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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Annual Report and Accounts

2021/22

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2021/22

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

Contents

Section 1.0 Welcome from the Chair

It is my pleasure to welcome you to our Annual Report and Accounts for 2021/22. This report looks back over the year and shares some of our challenges and achievements.

I joined Sheffield Health and Social Care NHS Foundation Trust (SHSC) as Chair in October 2021. It has been a busy and enjoyable first 8 months at the Trust.

On joining the Trust I was immediately impressed with the hard work, commitment and dedication of the board and staff and with their passion to deliver high quality services.

We recognise that there is still work to do but we are committed to continue with our journey of learning and improvement. As our Chief Executive mentions in her review of the year, we are also looking ahead, planning for the future and implementing changes that will sustain our drive to provide both high quality services and a great place to work.

Together we will strive to build further on our achievements to date and will continue to work with partners in Sheffield, the South Yorkshire and Bassetlaw Mental Health and Learning Disabilities and Autism Alliance and the South Yorkshire and Bassetlaw Integrated Care System to make a positive difference for the communities we serve.

I would like to take this opportunity to thank the board, our staff, governors, and volunteers for all they have done and continue to do. I would also like to thank the former Chair, Mike Potts, for his leadership during what was a particularly challenging time.

Thank you for your interest in the Trust and for taking the time to read this report.

Sharon Mays
Chair

Section 2.0 Performance Report

2.1 Performance Overview

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

Jan Ditheridge, Chief Executive

2.1.1 Chief Executive's review of the year

March 2022 marks the end of another financial year, the time to prepare and share this annual report and our annual accounts, a time to reflect, consider our achievements and reaffirm our priorities for the new year.

I would like to take a moment to reflect on our four strategic priorities, bringing to life some of our achievements and challenges. You will find more detail within this report, but I hope you find these headlines helpful.

2021/22 has been the year we have learned to live with COVID-19, ensuring we keep our service users and staff safe from the disease, taking the learning from the last two years of working very differently and planning our services to meet the needs of our populations in the future.

In April 2020 the Care Quality Commission (CQC) rated Sheffield Health and Social Care NHS Foundation Trust Inadequate, attracting Special Measures or Strategic Operating Framework Level 4 (SOF4).

In May 2021 while they could see improvements in our acute services, our learning disability inpatient services were rated as inadequate. This was a significant set-back and not what any of us would have wished for.

However, we used this challenging time to reset our plans and have since made real progress to improve our services. This is evidenced in our improved overall CQC rating to requires improvement and removal of our Special Measures status (SOF4).

We are now looking forward to 2022/23 and continuing our 'Back to Good' journey.

Alongside our COVID-19 management and urgent actions to address our quality challenges, we are planning for the future, implementing change that will sustain our drive to provide high quality services and a great place to work.

Importantly, but not exclusively, we have transformed many of our ward environments to provide safer, more therapeutic and dignified spaces, chosen an electronic patient record system which will support our clinicians to do their jobs, agreed the sale of our headquarters at Fulwood to provide capital to further improve our clinical environments and probably most importantly we have significantly improved the way we involve service users and carers in their care and the planning of future services.

While working in partnership has always been critical for us, we have used this year to refresh our understanding of who our partners are and how we can optimise those relationships for the benefit of our service users and our staff.

We are also preparing for the changes the Health and Care Bill set out, supporting us to work in a more integrated way for patients.

This report and our annual accounts will tell you more about how we have performed against our national and local targets, and how we have spent the money allocated to us for the benefit of our service users and their families.

I hope this introduction gives you a flavour of the breadth of our work and demonstrates the commitment and passion everyone in Team SHSC has to deliver high quality services to the people we serve.

Jan Ditheridge
Chief Executive

2.1.2 Who we are

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

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

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

- NHS Sheffield Clinical Commissioning Group
- Sheffield City Council
- Sheffield Hallam University
- University of Sheffield
- Sheffield Carers Centre
- Pakistan Muslim Centre
- Sheffield African and Caribbean Mental Health Association
- MENCAP Sheffield

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

2.1.3 Our services

We have an annual income of approximately £145m and employ 2,440 members of staff. We provide mental health, learning disability, substance misuse and a range of specialist services to the people of Sheffield. Our integrated approach to service delivery enables us to meet our service users' mental, physical and social care needs.

The wide range of our services includes:

- rehabilitation services for people with brain injuries and those living with the consequences of a long-term neurological condition
- services for adults with drug and alcohol misuse problems
- psychological therapies for people with mild and moderate mental health problems
- community-based mental health services for people with serious and enduring mental illness
- low-secure forensic inpatient services
- services that support people with a learning disability, their families and carers
- services that support people with dementia, their families and carers
- inpatient mental health services for adults and older people
- rehabilitation services for people with mental health illness

- specialist services including: eating disorders, adult autism, health services for homeless people and members of the traveller community, perinatal mental health services and gender identity services
- supported employment and health promotion
- teaching and research.

