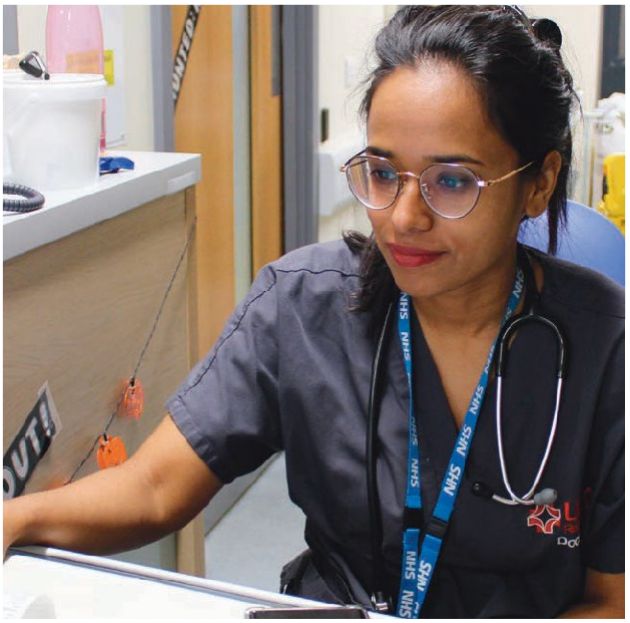
NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2023/24



Ambitious
Caring
Together

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2023-24

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

Contents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Welcome from the Chair

It has been a great honour and privilege to have been appointed Chairman of The Rotherham NHS Foundation Trust, a position I took up from 1 January 2024. I would first of all like to extend my personal thanks to Martin Havenhand for his many years of dedicated service as the Chairman of this Trust.

What has struck me since I started at the Trust is the overwhelming dedication from our clinical and non-clinical staff who work so hard to meet the significant operational challenges.

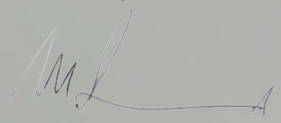
The last year has been a particularly challenging year for our staff with unprecedented episodes of industrial action which have caused significant disruption for our patients. Despite this, the Trust should be incredibly proud of its achievements during the last year. We have continued to find ways to provide the right support for our staff and we will continue to do so over the next year. Our excellent staff survey results, with improvement across all domains is excellent and we will not rest on our laurels and will work hard with staff to further improve those scores.

Throughout the last year, we have continued to work collaboratively within the Integrated System and further strengthened our partnership working with Barnsley Hospital NHS Foundation Trust, a partnership which is already showing positive signs of improving patient care and I am looking forward to developing this further in the next year.

On behalf of the Board and as Chairman of the Council of Governors I would like to record my thanks to our Governors and volunteers who help us provide the best possible care to our communities.

Finally I would like to welcome Hannah Watson and Julia Burrows who joined our Board as Non-Executive Directors and extend my thanks to Dee Sissons and Jo Bibby who stepped down from the Board this year.

Best wishes,



Dr Mike Richmond
Chair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40 Years Service Award
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Performance Report
Overview of Performance: About Us

The purpose of this overview section is to provide a brief summary of information about the organisation, its purpose, key risks and performance.

A brief history and statutory background

The Rotherham NHS Foundation Trust was established on 01 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, are a membership based, public benefit corporation and the Care Quality Commission regulates the quality of the services the Trust provides.

Prior to 2005, the Trust was known as Rotherham General Hospital NHS Trust. In 2011, the Trust acquired Rotherham Community Health Services resulting in a combined Trust providing 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 carry out the following regulated services:

- 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 provided at the Trust's Moorgate Road site. The Trust also provides services at Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre and New Street Health Centre in Barnsley.

As at 31 March 2024, the Trust had a total of 5,150 dedicated members of staff working across an Acute and Community model of care serving a population of over 270,000 across the South Yorkshire region. The Trust has a Divisional management structure in order to co-ordinate and deliver healthcare services throughout the following structure:

- Medicine
- Surgery
- Urgent and Emergency Care Centre
- Community
- Family Health
- Clinical Support Services

The Trust has additional support services comprising Health Informatics, Estates and Facilities, Strategy, Planning and Performance, Workforce and Finance, all of which are led by an Executive Director.

Rotherham is a town with high levels of deprivation with over 50,000 people living in deprived areas. Deprivation often leads to inequality of health care and a key aspect of our ambition is to improve fair access to healthcare for all. The population is older than the national average, the majority being white British with approximately 20,000 people from minority ethnic groups.

System and Partnership working

The Trust continues to be a core member of the Acute Federation of hospitals in South Yorkshire.

In addition, we have further developed our partnership working with Barnsley Hospital NHS Foundation Trust by creating a Joint Strategic Partnership Group comprising both Chairs, Joint Chief Executive, both Managing Directors, a Non- Executive Director from each Trust and the Joint Director of Corporate Affairs. The Group meets on a quarterly basis providing oversight on behalf of both Boards on the development and delivery against the planned programme.

During the last financial year we have also brought together a number of members from both Executive Teams to form the Joint Delivery Group, responsible for the delivery of the joint work programme on an ongoing basis. The partnership work programme was developed through a structured engagement approach involving both Executive Teams and the wider Senior Leadership groups. During this inaugural year, various individual prices of work were grouped into three main themes, namely governance, major programmes and smaller projects.

The governance theme covered the formal structures necessary to ensure delivery of the programme. Joint Senior Leaders meetings have taken place with a focus on cross-organisational and divisional collaboration. In addition, teams have continued to engage with each other over potential mutual support.

Three major programmes of work were identified for 2023-24, namely a Clinical Services Review, Joint Leadership Development Programme and Commercial Opportunities.

Having successfully delivered a joint gastroenterology service and embedded this into business as usual, we looked at other opportunities to directly collaborate within services which will continue into 2024-25. Both Trusts recognised that effective, empowered and valued leadership is the key to the success of the partnership as well as both Trusts delivering on their own objectives and ambitions. Both leadership teams began a 12 month engagement programme focused on developing leadership behaviours and skills to thrive.

During the last year there have been smaller, more discrete opportunities which nevertheless in the aggregate, will provide considerable benefits to both organisations. One notable benefit of the partnership is the enablement of potential joint roles across both organisations where they can support sustainability. We currently have a joint Chief Executive, Director of Corporate Affairs and Joint Head of Procurement. In addition, the Chief Pharmacist at the Trust supported Barnsley on an interim, short term basis. Whilst there is no intention for joint roles to be the default position, these positive examples of how the two organisations can work together to manage critical workforce gaps demonstrate the significant benefit to be gained from consideration of these arrangements.

In 2023 we submitted a joint bid to NHS England to host NHS Graduate Scheme individuals with the intention of rotating any successful candidates across the two organisations. As a result four graduates commenced their placements and being able to offer the NHS Graduate Scheme trainees this mixed experience within two providers was seen as unique and highly positive.

We are beginning to look forward to 2024-25 by developing the work programme to share further opportunities both internally and the wider NHS.

Our Purpose

We are incredibly proud of the achievements of the Trust, and in particular over the last 12 months. We are determined to continue our improvement journey and 'Our New Journey Together' sets out our Strategic Ambitions until 2027, giving us a clear direction as we all navigate through the changing landscape.

Key Issues, Opportunities and Risks

It is essential we continue to maintain a high standard of quality care. The Board of Directors and senior managers continually review key metrics and risks that have the potential to undermine the achievement of our Strategic Ambitions.

The Board Assurance Framework was redrafted in 2020-21 to align with our new Strategic Ambitions for 2022-2027. The Assurance Committees and Board continued to review the Board Assurance Framework on a monthly and bi-monthly basis respectively and will continue to monitor its' relevance to ensure it reflects the risks within the organisation and remains relevant to the work we do.

The key risks identified in year are described within the Annual Governance Statement.

The risks relevant for the end of the financial year and going forward as future risks relate to the following:

- Risk we will not embed quality care due to the lack of resource, capacity and capability leading to poor clinical outcomes and patient experience
- Risk that robust service re-configuration across the system will not progress and deliver seamless end to end patient care across the system due to a lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.
- Risk we do not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased health inequalities.
- Risk we will not deliver safe and excellent performance due to insufficient resources (financial and human) leading to an increase in our patient waiting times and potential of patient deterioration and inability to deliver our Operational Plan.
- Risk we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023-24 leading to further financial instability.

Environmental Sustainability and Net Zero

The Rotherham NHS Foundation Trust Green Plan sets out how we will address the Net Zero challenge for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and a totally emissions free site by 2040.

Our Green Plan intends to exceed the current NHS commitments towards environmental sustainability by:

- Achieving at least an 80% reduction in emissions from on-site sources by 2032
- Achieving a further 5% reduction in general waste, based on 2020's levels Reduce patient service mileage by 25% based on 2020 by 2023, by delivering care closer to home and in the community settings
- Ceasing use of all single use plastics
- Reducing water consumption by 10% by 2025.

The Trust continues to make progress against the agreed commitments as set out in our approved Green Plan.

Performance Analysis – Statement from the Chief Executive

During the last year, we have seen an ever increasing demand for our services and despite the challenging environments, we have worked exceptionally hard to improve our performance. The impact of the industrial action during the last year cannot be underestimated and we are grateful for all staff who stepped in to ensure we delivered safe care to our patients.

The Trust measures performance in a variety of ways. Clinical performance is monitored against key national standards with the Board having oversight of a range of internal and external metrics. The Trust produces a monthly Integrated Performance Report (IPR) based around four key domains, namely quality, workforce, operational delivery and financial performance. This includes performance against all the appropriate constitutional standards in addition to key local targets. Following detailed scrutiny at the Board Committees, the IPR is discussed at the Board meeting held in public whereby any escalations from the Board Committees can be further discussed. The IPR comprises the latest performance against target, year-to-date performance, time-series performance information and where available, comparable benchmarking data. Key metrics are shown on Statistical Process Control (SPC) charts which enable a clearer assessment of potential risk of delivery; the Trust is developing a new IPR for 2024-25 providing increased focus on performance based on an SPC analysis.

In addition to the formal reporting process described above, a number of additional fora provide the opportunity for scrutiny of performance including monthly Divisional Performance meetings where each Division is challenged by the Executive Team around their recent performance. These meetings are based around Divisional performance dashboards which flow from the IPR thus ensuring a clear connection between the Trust and Divisional performance. In addition, the Executive Team scrutinise the performance of the corporate teams once a month across all corporate areas (Estates, Nursing, People and Finance). The Trust has recently focused on developing its live performance reports and business intelligence function in order to empower colleagues to deliver improvement through access to real-time performance data.

Despite a number of unprecedented challenges, such as sustained periods when our services were disrupted by industrial action, staff continued to work with exceptional dedication. During the financial year 2023-24, the Trust returned, for the first time since 2019, to the 4-hour urgent and emergency care standards which was a significant change from the previous four years of operating under the national field test standards. Equally, last year was the first year since the pandemic where the NHS nationally has set a different 4-hour performance expectation to the constitutional standard of 95%, which inevitably led to a doubling down of national efforts to deliver the in-year 4-hour target of 76%.

As the Trust had previously been working to a very different set of urgent care metrics and had redesigned urgent care pathways to meet those, the two aforementioned external factors combined, led to the need for the development and implementation of an intensive programme of change throughout the year. This required an ongoing effort to change our processes, our decision-making and our capacity to be more responsive to the 4-hour standard. A Trust-wide programme of work continued throughout the year, with a broad range of work streams, including urgent care pathways, workforce development, operational capacity and patient experience. Whist significant progress has been made, further work remains to embed many of the new ways of working across the whole organisation and deliver the expectation around 4-hour performance.

As alluded to above, 2023-24 was a year heavily affected by both the direct impact of industrial action and the backdrop of the challenges this created. During the last financial year, there were 12 periods of industrial action including two periods of combined industrial action by both the Consultant workforce and Doctors in Training. Whilst the immediate impact on patients was measurable and has been widely reported, perhaps more notably, there were significant wider effects on our teams due to the intense planning required in order to manage these periods including the continual need to ask clinical colleagues to support outside of their normal duties.

The operational pressures in 2023-24 were such that unfortunately the Trust saw 49 patients waiting 12 hours for a bed of which 30 (61%) were in January. Such pressures were driven in part by the industrial action which took place in early January which along with the 16% increase in demand in month compared to the same month in 2022-23, led to significant organisational challenges around flow.
These increased levels of demand along with the prolonged impact of industrial action, led to the Trust experiencing significant operational pressures.

The Trust continued to work closely with partner organisations to ensure an appropriate Place-based response to managing the increased risks during these times of heightened pressure, implementing full command and control structures as appropriate. The operational, medical and nursing teams coped admirably, continuing to work tirelessly to deliver wider healthcare services to the population.

As in previous years, the Trust worked with Place partners to develop the Winter Plan. This consisted of modelling the anticipated demand that would be placed upon critical care and the acute and community services in addition to the actions required to be taken to meet this demand. All partners across the borough were engaged with the plan and contributed to key actions. The organisation continues to work closely with health and social care partners in Rotherham to reduce avoidable hospital admissions and avoid unnecessarily prolonged hospital stays throughout the year.

The national move to use of the Emergency Care Dataset to record same day emergency care activity will enable more comparable benchmarking of conversion rates during 2024-25.

During 2023-24, colleagues worked hard to return elective activity to 103% of 2019-20 in line with the requirements of the South Yorkshire Integrated Care Board. This has been particularly challenging due to workforce challenges in anaesthetic teams and theatres, compounded by the periods of industrial action. With additional investment to support additional capacity focussed in the second half of the year, activity levels have increased closer to 2019-20 levels. As a result, the Trust managed to almost eliminate all 65 week waits by the end of the year, as per the original national expectation.

Summary of performance against key healthcare targets

Emergency Access

Following a four year period of working to the national field test standards, the Trust returned to reporting performance against the urgent and emergency care 4-hour standard from May 2023. Nationally, the NHS was set a goal of achieving 76% performance by March 2024, with significant financial incentives announced in Quarter 4 2024 relating to performance against this goal.

However, following four years of operating under the field test standards, the Trust had to reset its way of managing urgent care pathways in order to revert back to a 4-hour delivery method. In particular we had to focus on earlier decision-making or ensuring that decisions on appropriate next steps were made in ambulatory units throughout our hospital. The Trust therefore started the year behind the curve compared to other type 1 providers in June 2023, the first month of data published for the Trust. However, whilst the Trust did not deliver the 76% target set nationally, improvements have been made starting April 2023 at 54.8% ending in March 2024 at 62.9%. In addition, by March 2024, relative performance for type 1 performance had improved to the 2nd quartile, with the Trust ranking 51st out of 122 acute or integrated providers. This has been as a result of the hard work our clinical and operations teams have done across the Trust to improve our waiting times for patients, whilst recognising we have more to do to achieve the standard in 2024-25.

UECC Performance

Number of attendance in UECC	
22/23	23/24
92,148	96,842

Up by 4694 attendance this financial year. That's a 5% increase overall this year.

Number of 4-hour breaches in UECC	
22/23	23/24
50,651	39,506

The number of 4-hour breaches has reduced by 11,145 as the Trust implements the 4-hour access standard.

