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The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2024/25

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The Rotherham NHS Foundation Trust

Annual Report and Accounts 2024-25

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

Contents


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Kerry

Welcome from the Chair

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

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

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

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

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

Best wishes,

Dr Mike Richmond
Chair


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Performance Overview 2024/25

A brief history and statutory background

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

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

Activities of The Rotherham NHS Foundation Trust

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

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

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

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

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

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

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

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

System and Partnership Working

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

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

The Joint Delivery Group, made up of Executive team members from both organisations, has continued to progress the delivery of our partnership ambitions.
This year we built on previous progress in:

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

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

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

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

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

Our Purpose

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

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

Key Issues, Opportunities and Risks

Delivering high-quality care remains our foremost priority.

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

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

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

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

Performance Analysis – Statement from the Chief Executive

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

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

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

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

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

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

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

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

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

Emergency Access

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

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

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

Same Day Emergency Care (SDEC) and Community Urgent Care

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

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

Elective Care and Referral to Treatment (RTT)

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

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

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

Cancer Waiting Times

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

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

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

Diagnostics

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

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

Community Services

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

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

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

Looking Ahead to 2025/26

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

Key priorities for 2025/26 include:

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

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

Digital and Technology

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

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

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

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

Data Excellence, Cybersecurity, and People Development

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

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

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

Health inequalities

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

Population needs of Rotherham

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

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

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

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

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

Our Response to Health Inequalities as a System Leader

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

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

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

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

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

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

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

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

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

Environmental Sustainability and Net Zero

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

Task force on climate-related financial disclosures (TCFD)

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

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

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

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

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

The Trust has seen mixed progress in this area in 2024/25. The trust's carbon emissions from utilities peaked at 8,437 CO2E in 2021-22, and have fallen by almost a quarter since then to 6,482 CO2E. Having fallen initially, water consumption at the trust has increased by around 3% since 2020-21.

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

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

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

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

Going Concern Disclosure

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

Preparation of the Report

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

Conclusion

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

R. Jenkins

Dr Richard Jenkins
Chief Executive
26 June 2025


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Accountability Report

Director's Report

The Board of Directors: Roles and Responsibilities

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

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

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

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

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

The day to day management of the organisation is delegated 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. Mike was Chair of the Board of Directors, Council of Governors, Board Nominations and Remuneration Committee and the Governor Nomination and Remuneration Committee. Terms of office 01.01.2024 to 31.12.2026	11/11
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 to resolve. Heather is the Senior Independent Director, a member, Vice Chair of the Quality Committee (until January 2025), member of the Audit and Risk Committee, Vice Chair of the Nominations and Remuneration Committee, Chair of the Charitable Funds Committee, and member of Finance and Performance Committee (from January 2025). Heather also Chairs the Organ Donation Committee. Terms of office 17.02.2017 to 16.02.2020 17.02.2020 to 28.02.2023 01.03.2023 to 31.03.2025 01.04.2025 to 30.09.2025	10/11
Rumit Shah Non-Executive Director	Rumit joined the Trust as a Non-Executive Director in January 2020. 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 Chair of the People and Culture Committee, and a member of the Audit and Risk Committee and Nominations and Remuneration Committee. Terms of office 01.01.2020 to 31.12.2021 01.01.2022 to 31.12.2024 01.01.2025 to 31.12.2025	9/11

Non-Executive Directors		
Name and position	**Background**	**Total number of board meetings attended**
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. 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 is the Chair of the Audit and Risk Committee, a member of the Finance and Performance Committee and a member of the Nomination and Remuneration Committee. Terms of Office Associate NED: April 2021 to September 2021 NED :11.09.2021 to 10.09.2024 11.09.2024 to 10.09.2027 Kamran was appointed Interim Chair from 01 September 2023 to 31 December 2023	9/11
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 and Culture Committee and Nominations and Remuneration Committee. Term of Office 01.10.2022 – 30.09.2025	9/11
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 commercial organisations. Hannah is a member of the Finance and Performance Committee (until January 2025), Vice Chair of the People and Culture Committee, member of the Quality Committee (from January 2025) and member of the Nomination and Remuneration Committee. Term of office 17.08.2023 – 16.08.2026	9/11

Non-Executive Directors		
Name and position	**Background**	**Total number of board meetings attended**
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. Term of Office 01.10.2023 – 30.09.2026	11/11
Shirley Congdon Non-Executive Director	Shirley was delighted and honoured to join the Trust as a Non-Executive Director in November 2024. She has had a long and successful career in the health and care sector and higher education and is currently the Vice-Chancellor of the University of Bradford. With a professional background in Nursing, she is committed to both advancing the quality of patient care and supporting the Trust to understand how best to enhance staff wellbeing and engagement. Shirley has led the University to be first in England for Social Mobility. Shirley has served on the Governing Body of Bradford District Care Trust as a Stakeholder Governor and works closely with NHS Trusts in West Yorkshire. She is a member of the Health and Wellbeing Board and is involved in many population health research programmes and initiatives as well as having significant experience of workforce planning and education and training. Shirley is a member of the Quality Committee, People and Culture Committee, Charitable Funds Committee, and Nomination and Remuneration Committee. Term of Office 01.11.2024 to 31.10.2027	5/5

Non-Executive Directors		
Name and position	**Background**	**Total number of board meetings attended**
Andrew Mondon Associate Non-Executive Director	Andrew is a Chartered Accountant, having qualified within an audit background. He has worked in a service environment for several large organisations, including significant experience of providing outsourced government contracts in defence, education and employability. Having recently completed a five-year period as the Chief Finance Officer at Change Grow Live, a national charity that helps tens of thousands of people each day to make a difference in their lives, Andrew is now moving to a portfolio of roles, which includes the Trustee of an education charity that supports individuals to develop their potential through vocational training, where Andrew is chair of the Finance and Audit Committee. Previously, Andrew worked as a Finance Director in a skills and employability provider, which offered a wide range of apprenticeships and a variety of employability solutions aimed at providing individuals with the skills needed to gain and improve employment. Andrew has also consistently driven change aimed at improving delivery at the frontline and is committed to playing a part in improving the lives of others. Term of Office 01.11.2024 to 31.10.2025	4/5
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. Term of office 01.10.2022 – 30.09.2023 01.10.23 – 30.09.24	4/4

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.	11/11
Bob Kirton, Managing Directorr	Bob Kirton joined the Trust on 6 January 2025. Bob was previously Managing Director of Barnsley Hospital NHS Foundation Trust, where he has held a number of other director roles, including Director of Strategy and Chief Delivery Officer. Prior to this, he had a successful career in retail. He has a BA in History from Leicester University and an MSc in Strategy and Leadership in Healthcare from Bradford University. Bob also completed the Aspiring CEO programme in 2022.	3/3
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. Michael left the Trust on 5 January 2025 to take up the Managing Director role at Barnsley Hospital NHS Foundation Trust.	8/8
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, with recent roles at Chesterfield Royal Hospital NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).	11/11
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.	7/11

Executive Directors		
Name and position	**Background**	**Total number of board meetings attended**
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.	10/11
Sally Kilgariff, Chief Operating Officer	Sally became the Chief Operating Officer in May 2022 after being the Deputy Chief 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.	11/11
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.	10/11

Directors' Register of Interests

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

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

Better Payment Practice Code

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

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

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

Information on fees and charging

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

Income disclosures as required by Section 43(2A) of the NHS Act 2006 Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income 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 2024-25.

NHS England Well-Led Framework

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

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

Statutory Committees of the Board

Audit and Risk Committee (Statutory Committee)

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

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

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

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

- Approved the Internal Audit Plan for 2024-25
- Approved the Anti-Fraud Annual Work Plan for 2024-25
- Reviewed the Board Assurance Framework and Trust wide Risk Register
- Monitored responses by management to the recommendations made by Internal Audit through associated reviews
- Received assurance in relation to the improvement plan to strengthen the Trust's processes for managing litigation and inquests in addition to actions as a result of litigation

- Maintained oversight of the Trust's schedule of outstanding debt and the schedule of losses and compensations
- Maintained oversight of the Tender Waivers
- Reviewed the work of External Audit
- Reviewed the work and findings from Anti-Fraud
- Reviewed the 2024-25 Financial Statements seeking assurance they are appropriately compiled on a going concern basis

- Reviewed the Trust's Standing Financial Instructions and Standing Orders in addition to Scheme of Delegation and Matters Reserved for the Board
- Received assurance in relation to cyber security
- Received the Register of Interests
- Reviewed the Annual Report and Accounts (2023-24)
- Received the Annual Review of Standards of Business Conduct
- Received the Annual Report from the Freedom to Speak Up Guardian
- Reviewed the position in relation to Risk Management and the Trust's Risk Register.