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

Our main commissioning partners are NHS Sheffield Clinical Commissioning Group and Sheffield City Council who commission around 70% of our business. We are also commissioned by NHS England to provide some of our services nationally.

2.1.4 How we provide our services

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

The services we provide, and the locations they are provided in, are tailored to suit the individual needs of our service users, their families, and carers. That means that some of our services are provided in the community, to ensure we can provide support, care and treatment to service users close to their homes and help them to maintain their independence as much as possible. We also provide a range of inpatient services for individuals who cannot be best supported within their community.

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

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

Working in partnership is a huge part of the services we provide across the city. We work closely with the Child and Adolescent Mental Health Services (CAMHS) within Sheffield Children's NHS Foundation Trust to ensure care is carefully co-ordinated as young people move into adulthood and need the ongoing support of our mental health services. We also deliver integrated health and social care services for adults of a working age alongside Sheffield City Council, although arrangements for this will change over the next 12-18 months.

2.1.5 The care we want to provide

The bedrock of our Clinical and Social Care Strategy is based on our values and the recovery principles, delivering care that is person-centred, strengths-based, evidence-led and trauma-informed.

Our development plans focus on:

- **Understanding what matters to people:** Improving the experience, safety, and quality of care for service users, carers and families through understanding what matters to people and co-producing systems and models of care.
- **Knowing we make a difference:** Seeking to help people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health care to be closer to communities and capturing impact and outcomes. We will develop systems and clinical practice where outcome measures are routinely used with service users to know If services are effective. We will develop a person-centred outcomes framework, tailored to what matters to people.
- **Creating environments for excellence:** Promoting the development of therapeutic teams through a well-trained workforce, working within healing environments. To create therapeutic environments for excellence that support care, are safe, compassionate, enable best practice and provide the best for service users. These will be environments where people feel valued and listened to, and staff enjoy coming to work because they are supported to learn and develop together.
- **Transforming care in Sheffield:** Building further and faster the partnerships and transformation with other organisations to become a more integrated health and social care system with improved outcomes, including a Zero Suicide ambition.
- **Leading the system for outstanding care:** Developing system quality networks for MHLDA and building an equitable system in South Yorkshire.

2.1.6 Our strategies and objectives

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

Our vision will continue to guide us on our strategic journey to continuously improve. It will help us to focus our partnership work on what is most important to the people who need to access our services.

We will do this by:

- working with and advocating for the local population
- refocusing our services towards prevention and early intervention
- continuous improvement of our services
- locating services as close to people’s homes as we can

- developing a confident and skilled workforce
- ensuring excellent and sustainable services.

2.1.7 Our values

During 2021 we revisited our values with our staff. We also considered the NHS Constitution values during this process. Our values are a series of behaviours that everyone at the Trust is expected to live and breathe. We are proud to live our values every day. They outline how we will act to ensure we provide the very best care to the people we support.

These values will underpin our strategic direction and everything we do. Our values are as follows:

- working together (for service users)
- respect and kindness
- everyone counts
- commitment to quality
- improving lives

We use our vision and values to set our standards of care, service quality, shape our behaviour and cultural development and to test our strategic plans and how we work together with our partners.

2.1.8 Our strategic aims

In 2021/22 we reviewed our strategic direction with our staff, our Leadership Group, our Joint Consultative Forum, our Council of Governors, the Board, people who use services, their carers and our partners.

As a result of this work, we have refreshed our strategic aims to formally acknowledge the importance of addressing inclusion for people who use our services and our staff as follows:

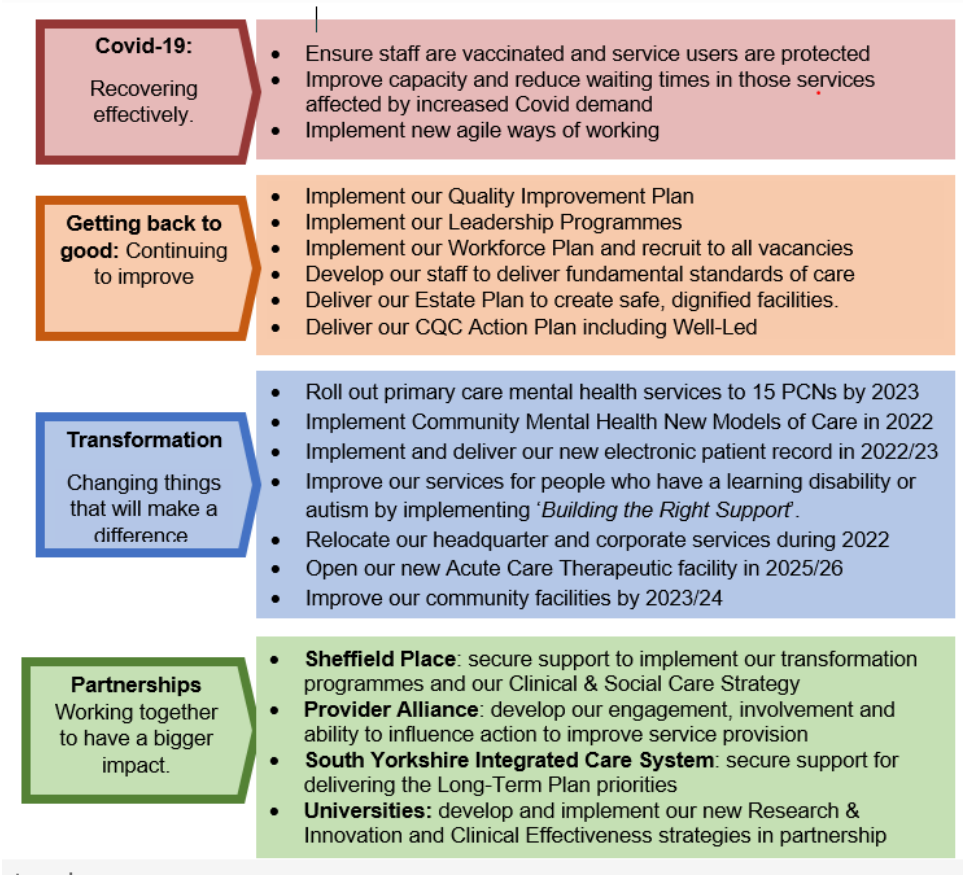
- Deliver outstanding care
- Effective use of resources
- Create a great place to work
- Ensure our services are inclusive

