.

What we want to do

We will help our residents to be safe, healthy, and live well.

Resident is someone who lives in Rotherham.



We will support everyone who needs care to live their best lives with people they love, close to home.

We will make sure they get the right help when they need it.



We want everyone to have the right information to make good choices.

We will make sure everyone has important relationships that support their strengths and needs.

Safeguarding Adults



Safeguarding means protecting people so they can live safely, free from abuse and neglect.



It also means helping people understand what abuse looks like. People should know how to spot the signs.

Safeguarding helps people speak up if they see something wrong. Reporting concerns is important.



The Rotherham Safeguarding Adults Board checks that safeguarding is working. They try to stop abuse and harm before they happen.

They make sure people are protected in a personal way.

More Safeguarding Adults



In 2024/2025 696 people had a new safeguarding **enquiry**.

864 enquiries were completed in total.

Enquiry is another word for a question.



Most enquiries were about Physical Support and Learning Disability Support.



At the end of 2024/2025, 96.7% of people said that what they wanted to happen had happened fully or happened a bit.

Our Purpose



We know everyone is different and has different needs and wants.



We understand that to help someone, we must know them well.



Adult social care helps people who need care and support.

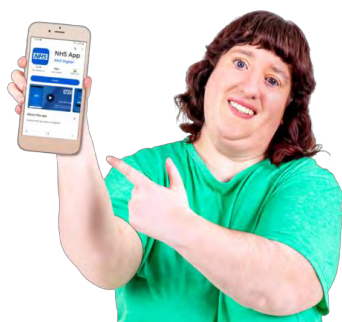
We help them live on their own, safe and well.

Our Purpose – Different types of help for people



Some help comes from special tools and gadgets.

This is sometimes called assistive technology or aids and adaptations.



You can also get advice and information.



There is help for family members who care for someone without getting paid, sometimes called unpaid carers.



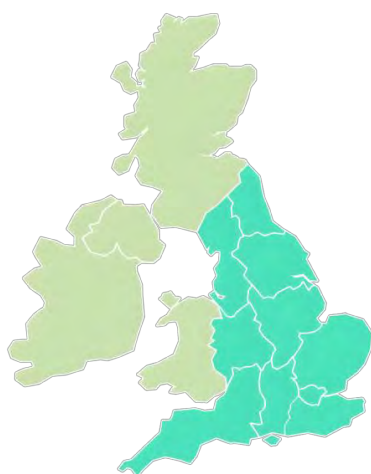
There is help like home care, day activities, or living in care homes.

Checks on care and support



The Adult Social Care Outcomes Framework (ASCOF) checks how well care and is given to people.

It shares local and national information to make sure care and support is working well for people



Care in Rotherham is good in some ways but needs to get better in others.

People using services, and carers, have a slightly lower quality of life compared to the England average.



Rotherham is very good at short-term care and support, with lots of people not needing more long-term support.

More young adults need residential care in Rotherham than the England average.

Good work in Rotherham



In 2024-2025 people who received care and support in Rotherham said that information for care is now simpler and easier to find.



People said new services and support helped people become more independent.



People were happy that extra funds improved care and support and a new facility is being built.



People said they like to give feedback about the care and support they have had, to make sure carers, people with learning disabilities, and autistic individuals are supported.

A Focus on Shared Lives



Shared Lives is when people who need support live with, or visit, a Shared Lives Carer in their home.



Care is not just about physical needs. It is also about feelings and having people to talk to.

Shared Lives is special because it helps both Carers and those that need support. This makes strong bonds and gives rewarding experiences.



It also gives people chance to learn new skills and join community activities.

Shared Lives allows you to live as part of a family giving you the opportunities to do the things you would like to do.

A Focus on Shared Lives



Shared Lives is for people with a learning disability, people with mental ill health, people with dementia and young people becoming adults.

Shared Lives newsletters are shared showing local events, activities people have done together and celebrating the Shared Lives community.



Shared Lives have strong relationships with local communities such as Rotherham Creative, Rotherham Minster and Rotherham Engineering Club.



Shared Lives Carers, and the cared for people, have face-to-face check-ins often. This is to make sure everyone has the support they need and are having positive experiences.

Shared Lives allows you to live as part of a family giving you the opportunities to do the things you would like to do.

The Difference Shared Lives Makes

Hayley, Anthony and Andrew's story: Hayley supports Anthony and Andrew to watch football matches and visit new places.

Together they travel to places like Cornwall and Scotland.

Sid's story: Sid has dementia and is supported by Karen to visit his wife, walk his dog and go to engineering club.

Recently, they visited Manchester Airport to see the Concorde as Sid remembers working on this as an engineer!

Gracie's story: with the support of her Shared Lives Carer Gracie has helped at a local food bank, learnt sign language and made many friends at local groups.

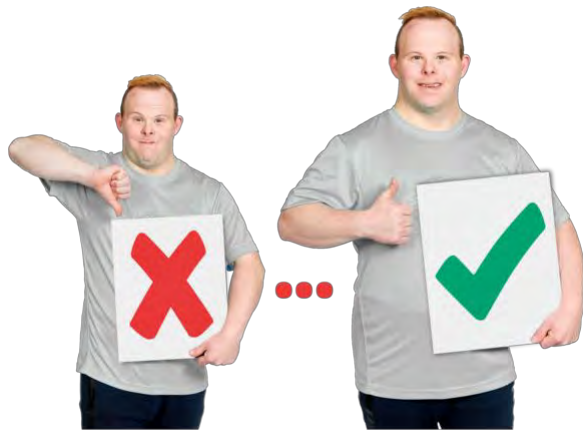
Gracie now has a job in Shared Lives!

June's story: June had lived with Carer Miriam since she was a baby and now has her own place. Miriam still supports June with day-to-day things, and they still enjoy holidays together.

Miriam has been a Carer for 50 years!



What we will focus on in 2025/2026



Feedback and Improvement: Use feedback to understand and improve care and support.



Support for Carers: Update the strategy with unpaid carers to help them get the support and resources they need.



Online Access: Create an online portal for self-assessment and information access.



Assistive Technologies: Get more technology to help people live more independently.

What we will focus on in 2025/2026



Employment: Improve job opportunities for young people with care needs.



Hospital Discharge: Implement a new system to support people returning home from the hospital.



Mental Health Support: Improve mental health services to help people live independently.

Collaborative Services: Work with partners to improve care and support services.

Voice of the resident – People living in Rotherham

In 2024/2025 we received 450 compliments and 63 complaints.

A very special thank you just to let you know your kindness means so much more than words can ever show.

I wanted to express my thanks for the excellent help and advice your worker gave to me when requesting support for my mum.



Thank you for your kindness, support and everything - it means so much.

Thank you for arranging funding for the respite...it is really appreciated. Please pass on our sincere thanks.

Voice of the resident – People living in Rotherham



Complaints have stayed low, with 63 received in 2024/2025.

Most complaints (92%) were resolved at the first stage.



Complaints were mainly about assessment timeliness and outcomes.

To address this, more information and additional social work staff have been provided.



A new appeals process was launched, but no appeals were received in 2024/2025.

The Best Work of our Lives



Janet's Story: Janet received help from the Mental Health Enablement Team to improve her mental and physical health.

She followed a plan that helped her sort out her home, improve self-care, and catch up with her studies. She also rebuilt family relationships.