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

Kamran Malik attended a total of 6 out of 6 meetings
Rumit Shah attended a total of 5 out of 6 meetings
Heather Craven attended a total of 5 out of 6 meetings
Andrew Mondon attended a total of 1 out of 1 meeting

Nominations and Remuneration Committee (Statutory)

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

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

Mike Richmond attended a total of 5 out of 5 meetings
Julia Burrows attended a total of 5 out of 5 meetings
Martin Temple attended a total of 3 out of 5 meetings
Hannah Watson attended a total of 2 out of 5 meetings
Shirley Congdon attended a total of 4 out of 4 meetings
Kamran Malik attended a total of 3 out of 5 meetings
R**umit Shah** attended a total of 5 out of 5 meetings
Heather Craven attended a total of 3 out of 5 meetings
Andrew Mondon attended a total of 4 out of 4 meetings

Remuneration Report

Annual Statement on Remuneration

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

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

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

Major decisions taken on senior managers' remuneration 2024-25

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

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

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

Senior Managers Remuneration Policy

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

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

Executive Directors

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

Component of Pay	Links to short and long-term strategic goals	How the Trust operates this in practice	Maximum potential value of the component	Performance measures
Base salary	Proud to be colleagues in an inclusive , diverse and welcoming organisation that is simply a great place to work	The Nomination & Remuneration Committee reviews the following in setting the remuneration: • Roles, responsibilities and accountabilities • Skills, experience and performance • Pay awards across the Trust • Local and national market conditions • Advice from NHS England if applicable • Benchmarking	There is no prescribed limit but senior managers are not treated more favourably than other staff.	The Chief Executive and Executive Directors participate in annual performance reviews undertaken by the Chair and Chief Executive respectively. Individual agreed objectives are agreed and any performance issues are managed through the Trust's Policies relating to performance.
Pension related benefit		The Trust operates the standard NHS Pension scheme which is open to all eligible.	The Pension scheme is open to Directors who are subject to the Scheme rules	Not applicable
Bonus	The Trust does not have any bonus arrangements in place.			
On-call Payments	Executive Directors do not receive on call payments but participate in the Strategic on call rota.			
Benefits	The Trust operates a number of salary sacrifice schemes including a lease car scheme, child care vouchers which are open to all members of staff.			
Travel Expenses	Appropriate travel expenses are remunerated for business mileage.			

Directors with a Total Remuneration Greater than £150,000

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

Service Contract Obligations

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

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

Service Contract Obligations
Policy on Payment for Loss of Office - subject to audit

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

Diversity and Inclusion

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

Statement of Consideration of Employment Conditions Elsewhere in the Trust

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

Directors' Remuneration Report and Pension Entitlements – subject to audit

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

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

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

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

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	
	2024/25	2023/24	**2024/25**	2023/24
Governors	**25**	21	**2**	1
Directors (including the Chair and non-executives)	**18**	19	**3**	3

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

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

A) Pension Benefits – Subject to audit

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

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

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

Cash Equivalent Transfer Values (CETV)

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

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

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

Staff costs

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

Staff Costs – subject to audit

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

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

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

Staff Exit Packages –Subject to audit

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

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

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

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

Analysis of non-compulsory departure payments

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

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

	Number of agreements		Total value of agreements £000s	
	2024/25	2023/24	2024/25	2023/24
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice*	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval**	0	1	0	11
Total	0	1	0	11
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

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

*'Other' staff includes secondments in, and trainee 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 2024/25 was £197,500 (2023/24: £187,500). This is a change between years of +5.33%, owing to an increase in pay, as is consistent with salary increases over the NHS workforce.

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

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

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

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

Of the four individuals who received remuneration in excess of the highest paid director in 2024/25, one is our Chief Executive who works under a shared arrangement for both the Trust and for Barnsley Hospital NHS Foundation Trust. The definition of the highest paid director under the Fair 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 three individuals who received remuneration in excess of the highest paid director in 2024/25 are doctors with specialist skills, which are in high demand due to limited availability.

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

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

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

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

Remuneration Report signed by the Chief Executive

Dr Richard Jenkins
Chief Executive
26 June 2025

Staff report

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

Analysis of Staff – Gender

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

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

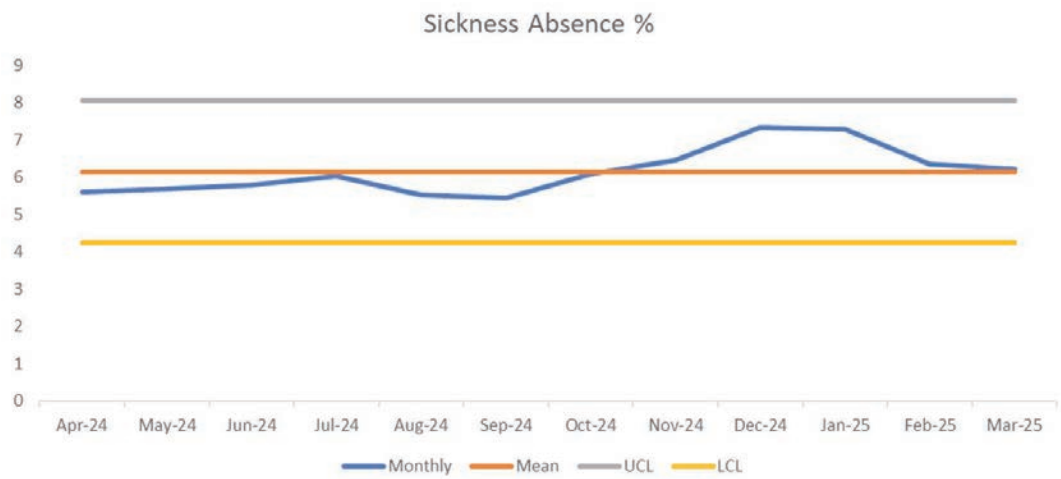
**Headcount based on primary assignments, previously calculated using a count of assignments (roles). Change in calculation required due additional assignment created as per pension draw-down process

Sickness Absence Data

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

Monthly Sickness Absence

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



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

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

Staff policies and actions applied during the financial year

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

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

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

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

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

Modern slavery is addressed under the umbrella of safeguarding at the Trust, all safeguarding training has been updated to include 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.

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

In addition to the information regarding Gender Pay Gap published on the Trust website, information is available on the Gender Pay Gap Gov.UK website

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

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

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

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

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

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

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

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

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

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

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

Health & Safety and Occupational Health

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

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

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

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

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

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

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

Analysis of Staff: Ethnicity of Staff

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

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

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

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

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

Information on staff turnover

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

NHS staff survey 2024

Staff experience and engagement

NHS staff survey

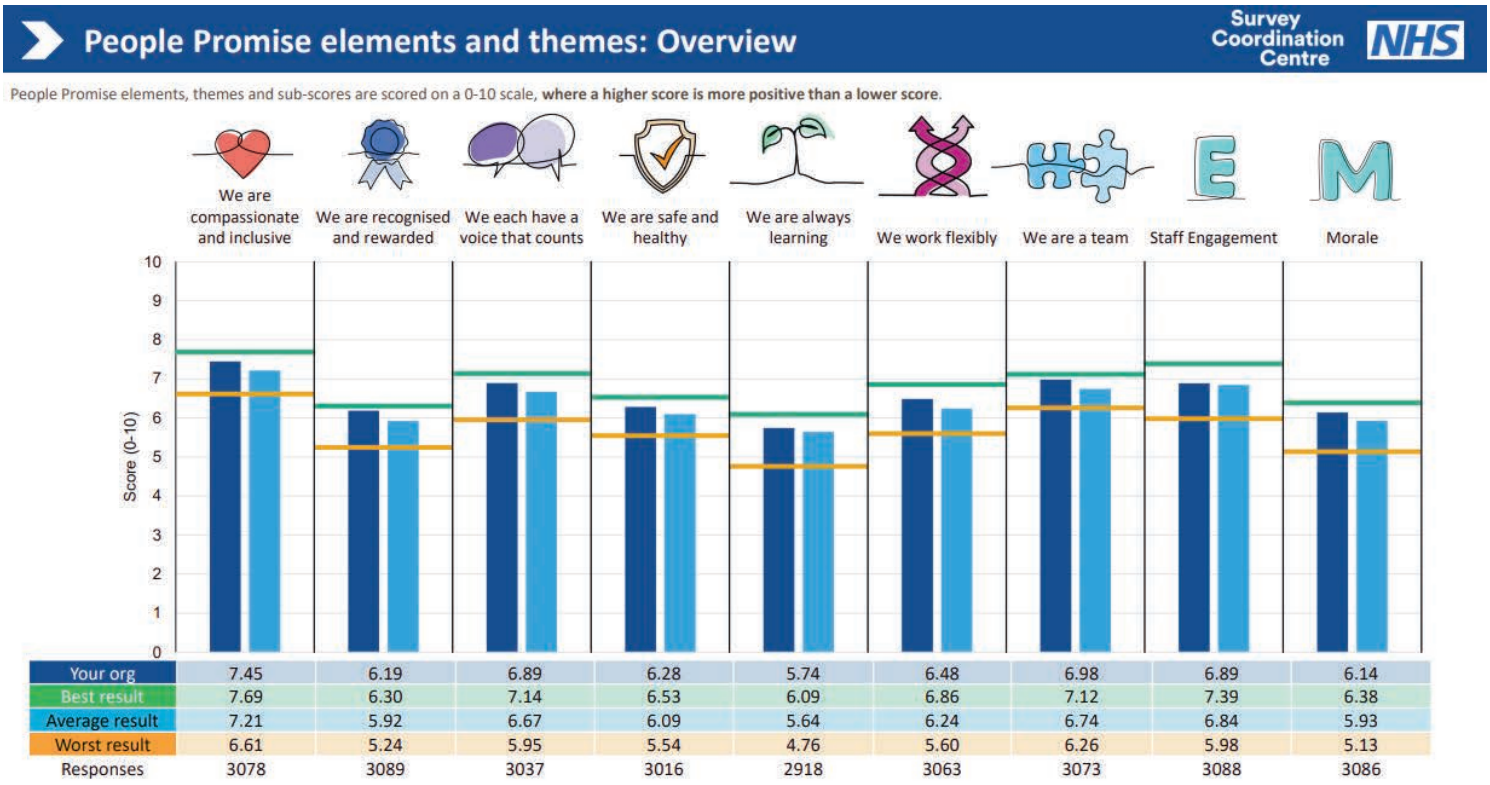
The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a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