Our strategic direction sets out where we aim to be by 2025 and what we need to do to get there, in an increasingly uncertain and changing world and a financially challenged environment. We are optimistic about our future and the important part we will continue to play in reducing health inequalities and improving the health and wellbeing of the population we serve by working with our health and social care partners in Sheffield and the Integrated Care System (ICS) in South Yorkshire and Bassetlaw.

2.1.9 Our strategic priorities to 2023

We reviewed our strategic priorities and added a focus on partnerships to reflect the strategic importance of the new South Yorkshire and Bassetlaw Integrated

Care System (ICS) NHS arrangements, working together in Sheffield and implementing new models of care with the local alliance of NHS providers.



2.2 Performance Analysis

2.2.1 The progress and improvements we made in 2021-22

COVID-19: Recovering effectively

- Traditional winter pressures and COVID-19 Omicron variant surges were managed, and we have mitigated the impact upon our service users, services and our staff. There were two incidents breaching safer staffing levels and infection outbreaks were low and safely managed.
- Our vaccination programmes have been successful for COVID-19 boosters and Flu vaccinations. We have achieved the highest rates of Flu vaccinations ever for our staff (over 75%) and over 94% of staff have two COVID-19 doses.
- Our services have generally returned to pre-pandemic ways of working. Levels of face-to-face activity have continued to rise and are around 10-15% lower than pre-pandemic levels, reflecting increased use of remove or digital contact. Our IAPT services have maintained high levels of online contact due to challenges in returning to previous accommodation across general practice

sites. New ways of working developed through the pandemic, where we want to continue with them, and where our services users have told us they prefer these methods, are being incorporated into general service plans.

- Challenges continue across several services in respect of numbers waiting or length of waits. These challenges are not considered to be COVID-19 related. Recovery plans are in place for all relevant services and additional investment has been made through the year to help with access challenges for the following services:
    - Single Point of Access
    - Emotional Wellbeing Service
    - Liaison Psychiatry
    - Memory Service
    - Sheffield Autism and Neurodevelopmental Service
    - Homeless Assessment Team
    - Substance misuse services (Sheffield Treatment and Recovery Team)
    - Crisis Resolution Home Treatment Team

Getting back to good: continuing to improve

- The Trust ended 2021/22 in a much improved position following the continued and extensive improvement work led through the 'back to good' programme:
    - Our overall rating has improved from 'inadequate' to 'requires improvement'
    - All our mental health services, other than those provided at Firshill Rise, are rated as 'requires improvement' or above
    - NHS England and Improvement have moved us out of Strategic Oversight Framework Level 4 (SOF 4) previously known as 'Special Measures' and into SOF 3.
- We have developed clear strategic plans that define our focus. Key plans are described in our:
    - Clinical and Social Care Strategy (approved in July 2021)
    - Quality Strategy (approved in March 2022)
    - Service User Engagement and Experience Strategy (approved in March 2022)
    - Research, Effectiveness and Innovation Strategy (approved in March 2022).
    - Sustainability Strategy (approved in January 2022)

Transformation: changing things that will make a difference

- Our longer-term strategic programme is transforming the way we work and provide treatment and care. We are improving the infrastructure (digital and built environment) required to support the people who use our services, their carers and staff, and we are implementing the priorities identified in the NHS Long Term Plan. Where required we have provided additional programme capacity which is now in place supporting the programmes to progress.
- Key areas of progress have been delivered in respect of the:

- Electronic patient record: has been procured and is now in the implementation stage and due for implementation in 2023
- Leaving Fulwood: we have sold our current headquarters at Fulwood House and the leases for the new sites at Distington House and Centre Court were signed in March 2022 with the move planned for summer 2022
- Leadership development project: has been developed and launched as part of a broader suite of leadership development support plans.