Mental Health Enablement team helps people to improve the thoughts and feelings in their mind to live a healthier and happier life.



Brenda's Story: Brenda, an older lady with COPD, received support from hospital and community teams.

After a short stay in a care home, her health improved a lot.

She returned home with a small amount of support and then no longer needed a care package, just having some help from her daughter.

COPD is a lung disease that makes it hard to breathe, often caused by smoking or breathing in harmful things for a long time.

The Best Work of our Lives



Sarah's Story:

Sarah has been a full-time carer for her son, who has multiple health needs, for 18 years.

Despite the financial and personal challenges, she is proud of helping him attend mainstream school and college.



Sarah finds connecting with other carers through local groups and social media essential for support and friendship.

Social media is a way for people to connect and share information online.



Sarah believes that everyone should understand the role of a carer. It is important because many people depend on them to live full lives.

Here are some useful contacts

1. Adult Safeguarding (Adult Contact Team) – 01709 822330
2. Children's Safeguarding (MASH Team) – 01709 336080
3. Mental Health Crisis Team – 0800 6529571
4. RDASH Switchboard – 03000 213000
5. Housing Services – 01709 336009
6. Reablement Services – 01709 336096
7. Shared Lives – 01709 334948
8. Supported Employment – 01709 249600
9. Age UK Rotherham – 01709 835214
10. Citizen's Advice Bureau – 0808 2787911

Health and Wellbeing Strategy for Rotherham 2025-2030



Vision

Our vision is to enable the people of Rotherham to live happy, healthy, independent lives within thriving communities, regardless of background and personal circumstance.

Foreword from the Chair

I am pleased to introduce our refreshed Health and Wellbeing Strategy for Rotherham, a document which reflects the aims and ambitions of our Health and Wellbeing Board. Good and improving health and wellbeing is essential to the people of Rotherham, enabling them to live fulfilling, active and connected lives. This Strategy sets out some of the progress and achievements we have delivered during the last five years against our ambitions to support the wellbeing of the population. This reflection will enable us to build upon past successes as we look to further improve outcomes moving forwards.

However, there is still work to do. There are still too many people in our Borough living in poor health with substantial differences in need, experience and health outcomes across our communities amid widening gaps in life expectancy. These differences have become more pronounced for those most in need, particularly in the aftermath of the Covid -19 pandemic, and at a time of increased economic pressures on people and public services.

The 2025 Strategy sets out our approach to maintaining our momentum and continuing to invest our efforts in the areas which the evidence suggests are the highest priority. Our new aims focus the Board on maximising its impact on children and young people, supporting all to live in good and improving physical and mental health, and to reduce the detrimental impacts of commercial and wider determinants of health. These aims have been identified as most effectively ensuring that the efforts of the Board are focussed where they are most needed. We will deliver these aims through our renewed ways of working. These encompass the values of the Board

and will ensure all activities are carried out according to best practice. This refreshed set of aims and ways of working will work in tandem to enable the Health and Wellbeing Board to deliver better health outcomes and reduce the challenges faced by Rotherham people.

As a Board, we recognise that one of our key strengths is that of partnership working. The value of this approach is more important than ever, in an era of uncertainty around public sector funding, as we look to maximise the impact of the Health and Wellbeing Board agenda. We must ensure we realise the ability of our partnerships to overcome challenges and use the Board to empower our partners to offer more effective and efficient opportunities to improve health outcomes.

We have taken the decision to make this Health and Wellbeing Strategy a more streamlined version of the previous one by significantly reducing the number of priorities. This will enable the Board to ensure that our priorities are ambitious, achievable and are cross-cutting across all four of the strategic aims.

With this new edition of the Health and Wellbeing Strategy, I am confident that we will see further improved outcomes for Rotherham people under the guidance of our new aims and ways of working.



Councillor Baker-Rogers

Cabinet Member for Adult Social Care and Health
Chair of Rotherham Health and Wellbeing Board

Overview

Our mission is to enhance and support the good and improving health and wellbeing of our residents by empowering individuals and communities, building resilience, providing access to resources and opportunities, and tackling health inequalities.

Our aims are to:

1. Enable all **children and young people** up to age 25 to have the best start in life, maximise their capabilities and have influence and control over their lives.
2. Support the people of Rotherham to live in good and improving **physical health** throughout their lives, accessing and shaping the services and resources they need.
3. Support the people of Rotherham to live in good and improving **mental health** throughout their lives, accessing and shaping the services and resources they need.
4. Sustain an environment where detrimental impacts from **commercial and wider determinants of health** are reduced, and opportunities for healthier living are nurtured.



Introduction

The Health and Wellbeing Board believes that everyone in Rotherham has the right to live a happy, healthy and fulfilled life. The purpose of this strategy is to set out our aims to enable people to live in good and improving health, and to enable effective partnership working to commission and deliver services to realise these aims.

Reflections on the 2020 Health and Wellbeing Board Strategy

This refresh updates the previous 2020 strategy which supported delivery of some important milestones in Rotherham. A selection of these is shared below, with more detail in the appendix.

We have seen the introduction of **Family Hubs** in Rotherham which provide a range of support and advice services to help families live well and children have the best start in life. Rotherham has pledged to become a **Breastfeeding Friendly Borough**.

The strategy transformed **key care pathways** and established **new health services** to support patients, such as developing **state-of-the-art orthopaedic surgery pathways** to reduce patient waiting and recovery times and the introduction of **lung health checks** to detect lung cancer early.

The positive impacts of our **suicide prevention and loneliness work** have been nationally recognised, and the Board recently approved the Prevention Concordat for Mental Health. We have also implemented targeted mental health support for children and young people.

Rotherham continues to be a national leader in the design and delivery of **social prescribing** and **voluntary sector** initiatives to support good health in communities and patient groups. The **Rotherhive** website

was launched to facilitate access to a range of services and groups for residents and the workers who support them.