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

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

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

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



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

NHS Response Rate

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

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

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

Future priorities and targets

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

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

Key Areas for Improvement and Future Priorities

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

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

Top 5 Priorities for 2025/26

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

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

Monitoring arrangements - future priorities and how they will be measured

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

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

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

Trade Union Facility Time disclosures

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

The trust is committed to maximising staff involvement by:

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

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

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

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

Table 1: Relevant union officials

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

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

Table 2: Percentage of time spent on facility time

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

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

Table 3: Percentage of pay bill spent on facility time

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

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

Table 4: Paid trade union activities

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

Time spent on paid trade union activities as a percentage of total paid facility time	2.57

(Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

note that this is slightly different to what we are asked to report on gov.uk – they ask for total number of staff (headcount not WTE – this puts us over 5000) and ask for both headcount and employed WTE (12.6) for TU reps.

Table 1. Highly paid off-payroll worker engagements as at 31 March 2025, earning £245 per day or greater	
Number of existing engagements as of 31 March 2025 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

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

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

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

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

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

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

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

Council of Governors

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

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

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

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

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

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

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

All governors are required to comply with the Trust's Code of Conduct and Constitution and declare any interests that may result in a conflict of interest in their role as governors. At each meeting of the Council of Governors a standing agenda item also requires all governors to make known any interest in relation to the agenda and any changes to their declared interests. Each Governor is required annually to renew their declarations with regard to the Code of Conduct and Register of Interest. The register of governor's interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

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

Members who wish to communicate with the Governors can do so by sending an email to 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

Foundation Trust Membership

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

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

In order to become a Public Member, the individual must:
- Be at least 16 years of age; and
- Live within one of the trust's constituency areas ('Rotherham' constituency and a 'Rest of England' constituency); and
- Not be a member of the staff constituency; and
- Have made an application for membership to the Trust.

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

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

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

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

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

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

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

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

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

- Objective 1 : To build and maintain our membership numbers by actively recruiting and retaining our members

- Objective 2 : To effectively engage and communicate with members

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

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

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

The Annual Members Meeting (AMM) 2024 was another opportunity the Governors used to meet members and the public, share achievements and challenges from the year and outline future plans. The Annual Members Meeting on 19th September 2024 was held in person for the first time since the Covid-19 pandemic.
In March 2025, elections for the Council of Governors commenced, seeking nominations for six 'Rotherham-wide' Public Governor seats and two Staff Governor seats. Once the election has ended and results declared, the new governors will be introduced to members at the AMM in September.
Members have and continue to be able to contact their Governor by sending an e-mail to: 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 2024

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

The Committee met on four occasions during 2024-25.

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

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

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

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

NHS Foundation Trust Code of Governance

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

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

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

Table 1.

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
Disclose	A 2.1	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 Directors Report and Annual Governance Statemen
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
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 or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. 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

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
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. The Trust did not engage any external consultancies. The Trust's recruitment of a non-executive director and an associate non-executive director was supported by Gatenby Sanderson. The company was also engaged by the Trust to support compliance with Fit and Proper Persons Test framework.
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
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 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

Part of Schedule A	Code Section	Summary of requirement
Required disclosures		
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
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

Table 2

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

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

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

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

Provision	Requirement
Section C, 4.6	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 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's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities. Comply
Section D, 2.3	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. Comply

Provision	Requirement
Section D, 2.5	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 against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement. Not applicable during the reporting period
Section E, 2.1	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure. Comply
	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, 2.2	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

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

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

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

NHS England System Oversight Framework

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

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

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

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

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

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

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

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

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

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

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

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

Signed

Richard Jenkins
Chief Executive
Date: 26 June 2025

Annual Governance Statement

Scope of Responsibility

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

The Purpose of the System of Internal Control

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

Capacity to Handle Risk

Leadership of the Risk Management Process

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

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

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

Equipping Staff to Manage Risk

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

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

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

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

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

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

The Risk and Control Framework

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

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

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

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

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

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

The Board of Directors review, on an annual basis the principles and appetite around the level of risk which the Trust is prepared to accept or not in pursuit of agreed ambitions. These were reviewed and discussed at the Board's Strategic session in June 2024. The principles focused on quality, partnerships, workforce, finance and value for money, innovation, commercial opportunities, compliance and regulatory in addition to business continuity including Information Governance and Cyber Security.

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

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

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

Quality Governance

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

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

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

Compliance with Developing Workforce Safeguards

The Board receives assurance that the processes relating to safe, sustainable and effective staffing are in place within the Trust and compliant with the 'Developing Workforce Safeguards'. Staff establishments are reviewed annually during the budget setting cycle and the Quality Committee and Board receive a Safer Staffing Report every six months.
Workforce metrics are monitored through the People and Culture Committee and ultimately Board with staffing levels being reviewed regularly and e-rostering systems in place for nursing staff.
Our people remain intrinsic to what we do and our Board approved People and Culture Strategy contains key objectives to support and enable Care Groups and Corporate Services to develop robust workforce planning strategies.

Information Governance

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

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

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

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

Public Stakeholders' Involvement in Managing Risk

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

Data Quality and Governance

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

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

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

Provider Licence

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

Compliance with the Care Quality Commission Registration

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

Review of Economy, Efficiency and Effectiveness of the Use of Resources
The Trust continues to have in place processes to ensure that resources are used economically, efficiently and effectively.

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

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

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

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

Other Compliance Matters

The Trust has published on its website an up to date register of interests, including gifts and hospitality, for decision-making staff as defined by the Trust's Standards of Business Conduct Policy within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

Review of Effectiveness

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

During the reporting period, the Board of Directors has continued to meet every month, alternating between a full Board meeting and strategic Board sessions. The Board has received reports on operational performance via the Integrated Performance Report. The aforementioned report incorporates performance monitoring in respect of key national priorities, regulatory and statutory indicators, quality, patient safety and our people.

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

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

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

One 'Substantial Assurance':

- Data Security and Protection Toolkit

Six 'Significant Assurance':

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

Three 'Moderate/Split Assurance':

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

Three 'Limited Assurance':

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

Two are currently in progress:

- Care Group governance
- Absence management re-audit.