Partnerships: Working together to have a bigger impact

We continue to work collaboratively across the Sheffield health and social care system, particularly within the Sheffield Accountable Care Partnership (ACP). This has been an important area of focus for the Trust as we continue to develop city wide plans that respond to the needs of local people, the shared transformation agendas and the developing financial environment as we recover from COVID-19.

Key areas of focus have been:

- Addressing access challenges: Partnerships with the Voluntary, Community and Social Enterprise (VCSE) sector have been explored and are progressing. Capacity for signposting, follow on and follow up support from the VCSE has been commissioned to support the Single Point of Access and Emotional Wellbeing Service pathway, as well as access and waiting list challenges.
- Supporting integrated approaches: Close work with NHS Sheffield Clinical Commissioning Group (CCG), Sheffield City Council and the private landlord sector has progressed to scope and identify opportunities for service accommodation solutions. This supports several Transformation Programme priorities (Leaving Fulwood, community facilities and Community Mental Health Teams) and our growth plans in line with NHS Long Term Plan projections (Improving Access to Psychological Therapies) and our Estates Strategy.
- Social care developments: A clear change and governance structure is in place and being mobilised between the Trust and Sheffield City Council to ensure the required changes for the future access to and provision of social care assessment and care management.
- A strong focus on staff engagement has strengthened our working together through our Joint Consultative Forum and our five staff network groups. We continue to build and extend our approach to engaging and co-producing plans with our staff.

2.2.2 Our Performance Framework

The Board has a robust framework in place to assure itself, our Council of Governors and external regulators that our services are performing well, are high quality and that we are providing the best possible treatment and care to our service users and their carers within the resources available to us.

We also want to assure ourselves that we are making good progress towards delivering our vision and implementing our strategies and plans.

The set of key performance indicators (KPIs) which comprise our Performance Framework is reviewed and set each year considering any changes in local, national, contractual and regulatory requirements.

These are then presented to the Board committees for approval. That list can be varied in-year as required with the approval of the committees.

The Integrated Performance and Quality Report (IPQR) is provided to the Finance and Performance and the Quality Assurance Committees every month. It is also considered by People Committee with a specific focus on people at its bi-monthly meetings. It is reported to the Trust Board for assurance together with a summary of the key messages, risks and exceptions, discussed at each respective committee.

We examine a range of indicators that are either set for us contractually by commissioners, or because we have set ourselves an ambition to achieve or improve the services we deliver.

In 2021/22 there were deliverables from the NHS Long Term Plan which we continued to monitor ourselves against, even though we were not performance managed as part of our contracts with NHS Sheffield Clinical Commissioning Group because of the ongoing COVID-19 pandemic.

The key metrics and our performance is laid out below.

Measure Name	Target 21/22	Internally Reported Performance 2021/22	Reported Performance 2020/21
Total access to IAPT services	14,782	13,999	11,295
IAPT Recovery Rate	50%	50.10%	40.2%
IAPT Waiting Times (6 weeks)	75%	97.40%	91.1%
IAPT Waiting Times (18 weeks)	95%	99.80%	99.3%
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	0	5,556	5,810
Inpatient admissions for people who have had no previous contact with community mental health services	Not reported internally 2021/22. Captured in Annual benchmarking data. 20/21 reported 4.8% compared to the national average of 11.7%		
Adult mental health inpatients receiving a follow up within 72 hours of discharge	80%	78.50%	78.60%
First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral	60%	57%	70%
*Mental Health Services Dataset - Data Quality Maturity Index score	80%	*88.7%	89.7%

*As at January 2022 Data Quality Maturity Index score for the Trust was 88.7%, made up of three data quality scores for submissions to Community Services Dataset (CSDS) 69%, Mental Health Services Dataset (MHSDS) 94% and IAPT Dataset 99%.

Alongside ensuring we continue to progress these important issues, we also routinely look at demand, activity, quality and safety and workforce indicators in the IPQR.

You can take a look at the Trust's monthly IPQR reports at www.shsc.nhs.uk/about-us/board-directors/meeting-minutes-and-agendas

2.2.3 Capacity to handle risk

Effective risk management ensures that we can manage all key risks, clinical and non-clinical, providing confidence that we will achieve its objectives.

The Board of Directors has overall responsibility for:

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

Over the last year we have reviewed and made substantial changes to improve and strengthen our governance arrangements as part of our well-led development plan. Our focus has been to ensure all parts of our organisation are better aware of the quality, safety and effectiveness of the care we provide and that the right decisions are taken by the right people, at the right time, to maintain and improve quality.

The Board of Directors, the executive team and senior leadership of the Trust have clear lines of accountability and a renewed focus on supporting our staff to deliver the best care they can. We now have a clear and consistent approach to reviewing how we perform, responding to new challenges and ensuring that our improvement plans are delivered.