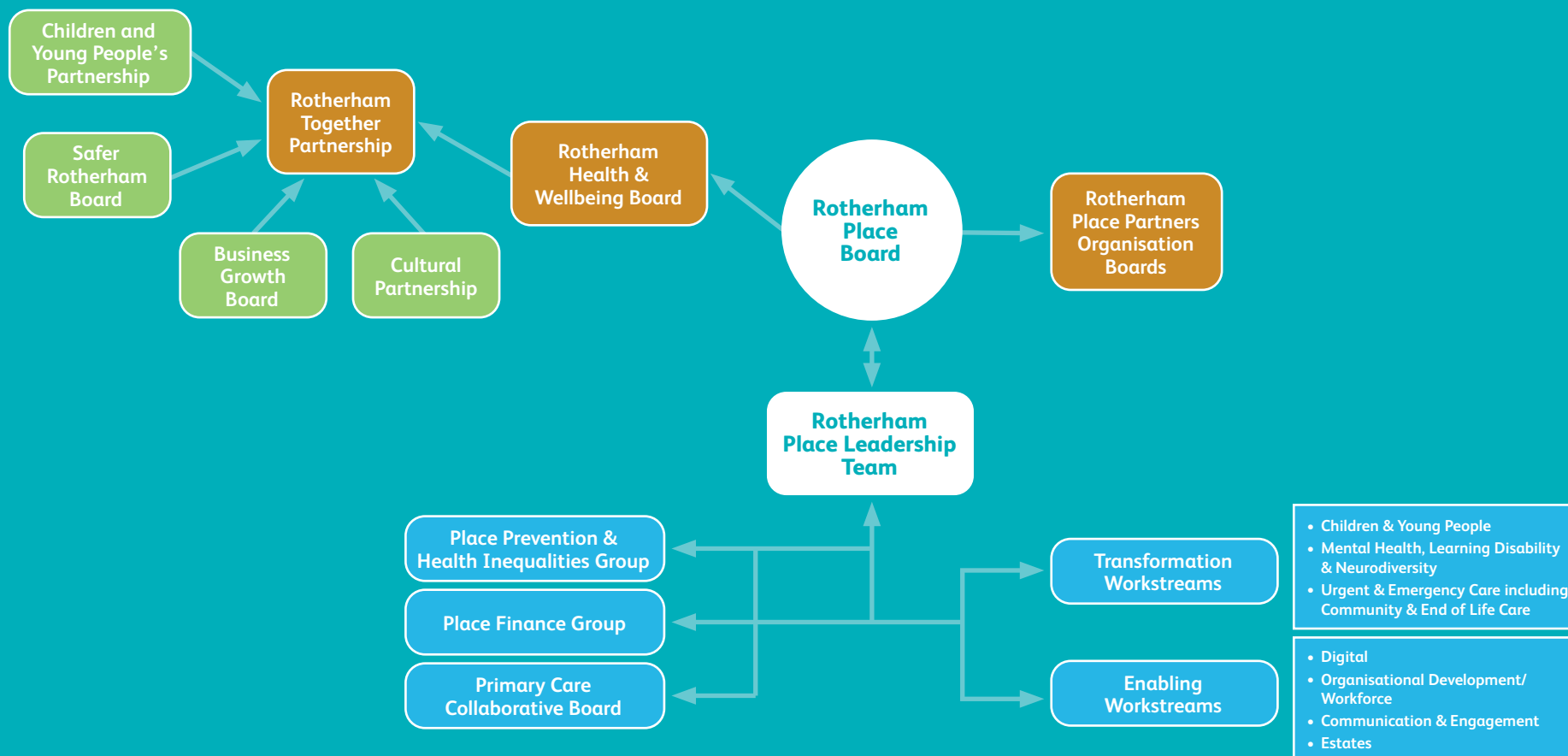
The Health and Wellbeing Board has built a coherent strategic approach to tackle the socioeconomic determinants of health. This includes **Rotherham's Sustainable Food Places Bronze award-winning food network**, and **promotion of physical activity** through **Healthwave** and the **voluntary sector**. We have also developed a multitude of initiatives to support staff and carers in the Borough, such as **workplace health checks** and **mental health support** offers.

However, there have been huge challenges to our society since the last strategy was written. This includes the Covid -19 pandemic and significant pressures on the cost of living. Both have had an impact on general population health and the affordability of services and resources which can support healthy living. This requires us to take stock of our direction and to refocus our efforts.

There have also been new opportunities. This includes the establishment of **Integrated Care Systems (ICS)**, which offer more ways of collaborating to join up and co-ordinate our services as we deliver improved population health.

Partnership working in Rotherham is strong. We are in a good position to maintain the momentum needed to be able to face the challenges set out in the context of declining public sector funding. The work that needs to be done will be supported by the **South Yorkshire Mayoral Combined Authority**, the **Rotherham Together Partnership**, **Rotherham Place Board** and the strong bonds between individual organisations in the Borough. The reporting structure of Rotherham's Boards and Partnerships are outlined on in figure 1. Links to the strategies and plans of these organisations can be found in the Appendix.

Fig 1. The Rotherham Health and Wellbeing Board in partnership



Developing the 2025-2030 Health and Wellbeing Strategy

We have used several sources of evidence to inform the refresh of the strategy, which are set out in more detail in the next three sections of this document.

Partners have used the Joint Strategic Needs Assessment (JSNA) to understand the underlying needs of the population across a range of health-related issues. To this, we added an extensive review of population engagement and consultation activity over the past three years to understand the views and experiences of residents, service users and patients about their health and wellbeing.

We also developed several questions to ask residents around the existing Health and Wellbeing Strategy and how it could change to promote and maintain good health in Rotherham.

In addition, stakeholder organisations have been consulted about the effectiveness and focus of the strategy in supporting and enabling the delivery of services in the borough.

A summary of this evidence and how it has shaped the development of the strategy is presented on the following pages. More detail on each of these evidence bases is available in the Appendix.



The needs of our population

The Health and Wellbeing Board has a statutory duty to commission a JSNA of the local population to highlight health inequalities that need to be addressed. The JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services.

Rotherham borough covers an area of 110 square miles and has a population of 268,400. Around half of the population lives in the central part of the Borough. Others live in many outlying small towns, villages and rural areas. Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large Council housing estates, leafy private residential suburbs, industrial areas, rural villages, and farms.

There has been significant investment in the health of our population in recent years, but some substantial challenges remain. The points below give a sense of the challenges and opportunities facing us over the next decade. Tools to explore this and further information can be found in the Rotherham JSNA.

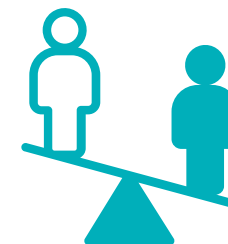
Population

- Rotherham has an age structure that is slightly older than the national average and a below-average percentage of people aged 18 to 29 because of students leaving Rotherham to study elsewhere, and young adults leaving the area for work
- The population is growing due to there being more births than deaths, and more people moving to Rotherham to live.



Health Inequality

- 36 % of the population live in the most deprived quintile. Deprivation is a major cause of health inequalities
- English is not the main language of 4.1 % of the population
- Almost nine in ten eligible two-year-olds are taking up a place in early education, and nearly three quarters engage with children's centres
- Over 11,000 children in Rotherham are living in absolute poverty
- Over 3,700 people are currently accessing adult social care services, with around half of these over the age of 75
- Over 23,000 people provide unpaid care, with over half of these doing so for more than 35 hours per week. A third of adult carers feel socially isolated



- In 2023, 1,236 families were identified as being at risk of homelessness
- Life expectancy is lower than the national average for the people of Rotherham, and there is an inequalities gap of over 10 years between the most deprived and least deprived
- Our residents develop poor health earlier than average and live longer in poor health than average. The age to which a female born in Rotherham today can expect to live healthily (without chronic, life-changing illness) is 55.6 years old, and for a male, healthy life expectancy is 56 years.

Mental Health

- The prevalence of depression has risen to 17 % in 2022, and 25 % of school children report issues with mental wellbeing
- Deprivation significantly impacts patient experience and outcomes of chronic pain, mental health, diabetes, cardiovascular and other long-term conditions.



Access to care

- Screening uptake rates have generally been good in Rotherham compared to England, but for breast and cervical cancer, screening rates have not yet returned to pre-Covid-19 levels
- Those in the most deprived areas are more likely to miss appointments and experience difficulties in accessing healthcare.