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

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

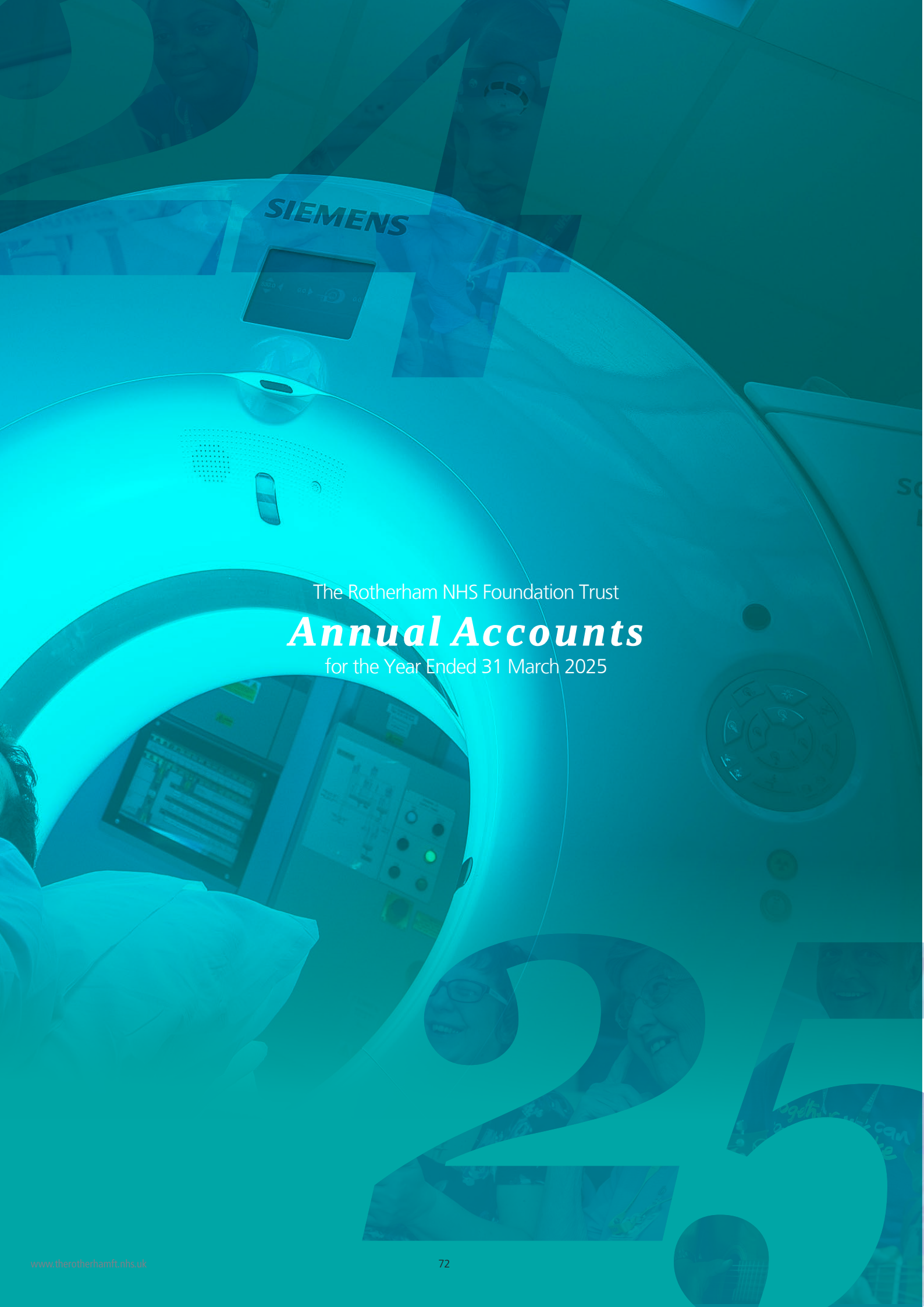
I am providing an opinion of **significant** assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

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

Conclusion

The Board remains committed to continuous improvement to ensure that robust systems continue to be in place to identify and 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
26 June 2025



The Rotherham NHS Foundation Trust

Annual Accounts

for the Year Ended 31 March 2025

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

Report on the audit of the financial statements

Opinion on the financial statements

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

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

In our opinion, the financial statements:

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

Basis for opinion

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

Conclusions relating to going concern

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

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

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

Other information

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

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

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Matter on which we are required to report by exception

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

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

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

Responsibilities of the Accounting Officer

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

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

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

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

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

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

We are required to report to you if:

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

We have nothing to report in respect of these matters.

Use of the audit report

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

Certificate

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

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

One St Peter's Square
Manchester
M2 3DE

26 June 2025

Foreword to the Account

The Rotherham NHS Foundation Trust

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

Signed:

R. Jenkins

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

Statement of Financial Position (SOFP)

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

Signed:

Name: Dr R Jenkins

Job title: Chief Executive

Date: 26 June 2025

Statement of Comprehensive Income (SOCI)

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

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

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

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

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

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

Information on Reserves

Public Dividend Capital

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

Revaluation Reserve

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

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

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

Income and Expenditure Reserve

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

Statement of Cash Flows (SOCF)

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

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

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

NHS England has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

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

1.1.1 Accounting Convention

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

Note 1.2 Going Concern

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

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

Note 1.3 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

1.3.1 Critical Judgements in Applying Accounting Policies

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

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

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

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

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

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

1.3.2 Sources of Estimation Uncertainty

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

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

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

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

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

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

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

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Adjustments to estimated lives may be made, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset, but any difference would not be material.

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

Note 1.4 Operating Segments

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

Note 1.5 Income (Revenue from Contracts with Customers)

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

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

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

Revenue from NHS Contracts

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

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

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

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

The Trust also receives income from Commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the Commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and 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 NHS Payment Scheme documentation. Such income is classified as 'other clinical income' in these accounts.

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

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

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

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

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

Payment terms are standard reflecting cross government principles.

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

Note 1.6 Expenditure on Employee Benefits

1.6.1 Short-Term Employee Benefits

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

1.6.2 Retirement Benefit Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

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

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

Note 1.7 Expenditure on Other Goods and Services

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

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

Note 1.8 Property, Plant and Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised where:

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

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

1.8.2 Measurement

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

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

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

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

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

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

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

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

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

1.8.3 Subsequent Expenditure

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

1.8.4 Depreciation

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

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

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

1.8.5 Revaluation Gains and Losses

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

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

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

1.8.6 Impairments

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

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

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

1.8.7 De-recognition

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

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

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

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

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

1.8.8 Donated, Government Grant and Other Grant Funded Assets

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

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

1.8.9 Useful Economic Lives of Property, Plant and Equipment

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

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

Note 1.9 Investment Properties

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

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

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

Note 1.10 Intangible Assets

1.10.1 Recognition

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

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

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

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

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

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

1.10.2 Measurement

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

1.10.3 Subsequent Expenditure

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

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

1.10.4 Amortisation

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

1.10.5 Useful Economic Life of Intangible Assets

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

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

Note 1.11 Revenue Government and Other Grants

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

Note 1.12 Inventories

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

Note 1.13 Cash and Cash Equivalents

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

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

Note 1.14 Financial Assets and Financial Liabilities

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

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

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

1.14.1 Financial Assets At Amortised Cost

Financial assets and financial liabilities at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other trade receivables, trade and other payables and obligations under lease arrangements and loans receivables and payables.

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

1.14.2 Financial Assets At Fair Value Through Other Comprehensive Income

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

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

1.14.3 Financial Assets and Financial Liabilities At Fair Value Through Profit and Loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

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

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

1.14.4 Impairment of Financial Assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14.5 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

1.14.6 Financial Liabilities At Fair Value Through Profit and Loss

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

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

1.14.7 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly

discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.15.1 The Trust As Lessee

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% was applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to the following leases:

- with a term of 12 months or less

- where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT

Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent Measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.15.2 The Trust As A Lessor

A lessor shall classify each of its leases as an operating or finance lease.

A lease is classified as finance lease when the lease substantially transfers all of the risks and rewards incidental to ownership of an underlying asset. Where substantially all of the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Private Finance Initiative (PFI) Transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the financial cost, the charge for the services (and lifecycle replacement of component of the asset, where applicable).

Initial Measurement
In accordance with, HM Treasury's FReM the underlying assets are recognised as property, plant and equipment, together with an equivalent PFI liability measured in alignment with the principles of IFRS 16.

Subsequent Measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate. The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical Negligence Costs
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust's Accounts.

Non-Clinical Risk Pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Early Retirement Provisions
Early retirement provisions are discounted using the HM Treasury's post-employment benefit discount rate of 2.40% (2.450% in 2023/2024) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (4.26% in 2023/2024) for inflation adjusted expected cash flows up to and including 5 years from the Statement of Financial Position date

- A nominal medium-term rate of 4.07% (4.03% in 2023/2024) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date

- A nominal long-term rate of 4.81% (4.72% in 2023/2024) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date

- A nominal very long-term date of 4.55% (4.40% in 2023/2024) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date

Note 1.18 Contingent Assets and Contingent Liabilities

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

Contingent liabilities are not recognised but are disclosed in the notes.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

Note 1.19 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

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

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

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is

based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

Note 1.20 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation Tax

The Finance Act 2004 amended section 519A of the Income and Corporation Tax Act 1998 to provide power to HM Treasury to make certain non-core activities of NHS Foundation Trusts potentially subject to corporation tax.

However, the Trust has evaluated that it 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 2024/2025.

Note 1.28 Standards, Amendments and Interpretations in Issue But Not Yet Effective Or Adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/2025:

- IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FreM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

- Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

  Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
  - Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
  - Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

  Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
  - A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
  - Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. Building assets, including right of use assets where there is a building lease, currently subject to revaluation have a total book value of £132.904million as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £10million at 31 March 2025.

Note 2 Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which generate revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the Board of Directors, including senior professional Non-Executive Directors. The Board of Directors reviews the financial position of the Trust as a whole in its decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

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

	Healthcare		Total	
	2024/25 £000	2023/24 £000	**2024/25 £000**	2023/24 £000
Income	**408,001**	365,891	**408,001**	365,891
Retained Earnings / (Accumulated Deficit)	**(760)**	(8,666)	**(760)**	(8,666)
Segment net assets	**143,556**	138,412	**143,556**	138,412

Note 3 Operating Income From Patient Care Activities

All income from patient care activities relates to contract income recognised in line with the Trust's accounting policies.

Note 3.1 Income From Patient Care Activities (by Nature)

	2024/25 £000	2023/24 £000
Acute services		
Income from Commissioners under API contracts – variable element*	71,159	60,489
Income from Commissioners under API contracts – fixed element*	230,468	216,610
High cost drugs income from Commissioners	7,217	5,535
Other NHS clinical income	67	80
Community services		
Income from Commissioners under API contracts*	36,302	32,836
Income from other sources (e.g. local Authorities)	9,608	9,281
All services		
National pay award central funding***	748	149
Additional pension contribution central funding**	15,286	9,499
Other clinical income	4,738	1,084
Total income from activities	**375,593**	**335,563**

* Aligned payment and incentive contracts are the main form of contracting between NHS providers and their Commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

** Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7% in 2024/25, and 20.6% in 2023/24) and related NHS England funding (9.4% in 2024/25, and 6.3% in 2023/24) have been recognised in these accounts.

*** Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income From Patient Care Activities (By Source)

	2024/25 £000	2023/24 £000
NHS England	30,951	22,870
Integrated Care Boards	331,109	297,034
Other NHS providers	67	80
Local Authorities	9,388	9,652
Non-NHS: overseas patients (chargeable to patient)	126	158
Injury cost recovery scheme	580	877
Non NHS: other	3,372	4,892
Total income from activities	**375,593**	**335,563**

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

	2024/25 £000	2023/24 £000
Income recognised this year	126	158
Cash payments received in-year	31	16
Amounts added to provision for impairment of receivables	46	119
Amounts written off in-year	43	-

Note 4 Other Operating Income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	581	-	**581**	534	-	**534**
Education and training	15,106	700	**15,806**	13,290	592	**13,882**
Non-patient care services to other bodies	9,710		**9,710**	8,402		**8,402**
Income in respect of employee benefits accounted on a gross basis	3,320		**3,320**	3,530		**3,530**
Receipt of capital grants and donations and peppercorn leases		76	**76**		-	**-**
Charitable and other contributions to expenditure		6	**6**		63	**63**
Revenue from operating leases		471	**471**		468	**468**
Other income	2,436	2	**2,438**	3,449	-	**3,449**
Total other operating income	**31,153**	**1,255**	**32,408**	**29,205**	**1,123**	**30,328**

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

	2024/25 £000	2023/24 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,819	2,375

Note 5.2 Transaction Price Allocated to Remaining Performance Obligations

At the 31 March 2025, the Trust had no performance obligations that were either partially or fully unsatisfied that it has not accounted for in revenue recognition in year. Therefore, there are no contracts that commenced prior to the period end, with performance obligations outstanding and income not yet recognised.

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

Note 5.3 Income from Activities Arising from Commissioner Requested Services

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

	2024/25 £000	2023/24 £000
Income from services designated as Commissioner requested services	370,855	334,479
Income from services not designated as Commissioner requested services	37,146	31,412
Total	**408,001**	**365,891**

Note 5.4 Profits and Losses On Disposal of Property, Plant and Equipment

The Trust has not disposed of any land or buildings assets in year used in the provision of Commissioner requested services.

Note 5.5 Fees and Charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

In 2024/25 The Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1million. This was also the case during the 2023/24 financial year.

Note 6 Operating Leases (The Rotherham NHS Foundation Trust as Lessor)

This note discloses income generated in operating lease agreements where The Rotherham NHS Foundation Trust is the lessor.

Note 6.1 Operating Lease Income

The leases held by the Trust relate to various retail facilities provided at the General Hospital site, land used by other healthcare providers, and creche facilities.

	2024/25 £000	2023/24 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	471	468
Total in-year operating lease income	**471**	**468**

Note 6.2 Future Lease Receipts

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due in:		
- not later than one year	387	424
- later than one year and not later than two years	349	370
- later than two years and not later than three years	226	346
- later than three years and not later than four years	226	223
- later than four years and not later than five years	226	223
- later than five years	4,901	5,066
Total	**6,315**	**6,652**

Note 7.1 Operating Expenses

The following table shows the operating expenses incurred by the Trust during both the 2024/25 and 2023/24 financial years:

	2024/25 £000	2023/24 £000
Purchase of healthcare from NHS and DHSC bodies (*)	7,008	-
Purchase of healthcare from non-NHS and non-DHSC bodies	2,356	1,166
Staff and Executive Directors costs	277,375	256,783
Remuneration of Non-Executive Directors	152	145
Supplies and services - clinical (excluding drugs costs)	31,961	30,218
Supplies and services - general	5,996	5,378
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	24,390	22,453
Inventories written down	61	13
Consultancy costs	-	104
Establishment	2,437	2,626
Premises	16,096	15,503
Transport (including patient travel)	4,389	3,994
Depreciation on property, plant and equipment	13,015	12,858
Amortisation on intangible assets	1,498	1,266
Net impairments	143	2,606
Movement in credit loss allowance: contract receivables / contract assets	124	227
Movement in credit loss allowance: all other receivables and investments	31	9
Change in provisions discount rate(s)	2	(31)
Fees payable to the External Auditor		
audit services- statutory audit (**)	151	145
Internal Audit costs	114	109
Clinical negligence	11,590	10,252
Legal fees	265	452
Insurance	278	257
Research and development	574	490
Education and training	775	1,016
Expenditure on low value leases	-	6
Redundancy	39	128
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	710	687
Losses, ex gratia and special payments	69	74
Other services, for example External Payroll	2,144	668
Other	747	705
Total	**404,490**	**370,307**

Note:

* From the 1 April 2024, Pathology Services for The Rotherham NHS Foundation Trust transferred to Sheffield Teaching Hospital under the South Yorkshire and Bassetlaw Pathology Network. As such costs relating to 2024/25 are showing against Purchase of healthcare from NHS and DHSC bodies in the table above, whereas for the 2023/24 financial year these costs were split over the relevant operating expense headings, such as staffing, supplies and services.

** Audit fees are inclusive of VAT.

Note 7.2 Other Auditor Remuneration

No other External Auditor remuneration was paid during the 2024/25 financial year for work over and above the statutory audit fee, nor was there in 2023/24.

Note 7.3 Limitation on Auditor's Liability

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

Note 8 Impairment of Assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	143	(747)
Other	-	3,353
Total net impairments charged to operating surplus / deficit	**143**	**2,606**
Impairments charged to the revaluation reserve	-	1,709
Total net impairments	**143**	**4,315**

During 2024/25, an interim revaluation was undertaken on three leased building assets where the annual payment increased during the financial year; this led to impairment costs in year totalling £143k.

In 2023/24, an interim revaluation was undertaken on leased building assets and the Special Care Baby Unit, which led to some impairment costs in year. In addition, some impairment previously charged to the Statement of Comprehensive Income was reversed.

Note 9 Employee Benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	202,579	190,775
Social security costs	20,615	18,489
Apprenticeship levy	957	937
Employer's contributions to NHS pensions	38,675	31,252
Pension cost - other	119	78
Temporary staff (including agency)	15,649	16,678
Total staff costs	**278,594**	**258,209**
Of which:		
Costs capitalised as part of assets	617	813
Cost attributable to research and development	563	485
Cost of redundancies	39	128

Note 9.1 Retirements Due to Ill-Health

During 2024/25, there were four early retirements from the Trust agreed on the grounds of ill-health (six in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £215k (£1.121million in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Finance Income

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

	2024/25 £000	2023/24 £000
Interest on bank accounts	813	1,169
Total finance income	**813**	**1,169**

Note 11.1 Finance Expenditure

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

	2024/25 £000	2023/24 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	241	272
Interest on lease obligations	225	250
Finance costs on PFI and other service concession arrangements:		
Main finance costs	284	280
Remeasurement of the liability resulting from change in index or rate	201	665
Total interest expense	**951**	**1,467**
Unwinding of discount on provisions	17	17
Total finance costs	**968**	**1,484**

Note 11.2 The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015

The Late Payment of Commercial debts (Interest) Act 1998 / Public Contract Regulations requires the Trust to disclose its:

- total liability accruing in year under this legislation as a result of late payments
- amounts included within interest payable arising from claims made under this legislation
- compensation paid to cover debt recovery costs under this legislation.

In 2024/25, the Trust paid £295.36 in late payment fees under the above Act. In 2023/24, the Trust paid £298.35 in late payment fees.

Note 12 Other Gains / (Losses)

	2024/25 £000	2023/24 £000
Gains on disposal of assets	10	9
Losses on disposal of assets	(1)	(12)
Total gains / (losses) on disposal of assets	**9**	**(3)**
Total other gains / (losses)	**9**	**(3)**

Note 13 Discontinued Operations

No services provided by The Rotherham NHS Foundation Trust were discontinued in either the 2024/25 or 2023/24 financial years.