This is delivered through the following governance systems:

- **Board committees** – Our Board committee structure ensures Board oversight of performance and delivery of our plans in respect of quality, people, risks, transformation and finance.
- **Performance reviews** – All operational services have a consistent and established integrated performance and quality review framework that ensures day-to-day performance is reviewed. The executive team reviews performance of all departments periodically through the year.
- **Clear improvement priorities** – Priorities have been developed, agreed and are represented in our delivery plans. These priorities will ensure clarity of purpose and that each improvement priority has a defined timeframe, milestones and agreed measurements to ensure we can understand the progress made, outcomes delivered and agreed governance oversight.
- **Managing risks to the delivery of safe and effective services** – The Board Assurance Framework, alongside our corporate and service level risk registers ensure risks are identified, escalated and managed effectively.
- **Ensuring the delivery of our plan** – We have put in place robust arrangements to track progress against our Annual Operational Plan on a monthly basis and report progress against the plan to our Finance and

Performance Committee. Our monitoring arrangements are also explicitly linked to the Board Assurance Framework. We will keep this plan under review and take corrective action where required.

2.2.4 Challenges we face

As we come to the end of 2021/22, we naturally turn our attention to the next year. Our strategic direction, Clinical and Social Care Strategy and our eight aligned enabling strategies will be supported by clear implantation plans. The plan has also taken account of our key challenges which are reflected below:

- **The systemic inequality that exists and harms people in our communities** will be challenged further by the economic downturn anticipated post COVID-19 and the mental health impact of the virus. This will disproportionately affect the socially disadvantaged and people from ethnically diverse communities within Sheffield. We have an important role to play in helping Sheffield's recovery and we will monitor levels of need and resources required.
- **Demand for services is forecasted to increase** in the near to medium term as COVID-19 becomes more controlled through the UK vaccination programme and the socio-economic consequences of the last two years continue to emerge compounding pre-existing levels of inequality across Sheffield. We have developed demand, capacity and workforce plans to respond to the recovery phase.
- **It has been a very challenging two years** for the people who use our services, their carers and our staff. We must expand services to deliver on our strategy and the NHS Long Term Plan. We need to develop and expand our workforce with more and different roles, improve our succession planning and work closely with partner services to deliver integrated care. Should staff turnover due to retirees exceed the number of new people joining us, then we will have insufficient staff to meet demand.
- **Ensuring integrated care** for the people who use our services, and their carers has been a core feature of the way we deliver care. New arrangements are being introduced in 2022/23 by Sheffield City Council for the future provision of social care support and assessment and care management. We need to ensure these arrangements support our staff to deliver accessible, timely and integrated care for the people of Sheffield, with minimum added bureaucracy for individuals and our staff, and alignment with our transformation plans for crisis and community mental health services.
- **Financial constraints** will have an impact on our capacity to expand our workforce to extend services and to invest in our improvement priorities. There remains uncertainty over the new funding we can expect over the next period, and our efficiency requirements to support the delivery of our plans will be very challenging. We have worked closely with our partners and commissioners at Sheffield Place and the South Yorkshire and Bassetlaw

Integrated Care System to agree the priorities in 2022/23 and then 2023/24 and 2024/25.

2.2.5 How will we continue to make improvements

Our strategy is based on our values and the recovery principle, delivering care that is person-centred, strengths-based, evidence-led and trauma-informed, increasing quality and reducing inequality.

We will deliver our strategic priorities for 2022/23 through well-structured improvement plans which engage staff and have a clear reporting framework, with executive and Board oversight.

Our plans will focus on:

- **Addressing inequalities for our service users and our staff:** We will ensure all our plans take the necessary actions to improve access, experience and outcomes and contribute directly to reducing inequalities. Alongside the Core20PLUS5 programme we will focus on:
    - Restoring services inclusively
    - Mitigating against digital exclusion
    - Ensure datasets are complete and timely
    - Accelerating preventative programmes, particularly focussing on physical health checks, smoking cessation, better hospital food and early intervention
    - Strengthening leadership and accountability.
- **Improvement through co-production:** Continue to strengthen our approach to improvement and development with clear patient centred, co-produced approaches underpinning the work of each member of staff, our teams, and the Board of Directors.
- **Information driven decision making:** Use information effectively to underpin our approach and the decisions we make. We will continue to develop our Performance Framework. We will triangulate insights from patient and staff stories and feedback, performance and benchmarking data across patient,

workforce and financial metrics and outcomes and learning from improvement action already taken.

- **Staff wellbeing and effective leadership:** Focus on staff wellbeing, improve staff experience, and develop our leadership skills at all levels of our organisation.
- **Ways of working:** Build our culture and ways of working so that everyone can contribute, and we all take responsibility for improving the care we provide and ensuring safe and effective care is delivered. Effective co-production will underpin our approach.