Health behaviours

- Smoking is still the primary cause of morbidity and early mortality. Although smoking rates remain high (14 %), every year more people are successfully quitting
- Despite an increase in physical activity rates to 64 % of adults in 2021, conditions such as stroke, heart disease and hypertension remain higher than regional and national comparators
- 40 % of 11-year-old children and 72 % of adults are overweight or obese
- Adult community substance and alcohol services are able to support more people and now reach 950 people per year
- Around 800 people engage in problem gambling, and around 3,200 in moderate risk gambling.



What people are telling us

The themes emerging from the public consultation work were as follows:

- Prevention and the importance of accessing support to make and maintain healthy life choices were deemed to be very important, alongside good communication and information
- Access to healthcare and sufficient provision of staff and services was a recurring request from members of the public. Alongside this was a clear message that people want to manage their physical and mental health in a more proactive way, rather than simply being recipients of care from our providers
- The importance of tailoring our services to meet the needs of specific groups was also seen to be important, whether that be through considering protected characteristics, language, stigma, individual access to resources or individual needs
- There was also a strong sense that some of the answers to better health lie in strengthening our community networks and resources and investing in our natural and built environments. Health at work, poverty reduction and access to healthy food were also identified as key areas for development.

Stakeholders and partner organisations identified similar themes, recognising the importance of the wider determinants of health (see figure 2), the need to co-produce our plans with our population, and to work towards adopting the Marmot Principles to tackle the social

determinants of health (see figure 2). There was also a call for greater visibility of the Health and Wellbeing Strategy and for the system to facilitate joined up collaborative working against clear goals.

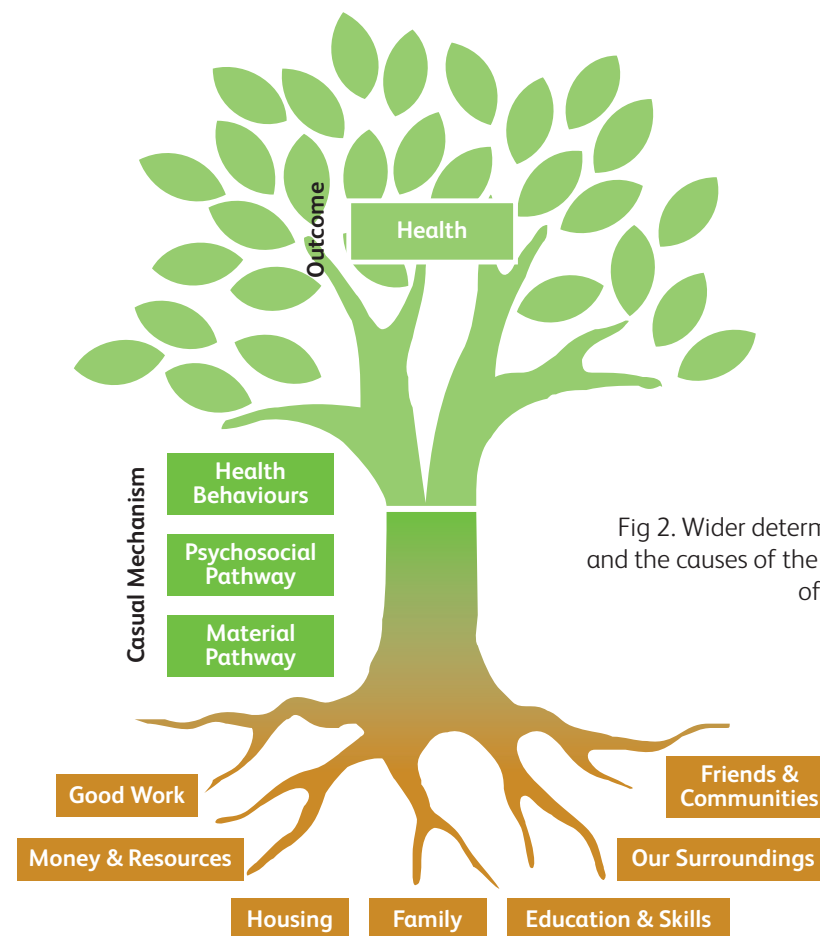


Fig 2. Wider determinants and the causes of the causes of health

The Marmot Principles

The recommended actions, covering the main social determinants of health in places are developed in the following areas (known as the 'Marmot Eight' principles):

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention
7. Tackle racism, discrimination and their outcomes
8. Pursue environmental sustainability and health equity together.

Based on these eight principles, Marmot Places develop and deliver interventions and policies to improve health equity; embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity. Places commit to improve health equity over the short, medium and long term by:

- A. Developing and delivering approaches, interventions and policies to improve health equity
- B. Strengthening their health equity systems
- C. Involving communities in the identification of the drivers of poor health and in the design and implementation of actions to reduce them
- D. Broadening advocacy on health equity and engaging with other Marmot Places to share knowledge, roll out best practice alongside partners in local regions and nationally.

What we will do

The Health and Wellbeing Board met in January 2025 to review the aims and priorities of the previous strategy. While the aims were broadly felt to be useful, recommendations were made to update them to be clearer about our areas of priority focus over the next five years. The aims and our methods to deliver them have emerged from the evidence and engagement described above.

Our aims now cover - children and young people; physical health; mental health and the wider determinants of health. Alongside the aims we have identified, through consultation, seven ways of working to guide and enable efforts across the partnership to deliver the aims. These are shown on the following page in figure 3.

Rotherham Health and Wellbeing Strategy 2025-30

Our vision is: to enable the people of Rotherham to live happy, health and independent lives within thriving communities, regardless of background and personal circumstance.

We will achieve this by:

Enabling all **children and young people** up to the age of 25 to have the best start in life, maximise their capabilities and have influence and control over their lives.

Supporting the people of Rotherham to live in good and improving **physical health** throughout their lives, accessing and shaping the services and resources they need.

Supporting the people of Rotherham to live in good and improving **mental health** throughout their lives, accessing and shaping the services and resources they need.

Sustaining an environment where detrimental impacts from **commercial and wider determinants of health** are reduced and opportunities for healthier living are nurtured.

And by working in the following ways:

Ensuring our practice is evidence-informed

Applying a strong emphasis on prevention

Strengthening population independence and resilience

Tackling health inequality

Taking a compassionate approach

Making the most of community assets

Taking joint responsibility across system

Fig 3. Our Vision, Aims and Ways of Working

The ways of working mean that across Rotherham, we commit to the following:

- **Ensuring our practice is evidence informed**

- Continue to seek high-quality evidence and apply to commissioning and management of services
- Ensure that community voice is captured and acted upon
- Follow best practice, but also innovate and share good practice and research back to the wider system
- Using tools such as the JSNA, Core20PLUS5 and the inclusion framework to ensure that we allocate our resources according to need.

- **Applying a strong emphasis on prevention**

- Developing prevention-promoting environments
- Developing good educational interventions and information resources for residents and the workforce
- Promoting screening and vaccine uptake
- Support to manage long-term conditions
- Consider opportunities for 'upstream' intervention
- Support early identification of need and intervene with holistic approaches.

- **Strengthening population independence and resilience**

- Supporting individual ownership of health and wellbeing
- Co-production and co-design approaches to make sure services match need
- Develop models of care which make the most of non-medical support, such as peer support and voluntary and charity sector services.