Note 14.1 Intangible Assets – 2024/25

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	**17,321**	**17,321**
Additions	647	**647**
Valuation / gross cost at 31 March 2025	**17,968**	**17,968**
Amortisation at 1 April 2024 - brought forward	**9,727**	**9,727**
Provided during the year	1,498	**1,498**
Amortisation at 31 March 2025	**11,225**	**11,225**
Net book value at 31 March 2025	**6,743**	**6,743**
Net book value at 1 April 2024	**7,594**	**7,594**

Note 14.2 Intangible Assets – 2023/24

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2023	**21,171**	**21,171**
Additions	1,016	**1,016**
Reclassifications	276	**276**
Disposals / derecognition	(5,142)	**(5,142)**
Valuation / gross cost at 31 March 2024	**17,321**	**17,321**
Amortisation at 1 April 2023	**13,555**	**13,555**
Provided during the year	1,266	**1,266**
Reclassifications	48	**48**
Disposals / derecognition	(5,142)	**(5,142)**
Amortisation at 31 March 2024	**9,727**	**9,727**
Net book value at 31 March 2024	**7,594**	**7,594**
Net book value at 1 April 2023	**7,616**	**7,616**

Note 15.1 Property, Plant and Equipment – 2024/25

	Land	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 2024 - brought forward	**11,000**	**124,048**	**480**	**42,814**	**245**	**11,121**	**399**	**190,107**
Additions	-	5,758	4,890	3,095	-	2,550	-	**16,293**
Reclassifications	-	-	-	31	-	-	-	**31**
Disposals / derecognition	-	-	-	(405)	-	-	-	**(405)**
Valuation/gross cost at 31 March 2025	**11,000**	**129,806**	**5,370**	**45,535**	**245**	**13,671**	**399**	**206,026**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**4,926**	**-**	**20,182**	**198**	**3,947**	**250**	**29,503**
Provided during the year	-	5,257	-	2,850	9	1,637	40	**9,793**
Disposals / derecognition	-	-	-	(404)	-	-	-	**(404)**
Accumulated depreciation at 31 March 2025	**-**	**10,183**	**-**	**22,628**	**207**	**5,584**	**290**	**38,892**
Net book value at 31 March 2025	**11,000**	**119,623**	**5,370**	**22,907**	**38**	**8,087**	**109**	**167,134**
Net book value at 1 April 2024	**11,000**	**119,122**	**480**	**22,632**	**47**	**7,174**	**149**	**160,604**

Note 15.2 Property, Plant and Equipment – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**11,000**	**116,447**	**177**	**43,221**	**256**	**13,101**	**393**	**184,595**
Additions	-	8,153	303	1,627	17	1,132	6	**11,238**
Impairments	-	(2,610)	-	-	-	-	-	**(2,610)**
Reversals of impairments	-	1,621	-	-	-	-	-	**1,621**
Reclassifications	-	437	-	(726)	-	13	-	**(276)**
Disposals / derecognition	-	-	-	(1,308)	(28)	(3,125)	-	**(4,461)**
Valuation/gross cost at 31 March 2024	**11,000**	**124,048**	**480**	**42,814**	**245**	**11,121**	**399**	**190,107**
Accumulated depreciation at 1 April 2023	**-**	**47**	**-**	**18,517**	**188**	**5,719**	**210**	**24,681**
Provided during the year	-	4,864	-	3,052	37	1,351	40	**9,344**
Impairments	-	(27)	-	-	-	-	-	**(27)**
Reclassifications	-	42	-	(92)	-	2	-	**(48)**
Disposals / derecognition	-	-	-	(1,295)	(27)	(3,125)	-	**(4,447)**
Accumulated depreciation at 31 March 2024	**-**	**4,926**	**-**	**20,182**	**198**	**3,947**	**250**	**29,503**
Net book value at 31 March 2024	**11,000**	**119,122**	**480**	**22,632**	**47**	**7,174**	**149**	**160,604**
Net book value at 1 April 2023	**11,000**	**116,400**	**177**	**24,704**	**68**	**7,382**	**183**	**159,914**

Note 15.3 Property, Plant and Equipment Financing – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,000	116,944	5,370	15,894	38	8,087	109	**157,442**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	6,114	-	-	-	**6,114**
Owned - donated/granted	-	2,679	-	899	-	-	-	**3,578**
Total net book value at 31 March 2025	**11,000**	**119,623**	**5,370**	**22,907**	**38**	**8,087**	**109**	**167,134**

Note 15.4 Property, Plant and Equipment Financing – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,000	116,256	480	15,081	47	7,174	149	**150,187**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	6,490	-	-	-	**6,490**
Owned - donated/granted	-	2,866	-	1,061	-	-	-	**3,927**
Total net book value at 31 March 2024	**11,000**	**119,122**	**480**	**22,632**	**47**	**7,174**	**149**	**160,604**

Note 15.5 Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	588	2,589	-	-	-	-	-	**3,177**
Not subject to an operating lease	10,412	117,034	5,370	22,907	38	8,087	109	**163,957**
Total net book value at 31 March 2025	**11,000**	**119,623**	**5,370**	**22,907**	**38**	**8,087**	**109**	**167,134**

Note 15.6 Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	588	2,589	-	-	-	-	-	**3,177**
Not subject to an operating lease	10,412	116,533	480	22,632	47	7,174	149	157,427
Total net book value at 31 March 2024	**11,000**	**119,122**	**480**	**22,632**	**47**	**7,174**	**149**	**160,604**

Note 16 Donations of Property, Plant and Equipment

The Trust did not receive any donated assets or cash donations for the purchase of assets during 2024/2025 or 2023/2024.

The Trust did re-enter a building lease during the year, where a rental below market value (known as a peppercorn rent) is paid to the lessor.

Note 17 Revaluations of Property, Plant and Equipment

A full 5 yearly cyclical valuation of the Trust's estate was carried out during 2022/23.

Following a full site inspection and review, the Trust's independent qualified valuer, Clark Weightman (since merged and operating as Sanderson Weatherall LLP), issued their report with a valuation date of 31 March 2023; this included all relevant owned land and buildings, it also includes one peppercorn leased building (see Note 18.3).

The report took account of changes in buildings cost indices, location factors and the effect of capital expenditure during the year. The report was completed in accordance with guidance issued by the Royal Institution of Chartered Surveyors ("RICS") and gave an overall valuation of the Trust's estate (including land and buildings) of £127.279million.

A revaluation was undertaken in 2023/24 of buildings used by the Trust which are leased from third parties, as well as a formal valuation of the Special Care Baby Unit (SCBU) which underwent a refurbishment during the year.

During 2024/25, an interim revaluation was undertaken on three of the leased building assets where the lease payment had increased during the financial year. These revaluations resulted in impairment losses totalling £143k, as shown in Note 8.

Note 18 Leases (The Rotherham NHS Foundation Trust as a Lessee)

This note details information about leases for which the Trust is a lessee.

The Trust has finance leases for items of medical and non-medical equipment, vehicles and property lets used to carry out service provision.

Finance leases are recognised on the Trust's Statement of Financial Position as Right Of Use Assets (non-current assets).

Note 18.1 Right of Use Assets – 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**16,261**	**5,598**	**17**	**21,876**	**17,473**
Additions	85	427	15	**527**	85
Remeasurements of the lease liability	166	162	-	**328**	159
Impairments	(358)	-	-	**(358)**	(296)
Reclassifications	-	(31)	-	**(31)**	-
Disposals / derecognition	-	(103)	-	**(103)**	-
Valuation/gross cost at 31 March 2025	**16,154**	**6,053**	**32**	**22,239**	**17,421**
Accumulated depreciation at 1 April 2024 - brought forward	**990**	**3,556**	**15**	**4,561**	**1,728**
Provided during the year	2,098	1,120	4	**3,222**	2,410
Impairments	(215)	-	-	**(215)**	(157)
Disposals / derecognition	-	(103)	-	**(103)**	-
Accumulated depreciation at 31 March 2025	**2,873**	**4,573**	**19**	**7,465**	**3,981**
Net book value at 31 March 2025	**13,281**	**1,480**	**13**	**14,774**	**13,440**
Net book value at 1 April 2024	**15,271**	**2,042**	**2**	**17,315**	**15,745**

Net book value of right of use assets leased from other NHS providers	2,592
Net book value of right of use assets leased from other DHSC group bodies	10,848

Note 18.2 Right of Use Assets – 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**21,201**	**5,598**	**17**	**26,816**	**22,268**
Remeasurements of the lease liability	1,158	-	-	**1,158**	1,158
Impairments	(6,328)	-	-	**(6,328)**	(6,183)
Revaluations	230	-	-	**230**	230
Valuation/gross cost at 31 March 2024	**16,261**	**5,598**	**17**	**21,876**	**17,473**
Accumulated depreciation at 1 April 2023 - brought forward	1,894	2,450	8	**4,352**	2,201
Provided during the year	2,401	1,106	7	**3,514**	2,708
Impairments	(2,975)	-	-	**(2,975)**	(2,851)
Revaluations	(330)	-	-	**(330)**	(330)
Accumulated depreciation at 31 March 2024	**990**	**3,556**	**15**	**4,561**	**1,728**
Net book value at 31 March 2024	**15,271**	**2,042**	**2**	**17,315**	**15,745**
Net book value at 1 April 2023	**19,307**	**3,148**	**9**	**22,464**	**20,067**
Net book value of right of use assets leased from other NHS providers					3,160
Net book value of right of use assets leased from other DHSC group bodies					12,585

Note 18.3 – Revaluation of Right of Use Assets

During 2024/25, a revaluation of three leased buildings was undertaken, where the annual lease rental payment increased during the financial year. These leased buildings are used in the delivery of healthcare services.

Overall, this resulted in impairment losses of £143k, taken to the Statement of Comprehensive Income.

For further information regarding the revaluation carried out, please see Note 17.

Note 18.4 – Reconciliation of the Carrying Value of Lease Liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in Note 26.