The South Yorkshire Integrated Care System (ICS) will be formally established in 2022/23. We will continue to develop our partnership approaches to support the delivery of our plans and system plans in local neighbourhoods and Primary Care Networks, across Sheffield and South Yorkshire. We will continue to develop shared approaches with our local voluntary, community and social enterprise partners and our health and social care and academic partners

All teams and services have agreed their business plans for 2022/23. This has informed and shaped the following key deliverables for the next year. These key deliverables support our strategic priorities and respond to our key challenges and are outlined below.

2.2.6 Going concern

After making enquiries, the directors have a reasonable expectation that the services provided by the 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**.**

2.2.7 Social, community and human rights

We are committed to working with and within the local communities where we provide services

As an NHS Foundation Trust, we are directly accountable to the local communities across Sheffield through our membership as represented by the Council of Governors.

We hold an annual members meeting where people can raise topics with us.

We work closely with the commissioners of our services at NHS Sheffield Clinical Commissioning Group, Sheffield City Council and NHS England. As well as our local partners in Sheffield, for example South Yorkshire Police through our 136 Suite and Liaison Service, and South Yorkshire Housing Association as part of the work they do in partnership with our Community Enhancing Recovery Team (CERT).

We are committed to working for equality and fairness in employment and in service delivery, and not to discriminate on the grounds of age, disability, race, nationality, ethnic or national origin, sex, gender, marital or family status, domestic

circumstances, religious belief or similar philosophical belief, sexual orientation, social and employment status, HIV status, physical appearance, gender reassignment or trade union membership.

We deliver our commitment to human rights through our Equality Objectives, our Workforce Disability Equality Standard and our Workforce Race Equality Standard. Progress is recorded in our Equality and Human Rights Annual Report, available separately, and through regular reports to the Board of Directors (see our Equality Report in Section 3.8).

2.2.8 Any important events since the end of the financial year affecting the Foundation Trust

At the time of finalising this annual report there are no important events that have happened between March 2022 and the report being issued in June 2022.

2.2.9 Details of any overseas operations

The Trust had no overseas operations during 2021/22 in respect of the provision of healthcare services.

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

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

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

2.2.10 Closing statement

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

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

Section 3.0 Accountability Report

3.1 Directors Report

3.1.1 The Board of Directors

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

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

Sharon Mays was appointed as Chair in October 2021, replacing Mike Potts. Dr Olayinka Fadahunsi-Oluwole was appointed as a Non-Executive Director in June 2021. Sandie Keene, Non-Executive Director left the Trust in December 2021 and recruitment is underway for the vacant post.

An interim Director of Corporate Governance (Susan Rudd) was appointed in November 2021 as David Walsh left the Trust in October 2021. Deborah Lawrenson has been appointed as Director of Corporate Governance with effect from April 2022.

The Board comprises Executive Directors, Non-Executive Directors and Directors who sit on the Board in a non-voting capacity.

At the end of 2021/22, the Board of Directors comprised five voting Non-Executive directors including the Chair, one non-voting Associate Non-Executive Director, five voting Executive Directors including the Chief Executive and two non-voting directors, including the Director of Corporate Governance/Board Secretary and Director of Strategy.

3.1.2 The Non-Executive Team

- Sharon Mays (Chair)
- Richard Mills (Vice-Chair)
- Anne Dray (Senior Independent Director)
- Heather Smith
- Dr Olayinka Fadahunsi-Oluwole
- Professor Brendan Stone (Associate – non-voting)

3.1.3 The Executive Team

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

3.1.4 Non-voting directors

- Susan Rudd (interim Director of Corporate Governance and Board Secretary)
- Pat Keeling, (Director of Strategy)

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

3.1.5 Directors' statement as to disclosure to the auditors

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

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

3.1.6 Accounting policies statement

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

3.1.7 Our auditors

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

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

3.1.8 The role of the Board of Directors

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

The Board is responsible for:

- Directing and supervising the organisation's affairs
- Providing proactive leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed
- Setting the Trust's strategic aims and ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives

- Overseeing the organisation's progress towards attaining its strategic goals
- Monitoring the operational performance of the organisation
- Promoting the success of the organisation so as to maximise the benefits for the members as a whole and for the public.

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

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

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

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

During 2021/22, the Board met every month. Open Board of Directors meetings were held in public and were open (in part) to members of the public and the press via livestreaming in November 2021, December 2021, January 2022 and March 2022. Elements of the Board's business that are of a confidential nature or commercially sensitive are transacted in private and the Board has been open about the need to do this.

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

3.1.9 Attendance at Board of Directors meetings

A full list of all the directors who have served on the Board during 2021/22, including their attendance at the Board's meetings, is set out below.