Number of ambulance handovers - over 30 minutes	
22/23	23/24
5748	3880

Despite the increase in attendances our ambulance handovers within 30 minutes has improved

The operational improvement programme during 2023-24 related to a number of areas with a focus on improved ways of working and the introduction of an expanded Same Day Emergency Care Unit in order to better support increased volumes of ambulatory care patients.

The Trust developed the Winter Plan in partnership with the Rotherham Place system. All partners across the borough were engaged with the plan and contributed to specific actions. The plan included additional acute and community capacity being brought on stream at appropriate points in the year in order to ensure patients could receive timely care and discharge. At the same time as increasing our direct capacity, the rollout of our Discharge to Assess model, expansion of Virtual Ward capacity and enhanced access to our community hub via the Care Coordination Centre, the Trust improved the efficiency of our pathways and supported patients to live independently wherever possible.

The Trust placed significant focus on the challenges posed by operational pressures, especially throughout winter with colleagues working closely with partner organisations to improve the quality and timelines of the transfer of patients from acute settings once they were medically fit to do so. The new national metric around date of discharge was incorporated during the year ensuring we maintained daily oversight of our position regarding patients who were medically fit to be discharged.

18 Week referral to treatment waiting times

The waiting list continued to increase during 2023-24 and we know that we will need to focus on this during 2024-25 if we are to see a reduction in waiting times and a return to compliance with the Referral to Treatment time standard in a number of specialities. At the end of 2023-24, over 30,500 patients were on the waiting list (concentrated in four specialities, Ear, Nose and Throat, Trauma and Orthopaedics, Gynaecology and Gastroenterology) compared to approximately 26,500 the previous year and 17,000 in April 2021.

The Trust's elective care activity was impacted by industrial action however, the greatest challenges were within our inpatient and day case activity where ongoing workforce issues (in particular within our Theatres and Anaesthetic teams) left us unable to run our full theatre timetable through the year. During the second half of the year we invested in additional insourced capacity to bolster our internal resources, which generated an improvement in activity volumes from under 75% of 2019-20 levels (pre-pandemic) in the first six months of the year to approximately 88% in the latter half of the year (including an adjustment for March 2020). This improvement trajectory was also seen within our outpatient activity due to additional investment in non-admitted activity, with performance against the 2019-20 volumes increasing from 102% in the first half of the year to approximately 112% in the second half (again, accounting for the impact of the pandemic in March 2020). Elective capacity was ring-fenced as much as possible during the winter months and whilst there were several periods where the emergency pressures required us to utilise our elective beds for our non-elective patients, the Trust was able to maintain some levels of elective activity throughout winter.

The combination of these challenges, specific workforce shortages and the need to reduce our elective operating activity in particular, led to an increase in the numbers of patients waiting over 52 weeks from under 350 patients to approximately 680 at the end of the year. We have therefore set a bold ambition for 2024-25 to return to the level seen at the start of 2023-24, which will require targeted interventions across five specialties in particular. Despite these challenges, the Trust ended the year with just 22 patients waiting over 65 weeks for their treatment. Whilst the Trust had originally planned to ensure no patients were waiting this length of time for their treatment, unfortunately due to the ongoing periods of industrial action, increased complexity for a small number of patients, as well as a particular national challenge around the availability of corneal graft tissue, we had to revise the timescale for this ambition to the end of Quarter 1 in 2024-25. From a Referral to Treatment perspective, there was a steady decline in performance throughout the year as all of these factors affected our ability to deliver the capacity we planned, with the Trust moving from just under 68% of patients waiting under the 18 week Constitutional Standard in March 2023 to just under 60% at the end of 2023-24

Cancer waiting times

Timely management of patients referred onto a cancer pathway has been a priority for the NHS since the pandemic led to significant backlogs and longer waiting times for patients. In 2022-23 the Trust's focus was on reducing those backlogs back to agreed levels, and in 2023-24 the priority was to ensure improvement around our Faster Diagnosis Performance. During October 2023, NHS England announced a simplification of the 10 previous cancer waiting time standards to focus on 3 core standards, which included a new 62-day general cancer standard as a successor to the historically split 62-day standard. As such, efforts were made during the second half of the year to re-introduce the focus on 62-day delivery, and although this was a change for operational and clinical teams they were able to significantly reduce the number of patients waiting more than 62 days to below the Trust target and were commended for their contribution to the achievement of the regional target reduction.

During 2023-24, the Trust was non-compliant with the newly-introduced 62-day standard of patients being treated following urgent referral from their GP, achieving 76% for the full year against the 85% constitutional standard. However, it is worth noting that for the 2024-25 year, the national team are expecting performance of at least 70% across all systems, which demonstrates the positive performance the Trust delivered in 2023-24 to achieve 76%. This is also evidenced by benchmarking information, with the Trust in the top quartile of acute or combined providers for the year. However, in order to achieve the constitutional standard of 85%, we will need to reduce the number of patients having to wait longer than the 62-day period each month for their diagnosis and treatment from approximately 25 to no more than 15. This will require a step- change in focus on this deliverable, as well as ongoing improvement to our pathways, particularly during diagnostic phases.

The Trust achieved 80.4% performance overall against the Faster Diagnosis Standard; however performance was not consistent month-on-month with capacity challenges at certain periods in the year within some of the larger volume tumour sites impacting on overall delivery. In order to achieve the continual improvement we want for our patients, we will need to focus in 2024-25 on supporting the necessary reduction in time between pathway periods. Due to non-recurrent funding from the South Yorkshire & Bassetlaw Cancer Alliance, the Trust has been able to recruit a small Cancer Improvement team to focus on the

necessary pathway redesign. The trust has also focused on strengthening the Cancer Services Team with renewed focus on PTL management and increased support to clinical teams to progress patient pathways. This will be particularly important given the national expectation has risen to 77% by March 2025.

Diagnostic Waiting Times

The Trust continued to increase activity within diagnostic services in a safe and appropriate manner, investing in additional endoscopy, cardiac-physiology and imaging capacity in order to ensure waiting times for patients reduced to pre- pandemic levels by the end of the year. As a result of this additional activity, the Trust was one of only a few to achieve the constitutional DMO1 standard in March 2024, benchmarking in the top 5 Trusts in the country.

Community Performance Indicators

Community services continued to see increased activity across adult and children's services. The teams responded positively by introducing or expanding a number of new initiatives to improve our pathways and maximise the use of our resources. We utilised service experts and our own software developers to develop a Place Community Escalation Wheel in order to ensure the pressures in our Community services are part of our organisation-wide OPEL assessment. This has enabled us to provide a whole system view of system flow and OPEL escalation levels, and more effectively use the action cards for each escalation level. Stakeholders include the Trust, Integrated Discharge Team, the Council's re-enablement and home care provision, commissioned community bed base, commissioned voluntary care service urgent response services, the GP Federation, Mental health services and the local equipment supplies.

Alongside these improvements, the Transfer of Care Hub has been established with pathway 1 and 2 community partners now joining discharge board rounds to identify capacity and allocate discharges earlier in the day. Our virtual ward expanded to capacity for a caseload of 100 patients (with a target of 80% utilisation), with newly purchased remote technology due to be rolled out in 2024/25 which will further support the development of this service.

The Trust met the Urgent and Community Response standard for the year, although there was some deterioration in performance throughout. Work has taken place to integrate the urgent and unplanned teams into a single team in order to increase the flexibility of resource across admission avoidance and discharge pathways according to demand.

Looking ahead to 2024-25

The Trust has made tangible progress against our operational objectives in 2023-24, and has a clear plan for improvement in 2024-25. One of the two areas we are targeting the biggest step change on performance next year is our delivery of the national expectation against the 4-hour standard. We know that 2023-24 was a year of consolidation for us as we re-introduced the 4-hour standard across the organisation, but we also recognise that too many of our

patients who access our Urgent and Emergency Care Centre continue to wait for too long before they are admitted or discharged. The almost 50% reduction in ambulance handovers over an hour in 2023-24 compared to the previous year is evidence of our ability to deliver significant improvements over a relatively short time-period within our urgent care pathways, and 2024-25 will be the year where we accelerate this work and drive a direct impact on 4-hour performance.

The second critical area of focus lies within elective care following some positive progress in 2023-24 on long waits but a continued growth in our waiting list, indicating a persistent demand and capacity gap. Whilst delivery of the Referral to Treatment constitutional standard itself has not been identified as a national objective for 2024-25, we recognise the impact that extended waiting times have on our communities, and are determined to continue our journey of improvement in 2024-25. As such, we plan to set challenging specialty-level performance ambitions against the national Referral to Treatment constitutional standard for 2024-25. We believe that in order to shift the dial on elective care waiting times, it is imperative that we re-focus back to delivery of the standard in those specialties where there is an opportunity to do so.

Following a year of interrupted elective care delivery within the NHS in 2023-24 due to the ongoing industrial action, it is hoped that the Trust will be able to push forward our activity levels in 2024-25 in order to achieve the national ask of our system of delivery of 103% of 2019/20 value-weighted activity. This will need to come from a resetting and re-doubling of efforts around our productivity in particular, in both outpatient and theatre settings. Since the pandemic, it has been recognised nationally that there has been an unexplained productivity loss within the NHS which is affecting our ability to return to pre-pandemic levels of activity. The South Yorkshire Acute Federation is developing a suite of productivity metrics to be monitored, to support providers' focus on this area of our work throughout 2024/25. We will use the GIRFT Further Faster specialty- level guidance to direct our work, and to ensure clinical engagement and buy-in to our efforts.

Digital

During the last year we continued to make significant strides in our digital transformation, focusing on enhancing patient engagement and leveraging cutting-edge technology. By integrating with the NHS App, we empowered patients with convenience and transparency throughout their healthcare journey. Patients can now seamlessly manage hospital appointments, complete pre-operative surveys and communicate their treatment preferences, ensuring a patient-centric experience whilst reducing unnecessary delays or cancellations.

Moreover, we have initiated the development of e-consent technology, which plays a pivotal role in fostering informed decision-making for patients. This innovative solution provides patients with comprehensive information about their clinical procedures, enabling them to make well-informed choices regarding their care.

For healthcare professionals, we have implemented Voice Recognition Technology (VRT) across various departments, leveraging cloud-based artificial intelligence to transcribe speech to text automatically. This cutting-edge technology streamlines clinical documentation, enhancing efficiency and reducing the administrative burden on healthcare staff. Furthermore, we have integrated artificial intelligence into our radiology service, enabling the automatic highlighting of suspected bone fractures to clinicians in near real-time. This advanced technology not only enhances diagnostic accuracy but also expedites the identification of critical cases, ensuring timely and effective treatment. By augmenting clinicians' expertise with artificial intelligence powered decision support, we are improving patient outcomes and providing a safer, more efficient healthcare experience.
Our connected Vital programme has concluded successfully, enabling the automatic uploading of observation medical equipment data directly into the electronic patient record. This seamless integration eliminates the need for manual data entry, reducing the risk of transcription errors and enhancing the accuracy and completeness of patient records.

Technology

We have successfully completed work on our infrastructure upgrades, including WiFi and data network enhancements. These improvements enable real-time tracking location services for equipment and other resources utilising both WiFi and Bluetooth technology. This capability not only optimises asset utilisation but also enhances operational efficiency by reducing the time and resources spent locating essential medical equipment, ultimately improving patient care delivery.

Additionally, we have replaced all data links to primary care GP's with faster and more resilient services, ensuring seamless communication and efficient data exchange between healthcare providers. Furthermore, we have implemented a modern unified communications platform across the organisation, replacing the outdated telephone system. This advanced solution integrates various communication channels, including voice, video, messaging and conferencing into a seamless experience. By streamlining communication, healthcare professionals can collaborate more effectively, share critical information promptly and provide timely responses to patient inquiries or emergencies, ultimately improving the overall quality of care and patient satisfaction.

Clinical Coding

Our clinical coding team continues to consistently meet all the Freeze and Flex deadlines. They now routinely meet freeze deadlines, ensuring accurate and timely coding of patient records. Precise clinical coding is crucial for effective health date management, enabling informed decision-making, resource allocation and the identification of areas for improvement within the healthcare system.

Cybersecurity

We continued to have a focus on cybersecurity across the organisation and with our system partners. During the year, we have implemented Multi-factor-authentication with strong passwords for sensitive systems and users, upgraded over 30 systems onto new platforms to reduce their cyber risk, responded within 48 hours to national alerts and used national funding to improve our backup capability and technology.

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. One in five of our households are workless compared to the England average of 13%. In addition, 29% of the Rotherham working age population are long term sick (this is 7% above the England average), resulting in 11.5% of the working age population receiving out of work benefits (3.4% 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.

Females in Rotherham have consistently lower rates of employment compared to males, 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. 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 (years lived in good health before developing illness) is 59 years old for a boy born today and 56 for a girl: nine years earlier than current 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 (13%) 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). 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.

NHS England health inequalities measures

These wider determinants of health can impact underlying health needs, access to services, experience of health care and health outcomes. The Trust and its partners use these measures and other data to identify areas for action to ensure that there is equitable access to and experience of healthcare services and that outcomes are optimised. Health inequality data is continuously reported in a suite of dashboards and reports across the Trust and is escalated to Board on a regular basis.

Our response to health inequalities as a trust and system leader

As a trust, we are firmly committed to tackling health inequalities. In March 2023, a new Consultant in Public Health post was established to work across the Trust and partners with the aim of strengthening our approach to tackling health inequalities in the local healthcare system. A bespoke analytical role was also established in the Trust to focus on health inequalities analysis across the Rotherham healthcare system, and collaboration between partners is facilitated through the multi-agency Rotherham Office of Data Analytics. The Trust working group on health inequality has developed a work plan, organised across six domains: understanding patient needs; providing patient-centred care; supporting staff to live healthy lives; ensuring equity of access; building prevention into our pathways and improving the lives of our communities (see figure on following page).

Health Inequalities Plan on a page 2024

Understand our population and patients' needs better

- Carry out deep dives on our patient demography
- Undertake detailed analysis of patient behaviours (e.g. DNAs, 'frequent flyers')
- Identify areas of inequality of access and relevant drivers (e.g. Insulin pumps)
- Develop a universal health inequalities dashboard and other HI tools

Ensure equity of access to our services

- Reduce barriers to outpatient access, informed by 'Did Not Attend' analysis
- Work with Place colleagues to fill gaps in primary care provision
- Undertake targeted equity impact assessments (e.g. MEOC)
- Consider evidence base for developing an equitable elective recovery model

Provide tailored, patient-centred care, adapted to individual patient needs

- Include lifestyle / teachable moment support page in bedside information folders
- Continue to develop Learning Disability and Autism staff resources
- Grow the newly recruited Armed Forces Welfare support worker role

Build prevention into our pathways

- Develop an enhanced 'Making Every Contact Count' training offer
- Continue development of appropriate, targeted waiting well support
- Build in exercise to our clinical pathways (eg ActiveTogether)
- Evaluate impact of embedded social prescriber role within UECC

Support our staff to live healthy lives

- Provide routes to financial assistance and advice to colleagues
- Offer full health and wellbeing programme to staff
- Expand QUIT programme to staff to reduce smoking levels

Act as a leader across Rotherham at improving the lives of our communities

- Explore procurement options to reduce carbon emissions and other environmental impacts
- Support Rotherham recruitment events to source local talent
- Increase use of and support local suppliers where possible
- Collaborate with groups at Place and System to join up on population health initiatives

Some of the successes and innovations delivered within the Trust over the past year include:

- Recognising the specific health needs of veterans, we have established the Armed Forces Welfare Officer post in March this year, in collaboration with local veterans' charities. The post-holder has already made contact with a number of patients and has provided signposting and bespoke support to veterans and their families.