	2024/25 £000	2023/24 £000
Carrying value at 1 April	**16,836**	**18,754**
Lease additions	451	-
Lease liability remeasurements	328	1,158
Interest charge arising in year	225	250
Lease payments (cash outflows)	(3,363)	(3,326)
Carrying value at 31 March	**14,477**	**16,836**

Lease payments for short term leases (less than 12 months) or leases of low value (less than £5K) underlying assets are recognised in operating expenditure.

These payments are disclosed in Note 7.1, Operating Expenses. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 – Maturity Analysis of Future Lease Payments at 31 March 2025 and 31 March 2024

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year	3,129	2,542	3,142	2,550
- later than one year and not later than five years	7,039	6,521	8,922	8,235
- later than five years	5,454	5,442	6,086	6,086
Total gross future lease payments	**15,622**	**14,505**	**18,150**	**16,871**
Finance charges allocated to future periods	(1,145)	(1,115)	(1,314)	(1,287)
Net lease liabilities at 31 March 2025	**14,477**	**13,390**	**16,836**	**15,584**
Of which:				
Leased from other NHS providers		2,085		2,642
Leased from other DHSC group bodies		11,305		12,942

Note 19 Investment Property

The Rotherham NHS Foundation Trust holds assets which are rented to other organisations and are not held for primary healthcare provision purposes. These are however deemed to support service provision and as such have not been categorised as Investment Property. This includes the Lodge, the Creche and staff residencies.

Note 20 Disclosure of Interests in Other Entities

The Trust has considered the need to consolidate Charitable Funds (The Rotherham Hospital and Community Charity) within the main Trust accounts and concluded that, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Funds is not material and will not therefore be consolidated within the Trust's main accounts.

The table below summarises the Charitable Funds Statement of Financial Activities and Balance Sheet.

	31 March 2025 £000	31 March 2024 £000
Total incoming resources	245	345
Resources expended	(344)	(243)
Net movement in funds	**(99)**	**102**
Total assets	490	601
Total liabilities	(7)	(19)
Total Charitable Funds	**483**	**582**
Total funds made up of:		
Restricted /endowment funds	288	310
Unrestricted funds	195	272

The 2024/25 Charitable Funds accounts have not yet been subject to independent review. The 2023/24 Charitable Funds accounts were subject to independent examination and were finalised in November 2024.

Note 21 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	1,508	1,254
Consumables	2,687	3,743
Energy	51	46
Total inventories	**4,246**	**5,043**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £35.137million (2023/24: £31.865million). Write-down of inventories recognised as expenses for the year were £61k (£13k in 2023/24).

Note 22.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	7,532	6,221
Allowance for impaired contract receivables / assets	(909)	(785)
Allowance for other impaired receivables	(98)	(67)
Prepayments (non-PFI)	4,680	4,039
VAT receivable	1,672	984
Other receivables	133	290
Total current receivables	**13,010**	**10,682**
Non-current		
Other receivables	428	404
Total non-current receivables	**428**	**404**

Note 22.2 Allowances for Credit Losses

	2024/25		2023/24	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**785**	**67**	**558**	**58**
New allowances arising	407	56	450	23
Reversals of allowances	(283)	(25)	(223)	(14)
Allowances as at 31 March 2025	**909**	**98**	**785**	**67**

The in-year movement in credit loss allowance relating to contract receivables / contract assets (£124k) and all other receivables and investments (£31k) are included within total expenditure in the Statement of Comprehensive Income, as shown in Note 7.1.

Note 22.3 Exposure to Credit Risk

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

Note 23.1 Cash and Cash Equivalents Movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents.

Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25 £000	2023/24 £000
At 1 April	**12,116**	**24,356**
Net change in year	3,796	(12,240)
At 31 March	**15,912**	**12,116**
Broken down into:		
Cash at commercial banks and in hand	118	106
Cash with the Government Banking Service	15,794	12,010
Total cash and cash equivalents as in SoFP	**15,912**	**12,116**
Total cash and cash equivalents as in SoCF	**15,912**	**12,116**

Note 23.2 Third Party Assets Held by the Trust

On occasions, Trusts hold cash and cash equivalents which relate to monies held on behalf of patients or other parties and in which the Trust has no beneficial interest. Where this is the case, this has been excluded from the cash and cash equivalents figure reported in the Accounts.

At 31 March 2025 the Trust did not hold any cash or cash equivalents which relate to monies held on behalf of patients or other parties. At 31 March 2024, the Trust held £254.48 in cash or cash equivalents which relate to monies held on behalf of patients or other parties.

Note 24 Trade and Other Payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	8,141	6,653
Capital payables	9,291	4,117
Accruals	15,863	15,524
Social security costs	2,373	2,342
VAT payables	81	58
Other taxes payable	2,489	2,310
PDC dividend payable	169	8
Pension contributions payable	3,307	3,024
Other payables	122	68
Total current trade and other payables	**41,836**	**34,104**
Of which payables from NHS and DHSC group bodies:		
Current	6,011	6,648

The Trust had no non-current payables at 31 March 2025, nor did it at 31 March 2024.

Note 25 Other Liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	2,612	1,819
Total other current liabilities	**2,612**	**1,819**

The Trust had no non-current other liabilities at 31 March 2025, nor did it at 31 March 2024.

Note 26.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	1,311	1,317
Lease liabilities	2,954	2,945
Obligations under PFI or other service concession contracts	356	332
Total current borrowings	**4,621**	**4,594**
Non-current		
Loans from DHSC	9,000	10,250
Lease liabilities	11,523	13,891
Obligations under PFI or other service concession contracts	7,784	7,942
Total non-current borrowings	**28,307**	**32,083**

Note 26.2 Reconciliation of Liabilities Arising from Financing Activities – 2024/25

	Loans from DHSC £000	Lease Liabilities £000	PFI or other service concession schemes £000	Total £000
Carrying value at 1 April 2024	**11,567**	**16,836**	**8,274**	**36,677**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(3,138)	(335)	**(4,723)**
Financing cash flows - payments of interest	(247)	(225)	(284)	**(756)**
Non-cash movements:				
Additions	-	451	-	**451**
Lease liability remeasurements	-	328	-	**328**
Remeasurement of PFI or other service concession liability resulting from change in index or rate			201	**201**
Application of effective interest rate	241	225	284	**750**
Carrying value at 31 March 2025	**10,311**	**14,477**	**8,140**	**32,928**

Note 26.3 Reconciliation of Liabilities Arising from Financing Activities – 2023/24

	Loans from DHSC	Lease Liabilities	PFI or other service concession schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**12,823**	**18,754**	**7,038**	**38,615**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(3,076)	(300)	**(4,626)**
Financing cash flows - payments of interest	(278)	(250)	(280)	**(808)**
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023			871	**871**
Lease liability remeasurements	-	1,158	-	**1,158**
Remeasurement of PFI or other service concession liability resulting from change in index or rate			665	**665**
Application of effective interest rate	272	250	280	**802**
Carrying value at 31 March 2024	**11,567**	**16,836**	**8,274**	**36,677**

Note 27.1 Provisions for Liabilities and Charges Analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**297**	**411**	**133**	**1,905**	**2,746**
Change in the discount rate	1	1	-	(4)	**(2)**
Arising during the year	34	56	83	11	**184**
Utilised during the year	(31)	(39)	(13)	(433)	**(516)**
Reversed unused	(37)	-	(33)	(1,065)	**(1,135)**
Unwinding of discount	6	11	-	21	**38**
At 31 March 2025	**270**	**440**	**170**	**435**	**1,315**
Expected timing of cash flows:					
- not later than one year	31	39	141	7	**218**
- later than one year and not later than five years	239	401	29	45	**714**
- later than five years	-	-	-	383	**383**
Total	**270**	**440**	**170**	**435**	**1,315**

The Pensions (early departure) provision relates to the ongoing costs of making early payment of pensions. Legal claims relate to liabilities to third parties (administered by NHS Resolution). The main uncertainty in terms of the timing of the cash flows relates to the pensions provision as assumptions need to be made (in accordance with guidance) as to the estimated length of life of the pensioners and the consequent cost to the Trust. These are discounted per the guidance along with Injury Benefits provisions. At present there is no expectation that the Trust will receive any reimbursement in respect of these provisions.

Clinicians who are members of the NHS Pension Scheme and face an annual allowance tax charge for work undertaken in 2019/20 and thereafter can elect to have this charge paid by the NHS Pension Scheme. The employing Trust makes a contractually binding commitment to pay a corresponding compensated amount on retirement, therefore there is a future obligation upon retirement. This payment is nationally funded, therefore any provision recognised here is matched with a non-current receivable from NHS England.

The Trust has made provision for potential claims that it is aware of; these are shown under “other provisions.”

Note 27.2 Clinical Negligence Liabilities

At 31 March 2025, £63.536million was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (£55.619million at 31 March 2024).

Note 28 Contingent Assets and Liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(23)	(35)
Net value of contingent liabilities	**(23)**	**(35)**
Net value of contingent assets	**797**	**-**

The Trust has submitted a claim to HMRC for the recovery of VAT on car parking charges following the principles established in the Northumbria Healthcare NHS Foundation Trust case, amounting to £797k (covering the period April 2018 to June 2024). The case considers whether VAT is due on hospital car parking when provided by NHS Trusts.