Board members with voting rights

Name	Position	Term	Attendance
Mike Potts	Chair	In role from 01 August 2020 until 30 September 2021	6/6
Sharon Mays	Chair	In role from 01 October 2021 to 31 March 2023	5/6
Richard Mills	Non-Executive Director	Second term commenced 01 August 2019 running to 30 November 2023.	11/12
Sandie Keene CBE	Non-Executive Director/ Senior Independent Director	Left role 31 December 2021	9/9
Heather Smith	Non-Executive Director	Four-year term ending 31 July 2023	12/12
Anne Dray	Non-Executive Director/ Senior Independent Director	Joined 01 November 2020. Four year term ending 31 October 2024	11/12
Dr Olayinka Fadahunsi-Oluwole	Non-Executive Director	Joined June 2021, term ending 31 May 2024	9/10
Jan Ditheridge	Chief Executive	N/A	12/12
Beverley Murphy	Executive Director of Nursing, Professions and Operations and Deputy Chief Executive	N/A	12/12
Phillip Easthope	Executive Director of Finance	N/A	12/12
Mike Hunter	Executive Medical Director	N/A	11/12
Caroline Parry	Executive Director of People	N/A	11/12

Non-voting capacity or associates in attendance

Name	Position	Term	Attendance
Professor Brendan Stone	Associate Non-Executive Director	Four-year term ending 31 July 2023	9/12
Pat Keeling	Director of Strategy	Interim role (Director of Special Projects from 7 December 2020) Substantive role (Director of Strategy) 1 February 2022.	12/12
David Walsh	Director of Corporate Governance (Board Secretary)	Left role October 2021	5/6
Susan Rudd	Interim Director of Corporate Governance (Board Secretary)	Joined 4 November 2021	5/5

3.1.10 The Management Team

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

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

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

3.1.11 Board Committees

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

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

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

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

The Mental Health Legislation Committee is an assurance Committee for matters of statutory and regulatory compliance in respect of Mental Health and Human Rights Legislation.

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

3.1.11.1 Audit and Risk Committee

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

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

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

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

The committee's meetings are attended, in accordance with the agenda, by the internal and external auditors, local counter fraud specialist, the Trust's Executive Directors, the Director of Corporate Governance, Head of Clinical Governance and Deputy Director of Finance. Other directors and senior managers attend when invited by the committee. The Chief Executive attended the meeting at which the annual accounts are presented.

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

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

The committee has met on six occasions during 2021/22 and discharged its responsibilities as set out in the terms of reference. Details of members' attendance at its meetings are as shown in the table below:

Name	Position	Number of meetings attended
Anne Dray	Committee Chair and Non-Executive Director	6/6
Sandie Keene	Non-Executive Director (left role 31 December 2021)	5/5
Richard Mills	Non-Executive Director	6/6

3.1.11.1.1 Significant issues considered by the committee

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

Significant activity considered by the committee during 2021/22 included:

- Annual Accounts
- Annual Report
- Annual Governance Statement
- Head of Internal Audit Opinion
- External Audit Opinion and annual reporting
- Counter-Fraud, Bribery and Corruption Annual Report
- Self-Certification of compliance with licence conditions
- Losses and Special Payments Annual Report
- Annual Reports for other committees
- Receipt of Register of Interests, Gifts and Hospitality
- Annual committee self-assessment
- Regular reporting from 360 Assurance (internal audit), including the annual Audit Plan and KPMG (external audit).
- Regular reporting and monitoring of the Board Assurance Framework and Corporate Risk Register
- Freedom to Speak Up quarterly reporting
- Reporting on Information Governance and security breaches
- Emergency planning and preparedness, including EPRR compliance

- Policy governance – including the both the ratification of policy approvals within the committee's area of responsibility and the approval of the Policy Framework

3.1.11.1.2 External Audit

For the financial year ending 2021/22, the Trust's external audit function was carried out by KPMG.

The statutory fee for the 2021/22 audit was £97, 378 including VAT.

The effectiveness of the external audit function is assessed annually by the members of the Audit and Risk Committee utilising the methodology provided for such an evaluation by the The Audit Committee Institute. For 2021/22 this was carried out as part of a self-assessment questionnaire of members.

KPMG has carried out no other services for the Trust during the financial year 2021/22.

3.1.11.1.3 Internal Audit

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

The internal audit plan was developed through discussion with members of the Audit and Risk Committee, the executive team and other directors and a review of the Board Assurance Framework to identify a range of key risks, including those affecting the health sector generally. Reviews were identified across a range of areas including financial management, information management and technology, performance, clinical quality, people management and governance and risk.

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

The Audit and Risk Committee reviewed the performance and value for money of the internal audit function during 2021/22.

3.1.11.2 Remuneration and Nomination Committee

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

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

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

3.1.12 Executive and Non-Executive Directors' qualifications and experience

Sharon Mays, Chair

Sharon joined the Trust as Chair on 1 October 2021. Prior to her appointment Sharon had been Chair at Humber Teaching NHS Foundation Trust for seven years and has been a non-executive director on the boards of NHS organisations since 2006.

During her tenure as Chair of Humber Teaching NHS Foundation Trust, the organisation improved its overall Care Quality Commission (CQC) rating from 'requires improvement' to 'good', gained national recognition for its work on patient and carer experience, and in 2019 won the Health Service Journal Mental Health Provider of the Year award.