- Getting fit for surgery can make a significant difference in health outcomes and healthcare resource usage. As part of a suite of approaches including signposting to community weight management services and to the Rotherhive resource, we have signed up to be part of the national digital weight management pilot which offers weight management interventions for patients in the five key surgical pathways selected nationally. Over 60% of patients we have contacted in this way have engaged with the process, and around half have a recorded start date. The Trust will be engaging with the evaluation process in 2024-25, and we will look to apply lessons learned from this intervention.

- An enhanced programme of supporting healthy conversations approaches in **Making Every Contact Count** training has been piloted with health care assistants, and will be rolled out more widely to staff and partners this summer. We are working with clinicians, the HR team and local partners to ensure we have a package of training which can help all staff have confident, health-promoting, coaching style conversations with patients, visitors and other staff members which looks beyond clinical conditions and takes a more holistic view of patient needs and the support we and partners can offer.

- Development of cancer care initiatives such as personalised care and support planning through holistic needs assessment and creation of better cancer information and signposting, supported by care navigators and a new cancer app. A steering group has been set up to monitor and target resources to support high-quality care for patients and families.

- Working to improve our intelligence and develop actionable insight within the Trust. For example, identifying areas to target for improved recording of patient demographic information, and providing a monthly update to our waiting list demographic data to ensure that particular groups are not being disadvantaged. As part of this work, we have identified that our recording of ethnicity information about our patients is not as complete as it could be, and this has led to innovations in our patient 'check in' process, which allows patients to provide more complete data to support their own healthcare. This includes age, sex, ethnicity and geographical data to ensure that we are able to better identify inequity.

- In the case of new pathways, such as the development of Mexborough Elective Orthopaedic Centre, we have commissioned a deep-dive analysis of the impacts, both positive and negative on patient access and experience in order to ensure that inequalities are not widened.

- Analysis and development of a toolkit to understand the circumstances of patients who have missed appointments, including an interactive dashboard to provide monthly monitoring and analysis of inequalities. Nearly 14% of all outpatient appointments for patients living in the most deprived areas were missed: double that of the least deprived areas (7%). Causal factors appear to range from timing of appointments, to transport access and cost issues, to health literacy. To address patient needs across the hospital, we are developing a pilot, scalable approach to undertaking health equity audit work, which can be applied to a wide range of observed inequalities going forward.

- The Trust has a strong approach to partnership working, and amongst others, ongoing projects involve: supporting fluoridation across South Yorkshire to tackle tooth decay; working with social services and prevention teams to reduce service demand and promote elective recovery; working with commissioners to transform services and reduce unplanned admissions in respiratory, diabetes and frailty services and developing population health interventions to increase reach and access to healthcare in the borough.

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.

Dr Richard Jenkins Chief Executive
21 June 2024


NHS
COSTA

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 Assurance Committees supporting the Board in seeking assurance on all matters relating to quality, finance, performance, people and risk. The aforementioned Assurance Committees are Audit and Risk Committee, Finance and Performance, People, and the Quality Committee. The Nominations and Remuneration Committee is also a statutory committees.

The day to day management of the organisation is delegated form 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**	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.	3/3
Martin Havenhand **Chair**	Martin was a very experienced Chair and Non-Executive Director. He had a wealth of experience from both the public and private sectors being knowledgeable and experienced in regulated industries. Martin brought extensive experience and knowledge of the South Yorkshire community which wasinvaluable as the	4/5

	Trust continued to develop and enhance local health care services. Martin was Chair of the Board of Directors, Council of Governors, Board Nominations and Remuneration Committee and the Governor Nomination and Remuneration Committee. <u>Terms of office</u> 01.01.2014 to 31.01.2017 01.02.2017 to 31.01.2020 01.02.2020 to 31.02.2023 The Council of Governors approved a final one year term from March 2023 to February 2024 however Martin stood down as Chair on 31 August 2023 to take up another Chair position.	
Heather Craven **Non-Executive Director &** **Senior Independent Director**	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. 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 toresolve. Heather is the Senior Independent Director, a member and Vice Chair of the Quality Committee, member of the Audit and Risk Committee, Vice Chair of the Nominations and Remuneration Committee, Chair of the Charitable Funds Committee. Heather also Chairs the Organ Donation Committee. <u>Terms of office</u> 17.02.2017 to 16.02.2020 17.02.2020 to 28.02.2023	12/12

	01.03.2023-29.02.2025	
Rumit Shah **Non-Executive Director**	Rumit joined the Trust as a Non-Executive Director in January 2020 for a two year term of office. The Council of Governors approved a further three year term of office from January 2022. 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. 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. Rumit is a keen advocate for excellent quality of care delivered in a timely manner and from August 2020 he has been the Chair of the Quality Committee. Rumit is Chair of the People and Culture Committee, and a member of the Audit and Risk Committee and Nominations and Remuneration Committee. <u>Terms of office</u> 01.01.2020 to 31.12.2021 01.01.2022 to 31.12.2024	12/12
Joanna Bibby **Non-Executive Director**	Jo Bibby joined the Trust as a Non-Executive Director on 01 June 2021 for a three year term of office until 31 May 2024. Jo has worked in health and healthcare throughout her career, at both national and local level. During ten years at the	4/6

	Department of Health, she was responsible for a range of policy areas including research and development and finance and performance. Jo has led development of approaches to improve the safety and quality of health care, many of which are now applied routinely across the NHS. Jo works at the Health Foundation, an independent charity and 'think tank' where she is responsible for a nationally recognised strategy to improve health and reduce health inequalities. Jo Chaired the People and Culture Committee, was Vice Chair of the Quality Committee and a member of the Nomination and Remuneration Committee. <u>Term of Office</u> 01 June 2021 to 31 May 2024 Jo stood down on 31 August 2023	
Kamran Malik **Non-Executive Director & Vice Chair**	Kamran Malik joined the Trust as an Associate NED in April 2021 and was subsequently appointed as a substantive NED from 11 September 2021 until 10 September 2024. 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. Kamran carried out the role of Interim Chair from 1 September to 31 December 2023. He is the current Chair of the Audit and	11/12

	Risk Committee, a member of the Finance and Performance Committee and a member of the Nomination and Remuneration Committee. Terms of Office Associate NED: April 2021 to September 2021 NED 11 September 2021 to 10 September 2024 Kamran was appointed Interim Chair from 01 September 2023 to 31 December 2023	
Martin Temple **Non-Executive Director**	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. 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. 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. Martin is the Chair of the Finance and Performance Committee and a member of the People Committee and Nominations and Remuneration Committee. Term of Office 01.10.2022 – 30.09.2025	10/12
Dee Sissons **Non-Executive Director**	Dee Sissons was a palliative care nurse by background and the CEO of a children's hospice offering services across the East Midlands. Living locally she trained in Sheffield and her career spanned commissioning, acute services and the independent sector. She	6/10

	has represented nursing and end-of –life care locally and nationally. Dee plays a key role in nursing leadership and the profession and is passionate about developing others. Dee was a member of the Quality Committee, Charitable Funds Committee and Nomination and Remuneration Committee. <u>Term of Office</u> 01.10.2022-30.09.2025 Dee stood down on 8 March 2023.	
Zlakha Ahmed **Associate Non-Executive Director**	Zlakha Ahmed has nearly 40 years' experience of working, leading, managing and overseeing the development work within Black and minority communities. She set up the Apna Haq organisation which supports BME women and girls in Rotherham who have been subjected to domestic and sexual violence. Zlakha 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. <u>Term of office</u> 01.10.2022 – 30.09.2023 01.10.23 – 30.09.24	9/12
Hannah Watson **Non-Executive Director**	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	4/7

	commercial organisations. Hannah is a member of the Finance and Performance Committee, member of the People and Culture Committee and member of the Nomination and Remuneration Committee. <u>Term of office</u> 17.08.2023 – 16.08.2026	
Julia Burrows **Non-Executive Director**	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. 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. 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. Julia is Chair of the Quality Committee, a member of the Charitable Funds Committee and a member of the Nomination and Remuneration Committee. <u>Term of Office</u> 01.10.2023 – 30.09.2026	4/5

Executive Directors		
Name and Position	**Background**	**Total Number of Board Meetings attended**
Dr Richard Jenkins, Chief Executive	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. 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. Richard was a trainee doctor in South Yorkshire before he became a Consultant in 2002, specialising in diabetes and endocrinology. Richard became the substantive Joint Chief Executive between the Trust and Barnsley Hospitals NHS Foundation Trust in September 2022.	12/12
Michael Wright, Managing Director	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. 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.	11/12
Steve Hackett, Director of Finance	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,	12/12

	with recent roles at Chesterfield Royal Hospital NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).	
Steven Ned, Joint Director of Workforce	Steven joined the Trust in April 2019 as the Joint Director of Workforce with Barnsley Hospital NHS Foundation Trust. He has previously worked at Sheffield Children's Hospital as the Director of Human Resources and Deputy Chief Executive. Steven has over 30 years' experience within the NHS and over 10 years working in senior roles within South Yorkshire. Steve left the Trust on 31 May 2023 to concentrate on the Director of People role in Barnsley.	1/2
Daniel Hartley **Director of People**	Daniel joined the Trust in June 2023 as Director of People. 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.	9/10
Helen Dobson, Chief Nurse	Helen was appointed as Interim Chief Nurse in October 2021 and subsequently appointed to the substantive Chief Nurse role in April 2022. 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.	12/12
Sally Kilgariff, Chief Operating Officer	Sally became the Chief Operating Officer in May 2022 after being the Deputy Chief	11/12

	Operating Officer and Director of Operations since November 2018. 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.	
Jo Beahan **Medical Director**	Jo joined the Trust in December 2022 as Medical Director having previously been Deputy Medical Director at Barnsley Hospital NHS Foundation Trust. 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.	12/12

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 2023-24 the Trust paid 94.88% by number and 90.29% 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 2023-24 was £298.35.

	Number	Value £000's
NON NHS		
Total Bills Paid in Year	51629	121924
Total Bills Paid Within Target	49184	111115
Percentage of Bills Paid in Target	95.26%	91.13%
NHS		
Total Bills Paid in Year	2056	16109
Total Bills Paid Within Target	1753	13515
Percentage of Bills Paid in Target	85.26%	83.90%
Total		
Total Bills Paid in Year	53685	138033
Total Bills Paid Within Target	50937	124630
Percentage of Bills Paid in Target	94.88%	90.29%

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 form 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 2023-24.

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.

Work commenced during the last financial year to re-define our Divisional structure into Care Groups, due to be completed in 2024-25. This will result in a further review of our governance framework. The Trust has begun the process of tendering for an external Well-Led Review that will be completed in 2024-24.

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. 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 five times and met its key responsibilities by considering the following matters;

- Approved the Internal Audit Plan for 2023-24
- Approved the Anti-Fraud Annual Work Plan for 2023-24 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 2023-24 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 five times with the following attendance by the Committee members:

Kamran Malik attended a total of 4 out of 5 meetings Rumit Shah attended a total of 4 out of 5 meetings Heather Craven attended a total of 4 out of 5 meetings

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 three occasions during the reporting period.

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 manager's remuneration policy and
- The Annual Remuneration Report

I am pleased to present the Remuneration Report of the financial year 2023-24 on behalf of The Rotherham NHS Foundation Trust Nominations and Remuneration Committee. As delegated by the Board of Directors, the Nominations and 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 Nomination and Remuneration Committee established by the Council of Governors.

Major decisions taken on senior managers' remuneration 2023-24

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 2023-24 the Nominations and Remuneration Committee continued to utilise annual benchmarked data, including that provided by NHS Providers as the pay and reward framework upon which to base Executive salary awards.

For the period 2023-24 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 3% non- consolidated award on salaries in place as at 01 April 2023.

Dr Mike Richmond
Chair of the Trust's Nominations and Remuneration Committee
21 June 2024

Senior Managers Remuneration Policy

The Remuneration Policy for Executive Directors was updated during 2019-20 and remained in place for the period 2023-24. The aims of the pay and reward framework remaining in place 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 provides a transparent framework for determining senior level remuneration.

Future Policy Table – Senior Managers

During the reporting period 2023-24, 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: • 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.
Bonus	The Trust does not have any bonus arrangements in place.			
On-call Payments	Senior managers receive on-call payments in line with their responsibilities whilst on call			
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 would take 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 – substantive	Open ended	6 months
Steve Hackett	July 2021	Open ended	6 months
Steve Ned	April 2019	Open ended	6 months
Helen Dobson	October 2021 – Interim December 2021	Open ended	6 months
Sally Kilgariff	May 2022	Open ended	6 months
Jo Beahan	December 2022	Open ended	6 months
Daniel Hartley	1 June 2023	Open ended	6 months

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 2023-24 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 01/04/23 to 31/03/24						Period 01/04/22 to 31/03/23					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension–Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension–Related Benefits (bands of £2500)	Total (bands of £5000)
Mr M Havenhand, Chairman (1 April 2023 to 31 August 2023)	20 - 25	0	0	0	0	20 - 25	50 - 55	0	0	0	0	50 - 55
Mr K Malik, Non-Executive Director including acting Chair between 1 September and 31 December 2023	25 - 30	0	0	0	0	25 - 30	10 - 15	0	0	0	0	10 - 15
Dr M Richmond, Chairman (1 January 2024 to 31 March 2024)	10 - 15	0	0	0	0	10 - 15						
Mrs H Craven, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	15 - 20	0	0	0	0	15 - 20
Dr R Shah, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	15 - 20	0	0	0	0	15 - 20
Mr M Temple, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
Mrs D Sissons, Non-Executive Director (1 April 2023 to 8 March 2024)	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
Mrs Z Ahmed, Non-Executive Director	5 - 10	0	0	0	0	5 - 10	0 - 5	0	0	0	0	0 - 5
Dr J Bibby, Non-Executive Director (1 April to 31 August 2023)	5 - 10	0	0	0	0	5 - 10	10 - 15	0	0	0	0	10 - 15
Mrs H Watson, Non-Executive Director (17 August 2023 to March 2024)	5 - 10	0	0	0	0	5 - 10						
Ms J Burrows, Non-Executive Director (1 October 2023 to 31 March 2024)	5 - 10	0	0	0	0	5 - 10						
Dr R Jenkins, Chief Executive	135 - 140	2	0	0	0	135 - 140	125 - 130	7	0	0	80 - 82.5	205 - 210
Mr M Wright, Managing Director	155 - 160	11	0	0	0	155 - 160	145 - 150	11	0	0	35 - 37.5	185 - 190
Mr S Hackett, Director of Finance	150 - 155	4	0	0	0	150 - 155	145 - 150	10	0	0	0	145 - 150
Mr S Ned, Joint Director of Workforce (1 April to 31 May 2023)	10 - 15	0	0	0	0	10 - 15	70 - 75	0	0	0	0	70 - 75
Mr D Hartley, Director of People (1 June 2023 to 31 March 2023)	115 - 120	18	0	0	35 - 37.5	150 - 155						
Dr J Beahan, Medical Director	185 - 190	14	0	0	322.5 - 325	510 - 515	50 - 55	4			32.5 - 35	85 - 90
Mrs H Dobson, Chief Nurse	135 - 140	8	0	0	0	135 - 140	125 - 130	0	0	0	0	125 - 130
Mrs S Kilgariff, Chief Operating Officer	130 - 135	15	0	0	0	135 - 140	110 - 115	13	0	0	77.5 - 80	185 - 190

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 270K and 275K.
Taxable benefits shown in the above table relate to lease car schemes.