- **Tackling health inequality, and provide help to those that need it most**

- Ensure additional support and attention given to groups and individuals who have higher need, have poor experience of services or have poorer health outcomes
- Seek out and remove physical, social and economic barriers to accessing services
- Collect the right information to understand these patterns
- Engage directly with the people of Rotherham to ensure that we understand need
- Apply Marmot principles to tackle health inequalities across all partnership activity where possible.

- **Taking a compassionate approach**

- Address the social, economic and environmental drivers of health
- Support people to form healthy habits
- Recognise and challenge systemic barriers to positive behaviours.

- **Strengthening and making the most of community assets**

- Ensure communities are involved in local decision making
- Capitalise on the role of strong social connections in health outcomes
- Encourage communities to support those most at risk.

- **Taking joint responsibility across the system to tackle difficult challenges**

- Strengthen our ‘health in all policies’ approach
- Use the power and resources of existing partnership boards and groups to deliver the health and wellbeing agenda
- Identify gaps and aim to design joined-up services
- Empower place partnerships to prioritise pooled resources
- Deliver joined up multiagency solutions.



How we will do it

In the context of increasing demand and stretched public resources, our priorities, whilst ambitious for residents, need to be achievable and to support the wider partnership in applying sufficient focus. The delivery of our aims and priorities will be resourced from the pooled capacity of our individual organisations working together. In addition to supporting and enabling a broad range of projects and interventions, we have chosen to adopt a streamlined prioritisation system for the actions supporting the current strategy.

We will adopt three short-term priorities over the five-year period 2025-2030. These priorities will be shortlisted and chosen through stakeholder engagement and workshop events in autumn 2025, and reviewed in 2027.

The criteria for inclusion in the priority shortlist are:

- a) Is it an issue which would benefit from cross-partner intervention?
- b) Would tackling this issue have a significant impact on our population as a whole, or on one of our key vulnerable groups?
- c) Is it possible to make substantial, measurable progress within the given timeframe?

The chosen priorities will be built into a live action plan and a Board level champion will be identified for each priority. Through a regular meeting cycle, progress will be reported and discussed at Board meetings, including updates from supporting groups and other work associated in the delivery of the plan. Progress on our aims, priorities and action plan will be reported through the Health and Wellbeing Board website.

How we will see the impact

We will track our success in improving health and wellbeing in Rotherham through monitoring existing outcomes frameworks. The Rotherham JSNA will continue to provide insight into the detail of the health of our population. In addition, we will be monitoring the high-level outcomes of the South Yorkshire Integrated Care Boards (ICB) Outcomes Framework.

As part of the public consultation about the strategy, a range of questions have been developed to ask residents which, alongside various engagement events, will be used to gauge changing needs and priorities in the community. These will be regularly presented to Health and Wellbeing Board for discussion and challenge.

Conclusion

The Rotherham Health and Wellbeing Board brings together local organisations, working in partnership with our communities to deliver our ambitious vision “to enable the people of Rotherham to live happy, healthy, independent lives within thriving communities, regardless of background and personal circumstance.”

Together, we will drive and enable action across the life course, focusing on reducing health and social inequalities to support everyone in Rotherham to have the opportunity to live a healthy and satisfying life.

As we develop the priority projects necessary to deliver our aims over the life of the strategy, we will need to work closely and proactively with our residents and workforce to build resilience, deliver societal change and support a healthy, happy population.

Glossary

Core20PLUS5: a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.

Health Inequalities: avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequality, and many ways in which the term is used. This means that when we talk about a specific ‘health inequality’, it is useful to be clear on which measure is unequally distributed, and between which people.

HWBB: Health and Wellbeing Board. This is the statutory body with responsibility to set the strategic direction for local population health and wellbeing.

ICB: Integrated Care Boards are NHS organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the integrated care strategy.

ICS: Integrated Care Systems are local partnerships that bring health and care organisations together to develop shared plans and joined-up services.

JSNA: The Joint Strategic Needs Assessment looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services. It takes a wide view of health and is concerned with wider social factors that have an impact on people’s health and wellbeing, such as housing, deprivation and employment, it can be used to identify health inequalities, and it identifies gaps in health and care services, documenting unmet needs.

Stakeholders: Everyone with an interest in supporting and improving the health and wellbeing of the people of Rotherham.

Wider Determinants of Health: The wider determinants of health are a diverse range of social, economic and environmental factors which influence people’s mental and physical health. Systematic variation in these factors drives health inequalities.

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Appendix 2.

HWB Strategy 2025 Development Evidence Base

Presented to the Health and Wellbeing Board

22nd Jan 2025

1

Reviewing our situation

- Austerity / Poverty – continuing impact
- Post-pandemic – what should we pick back up?
- Continued financial and service system pressures
- Ageing population
- Significant impact of preventable illnesses

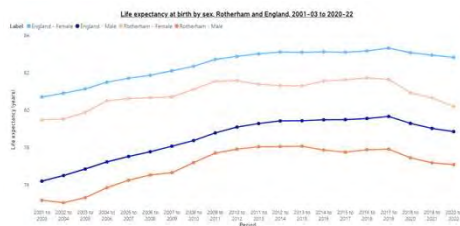
- A little bit of data...

2

Life Expectancy in Rotherham

Life expectancy

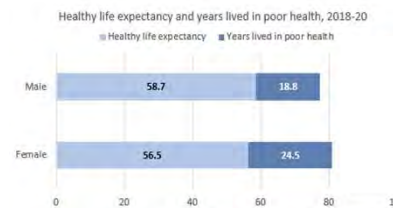
- Life expectancy at birth for males in Rotherham, 2020-22, is 77.1 years; significantly lower than the England value of 78.9 years.
- Life expectancy at birth for women in Rotherham, 2020-22, is 80.2 years; significantly lower than the England rate of 82.8 years.



Data sources: Life expectancy and healthy life expectancy data are from Fingertips - [Public health profiles - OHID \(phe.org.uk\)](https://publichealthprofiles.org.uk/) data source: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/healthstatelifeexpectancyallagesuk>
Index of Multiple Deprivation: [English indices of deprivation 2019 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/collections/english-index-of-multiple-deprivation)
Link to JSNA: [People - Rotherham Data Hub](#)

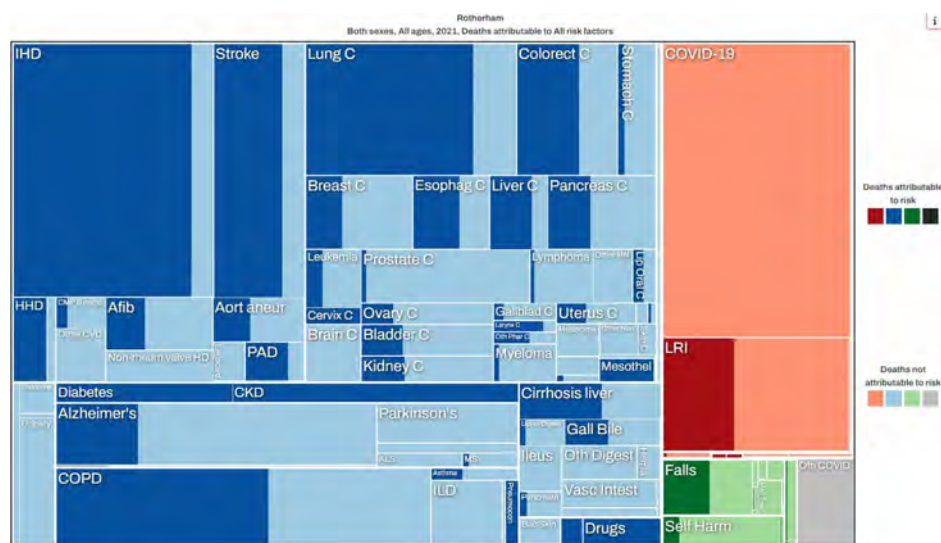
Healthy life expectancy

- Healthy life expectancy at birth, 2018-2020, in Rotherham is 58.7 years for a male, significantly lower than the England average of 63.1.
- Healthy life expectancy at birth, 2018-2020, in Rotherham is 56.5 years for a female, significantly lower than the England average of 63.9.