While this matter has been subject to legal proceedings and found in favour of Northumbria Healthcare NHS Foundation Trust, the final outcome and its implications for the Trust's claim are dependent on the pending judgment of the Supreme Court.

As the outcome of the case remains uncertain, the Trust has elected to defer recognition of these VAT recoveries in the financial statements for the year ending 2024/25. The Trust has continued to pay over VAT relating to car parking income, pending the outcome of the case.

In accordance with IAS 37, no amounts have been recognised in the financial statements for the year ending 2024/25. Any recoveries will be recognised in the financial statements only if and when the legal position is resolved in a manner that confirms the Trust's entitlement to these amounts.

The Trust continues to monitor developments in the case closely and will reassess the accounting treatment of these potential recoveries in future periods.

Note 29 Contractual Capital Commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	119	1,008
Total	**119**	**1,008**

The contractual capital commitments shown in the above table relating to 2024/2025 are for works started during the financial year, but not completed at year end.

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

Note 30 On-SoFP PFI or Other Service Concession Arrangements

The Rotherham NHS Foundation Trust entered into a 20-year Energy Saving Project agreement that supports third party investment in the energy provision infrastructure at the Rotherham General Hospital site. The contract for Energy Saving was procured through the Carbon and Energy Fund (CEF) framework. The service contract to enable energy savings across the Rotherham General Hospital site was signed on 12 December 2019.

The project involved significant investment in the hospital's energy infrastructure which transferred the operational and financial risk to a third party with the intention of realising energy consumption reduction and a reduction in carbon emissions. The Contract for the Energy Saving Project commenced 22 November 2021, following an installation period.

Note 30.1 On-SoFP PFI or Other Service Concession Arrangement Obligations

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

	31 March 2025 £000	31 March 2024 £000
Gross PFI or other service concession liabilities	**10,495**	**10,832**
Of which liabilities are due:		
- not later than one year	630	613
- later than one year and not later than five years	2,519	2,453
- later than five years	7,346	7,766
Finance charges allocated to future periods	(2,355)	(2,558)
Net PFI or other service concession arrangement obligation:	**8,140**	**8,274**
- not later than one year	356	332
- later than one year and not later than five years	1,594	1,493
- later than five years	6,190	6,449

Note 30.2 Total on-SoFP PFI and Other Service Concession Arrangement Commitments

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

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI or other service concession arrangements	**23,367**	**24,580**
Of which payments are due:		
- not later than one year	1,402	1,391
- later than one year and not later than five years	5,608	5,566
- later than five years	16,357	17,623

Note 30.3 Analysis of Amounts Payable to Service Concession Operator

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

	2024/25 £000	2023/24 £000
Unitary payment payable to service concession operator	**1,329**	**1,267**
Consisting of:		
- interest charge	284	280
- repayment of balance sheet obligation	335	300
- service element and other charges to operating expenditure	710	687
Total amount paid to service concession operator	**1,329**	**1,267**

Note 31 Financial Instruments

Note 31.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the Integrated Care Board and the way those Integrated Care Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's Internal Auditors.

Currency Risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk
The Trust has low exposure to interest rate fluctuations as it has borrowings only from the Department of Health and Social Care at fixed rates of interest.

Credit Risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity Risk
The Trust's operating costs are incurred under annual service agreements with Integrated Care Board and Local Authorities, which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Foreign Currency Risk
The Trust has negligible foreign currency income or expenditure.

Note 31.2 Carrying Values of Financial Assets

Fair value is considered to equate to carrying value in the note below unless otherwise disclosed.

Carrying Values of Financial Assets as at 31 March 2025

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Held at fair value through profit and loss £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	7,086	-	-	**7,086**
Cash and cash equivalents	15,912	-	-	**15,912**
Total at 31 March 2025	**22,998**	**-**	**-**	**22,998**

Carrying Values of Financial Assets as at 31 March 2024

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Held at fair value through profit and loss £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	6,063	-	-	**6,063**
Cash and cash equivalents	12,116	-	-	**12,116**
Total at 31 March 2024	**18,179**	**-**	**-**	**18,179**

Note 31.3 Carrying Values of Financial Liabilities

Carrying Values of Financial Liabilities as at 31 March 2025

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through profit and loss	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	10,311	-	**10,311**
Obligations under leases	14,477	-	**14,477**
Obligations under PFI and other service concession contracts	8,140	-	**8,140**
Trade and other payables excluding non financial liabilities	31,961	-	**31,961**
Total at 31 March 2025	**64,889**	**-**	**64,889**

Carrying values of Financial Liabilities as at 31 March 2024

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through profit and loss	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	11,567	-	**11,567**
Obligations under leases	16,836	-	**16,836**
Obligations under PFI and other service concession contracts	8,274	-	**8,274**
Trade and other payables excluding non financial liabilities	27,930	-	**27,930**
Total at 31 March 2024	**64,607**	**-**	**64,607**

Note 31.4 Maturity of Financial Liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	37,180	33,176
In more than one year but not more than five years	14,597	17,032
In more than five years	17,551	19,445
Total	**69,328**	**69,653**

Note 32 Losses and Special Payments

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	1	1
Bad debts and claims abandoned	31	54	11	1
Stores losses and damage to property	12	61	12	13
Total losses	**43**	**115**	**24**	**15**
Special payments				
Compensation under court order or legally binding arbitration award	6	9	11	55
Ex-gratia payments	19	6	26	6
Special severance payments	-	-	1	11
Total special payments	**25**	**15**	**38**	**72**
Total losses and special payments	**68**	**130**	**62**	**87**

Note 33 Gifts

During the 2024/25 financial year, the Trust did not receive any gifts, nor did it in 2023/24.

Note 34 Related Parties

The Rotherham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health and Social Care.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial position and results may have been affected by the existence of related parties and by material transactions with them. In the cases reported as related parties in year, all payments shown have been made by the Trust to the organisations concerned and not to the individual officers.

During the year the Trust entered into transactions with organisations with which key employees/directors of the Trust have some form of relationship. Only those bodies outside the Department of Health and Social Care parent body, are detailed below and are not considered material.

	31 March 2025 Expenditure to Related Party £000	31 March 2025 Income from Related Party £000	31 March 2024 Expenditure to Related Party £000	31 March 2024 Income from Related Party £000
Sheffield Hallam University	25	192	58	11
University of Sheffield	8	13	18	9
Total related party transactions	33	205	76	20

During the 2024/25 financial year, the following transactions were recorded as related parties, where a member of the Board was either related to a person or persons employed by the organisation, is a Trustee or Director of the Board, or a member of the organisation:

- £8k and £25k of expenditure was incurred with the University of Sheffield and Sheffield Hallam University (respectively) for course fees (including medical education).

- Sheffield Hallam University have been awarded funding from Yorkshire Cancer Research to undertake a study, in which they have invited NHS bodies across the region to assist in. The majority of income recognised in the above table represents staffing recharges for time spent assisting in this study.

- £13k of income was received from Sheffield University for course fees.

In 2023/24, £18k and £58k of expenditure was incurred with the University of Sheffield and Sheffield Hallam University (respectively) for course fees (including medical education). Income was received from Sheffield University (£9k) for course fees, and Sheffield Hallam University (£11k) for staff secondments.

The Rotherham NHS Foundation Trust shares key management personnel with Barnsley Hospital NHS Foundation Trust; for more information, please see the Remuneration Report which also forms part of the Annual Report and Accounts for the Trust.

The Trust as Corporate Trustee also has a relationship with The Rotherham Hospital and Community Charity. Income of £245k was received by the Charity during the 2024/25 financial year, (£345k in 2023/24) which was spent on goods and services provided to the Trust, including on staff and patients. The Rotherham Hospital and Community Charity also paid £127k in relation to recharges for management and staff costs (£113k in 2023/24). The accounts of The Rotherham Hospital and Community Charity are made separately, a summary of which can be found at Note 20.

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The Government Accounting Manual interprets this such that Department of Health and Social Care group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings. During the year, the Trust has had a significant number of material transactions with other entities within the public sector. These entities are listed below:

- Rotherham Metropolitan Borough Council
- Her Majesty's Revenue and Customs (HMRC)
- NHS Pension Scheme

Note 35 Adjusted Financial Performance

The Trust is monitored by NHS England against its adjusted financial performance; the following table shows the movement from the Total Comprehensive Income / (Expenses) for the Period shown within the Statement of Comprehensive Income to its Adjusted Financial Performance.

	Note	2024/25 £000	2023/24 £000
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(760)	(8,666)
Remove net impairments not scoring to the Departmental expenditure limit		143	2,606
Remove I&E impact of capital grants and donations		674	748
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis		1,571	945
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis		(1,329)	
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis			(348)
Adjusted financial performance surplus / (deficit)		**299**	**(4,715)**

Note 36 Events After the Reporting Date

There are no events after the reporting date at the point when these accounts were presented at Trust Board for approval on 26 June 2025.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