Mr S Ned was employed part time by both Rotherham FT, and Barnsley FT between April and May 2023. Mr S Ned worked for Rotherham FT on a 0.5 Full Time Equivalent (that is, 2.5 days per week).

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.

	Number in Office		Number receiving expenses	
	2023/24	2022/23	**2022/23**	2022/23
Governors	**21**	22	**1**	1
Directors (including the Chair and non-executives)	**19**	21	**3**	2

Expenses shown in hundreds £00s	**2023/24 £00**	**2022/23** £00
Aggregate sum of expenses paid to Governors	**2**	1
Aggregate sum of expenses paid to Directors	**7**	5
Total	**9**	6

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.

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 2024* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2024 £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 (1)	0.0 - 2.5	65.0 - 67.5	95.0 - 100.0	255.0 - 260.0	1,836	2,316	262	NA
Mr M Wright, Deputy Chief Executive (1)	0.0 - 2.5	0.0 - 2.5	35.0 - 40.0	0.0 - 5.0	518	652	61	NA
Mr S Hackett, Director of Finance (1)	0.0 - 2.5	25.0 - 27.5	55.0 60.0	160.0 165.0	999	1,308	188	NA
Mr S Ned, Joint Director of Workforce (1 April to 31 May 2023) (1)	0.0 - 2.5	2.5 - 5.0	60.0 - 65.0	185.0 - 190.0	1,377	1,594	11	NA
Mr D Hartley, Director of People (1 June 2023 to 31 March 2024)	0.0 - 2.5	0.0 - 2.5	20.0 - 25.0	0.0 - 5.0	240	300	16	NA
Dr J Beahan, Medical Director	12.5 - 15.0	82.5 - 85.0	65.0 - 70.0	175.0 - 180.0	830	1,482	544	NA
Mrs H Dobson, Interim Chief Nurse (1)	0.0 - 2.5	2.5 - 5.0	55.0 - 60.0	160.0 - 165.0	1,145	1,380	102	NA
Mrs S Kilgariff (1)	0.0 - 2.5	30.0 - 32.5	35.0 - 40.0	100.0 - 105.0	559	793	161	NA

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 – subject to audit

	2023/24			2022/23		
	Permanent	Other*	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries and wages**	181,834	8,941	**190,775**	177,101	7,163	**184,264**
Social security costs	18,489	-	**18,489**	18,256	-	**18,256**
Apprenticeship levy	937	-	**937**	851	-	**851**
Employer's contributions to NHS pensions***	31,252	-	**31,252**	29,078	-	**29,078**
Pension cost - other	78	-	**78**	112	-	**112**
Temporary Staff - External Bank	-	13,641	**13,641**	-	12,293	**12,293**
Temporary staff - agency/contract**	-	3,037	**3,037**	-	5,284	**5,284**
Total gross staff costs	**232,590**	**25,619**	**258,209**	**225,398**	**24,740**	**250,138**
Of which:						
Costs capitalised as part of assets	***363***	***450***	***813***	-	-	-
Research and Development staffing costs	***485***	***-***	***485***	*469*	-	***469***
Redundancy Costs	***128***	***-***	***128***	-	-	-
	231,614	***25,169***	***256,783***	***224,929***	***24,740***	***249,669***

** '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 6.3% in both 2023/24 and 2022/23.*

Staff Exit Packages –Subject to audit

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

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

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

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2023/24	2022/23	2023/24	2022/23	2023/24	2022/23
<£10,000	0	0	0	0	0	0
£10,000 - £25,000	0	0	1	0	1	0
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	1	0	0	0	1	0
Total number of exit packages by type	1	0	1	0	2	0
Total resource cost £000s	128	0	11	0	139	0

Analysis of non-compulsory departure payments

During the 2023-24 financial year there were two departures agreed (none in 2022/23). 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	
	2023/24	2022/23	2023/24	2022/23
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**	1	0	11	0
Total	1	0	11	0
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	*0*	*0*	*0*	*0*

** 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

Whole time equivalent basis

	2023/24			2022/23		
	Permanent	**Other***	**Total**	Permanent	Other*	Total
	No.	**No.**	**No.**	No.	No.	No.
Medical and dental	490	89	**579**	467	82	**549**
Administration and estates	1,026	48	**1,074**	1,034	64	**1,098**
Healthcare assistants and other support staff	861	105	**966**	830	105	**935**
Nursing, midwifery and health visiting staff	1,191	110	**1,301**	1,181	98	**1,279**
Scientific, therapeutic and technical staff	469	16	**485**	468	22	**490**
Healthcare Science Staff	109	5	**114**	105	3	**108**
	4,146	**373**	**4,519**	4,085	374	4,459
Of which:						
Number of employees engaged on Capital projects	**7**	**5**	**12**	**0**	**0**	**0**

*'Other' staff includes secondments in, and trainee medial 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 2023/24 was £187,500 (2022/23: £177,500). This is a change between years of +5.63%, 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 2023/24 was from £10,324 to mid-point band £272,500 (2022/23: £10,324 to mid-point band £252,500). The reason that the lower value of the range remains unchanged is that the Agenda for Change non-consolidated pay award which was agreed in May 2023 was backdated and therefore was included within the 2022/23 reported remuneration figures.

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 -0.47%. This is based on the average salary in 2023/24 being £38,021 (2022/23: £38,239). Similarly, this small percentage fall is due to the Agenda for Change non-consolidated pay award values being included within the 2022/23 average employee remuneration, resulting in no significant change in average employee remuneration between 2022/23 and 2023/24. In comparison, the change in average employee remuneration between 2021/22 and 2022/23 was +9.58%, with this large percentage rise representing the increase in average remuneration due to the Agenda for Change non-consolidated pay award.

Three employees received remuneration in excess of the highest paid director in 2023/24.

Of the three individuals who received remuneration in excess of the highest paid director in 2023/24, 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 Play 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 two individuals who received remuneration in excess of the highest paid director in 2023/24 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.

	2023/24	2022/23
Mid-point of £5k band of highest paid director's total remuneration (£000)	187.5	177.5
The percentage change from the previous financial year in respect of the highest paid director	+5.63%	
Average annualised salary and allowances over all employees (excluding the highest paid director) (£000)	38.0	38.2
The percentage change from the previous financial year in respect of the average annualised salary and allowances	-0.47%	

2023/24	25th Percentile	Median	75th Percentile
Mid-point of £5k band of highest paid director's total remuneration (£000)	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

Comparative figures, 2022/23	25th Percentile	Median	75th Percentile
Salary component of pay	24.9	34.9	42.8
Total pay and benefits excluding pension benefits	24.9	34.9	42.8
Pay and benefits excluding pension: pay ratio for highest paid director	7.13:1	5.09:1	4.15:1

Remuneration Report signed by the Chief Executive

Dr Richard Jenkins
Chief Executive
21 June 2024

Staff Report

As at 31 March 2024 we employed 5,150 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 2024 the breakdown of Trust employed staff by Gender was as follows:

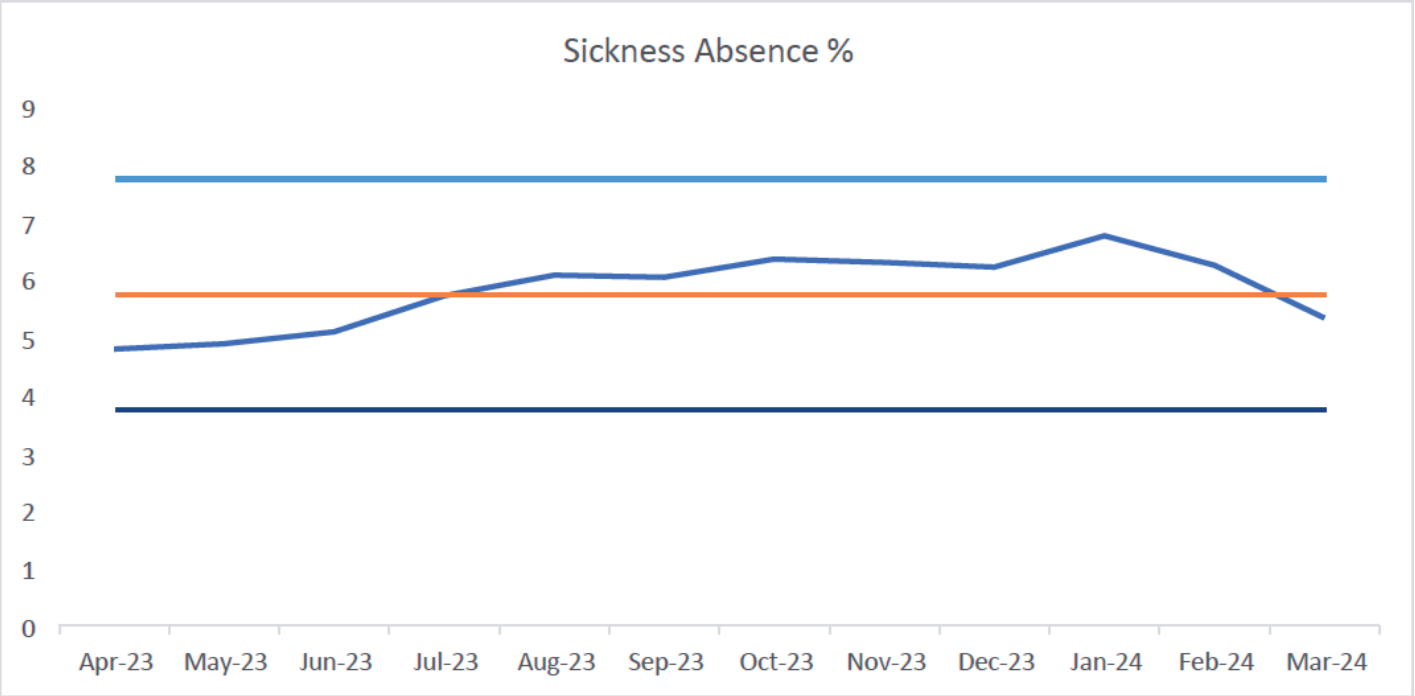
2023/24	Male	Female	Total
Mid-point of £5k band of highest paid director's total remuneration (£000)	4	3	7
Total pay and benefits excluding pension benefits	4	4	8
Pay and benefits excluding pension: pay ratio for highest paid director	945	4190	5135
	953	4197	5150

Sickness Absence Data

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

Monthly Sickness Absence

Month	Target	2023/2024				2022/2023			
		Long Term	Short Term	Monthly	Rolling	Long Term	Short Term	Monthly inc Covid	Rolling 12mth inc Covid
April	4.50%	3.05%	1.75%	4.79%	6.38%	4.85%	3.50%	8.35%	6.95%
May	4.50%	3.30%	1.59%	4.88%	6.25%	4.37%	2.07%	6.44%	7.00%
June	4.50%	3.39%	1.70%	5.09%	6.13%	3.91%	2.62%	6.54%	7.02%
July	4.50%	3.89%	1.82%	5.71%	6.00%	4.36%	3.05%	7.41%	7.09%
August	4.50%	4.26%	1.81%	6.07%	6.01%	4.17%	1.96%	6.14%	7.04%
September	4.50%	3.96%	2.07%	6.03%	5.97%	4.16%	2.53%	6.67%	7.01%
October	4.50%	4.13%	2.22%	6.35%	5.90%	4.54%	2.77%	7.31%	6.97%
November	4.50%	4.16%	2.13%	6.29%	5.89%	4.13%	2.50%	6.62%	6.94%
December	4.50%	3.94%	2.28%	6.21%	5.77%	4.64%	3.11%	7.75%	6.97%
January	4.50%	3.89%	2.82%	6.71%	5.79%	4.26%	2.35%	6.60%	6.75%
February	4.50%	3.93%	2.31%	6.24%	5.80%	4.05%	2.20%	6.25%	6.78%
March	4.50%	3.30%	2.04%	5.33%	5.79%	3.52%	2.12%	5.65%	6.65%



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 Human Resources, 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 works with a local specialist college to support young people aged 16-25 who have an Education, Health and Care Plan to develop their employability and life skills via Supported Internships. The Trust has a staff "All About Me" passport to facilitate person-centred approached to the management of staff, including reasonable adjustments. During the financial year, the Trust has piloted a Workplace Disability Advisor role to support disabled colleagues, students, and applicants.

The Learning and Development department acts as a contact point for all colleagues booking onto training provided by the Trust and supports colleagues who require reasonable adjustments or special arrangements to access training. In this way the organisation ensures that reasonable adjustments are made to support colleagues who disclose a disability which may mean they require extra support with their learning and development. Alongside the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), the Trust has piloted the EDS 2022 during the financial 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.

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

Throughout the financial year, the Trust's Equality, Diversity and Inclusion Steering Group has met regularly to review and drive progress against the Trust's equality, diversity and inclusion (EDI) action plans and has provided regular updates to the Board and relevant committees.

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 Trust website: https://beta.therotherhamft.nhs.uk/about-us/EDI

In addition to the information regarding Gender Pay Gap published on the Trust website, information is available on the Gov UK website: https://gender-pay- gap.service.gov.uk/

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 continued 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 worked with staff side colleagues to develop a revised Partnership Working Policy.

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, 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 2023 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 09 June 2023 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 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 high quality interventions to employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Supporting the health and wellbeing of all colleagues at the Trust is a key driver. The Head of Health & Safety and HR business partners 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.

The Health & Safety team work closely with the Health & Wellbeing team to promote their activities especially the growth of the Menopause café and awareness weeks. There is a Wellness Matters programme that provide complimentary therapy treatment as well as fitness session and a wide range of talking groups/workshops. These involve anything from a knitting and crochet group to soap making and sessions on how to make cheap and healthy meals. During the year the network of wellbeing champions has grown to include and emphasise the impact that the menopause can have on colleagues, then signposting colleagues to the various options available to support staff wellbeing.