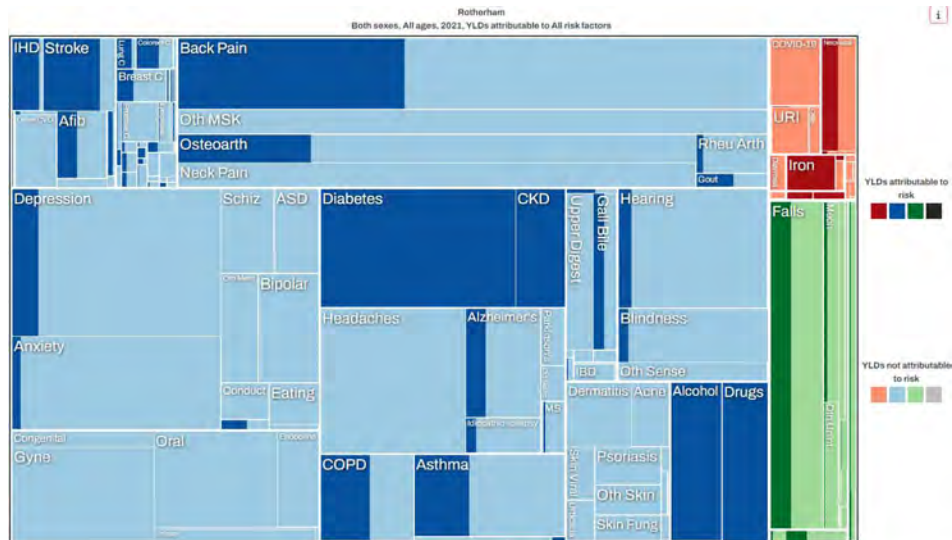
3

What we die of in Rotherham



4

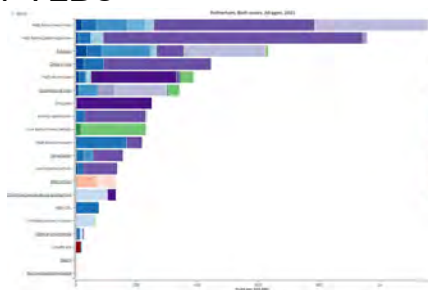
What we live with in Rotherham



5

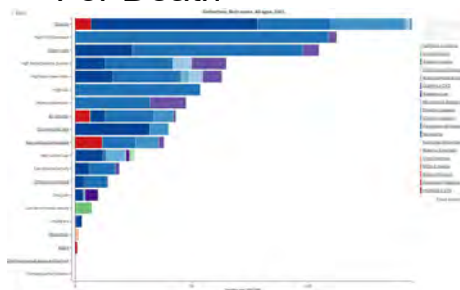
Risk Factors

• For YLDs



High Body Mass Index
High Fasting Plasma Glucose
Tobacco
Dietary Risks
High Alcohol Use
Occupational Risks

• For Death

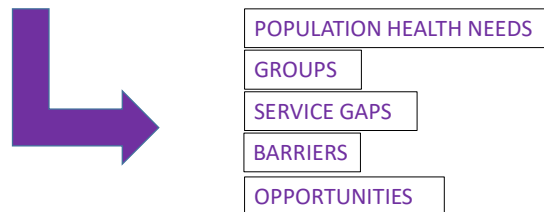


Tobacco
High Blood Pressure
Dietary Risks
High Fasting Plasma Glucose
High Body Mass Index
High LDL

6

Overview of evidence gathering process

- Summary of consultation work and approach:
 - Board members – 1:1 discussions
 - Working group – shaping the engagement plan
 - Stakeholders- working group, bespoke survey, individual submissions, events
 - Population – review of existing consultation; bespoke survey
 - Evidence – JSNA and partnership discussions around opportunity



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Discussions with Aim Sponsors

Summary of themes:

- Visibility
- Ownership across partnership boundaries/ complex systems working
- Effectiveness / How do we know if we're succeeding?
- Mechanics of the action plan: driving the activity.
- Challenge
- Avoiding passivity

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Evidence from prior consultation - community

Health and Wellbeing Strategy Refresh

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Reports included

- Rotherham Maternity and Neonatal Voices Partnership Annual Report 2023-24
- Engagement sessions with BAME women overview report (2023)
- Rotherham Insights – TRFT, Rotherham Opportunities College, Shiloh, Healthwatch Rotherham Group, Kashmiri and Yemeni Older People's Forum, Rotherham Drop-in (ICB), Mature Millers, Rotherham residents online, Military Community Veterans Centre, Social Supermarket (Rotherham Minster)
- SYICS engagement (2022)
- Healthwatch transport report (2024)
- Healthwatch LD & ASD report (2024)
- Rotherham Show (2024)
- SY Insights (Healthwatch, 2023/24) – care homes, RDaSH crisis team, unpaid/informal carers, Rotherham Deaf Futures Community Group, Rotherham hospital appointment wait times
- OSMB Youth Cabinet
- Chilypep (Children and Young People's Empowerment Project)

10

Key themes – health/healthcare

Information and Education

- Information on health prevention and availability of services
- Unpaid carers
- Antenatal
- Menopause

Communication

- Importance of good communication and feeling listened to
- e.g. clear explanations, easy read letters, care plans, using appropriate channels
- Communication between services

Prevention and Health Behaviours

- Importance
- Support to live well
- Barriers to living well - commercial determinants, financial constraints, time constraints, lack of information

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Key themes - health/healthcare

Access

- Waiting times
- Travel - mobility/accessibility, public transport (need to be frequent, reliable, inexpensive)
- Childcare allowances
- Staffing levels

Provision

- LD & ASD – specialist support and health passports valued
- Crisis MH care – after care/support
- Unpaid carers – desire for core dedicated team, 'one stop shop'

Agency

- Providing people with information, tools and capacity to manage their own care
- E.g. valuing personalised care plans, informed choice/consent

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Key themes - health/healthcare

Equality, Diversity and Inclusion

- Culturally competent care
 - End of life and bereavement support
 - Women's Health
- Language and communication
 - Need for more information in plain English
 - Challenges of securing interpreters (including BSL) for healthcare appointments
 - Reasonable adjustments for people with ASD or LD
 - Digitally excluded
- Tackling stigma and discrimination
 - Substance misuse issues
 - Mental health issues
 - Obesity
 - Unpaid carers – need for more recognition

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Key themes - wider determinants

Social and community

- Groups/activities
- Importance of friends and family for health
- Importance of feeling connected to community
- Community assets