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Analysis of Staff: Ethnicity of Staff

As at end March 2024 the breakdown of Trust employed staffby ethnicity was as follows:

Ethnicity Group	Total	% of Workforce
BME	808	15.71%
Not Stated	57	1.11%
White	4278	83.18%
Grand Total	**5143**	**100.00%**

Ethnicity	Headcount	% of Workforce
Asian/Asian British: Bangladeshi	10	0.19%
Asian/Asian British: Chinese	15	0.29%
Asian/Asian British: Indian	268	5.21%
Asian/Asian British: Other Asian	66	1.28%
Asian/Asian British: Pakistani	163	3.17%
Black/African/Caribbean/Black British: African	138	2.68%
Black/African/Caribbean/Black British: Caribbean	12	0.23%
Black/African/Caribbean/Black British: Other Black	6	0.12%
Mixed/multiple ethnic groups: Other Mixed	29	0.56%
Mixed/multiple ethnic groups: White and Asian	16	0.31%
Mixed/multiple ethnic groups: White and Black African	11	0.21%
Mixed/multiple ethnic groups: White and Black Caribbean	24	0.47%
Not Disclosed	57	1.11%
Other ethnic group: Any other ethnic group	50	0.97%
White: English/Welsh/Scottish/Northern Irish/British	4170	81.08%
White: Irish	15	0.29%
White: Other White	93	1.81%
Grand Total	**5143**	**100.00%**

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

2023 National Staff Survey Results

Staff Experience and Engagement

The Trust had its highest ever response to the national staff survey with 67% of colleagues completing it, providing valuable feedback to the organisation as to how it can improve and make it a better place to work. All clinical divisions had increased engagement with their teams with lots of innovative ideas, incentives, and a small element of competition to achieve the high response rates. This was visibly led by the Executive team and supported with targeted communications. In response to operational pressures we committed to continue to support our colleagues as we moved out of the pandemic phase into recovery and beyond. The demand on staff remains consistent and we are mindful of the need to address the treatment backlog faced across the NHS whilst continuing to support the workforce to be well and at work.

In response to last year's survey there was increased focus on the importance of wellbeing and self-care, improving the clinical environment, break out areas, changing facilities and provision of hot food has continued as an ambition to support staff. We have also continued to develop meaningful activities and health initiatives to promote colleagues to take care of their own health to enable them to care for others.

We have seen a consistent use of staff accessing our Employee Assistance Programme services, support through occupational health and ICB led initiatives and training both physical and online.

We have worked hard to embed good practice in line with the NHS People Promises such as our approach to supporting flexible working, to be compassionate and inclusive, understanding our colleague voice though emphasising the importance of the National Staff Survey.

We have worked with a number of regional stakeholders to showcase and recognise talent in the borough to plan for future healthcare roles and opportunities.

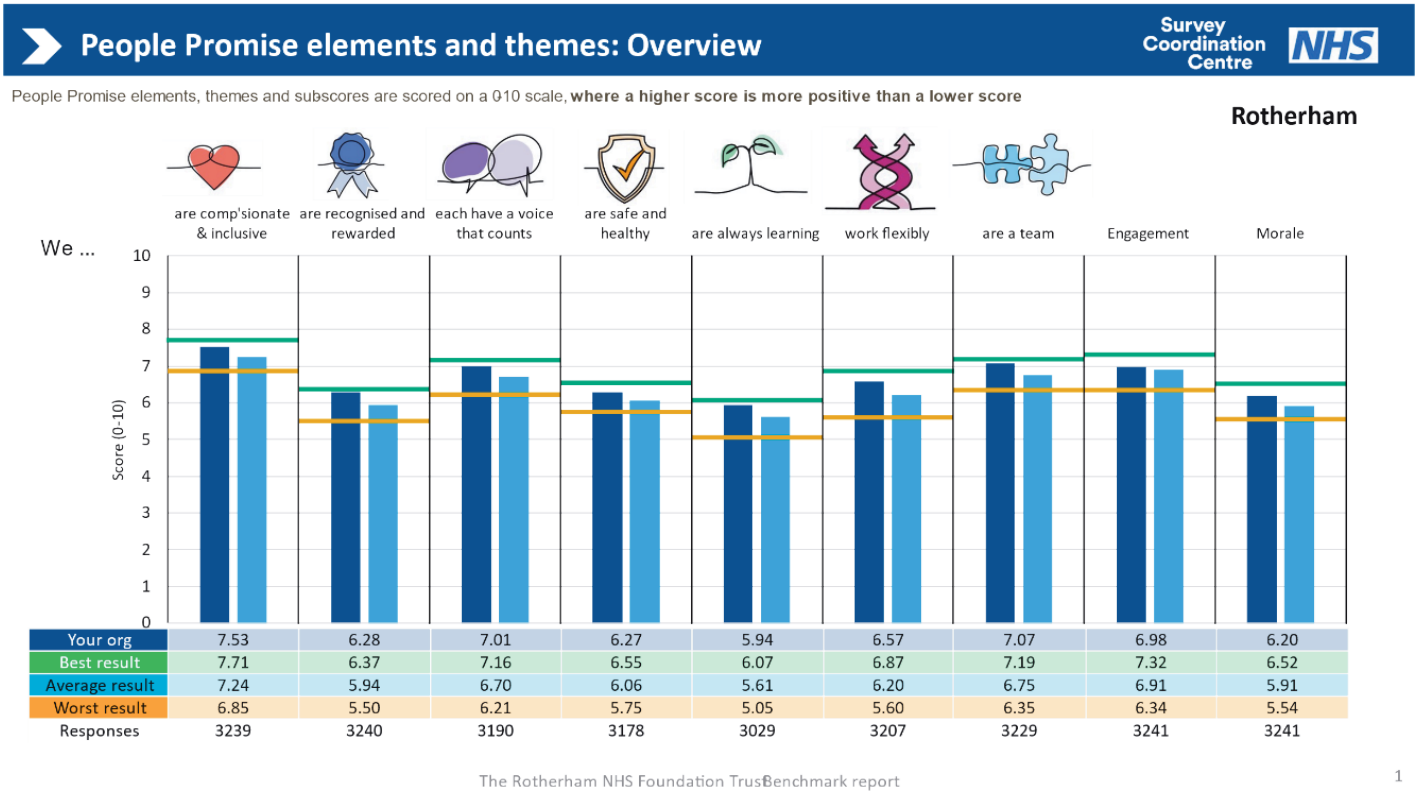
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a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

The response rate to the 2023/24 survey among trust staff was 67% (2022/23: 61%).

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)	2023/24		2022/23		2021/22	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.53	7.24	7.4	7.2	7.2	7.2
We are recognised and rewarded	6.28	5.94	6.0	5.7	5.9	5.8
We each have a voice that counts	7.01	6.70	6.8	6.6	6.7	6.7
We are safe and healthy	6.27	6.06	6.1	5.9	6.0	5.9
We are always learning	5.94	5.61	5.6	5.4	5.3	5.2
We work flexibly	6.57	6.20	6.2	6.0	6.0	5.9
We are a team	7.07	6.75	6.9	6.6	6.7	6.8
Staff engagement	6.98	6.91	6.7	6.8	6.7	6.8
Morale	6.20	5.91	5.9	5.7	5.8	5.7

The Trust has improved it's score against all the staff survey domains and benchmarks above the national average for all domains when compared to the peer group.



The 2023/24 NSS results are very positive and demonstrate the progress that TRFT continues to make, particularly in relation to the three advocacy questions (25a, 25c, 25d) where the Trust now ranks in the top 3 most improved organisations across England.

Advocacy / Year	2022	Rank	Quartile	2023	Rank	Quartile	Change +/-
Q25a							
Care of patient/service users is my organisation's top priority	69%	93th	bottom quartile	74%	68th	3rd quartile	Ranking up 25 places 5% increase = **3rd biggest increase in England**
Q25c							
I would recommend my organisation as a place to work	54%	77th	3rd quartile	63%	43rd	2nd quartile	Ranking up 34 places 9% increase = **2nd biggest increase in England**
Q25d							
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	50%	98th	bottom quartile	58%	90th	3rd quartile	Ranking up 8 places 8% increase = **biggest increase in England**
Engagement (Advocacy, Motivation and Involvement)	6.73	71st	3rd quartile	6.98	37th	2nd quartile	Ranking up 34 places

NHS Response Rate

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

The Trust had excellent engagement with the 2023 national staff survey, with 67% of colleagues responding to the questionnaire and providing their valuable feedback; this is the highest return rate the Trust has ever achieved and well above the national average.

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

Most improved scores	Org 2023	Org 2022
q25c. Would recommend organisation as place to work	63%	54%
q3i. Enough staff at organisation to do my job properly	34%	25%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	50%
q4c. Satisfied with level of pay	35%	27%
q6b. Organisation is committed to helping balance work and home life	55%	47%

Top 5 scores vs Organisation Average	Org	Picker Avg
q23a. Received appraisal in the past 12 months	93%	83%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	65%	56%
q19d. Feedback given on changes made following errors/near misses/incidents	69%	60%
q6c. Achieve a good balance between work and home life	63%	56%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	73%	66%

Most declined scores	Org 2023	Org 2022
q2c. Time often/always passes quickly when I am working	72%	74%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	76%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80%	81%
q13d. Last experience of physical violence reported	70%	71%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	94%

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%	63%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	84%	87%
q12c. Never/rarely frustrated by work	20%	22%
24b. There are opportunities for me to develop my career in this organisation	54%	55%
q23b. Appraisal helped me improve how I do my job	25%	26%

Top 5 Priorities for 2024/25

Taking on board feedback from the 2023 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	Appraisal	Director of People
2	Car Parking	Director of Estates & Facilities
3	Reasonable adjustments	Director of Finance
4	Sexual safety	Chief Nurse
5	Violence and Aggression	Managing Director

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 Division 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 Divisional 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 2023- 24 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

The table below illustrates the total number of employees who were relevant union officials during the reporting period.

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
14	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%	15
51%-99%	0
100%	1

Table 3: Percentage of pay bill spent on facility time

Figures requested in 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	£41,628
Provide the total pay bill	£232,590,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.018

Paid trade union activities

Below is the percentage of total paid facility time hours, the number of hours spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours	5.64

Off-payroll engagements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement is made at a very senior level and for exceptional operational reasons. During 2022-23 zero off-payroll engagements were entered into.

Table 1. Highly paid off-payroll worker engagements as at 31 March 2023, earning £245 per day or greater	
Number of existing engagements as of 31 March 2022 Of which:	0
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

Table 2. All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2022 Of which:	0
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 Of which:	0
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 2023	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0

Countering Fraud, Bribery and Corruption

Effective from 01 April 2021 the NHS Counter Fraud Authority (NHSCFA) implemented the Government Functional Standard 013: Counter Fraud ('the Functional Standard') within the NHS. During the year, the NHSCFA have developed their requirements in relation to the Functional Standard. All NHS funded services are required to comply with the Functional Standard. Progress against the requirements of the Functional Standard is overseen by the Trust's 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. The Trust demonstrated an overall 'Green' rating following the self-assessment. The Trust's Chief Executive and Director of Finance are jointly responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti-Crime Strategy for countering fraud, bribery and corruption. The NHSCFA is responsible for ensuring the quality of measures to counter fraud, bribery and corruption within NHS Foundation Trusts.

The Trust 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 in compliance with the Functional Standard overseen by the Director of Finance and Audit Committee. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities.

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 2023-24, six referrals were made to the CFS, demonstrating good awareness and understanding of the Fraud, Bribery and Corruption Policy.

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 2023-24. 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 were held in quarter four of 2023-24.

At the 15 February 2023 Council of Governors meeting, the Council supported the proposal subsequently approved at the 03 March 2023 Board of Directors meeting to amalgamate the seven Public Constituencies into one Rotherham-wide constituency in addition to the Rest of England constituency. This change in approach was to address the number of Public Governor vacancies and in preparation for the 2023 Governor elections and has been successful.

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 rgh-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

The 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 (consisting of seven local electoral wards 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 2023/24 there were 13,720 Members of The Rotherham NHS Foundation Trust (TRFT) as detailed below:

Public	
Rotherham	8812
Rest of England	1363
Total Public Members	10,175
Staff	
Staff Members	3,545
Total membership	**13,720**

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 below is a breakdown of a number of metrics pertaining to our membership.

	Public	Staff	Total
Age			
0-16	0	0	0
17-21	0	4	4
22-29	32	140	172
30-39	1,139	772	1,911
40-49	1,247	841	2,088
50-59	1,704	1,027	2,731
60-74	2,617	686	3,303
75+	2,317	22	2,339
Not stated	1,119	53	1,172
Gender			
Unspecified	3	14	17
Male	3,936	537	4,473
Female	6,236	2,994	9,230
Transgender	0	0	0
Ethnicity			
White - English, Welsh, Scottish, Northern Irish, British	3,506	2,337	5,843
White - Irish	14	8	22
White - Gypsy or Irish Traveller	0	0	0
White - Other	13	24	37
Mixed - White and Black Caribbean	2	5	7
Mixed - White and Black African	1	3	4
Mixed - White and Asian	1	10	11
Mixed - Other Mixed	10	4	14
Asian or Asian British - Indian	31	52	83
Asian or Asian British - Pakistani	164	24	188
Asian or Asian British - Bangladeshi	2	2	4
Asian or Asian British - Chinese	5	6	11
Asian or Asian British - Other Asian	22	16	38
Black or Black British - African	24	17	41
Black or Black British - Caribbean	5	6	11
Black or Black British - Other Black	14	2	16
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	64	25	89
Not stated	6,297	1,004	7,301
Total numbers of Members	**10,175**	**3,545**	**13,720**

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. Our Governor initiative 'Governors' Surgery' provides a monthly platform where Trust members, visitors, staff and patients can meet and chat to Governors and share their views. The comments are then distributed to relevant departments to share the learning and insights gained from 'Governors' Surgery'.

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.

The Governors have continued to be instrumental in promoting the Public Panel across their networks and constituencies.
During 2023-24 the Council of Governors monitored progress made in relation to the **Member Engagement Strategy 2022 - 2025 approved in 2021/22.**

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 strategy to engage and communicate with members, a key focus has been moving towards digitising the application process and membership management; the application form is now linked with the membership database and fully digital, with a Members Portal to allow members to change and update their membership independently. With this more progressive approach, contact with members can be more relevant and aligned with their chosen preferences to promote better and more meaningful engagement.

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 2024/25 whilst continuing the 2023/24 drive on staff membership.

The Annual Members Meeting (AMM) 2023 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 held in September 2023 was once again a virtual event with a focus on 'partnership working' describing areas of joint working between the Trust and Barnsley Hospital NHS Foundation Trust.

In March 2024, elections for the Council of Governors commenced, seeking nominations for six 'Rotherham-wide' Public Governor seats, one 'Rest of England' Public Governor seat and two Staff Governor seat. 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: rgh-tr.public.governors@nhs.net indicating the name of the Public Governor they wish to contact in the subject line of the e-mail.

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

Governor Nominations Committee / Non-Executive Director Appointments 2023-4

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 Lead Governor, Gavin Rimmer.

The Committee met on four occasions during 2023-24

The Chair and Non-Executive Directors' annual appraisal and objective setting process was undertaken early in quarter one of 2023-24.

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.z

Table 1.

Part of Schedule A	***Code* section**	**Summary of requirement**
Required disclosures		
Disclose	A 2.1	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. Contained within the Directors Report and Annual Governance Statement
Disclose	A 2.3	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. Contained within the staff report
Disclose	A 2.8	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. Contained within the Performance Report

Part of Schedule A	*Code* section	Summary of requirement
Disclose	B 2.6	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: • 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 orsenior 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 orsenior 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. 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. Within the Directors Report
Disclose	B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance. Within the Directors Report
Disclose	B 2.17	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. Within the Directors report
Disclose	C 2.5	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.
Disclose	C 2.8	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. Within the Directors Report
Disclose	C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
		Within the Directors Report

Part of Schedule A	*Code* section	Summary of requirement
Disclose	C 4.7	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. Within the Directors Report
Disclose	C 4.13	The annual report should describe the work of the nominations committee(s), including: • 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 and their directreports. Within the Directors Report
Disclose	C 5.15	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. Within the Directors Report

Disclose	D 2.4	The annual report should include: • 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. Within the Directors Report
Disclose	D 2.6	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. Within the Directors Report

Part of Schedule A	***Code* section**	**Summary of requirement**
Disclose	D 2.7	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. Within the Annual Governance Statement
Disclose	D 2.8	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. Within the Annual Governance Statement
Disclose	D 2.9	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. Within the Performance Report
Disclose	E 2.3	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. Not applicable to this reporting period

Disclose	Appendix B, para 2.3 (not in Schedule A)	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. Contained within the Governor and Membership Section
Disclose	Appendix B, para 2.14 (not in Schedule A)	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. Contained within the Governor and Membership Section
Disclose	Appendix B, para 2.15 (not in Schedule A)	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. Attendance contained within the Governor and Membership

Part of Schedule A	***Code* section**	**Summary of requirement**
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012) Not applicable

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

Provision	Requirement
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

Provision	Requirement
	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 responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues. 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

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

Provision	**Requirement**
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

Provision	**Requirement**
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

Provision	**Requirement**
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
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

Provision	Requirement
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 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
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	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. Comply

Section C, 4.8 (NHS foundation trusts only)	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: • 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. 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. Comply
Section C, 4.10 (NHS foundation trusts only)	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. Comply

Section C, 4.11	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. Comply
Section C, 4.12	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. Comply
Section C, 5.1	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. Comply
Section C, 5.2	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. Comply

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

Provision	Requirement
	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: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust'sfinancial 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 composedof 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

Provision	Requirement
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. Comply
Section D, 2.5	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
Section E, 2.1	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. • 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 againstsome 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 basicsalary. • The remuneration committee should consider the pension consequences and associated costs to the trust ofbasic

Provision	Requirement
	salary increases and any other changes in pensionable remuneration, especially for directors close to retirement. Not applicable during the reporting period
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure. Comply
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice. Comply
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity. Not applicable during the reporting period
Section E, 2.7	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. Comply

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

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

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision

Provision	Requirement
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

The 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's System Oversight Framework

NHS England's System Oversight Framework provides the framework for overseeing providers and identifying potential support needs. NHS organisations are allocated to 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 (the themes are: 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 behaviours, and improvement capability and capacity.

The Rotherham NHS Foundation Trust continues to be classified by NHS England as being in segment 3 as at 31 March 2024. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-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 The Rotherham NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS 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
- onfirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Signed R. Jenkins.....

Chief Executive

Dr Richard Jenkins

Date: 21 June 2024


CERTIFICATE
Fitzwilliam


Eliana
Special Care Baby Unit
My First Diary
NIKE


NHS

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 polices, 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 2024 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 Divisions, 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 Division 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 2024 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 38 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

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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, Divisional 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 Divisional 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 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 October 2023. 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 2024, 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 and capability leading to poor 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 develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
- The risk we do not deliver safe and excellent performance due to insufficient resource (financial and human) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.
- The risk we will not be able to deliver our services because we have not delivered on our Financial Plans for 2023-24 in line with national and system requirements leading to financial instability and the need to seek additional support to deliver out services.
- The risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023-24 leading to further financial instability was added to the BAF as a forward looking risk in Quarter 2.

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. Significant progress has been made during the last year in relation to the implementation of the Patient Safety Incident Response Framework, a system-based approach to learning from patient safety incidents.

In line with the Foundation Trust Annual Reporting Manual for 2023-234 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 Plan contains key objectives to support and enable Divisions 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 transferred in year from the Medical Director to 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 2023-24, the Trust reported a total of four 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 Division 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 Divisions at the Assurance 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, 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 (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. During 2023-24, clinical effectiveness was included as one of our Quality Priorities capturing both local and national audits in order to evaluate the quality of care delivered, promote best practice by influencing quality improvements.

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 10 reports relating to mandated, risk based and advisory reviews, the outcomes of which are detailed below:

One 'Substantial Assurance' relating to Data Security and Protection Toolkit

Four 'Significant Assurance' relating to Policy Management Framework; Clinical Engineering Maintenance; Clinical Audit and NICE Guidance and Financial Ledger and Reporting

Three 'Moderate/Split Assurance' relating to PSIRF; Waiting List Management; Patient Experience

One 'Limited Assurance' relating to IT Business Continuity

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 2023-24 and the overall opinion is as follows: "I am providing an opinion of Significant Assurance that there is a generally sound framework for governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

Strategic risk management and Board Assurance Framework – I am providing an opinion of significant assurance on this element; we have evidenced sound processes for the review of strategic risks at Board and committee-level throughout the year.

Internal Audit outturn – I am providing an opinion of significant assurance on this element. Two audits completed in 2023/24 have been allocated a limited assurance opinion and one has been allocated a split significant/ limited assurance opinion, however, we recognise that the Trust has directed us to some areas already identified as requiring further improvement. Two high risk findings have been raised in year.

Implementation of Internal Audit Actions – I am providing an opinion of significant assurance on this element as the Trust has attained a follow up rate of 77% in-year.

Conclusion

The Board remains committed to continuous improvement to ensure that robust systems continue to be in place to identify and mange 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
21 June 2024

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 2024 which comprise the Statement of Comprehensive Income, the Statement of 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 2023/24 as contained in the Department of Health and Social Care Group Accounting Manual 2023/24, 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 2024 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 2023/24; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

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

Based on the work we have performed, 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.

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

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements
As explained more fully in the Statement of 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 2023/24 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 identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

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 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;
- 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 evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to revenue and expenditure cut off, valuation of land and buildings, and IFRS 16 implementation for PFI liabilities.

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

- making enquiries of management 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; and
- addressing the risks of fraud through management override of controls by performing journal entry testing, performing procedures on accounting estimates impacting amounts included in the financial statements and consideration of identified significant transactions outside the normal course of business.

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

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in February 2023.

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 2024.

We have nothing to report in this respect.

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 May 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 2023/24; 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 2023/24; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

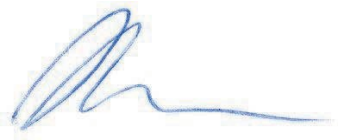
We have nothing to report in respect of these matters.

Use of the audit report

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

Certificate

We certify that we have completed the audit of The Rotherham NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.



Daniel Watson Key Audit Partner
For and on behalf of Mazars LLP

One St Peter's Square

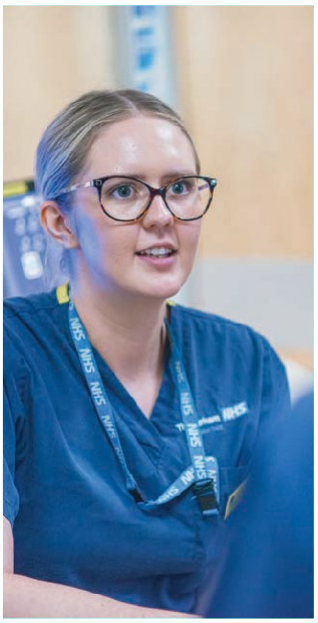
Manchester

M2 3DE

25 June 2024

The Rotherham NHS Foundation Trust

Annual Accounts for the Year Ended March 2024



Foreword to the Accounts

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:

Dr R Jenkins

Chief Executive

21 June 2024

Statement of Financial Position (SOFP)

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	14	7,594	7,616
Property, plant and equipment	15	160,604	159,914
Right of use assets	18	17,315	22,464
Receivables	24	404	479
Total non-current assets		**185,917**	**190,473**
Current assets			
Inventories	23	5,043	3,995
Receivables	24	10,682	18,368
Cash and cash equivalents	28	12,116	24,356
Total current assets		**27,841**	**46,719**
Current liabilities			
Trade and other payables	29	(34,104)	(47,125)
Borrowings	32	(4,594)	(4,573)
Provisions	34	(1,704)	(242)
Other liabilities	31	(1,819)	(2,375)
Total current liabilities		**(42,221)**	**(54,315)**
Total assets less current liabilities		**171,537**	**182,877**
Non-current liabilities			
Borrowings	32	(32,083)	(34,042)
Provisions	34	(1,042)	(1,198)
Total non-current liabilities		**(33,125)**	**(35,240)**
Total assets employed		**138,412**	**147,637**
Financed by			
Public dividend capital		169,520	168,059
Revaluation reserve		57,391	60,774
Income and expenditure reserve		(88,499)	(81,196)
Total taxpayers' equity		**138,412**	**147,637**

Signed:

R. Jenkins

Dr R Jenkins

Chief Executive

21 June 2024

Statement of Comprehensive Income (SOCI)

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	335,563	330,323
Other operating income	4	30,328	30,112
Operating expenses	7, 9	(370,307)	(364,701)
Operating surplus/(deficit) from continuing operations		**(4,416)**	**(4,266)**
Finance income	10	1,169	625
Finance expenses	11	(1,484)	(922)
PDC dividends payable		(3,932)	(3,805)
Net finance costs		**(4,247)**	**(4,102)**
Other gains / (losses)	12	(3)	(12)
Surplus / (deficit) for the year		**(8,666)**	**(8,380)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,709)	2,333
Revaluations	17	560	4,720
Total comprehensive income / (expense) for the period		**(9,815)**	**(1,327)**

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(8,666)	(8,380)
Remove net impairments not scoring to the Departmental expenditure limit	2,606	8,932
Remove I&E impact of capital grants and donations	748	(2,097)
Remove impact of IFRS 16 on IFRIC 12 schemes	597	
Adjusted financial performance surplus / (deficit)	**(4,715)**	**(1,545)**

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' 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' and others' equity at 31 March 2024	**169,520**	**57,391**	**(88,499)**	**138,412**

Statement of Changes in Taxpayer's Equity for the Year Ended 31 March 2023

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**166,750**	**55,911**	**(75,691)**	**146,970**
Implementation of IFRS 16 on 1 April 2022	-	-	685	**685**
Surplus/(deficit) for the year	-	-	(8,380)	**(8,380)**
Other transfers between reserves	-	(2,190)	2,190	**-**
Impairments	-	2,333	-	**2,333**
Revaluations	-	4,720	-	**4,720**
Public dividend capital received	1,309	-	-	**1,309**
Taxpayers' and others' equity at 31 March 2023	**168,059**	**60,774**	**(81,196)**	**147,637**

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 leased buildings and the Special Care Baby Unit was undertaken during 2023/2024.

Income and Expenditure Reserve

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

Statement of Cash Flows (SOCF)

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(4,416)	(4,266)
Non-cash income and expense:			
Depreciation and amortisation	7	14,124	12,520
Net impairments	8	2,606	8,932
Income recognised in respect of capital donations	4	-	(2,636)
(Increase) / decrease in receivables and other assets		7,642	(9,601)
(Increase) / decrease in inventories		(1,048)	(493)
Increase / (decrease) in payables and other liabilities		(12,689)	8,536
Increase / (decrease) in provisions		1,289	(3,311)
Net cash flows from / (used in) operating activities		**7,508**	**9,681**
Cash flows from investing activities			
Interest received		1,169	625
Purchase of intangible assets		(1,068)	(125)
Purchase of PPE and investment property		(12,082)	(13,452)
Sales of PPE and investment property		11	1
Lease termination fees paid (lessee)		-	(1)
Receipt of cash donations to purchase assets		-	2,302
Net cash flows from / (used in) investing activities		**(11,970)**	**(10,650)**
Cash flows from financing activities			
Public dividend capital received		1,461	1,309
Movement on loans from DHSC		(1,250)	(1,250)
Capital element of finance lease rental payments		(3,076)	(2,933)
Capital element of PFI, LIFT and other service concession payments		(300)	(248)
Interest on loans		(278)	(308)
Interest paid on finance lease liabilities		(250)	(334)
Interest paid on PFI, LIFT and other service concession obligations		(280)	(273)
PDC dividend (paid) / refunded		(3,805)	(3,941)
Net cash flows from / (used in) financing activities		**(7,778)**	**(7,978)**
Increase / (decrease) in cash and cash equivalents		**(12,240)**	**(8,947)**
Cash and cash equivalents at 1 April - brought forward		**24,356**	**33,303**
Cash and cash equivalents at 31 March	28	**12,116**	**24,356**

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 2023/2024 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), 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 2024, 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 £1,884K.

1.3.2 Sources of Estimation Uncertainty

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

Income Estimates
In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated that it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense Accruals
In estimating expenses for goods and services received, but that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Valuation of Property, Plant and Equipment
The Trust has used valuations carried out at 31 March 2024 and 31 March 2023 by its expert independent professional valuer (Clark Weightman) 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.

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 2024 totalled £160,604K; further details can be found in Note 15.

Estimation of payments for the PFI and service concession assets, including finance costs

The assets and liabilities relating to the Carbon Energy Fund (CEF) scheme have been brought onto the Statement of Financial Position in line with the requirements of IFRS 16.

Further detail regarding the Carbon Energy Fund (CEF) can be found in Note 38.

The carrying value of the CEF at 31 March 2024 was £6,490K, and is included within the £160,604K of property, plant and equipment. Please also see Note 15.3.

Recoverability of Receivables

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

The Trust is required to judge when there is sufficient evidence to impair individual receivables taking into account the age profile and class of receivable. The Trust adopts a prudent approach when setting the expected credit loss based on a forward look of credit risk. Every effort is made to collect the debt, even when it has been impaired, and it is only written off as a final course of action after all possible recovery efforts have been made. The actual level of debt eventually written off may be different to that which has been judged as impaired.

Allowances for credit losses, as shown in Note 24.2, amounted to £852K. Of the £852K, £785K related to contract receivables and other contract assets and £67K for all other receivables.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Wherever possible, the Trust will seek guidance from third parties when establishing individual provisions, such as NHS Resolution for legal claims.

Provisions, by their nature, are a matter of judgement, with the best estimate made based on the information available at the time. Once realised, provisions can differ from the original estimate. Management have taken into account all available information for disputes and possible outcomes when determining the level of provision to make.

Note 34.1 sets out the Provisions held by the Trust at 31 March 2024, which totalled £2,746K.