Neighbourhood and environment

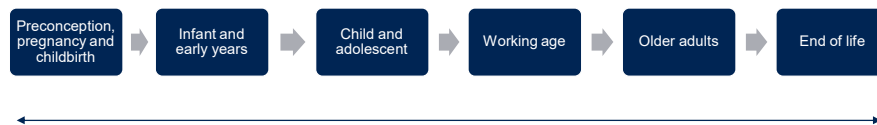
- Safety
- Nature and green space
- Access to outdoor space and leisure facilities
- Quality housing
- Improved transport and facilitation of active transport
- Dedicated youth spaces

Economic issues, work and school

- financial security, negative impacts of financial deprivation
- Importance of work/school for health and wellbeing
- Workplace issues

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Life stages and key groups



Key groups highlighted within consultation work

Mental health and wellbeing
 Informal carers
 Women's health
 People with learning disability or autism
 People with physical disability
 Ethnic minority and faith communities

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Bespoke consultation for strategy (and beyond)

R Response Summary

Question Number	1	2	3	4	5	6	7	8	9	10	11	12	Age Range	Working Age	Not Working Age
Access															
Access															
Gen															
Financial Constraints															
Access to Health															
Access to Health															
Lack of Information															
Time constraints															

"No takeaways"
"More exercise"
"Cleaner environment"
"Getting a GP appointment"
"Cost of living healthily"
"Not enough time"
"Not knowing what to do"

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Evidence from stakeholder consultation

H&WB Strategy Refresh

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Response summary

- Total responses: 17
- Organisations engaged:
 - The Sleep Charity
 - Rotherham United Community Trust
 - Sheffield and Rotherham Wildlife Trust
 - VAR
 - Rotherham Minster
 - Early Help
 - RMBC Registration & Bereavement Services
 - RMBC Public Health
 - RDaSH
 - The Rotherham NHS Foundation Trust
 - Hope and Dignity Hearth (Ubuntu Arts And Culture Environmental Health and Emotional Healing Initiative)
 - Children and Young People's Alliance (CYPA)
 - Healthwatch
 - Nayi Zindagi
 - Rotherham Carers Forum

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1. What do you think are the main needs of the population you serve?

- Wider determinants
- Holistic offer
- Mental health and wellbeing
- Nature and green space
- Knowledge and information
- Resources
- Voice

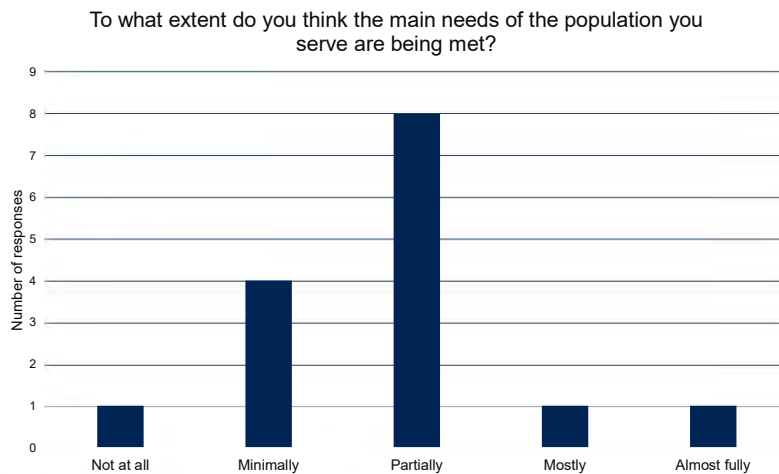
19

1. What do you think are the main needs of the population you serve?

"There is a need for human connection, people to spend time with, talk to and a place to belong. Mental health struggles are compounded when there are financial struggles and debt. Support with food is needed, but also 1:1 help to work out how to make progress. Holistic support. Body, mind and spirit"

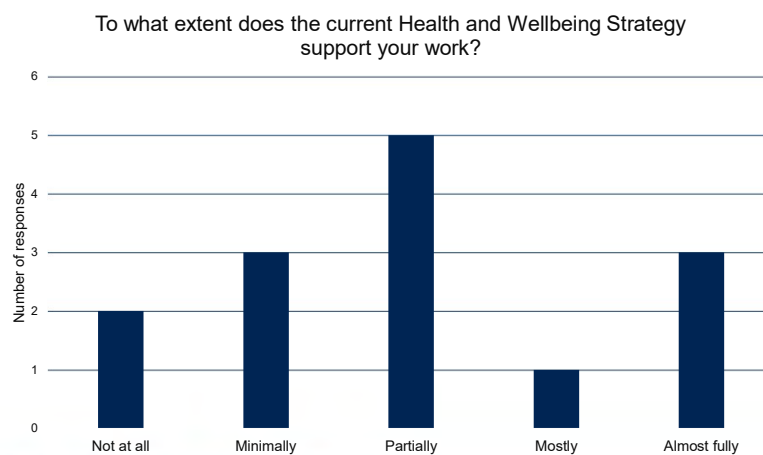
20

2. To what extent do you think those needs are currently being met?



21

3. To what extent does the current Health and Wellbeing Strategy support your work, and why?



22

3. To what extent does the current Health and Wellbeing Strategy support your work, and why?

Reasons for not at all/minimally/partially

- Some responders had no involvement or were not familiar with strategy
- Some responders highlighted key areas they felt were missing (related to individual areas of work)
- Greater cohesion needed between different organisations
- Communication links with H&W board
- Need for sustainable strategy that will look at whole life journey
- Need to strengthen the role and impact of ill-health prevention.
- Not enough consultation with minoritised groups

Reasons for almost fully

- Aims supportive of overall vision of services
- Relevant HWB priorities can help progress work across the partnership, create new opportunities and overcome challenges.

23

3. To what extent does the current Health and Wellbeing Strategy support your work, and why?

"We need greater cohesion between RMBC, NHS, PCN, ICB and the Vol Com to put a sustainable strategy together that will look at the whole life journey"

"It is sometimes hard to see the link between the H&W strategy and our RDaSH strategic plan."

"There has not been enough consultation with minoritised groups."

"There have been examples/incidences, when having these as HWB priorities has helped progress work across the partnership, create new opportunities and overcome challenges."

"Not sure as I don't know what the strategy is"

24

4. What do you think the overall vision should be for the health and wellbeing of Rotherham?

- Holistic
- Life course approach / Marmot principles
- Community-based
- Prevention focused
- Health inequality focused
- Mental health and wellbeing

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4. What do you think the overall vision should be for the health and wellbeing of Rotherham?

"Holistic, accessible support in the heart of the community"

"Improvements in prevention of ill health and greater equity"

"I think our vision needs to have a focus on addressing inequalities, creating supportive environments and communities and highlighting that it is a collective responsibility"

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5. Is there anything else you'd like us to consider while developing the 2025 HWB Strategy?

- A focus on specific groups - women, children and young people, different cultural groups
- Consideration of wider context
- Ensuring that current HWB plans are supported going forwards and link with other strategies
- Easy read version of strategy

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Summary

- Need for greater cohesion/ connection between organisations
- Need to strengthen role and impact of prevention
- HWB Strategy needs to be more visible
- Ensure that strategies across different boards are joined up
- Ensure that specific groups of need are supported
- Need to support people across the life course

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Rotherham JSNA 2024/5

Summary slides- areas of opportunity for the 2025-30 Strategy

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Population

- The population of Rotherham borough is 268,400 with an age structure that is slightly older than the national average.
- Rotherham has a below-average percentage of people aged 18 to 29 as a result of students leaving Rotherham to study elsewhere and young adults leaving the area for work.
- The population is growing due to there being more births than deaths, and higher net inward migration.