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 (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS 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 NHSPS. In 2023/24 (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 NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS 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.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

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 BTP 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 NHSPS 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. In 2023/24, 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. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

The Trust has apportioned income received under API contracts between acute services and community services. This is 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 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap 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 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.

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. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

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

1.10.4 Amortisation

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

1.10.5 Useful Economic Life of Intangible Assets

Useful 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 3.51% was applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

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 from 1 April 2023 as mandated by the FReM.

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.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve. Comparatives for PFI, LIFT and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising

from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

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 2.45% (1.70% in 2022/2023) 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 4.26% (3.27% in 2022/2023) 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 4.03% (3.20% in 2022/2023) 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 4.72% (3.51% in 2022/2023) 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 4.40% (3.00% in 2022/2023) 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 (including lottery funded assets)

- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable
- approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets, as set out in the “pre-audit” version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

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

Note 1.22 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 2023/2024.

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 2023/2024:

- IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FreM which is expected to be from 1 April 2025. Early adoption is not permitted

The Trust has not undertaken analysis of the impact of the new standard on its financial position.

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 overall Foundation Trust 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**	
	2023/24 £000	2022/23 £000	**2023/24 £000**	2022/23 £000
Income	**365,891**	360,435	**365,891**	360,435
Retained Earnings / (Accumulated Deficit)	**(8,666)**	(8,380)	**(8,666)**	(8,380)
Segment net assets	**138,412**	147,637	**138,412**	147,637

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)

	2023/24 £000	2022/23 £000
Acute services		
Income from commissioners under API contracts – variable element*	60,489	
Income from commissioners under API contracts – fixed element*	216,610	260,045
High cost drugs income from commissioners	5,535	5,146
Other NHS clinical income	80	57
Community services		
Income from commissioners under API contracts*	32,836	30,373
Income from other sources (e.g. local authorities)	9,281	9,455
All services		
Elective recovery fund	-	6,563
National pay award central funding***	149	8,166
Additional pension contribution central funding**	9,499	8,867
Other clinical income	1,084	1,651
Total income from activities	**335,563**	**330,323**

*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/

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

Note 3.2 Income From Patient Care Activities (By Source)

	2023/24 £000	2022/23 £000
NHS England	22,870	34,847
Clinical commissioning groups		68,176
Integrated care boards	297,034	213,202
Other NHS providers	80	57
NHS other	-	4,243
Local authorities	9,652	9,125
Non-NHS: overseas patients (chargeable to patient)	158	13
Injury cost recovery scheme	877	605
Non NHS: other	4,892	55
Total income from activities	**335,563**	**330,323**
Of which:		
Related to continuing operations	335,563	330,323
Related to discontinued operations	-	-

Note 3.3 Overseas Visitors (Relating to Patients Charged Directly By the Provider)

	2023/24 £000	2022/23 £000
Income recognised this year	158	13
Cash payments received in-year	16	8
Amounts added to provision for impairment of receivables	119	5
Amounts written off in-year	-	164

Note 4 Other Operating Income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	534	-	**534**	480	-	**480**
Education and training	13,290	592	**13,882**	12,241	639	**12,880**
Non-patient care services to other bodies	8,402		**8,402**	6,564		**6,564**
Reimbursement and top up funding				201		**201**
Income in respect of employee benefits accounted on a gross basis	3,530		**3,530**	3,093		**3,093**
Receipt of capital grants and donations and peppercorn leases		-	**-**		2,636	**2,636**
Charitable and other contributions to expenditure		63	**63**		463	**463**
Revenue from operating leases		468	**468**		477	**477**
Other income	3,449	-	**3,449**	3,318	-	**3,318**
Total other operating income	**29,205**	**1,123**	**30,328**	**25,897**	**4,215**	**30,112**
Of which:						
Related to continuing operations			30,328			30,112
Related to discontinued operations			-			-

Note 5.1 Additional Information on Contract Revenue (IFRS 15) Recognised in the Period

	2023/24 £000	2022/23 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	2,375	1,711

Note 5.2 Transaction Price Allocated to Remaining Performance Obligations

As at the year end the Trust has no performance obligations that are either partially or fully unsatisfied that it has not accounted for in revenue recognition in year. Therefore, there are no contracts that commenced prior to the period end, with performance obligations outstanding and income not yet recognised.

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from Activities Arising from Commissioner Requested Services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from Commissioner requested and non-Commissioner requested services. Commissioner requested services are defined in the provider licence and are services that Commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24 £000	2022/23 £000
Income from services designated as Commissioner requested services	334,479	328,672
Income from services not designated as Commissioner requested services	31,412	31,763
Total	**365,891**	**360,435**

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 £1,000K and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

In 2023/24 The Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1,000K. This was also the case during the 2022/23 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.

	2023/24 £000	2022/23 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	468	477
Total in-year operating lease income	**468**	**477**

Note 6.2 Future Lease Receipts

	31 March 2024 £000	31 March 2023 £000
Future minimum lease receipts due in:		
- not later than one year	424	463
- later than one year and not later than two years	370	424
- later than two years and not later than three years	346	373
- later than three years and not later than four years	223	349
- later than four years and not later than five years	223	226
- later than five years	5,066	5,310
Total	**6,652**	**7,145**

Note 7.1 Operating Expenses

The following table shows the operating expenses incurred by the Trust during both the 2023/24 and 2022/23 financial years:

	2023/24 £000	2022/23 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,166	1,618
Staff and executive directors costs	256,783	249,669
Remuneration of non-executive directors	145	176
Supplies and services - clinical (excluding drugs costs)	30,218	27,512
Supplies and services - general	5,378	4,946
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,453	20,856
Inventories written down	13	39
Consultancy costs	104	50
Establishment	2,626	3,038
Premises	15,503	15,589
Transport (including patient travel)	3,994	3,387
Depreciation on property, plant and equipment	12,858	11,685
Amortisation on intangible assets	1,266	835
Net impairments	2,606	8,932
Movement in credit loss allowance: contract receivables / contract assets	227	148
Movement in credit loss allowance: all other receivables and investments	9	25
Increase/(decrease) in other provisions	-	(274)
Change in provisions discount rate(s)	(31)	(171)
Fees payable to the external auditor		
audit services- statutory audit (*)	145	108
Internal audit costs	109	91
Clinical negligence	10,252	9,654
Legal fees	452	378
Insurance	257	222
Research and development	490	476
Education and training	1,016	2,076
Expenditure on short term leases	-	20
Expenditure on low value leases	6	2
Redundancy	128	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	687	597
Losses, ex gratia & special payments	74	685
Other services, eg external payroll	668	1,338
Other	705	994
Total	**370,307**	**364,701**
Of which:		
Related to continuing operations	370,307	364,701
Related to discontinued operations	-	-

Note:
*Audit fees are inclusive of VAT.

Note 7.2 Other Auditor Remuneration

No other External Auditor remuneration was paid during the 2023/24 financial year for work over and above the statutory audit fee, nor was there in 2022/23.

Within the “fees payable to the external auditor” line of Note 7.1 above, Operating Expenses, £7K relates to additional works undertaken on the statutory audit of the 2022/23 annual accounts which was paid during the 2023/24 financial year.

Note 7.3 Limitation on Auditor’s Liability

Mazars LLP are appointed by the Trust as their External Auditors; their limitation of liability is unlimited.

Note 8 Impairment of Assets

	2023/24 £000	2022/23 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(747)	8,932
Other	3,353	-
Total net impairments charged to operating surplus / deficit	**2,606**	**8,932**
Impairments charged to the revaluation reserve	1,709	(2,333)
Total net impairments	**4,315**	**6,599**

During 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.

The Trust undertook a refurbishment of the Special Care Baby Unit as part of its 2023/24 capital plan, which resulted in impairment. In addition, some impairment previously charged to the Statement of Comprehensive Income was reversed. The total of this is shown under “changes in market price” and “impairments charged to the revaluation reserve.”

Impairment shown under “other” relates to the revaluation of leased buildings. Leased buildings were revalued at 31 March 2024 based on the market rent (fair value) of what the Trust would expect to pay for a similar property; this represented a move from the cost model under which the leased buildings were brought onto the Statement of Financial Position at 1 April 2023, when the Trust adopted IFRS 16. Some of the lease buildings that were revalued were deemed to have a market value below the value established under the cost model valuation.

In 2022/23, the Trust's land and building assets (excluding leased buildings) were subject to a full revaluation which resulted in some impairment costs charged to the Statement of Comprehensive Income.

Note 9 Employee Benefits

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	190,775	184,264
Social security costs	18,489	18,256
Apprenticeship levy	937	851
Employer's contributions to NHS pensions	31,252	29,078
Pension cost - other	78	112
Temporary staff (including agency)	16,678	17,577
Total staff costs	**258,209**	**250,138**
Of which:		
Costs capitalised as part of assets	813	-
Cost attributable to research and development	485	469
Cost of redundancies	128	-
Total	**256,783**	**249,669**

Note 9.1 Retirements Due to Ill-Health

During 2023/24, there were six early retirements from the Trust agreed on the grounds of ill-health (seven in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £1,121K (£266K in 2022/23).

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.

	2023/24 £000	2022/23 £000
Interest on bank accounts	1,169	625
Total finance income	**1,169**	**625**

Note 11.1 Finance Expenditure

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

	2023/24 £000	2022/23 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	272	302
Interest on lease obligations	250	334
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	280	273
Remeasurement of the liability resulting from change in index or rate*	665	
Total interest expense	**1,467**	**909**
Unwinding of discount on provisions	17	13
Total finance costs	**1,484**	**922**

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 38.

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 2023/24, the Trust paid £298.35 in late payment fees under the above Act. During the 2022/23 financial year, the Trust did not incur any costs.

Note 12 Other Gains / (Losses)

	2023/24 £000	2022/23 £000
Gains on disposal of assets	9	-
Losses on disposal of assets	(12)	(12)
Total other gains / (losses)	**(3)**	**(12)**

Note 13 Discontinued Operations

No services provided by the Rotherham NHS Foundation Trust were discontinued in either the 2023/24 or 2022/23 financial years.

Note 14.1 Intangible Assets – 2023/24

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2023 - brought forward	**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 - brought forward	**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 14.2 Intangible Assets – 2022/23

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2022	**20,994**	**20,994**
Additions	177	**177**
Valuation / gross cost at 31 March 2023	**21,171**	**21,171**
Amortisation at 1 April 2022	**12,720**	**12,720**
Provided during the year	835	**835**
Amortisation at 31 March 2023	**13,555**	**13,555**
Net book value at 31 March 2023	**7,616**	**7,616**
Net book value at 1 April 2022	**8,274**	**8,274**

Note 15.1 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 - brought forward	**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 - brought forward	**-**	**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 15.2 Property, Plant and Equipment – 2022/23

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£0
Valuation / gross cost at 1 April 2022	**6,450**	**131,214**	**3,015**	**32,846**	**209**	**12,289**	**393**	**186,416**
IFRS 16 implementation – reclassification of existing finance leased assets to right of use assets	(150)	(5,646)	-	(3,327)	-	-	-	**(9,123)**
Additions	-	8,582	177	4,737	47	812	-	**14,355**
Impairments	-	(11,450)	-	-	-	-	-	**(11,450)**
Revaluations	4,700	-	-	-	-	-	-	**4,700**
Reclassifications	-	(6,253)	(3,015)	9,268	-	-	-	**-**
Disposals / derecognition	-	-	-	(303)	-	-	-	**(303)**
Valuation/gross cost at 31 March 2023	**11,000**	**116,447**	**177**	**43,221**	**256**	**13,101**	**393**	**184,595**
Accumulated depreciation at 1 April	**-**	**227**	**-**	**17,554**	**163**	**4,753**	**171**	**22,868**
IFRS 16 implementation – reclassification of existing finance leased assets to right of use assets	-	(102)	-	(1,343)	-	-	-	**(1,445)**
Provided during the year	-	5,132	-	2,102	25	966	39	**8,264**
Reversals of impairments	-	(4,710)	-	-	-	-	-	**(4,710)**
Reclassifications	-	(500)	-	500	-	-	-	**-**
Disposals / derecognition	-	-	-	(296)	-	-	-	**(296)**
Accumulated depreciation at 31 March	**-**	**47**	**-**	**18,517**	**188**	**5,719**	**210**	**24,681**
Net book value at 31 March 2023	**11,000**	**116,400**	**177**	**24,704**	**68**	**7,382**	**183**	**159,914**
Net book value at 1 April 2022	**6,450**	**130,987**	**3,015**	**15,292**	**46**	**7,536**	**222**	**163,548**

Note 15.3 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 15.4 Property, Plant and Equipment Financing – 2022/23

	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	113,348	177	16,603	68	7,382	183	**148,761**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	6,866	-	-	-	**6,866**
Owned - donated/granted	-	3,052	-	1,235	-	-	-	**4,287**
Total net book value at 31 March 2023	**11,000**	**116,400**	**177**	**24,704**	**68**	**7,382**	**183**	**159,914**

Note 15.5 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 15.6 Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 2022/23

	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	113,811	177	24,704	68	7,382	183	**156,737**
Total net book value at 31 March 2023	**11,000**	**116,400**	**177**	**24,704**	**68**	**7,382**	**183**	**159,914**

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 2023/2024.

The Trust received the following donated assets during the 2022/23 financial years:

	2022/23 £000
Donated Assets	
14 Anaesthetic Machines (received from Nightingale Hospitals)	334
Cash Donations - for the Purchase of Assets	
Cerebral Functioning Monitors	25
Total	**359**

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, 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 £127,279K.

During 2023/24, interim revaluations were undertaken on the Special Care Baby Unit and lease building assets. These revaluations resulted in both revaluation gains and impairments losses.

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 – 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023	**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	**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 18.2 Right of Use Assets – 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2022	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	5,796	3,327	-	**9,123**	5,796
IFRS 16 implementation - adjustments for existing operating leases / subleases	16,146	2,271	28	**18,445**	17,213
Remeasurements of the lease liability	(390)	-	-	**(390)**	(390)
Impairments	(371)	-	-	**(371)**	(371)
Revaluations	20	-	-	**20**	20
Disposals / derecognition	-	-	(11)	**(11)**	-
Valuation/gross cost at 31 March 2023	**21,201**	**5,598**	**17**	**26,816**	**22,268**
Accumulated depreciation at 1 April 2022	-	-	-	**-**	-
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	102	1,343	-	**1,445**	102
Provided during the year	2,304	1,107	10	**3,421**	2,611
Reversal of impairments	(512)	-	-	**(512)**	(512)
Disposals / derecognition	-	-	(2)	**(2)**	-
Accumulated depreciation at 31 March 2023	**1,894**	**2,450**	**8**	**4,352**	**2,201**
Net book value at 31 March 2023	**19,307**	**3,148**	**9**	**22,464**	**20,067**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**	**-**
Net book value of right of use assets leased from other NHS providers					3,818
Net book value of right of use assets leased from other DHSC group bodies					16,249

Note 18.3 – Revaluation of Right of Use Assets

During 2023/24, a revaluation of leased buildings was undertaken. These leased buildings are used in the delivery of healthcare services.