Opportunities

- Investment in retention of younger age groups to live and work in the borough: opportunity to attract and train young people in work which supports the socioeconomic and environmental benefit of all.
- Consider and plan for needs of ageing population in current system:
 - explore recommendations of DPH Annual Report 2024 in understanding role of primary care
 - Transformation work across the system around frailty
 - Development and ongoing support for programmes focusing on ageing well

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Population Groups

- 36% of population live in the most deprived quintile. Deprivation is a major cause of health inequalities.
- Almost 9 in ten eligible 2 year olds are taking up a place in early education, and nearly three quarters engage with childrens centres.
- Over 11,000 children in Rotherham are living in absolute poverty.
- Over 3,700 people are currently accessing adult social care services, with around half of these over the age of 75.
- Over 23,000 people provide unpaid care, with over half of these doing so for more than 35 hours per week. A third of adult carers feel socially isolated.
- In 2023, 1,236 families were identified as being at risk of homelessness.

Opportunities

- Develop population-focused interventions to support disadvantaged communities and groups.
- Capitalise on the Family Hubs initiative to continue to provide excellent, joined up services for children and families in the borough.
- Implement recommendations of the Rotherham Mental Health Needs Assessment.
- Operationalise Rotherham Inclusion Health Framework

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Health Overview

- Life expectancy is lower than average for the people of Rotherham, and there is an inequalities gap of over 10 years between the most deprived and least deprived.
- Our residents develop poor health earlier than average and live longer in poor health than average. The average age a girl born in Rotherham today can expect to live without chronic, life-changing illness is 56 years.
- The prevalence of depression has risen to 17% in 2022 and 25% of school children report problems with mental wellbeing
- Deprivation significantly impacts patient experience and outcomes of chronic pain, mental health issues, diabetes, cardiovascular and other long term conditions.
- Screening uptake rates have generally been good in Rotherham compared to England , but for breast and cervical cancer, screening rates have not yet returned to pre-covid levels.
- Those in the most deprived areas are more likely to missed appointments and experience difficulties in accessing healthcare.

Opportunities

- Improving life expectancy and healthy life expectancy can be achieved by:
 - Investing in preventative programmes which tackle the impacts of wider determinants of health,
 - Improving access to healthcare and improving healthcare outcomes,
 - Investing in community assets and socioeconomic infrastructure,
 - Targeting interventions to tackle inequalities
 - Empowering patients in decision making
- Focussed intervention on and prioritisation of specific disease pathways (e.g. CVD, pain, respiratory)

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Behavioural Risk Factors

- Smoking is still the primary cause of morbidity and early mortality. Although smoking rates remain high (14%), more people are successfully quitting.
- Despite an increase in physical activity rates to 64% of adults in 2021, conditions such as stroke, CHD and hypertension remain higher than regional and national comparators.
- 40% of 11 year old children and 72% of adults are overweight or obese.
- Adult presentations to community substance and alcohol services have increased to over 950 per year (this represents an increase in capacity of the service)
- About 800 people engage in problem gambling, and around 3,200 in moderate risk gambling.
- Increase in sexually transmitted diseases.

Opportunities

- Capitalise on 'Smokefree Generation' national policy and tobacco control investment initiatives to eradicate the harms of smoking.
- Build a health coaching, 'patient activation' model into our *Making Every Contact Count* programme to provide both workforce and general population with skills to make a healthy change.
- Work to address transitions across organisational boundaries for high-risk patients moving between community and acute services.
- Capitalise on physical activity local place partnership
- Address gaps in provision and support (e.g. gambling harms, advertising policies)

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Economic Determinants

- Over 40,000 working age adults are economically inactive, and around 13% are actively seeking employment.
- In 2023, there were over 16,000 working age adults with long-term sickness.
- More women than men were in work in 2023, due to a recent decrease in male employment rates.
- On average, female full-time earnings are £9,000 less than male full-time earnings in the borough.
- The employment rate for disabled people (42%) in Rotherham is around half that for non-disabled people (82%).
- 17% of households live in fuel poverty.

Opportunities

- Developing preventative workplace health interventions to reduce the numbers of employees being off work
- Roll out and support the Anchor approach, supporting local career development and investment in infrastructure to support partnership interventions.
- Encourage local organisations to formally support volunteering and social investment.
- Poverty-proofing work (cf RDaSH)
- Further mobilise CAB and third sector

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Social Determinants

- The largest proportion of crimes reported were for violence, sexual offences and anti-social behaviour.
- 40% of our population live in areas that are at the highest risk of food insecurity.
- Nearly 30% of school children are eligible for free school meals.
- 8% of our residents say they feel lonely always or often.
- Rotherham population's measures of personal wellbeing are lower than regional and national averages.
- Historically, Rotherham has had lower than average levels of investment in arts and culture, and has lower rates of participation.

Opportunities

- Creative health board and developing links to Cultural Strategy 2026 to support quality of life
- Develop and support community assets to meet locally identified needs
- Patient experience groups/ cafes
- Food network / link to commercial determinants
- Children's Capital of Culture 2025 and its legacy
- Develop and support the range of services offered by libraries
- Digital inclusion programmes

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Environmental Determinants

- Mortality attributable to particulate air pollution in 2021 was 5%
- Greenhouse gas emissions increased by 1.1%, with transport accounting for most. Car use is increasing.
- People living in areas of higher deprivation are more likely to be at risk of flooding and less likely to be able to respond to flooding incidents.
- Older people, the very young, and those with learning disabilities are most at risk of extreme temperatures. Heat exposure risk is concentrated on the town centre and areas bordering Sheffield conurbation.
- 15% of Rotherham households live in the private rented sector.
- 12% of council homes do not meet the Decent Homes Standard.

Opportunities

- Active travel developments
- Green space and exercise
- Development of household risk directory to provide multiagency support to vulnerable households.
- Engagement with housing and planning on:
 - Designing in healthy outcomes in new and existing developments
 - Ensuring high-quality homes
 - Improving access to adaptations

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Summary

- Importance of applying inequalities lens to different groups needs
- Tackling ageing population
- Growing demand requires preventative, supportive, early intervention approaches
- Gaps exist in services – which should we prioritise?
- Economic and Environmental determinants are particularly challenging

Opportunities

- Targeted population intervention approaches
- Ensure HI lens is built into system reporting standards
- Develop strong prevention ethos across partnership
- Seek, listen and respond to patient voice, develop capacity of insights databank
- Collaboration across partnerships to tackle complex systemic issues
- Develop approaches to support population resilience
- Consider methods of prioritising potential interventions (e.g. health economics, impacts on QALYs)

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Evidence Theme Summary

- A strong emphasis on prevention
- Strengthening population and patient resilience
- Tackling health inequality, and provide help to those that need it most
- Strengthening and making the most of community assets
- Strengthening joined-up approaches
- Tackling difficult challenges
- Taking joint responsibility across the system
- A visible strategy that enables and empowers

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