Overall, this resulted in some of the leased buildings going up in value, resulting in a revaluation gain of £560K taken to the Revaluation Reserve, and a downward value to some of the buildings resulting in impairment loss of £3,353K, 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 32.2.

	2023/24 £000	2022/23 £000
Carrying value at 31 March	**18,754**	**4,321**
IFRS 16 implementation – adjustments for existing operating leases		17,760
Lease liability remeasurements	1,158	(390)
Interest charge arising in year	250	334
Early terminations	-	(4)
Lease payments (cash outflows)	(3,326)	(3,267)
Carrying value at 31 March	**16,836**	**18,754**

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 2024 and 31 March 2023

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year	3,142	2,550	3,219	2,345
- later than one year and not later than five years	8,922	8,235	9,629	8,350
- later than five years	6,086	6,086	7,428	7,428
Total gross future lease payments	**18,150**	**16,871**	**20,276**	**18,123**
Finance charges allocated to future periods	(1,314)	(1,287)	(1,522)	(1,460)
Net lease liabilities at 31 March 2024	**16,836**	**15,584**	**18,754**	**16,663**
Of which:				
Leased from other NHS providers		2,642		3,219
Leased from other DHSC group bodies		12,942		13,444

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 Investments in Associates and Joint Ventures

In 2023/24, The Rotherham NHS Foundation Trust has no investments in associates and joint ventures, nor did it have in 2022/23.

Note 21 Other Investments / Financial Assets (Non-Current)

In 2023/24, The Rotherham NHS Foundation Trust has no other investments or financial assets, nor did it have in 2022/23.

Note 22 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, 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 2024 £000	31 March 2023 £000
Total incoming resources	345	238
Resources expended	(243)	(210)
Net movement in funds	**102**	**28**
Total Assets	601	536
Total Liabilities	(19)	(56)
Total Charitable Funds	**582**	**480**
Total funds made up of:		
Restricted /endowment funds	299	194
Unrestricted funds	283	286

The 2023/24 Charitable Funds accounts have not yet been subject to independent review. The 2022/23 Charitable Funds accounts were subject to independent examination and were finalised in December 2023.

Note 23 Inventories

	31 March 2024 £000	31 March 2023 £000
Drugs	1,254	1,070
Consumables	3,743	2,883
Energy	46	42
Total inventories	**5,043**	**3,995**

Inventories recognised in expenses for the year were £31,865K (2022/23: £30,527K). Write-down of inventories recognised as expenses for the year were £13K (2022/23: £39K).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £57K of items purchased by DHSC (2022/23: £457K).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 24.1 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	6,221	5,300
Allowance for impaired contract receivables / assets	(785)	(558)
Allowance for other impaired receivables	(67)	(58)
Prepayments (non-PFI)	4,039	4,171
PDC dividend receivable	-	119
VAT receivable	984	918
Non-consolidated pay award		8,166
Other receivables	290	310
Total current receivables	**10,682**	**18,368**
Non-current		
Other receivables	404	479
Total non-current receivables	**404**	**479**
Of which receivable from NHS and DHSC group bodies:		
Current	2,997	11,272
Non-current	404	479

Note 24.2 Allowances for Credit Losses

	2023/24		2022/23	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**558**	**58**	**684**	**33**
New allowances arising	450	23	194	33
Changes in existing allowances	-	-	76	-
Reversals of allowances	(223)	(14)	(122)	(8)
Utilisation of allowances (write offs)	-	-	(274)	-
Allowances as at 31 March 2024	**785**	**67**	**558**	**58**

Note 24.3 Exposure to Credit Risk

The level of allowance for credit losses (doubtful debts) is based upon analysis of the type of debtors and the age of the debt.

Note 25 – Finances Leases (The Rotherham NHS Foundation Trust as Lessor)

The Trust does not hold any finance leases where it is the lessor.

Note 26 Other Assets

The Trust does not hold any other assets; all assets are shown under the appropriate balance sheet headings. This was the case at 31 March 2024, and 31 March 2023.

Note 27.1 Non-Current Assets Held for Sale and Assets in Disposal Groups

At the 31 March 2024, the Trust did not have any assets that were held for sale, nor did it at 31 March 2023.

Note 27.2 Liabilities in Disposal Groups

At the 31 March 2024, the Trust did not have any liabilities in disposal groups, nor did it at 31 March 2023.

Note 28.1 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.

	2023/24 £000	2022/23 £000
At 1 April	**24,356**	**33,303**
Net change in year	(12,240)	(8,947)
At 31 March	**12,116**	**24,356**
Broken down into:		
Cash at commercial banks and in hand	106	111
Cash with the Government Banking Service	12,010	24,245
Total cash and cash equivalents as in SoFP	**12,116**	**24,356**
Total cash and cash equivalents as in SoCF	**12,116**	**24,356**

Note 28.2 Third Party Assets Held by the Trust

On occasion, 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 2024 the Trust held £254.48 in cash or cash equivalents which relate to monies held on behalf of patients or other parties. There was no cash held on behalf of third parties at 31 March 2023.

Note 29 Trade and Other Payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	6,653	5,989
Capital payables	4,117	5,013
Accruals	15,524	28,942
Social security costs	2,342	2,259
VAT payables	58	59
Other taxes payable	2,310	1,978
PDC dividend payable	8	-
Pension contributions payable	3,024	2,766
Other payables	68	119
Total current trade and other payables	**34,104**	**47,125**
Of which payables from NHS and DHSC group bodies:		
Current	6,648	4,802
Non-current	-	-

The Trust had no non-current payables at 31 March 2024, nor did it at 31 March 2023.

Note 30 Early Retirement in NHS Payables Above

During both the 2023/24 and 2022/23 financial years, there were no liabilities for early retirement buy out.

Note 31 Other Liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income: contract liabilities	1,819	2,375
Total other current liabilities	**1,819**	**2,375**

The Trust had no non-current other liabilities at 31 March 2024, nor did it at 31 March 2023.

Note 32.1 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Loans from DHSC	1,317	1,323
Lease liabilities	2,945	2,989
Obligations under PFI, LIFT or other service concession contracts	332	261
Total current borrowings	**4,594**	**4,573**
Non-current		
Loans from DHSC	10,250	11,500
Lease liabilities	13,891	15,765
Obligations under PFI, LIFT or other service concession contracts	7,942	6,777
Total non-current borrowings	**32,083**	**34,042**

Note 32.2 Reconciliation of Liabilities Arising from Financing Activities – 2023/24

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £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 / 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 32.3 Reconciliation of Liabilities Arising from Financing Activities – 2022/23

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	**14,079**	**4,321**	**7,286**	**25,686**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(2,933)	(248)	**(4,431)**
Financing cash flows - payments of interest	(308)	(334)	(273)	**(915)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022		17,760		**17,760**
Lease liability remeasurements	-	(390)	-	**(390)**
Application of effective interest rate	302	334	273	**909**
Early terminations	-	(4)	-	**(4)**
Carrying value at 31 March 2023	**12,823**	**18,754**	**7,038**	**38,615**

Note 33 Other Financial Liabilities

At the 31 March 2024, the Trust did not have any other financial liabilities to disclose; all liabilities held by the Trust are shown under the appropriate balance sheet headings. This was also the case at 31 March 2023.

Note 34.1 Provisions for Liabilities and Charges Analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2023	**372**	**416**	**148**	**504**	**1,440**
Change in the discount rate	(12)	(19)	-	(89)	**(120)**
Arising during the year	49	40	89	1,485	**1,663**
Utilised during the year	(33)	(36)	(55)	(5)	**(129)**
Reversed unused	(86)	-	(49)	(17)	**(152)**
Unwinding of discount	7	10	-	27	**44**
At 31 March 2024	**297**	**411**	**133**	**1,905**	**2,746**
Expected timing of cash flows:					
- not later than one year	33	37	133	1,501	**1,704**
- later than one year and not later than five years	125	137	-	36	**298**
- later than five years	139	237	-	368	**744**
Total	**297**	**411**	**133**	**1,905**	**2,746**

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 34.2 Clinical Negligence Liabilities

At 31 March 2024, £55,619K was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (31 March 2023: £119,161K).

Note 35 Contingent Assets and Liabilities

	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
NHS Resolution legal claims	(35)	(49)
Gross value of contingent liabilities	**(35)**	**(49)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(35)**	**(49)**
Net value of contingent assets	**-**	**-**

Note 36 Contractual Capital Commitments

	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	1,008	2,429
Total	**1,008**	**2,429**

The Trust has a number of multi-year schemes, starting in 2023/24 all of which are planned to be completed during 2024/25. The capital commitments at 31 March 2024 are mainly the result of orders being raised during 2023/24 for works planned to be completed during 2024/25.

The capital orders showing at 31 March 2023 were also mainly relating to orders raised for multi-year schemes which were completed during 2023/24.

Note 37 Other Financial Commitments

At 31 March 2024, there are no financial commitments classed as other. This was also the case at 31 March 2023.

Note 38 On-SoFP PFI, LIFT 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 & 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 38.1 On-SoFP PFI, LIFT or Other Service Concession Arrangement Obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2024 £000	31 March 2023 £000
Gross PFI, LIFT or other service concession liabilities	**10,832**	**9,334**
Of which liabilities are due:		
- not later than one year	613	500
- later than one year and not later than five years	2,453	2,000
- later than five years	7,766	6,834
Finance charges allocated to future periods	(2,558)	(2,296)
Net PFI, LIFT or other service concession arrangement obligation	**8,274**	**7,038**
Of which liabilities are due:		
- not later than one year	332	261
- later than one year and not later than five years	1,493	1,176
- later than five years	6,449	5,601

Note 38.2 Total on-SoFP PFI, LIFT and Other Service Concession Arrangement Commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2024 £000	31 March 2023 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**24,580**	**23,000**
Of which payments are due:		
- not later than one year	1,391	1,232
- later than one year and not later than five years	5,566	4,929
- later than five years	17,623	16,839

Note 38.3 Analysis of Amounts Payable to Service Concession Operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2023/24 £000	2022/23 £000
Unitary payment payable to service concession operator	**1,267**	**1,123**
Consisting of:		
- interest charge	280	273
- repayment of balance sheet obligation	300	253
- service element and other charges to operating expenditure	687	597
Total amount paid to service concession operator	**1,267**	**1,123**

Note 39 Impact of Change in Accounting Policy for on-SoFP PFI, LIFT and Other Service Concession Liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the Statement of Financial Position is remeasured to reflect the increase in future payments. Such increases were previously recognised within the Statement of Comprehensive Income as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

Note 39.1 Impact of Change in Accounting Policy on the Allocation of Unitary Payment

	IFRS 16 basis (new basis) 2023/24 £000	IAS 17 basis (old basis) 2023/24 £000	Impact of change 2023/24 £000
Unitary payment payable to service concession operator	**1,267**	**1,267**	**-**
Consisting of:			
- interest charge	280	239	**41**
- repayment of balance sheet obligation	300	261	**39**
- service element	687	687	**-**
- contingent rent	-	80	**(80)**

Note 39.2 Impact of Change in Accounting Policy on Primary Statements

	£000
Increase in PFI / LIFT and other service concession liabilities	(1,497)
Decrease in PDC dividend payable / increase in PDC dividend receivable	42
Impact on net assets as at 31 March 2024	**(1,455)**

Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:	**£000**
PFI liability remeasurement charged to finance costs	(665)
Increase in interest arising on PFI liability	(41)
Reduction in contingent rent	80
Reduction in PDC dividend charge	42
Net impact on surplus / (deficit)	**(584)**

Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:	**£000**
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(871)
Net impact on 2023/24 surplus / deficit	(584)
Impact on equity as at 31 March 2024	**(1,455)**

Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:	**£000**
Increase in cash outflows for capital element of PFI / LIFT	(39)
Decrease in cash outflows for financing element of PFI / LIFT	39
Net impact on cash flows from financing activities	**-**

Note 40 Financial Instruments

Note 40.1 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 (ICB) and the way those Integrated Care Boards (ICBs) 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 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 (ICB) 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 40.2 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 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**

Carrying Values of Financial Assets as at 31 March 2023

	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	13,639	-	-	**13,639**
Cash and cash equivalents	24,356	-	-	**24,356**
Total at 31 March 2023	**37,995**	**-**	**-**	**37,995**

Note 40.3 Carrying Values of Financial Liabilities

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, LIFT 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**

Carrying values of Financial Liabilities as at 31 March 2023

	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	12,823	-	**12,823**
Obligations under leases	18,754	-	**18,754**
Obligations under PFI, LIFT and other service concession contracts	7,038	-	**7,038**
Trade and other payables excluding non financial liabilities	42,829	-	**42,829**
Total at 31 March 2023	**81,444**	**-**	**81,444**

Note 40.4 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 2024 £000	31 March 2023 £000
In one year or less	33,176	48,100
In more than one year but not more than five years	17,032	17,409
In more than five years	19,445	21,223
Total	**69,653**	**86,732**

Note 41 Losses and Special Payments

	2023/24		2022/23	
	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	11	1	499	628
Stores losses and damage to property	12	13	12	39
Total losses	**24**	**15**	**511**	**667**
Special payments				
Compensation under court order or legally binding arbitration award	11	55	4	29
Ex-gratia payments	26	6	25	28
Special severance payments	1	11	-	-
Total special payments	**38**	**72**	**29**	**57**
Total losses and special payments	**62**	**87**	**540**	**724**
Compensation payments received				

Note 42 Gifts

During the 2023/24 financial year, the Trust did not receive any gifts, nor did it in 2022/23.

Note 43 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 & Social Care parent body, are detailed below and are not considered material.

	31 March 2024 Income from Related Party	31 March 2023 Income from Related Party	**31 March 2024 Expenditure to Related Party**	31 March 2023 Expenditure to Related Party
	£000	£000	**£000**	£000
University of Sheffield	**9**	30	**18**	-
Sheffield Hallam University	**11**	-	**58**	-
Royal College of Physicians	**-**	-	**-**	10
Marks and Spencer	**-**	-	**-**	19
Magna Enterprises Ltd	**-**	-	**-**	12
Total related party transactions	**20**	30	**76**	41

During the 2023/24 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:

- £18K and £58K of expenditure was incurred with the University of Sheffield and Sheffield Hallam University (respectively) for course fees (including medical education).

- £9K of income was received from Sheffield University for course fees.

- £11K of income was received from Sheffield Hallam University 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 £352K was received by the Charity during the 2023/24 financial year, (£238K 2022/23) which was spent on goods and services provided to the Trust, including on staff and patients. The Rotherham Hospital and Community Charity also paid £113K in relation to recharges for management and staff costs (£98K in 2022/23). The accounts of the Rotherham Hospital and Community Charity are made separately, a summary of which can be found at Note 22.

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 44 Transfers by Absorption

There have been no transfers by absorption during the 2023/24 financial year, nor were there any in 2022/23.

Note 45 Prior Period Adjustments

There have been no prior period adjustments during the 2023/24 financial year, nor were there any in 2022/23.

Note 46 Events After the Reporting Date

There are no events after the reporting date at the point at which these accounts were approved by Trust Board on 21 June 2024.