Sharon has previously been a member of the joint independent audit and integrated governance committee for the Police and Crime Commissioner for Humberside and Humberside Police Force. Prior to becoming Chair at Humber Teaching NHS Foundation Trust, she was also independent person for standards investigations at East Riding of Yorkshire Council.

Sharon is a commercial lawyer by profession.

Tenure of Office

1 October 2021 to 31 March 2023

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

Richard has more than 40 years senior management experience in the NHS, charitable, independent and public sector organisations, including Board level positions in NHS organisations.
Richard was an NHS manager and director from 1978-2012, working in London and Thames Valley area at Hospital, Health Authority and Primary Care Trust levels.

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

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

Tenure of office

1 December 2015 to 30 November 2018, extended to July 2019. Second term of office commenced on 1 August 2019 and will run to 30 November 2023.

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

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

Since retirement Heather has undertaken advisory and coaching support work with colleges around the country, as well as working on a voluntary basis with a local organisation which is focussed on reducing food waste and promoting sustainability. Heather's work in education has many links with the goals of the Trust. One of her early management roles was the introduction of pathways to employment and 35 apprenticeships with the NHS in Sheffield, a project which gained several national awards and still exists today. She is a passionate supporter of the need for city-wide organisations to work together collaboratively in order to improve lives and promote social justice and equality.

Heather's interest and expertise lies in organisational development and transition, culture change and improvement management. Heather is a member of the Quality Assurance Committee and is currently the interim Chair of that committee.

Tenure of office

1 August 2019 to 31 July 2023

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

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

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

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

Tenure of office

1 November 2020 to 31 October 2024.

Dr Olayinka Fadahunsi-Oluwole
(Chair of the Mental Health Legislation Committee)

Olayinka has lived in Sheffield since 2017, working at Sheffield Children's Hospital NHS Foundation Trust as a Specialty Doctor in Community Paediatrics and Neurodisability. Her other roles included Clinical Audit Lead for Community Paediatrics, Neurodisability and Looked After and Adoptive Children's Health services, member of the Rapid Review of Guidelines sub-committee of the Clinical Audit and Effectiveness Committee. She is also a Governor for doctors and dentists at Sheffield Children's Hospital NHS Foundation Trust. Olayinka is a member of our Ethnically Diverse Staff Network Group and believes in diversity of race, religion, sex, gender, sexual orientation and culture should be celebrated and respected with equal opportunities for all.

Olayinka also attends the Quality Assurance and Finance and Performance committees.

Tenure of office

1 June 2021 to 31 May 2024

Jan Ditheridge, Chief Executive

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

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

Phillip Easthope, Executive Director of Finance

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

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

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

Dr Mike Hunter, Executive Medical Director

Mike was appointed as the Trust's Executive Medical Director in October 2016. He has been a Consultant Psychiatrist for many years and was previously Clinical Director of Acute and Inpatient Services and Community Services at the Trust. His responsibilities include quality improvement, patient safety, clinical governance, medical leadership, medical education and service user engagement.

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

Beverley Murphy, Executive Director of Nursing, Professions and Operations and Deputy Chief Executive

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

On 30 July 2020 she was seconded as our Executive Director of Nursing and Professions and was appointed to the substantive role of Executive Director of Nursing, Professions and Operations and Deputy Chief Executive on 1 April 2021.

Beverley has worked as a Mental Health Nurse for over 37 years and has held a range of senior nursing and quality governance roles across the NHS. This is Beverley's fourth executive position in the NHS.

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

Caroline Parry, Executive Director of People

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

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

Pat Keeling, Director of Strategy

Pat was appointed to the role of Director of Strategy on a permanent basis in January 2022. Prior to this Pat had been working with the Trust since December 2020 as Director of Special Projects and played a key role in developing our Strategic Direction, Estates Strategy, and leading our broader strategy development and transformation programme.

She has previously held a variety of senior roles within the NHS including at Surrey and Borders Partnership NHS Foundation Trust and has worked latterly in strategic change and transformation roles at Brighton University Hospital NHS Trust and the Royal Cornwall Hospitals NHS Trust.

Susan Rudd, Interim Director of Corporate Governance (Board Secretary)

Susan held the interim role between November 2021 and April 2022 following the departure of the former Director of Corporate Governance, David Walsh.

3.1.13 Changes to the Board during the financial year

During 2021/22 two members of the Board stepped down from their roles.

Mike Potts stepped down from his interim role as Chair at the end of September 2021. Mike was appointed as our interim Chair for 12 months in August 2020.

After her four year term as a Non-Executive Director ended Sandie Keene CBE left the Trust in December 2021. Sandie was the Chair of our Quality Assurance Committee.

David Walsh left his role as Director of Corporate Governance/Board Secretary on 31 October 2021. The role was covered on an interim basis by Susan Rudd, with Deborah Lawrenson appointed to the role permanently in April 2022.

3.1.14 Directors' interests

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

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

3.1.15 Board evaluation

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

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

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

Appraisals took place for those Non-Executive Directors who had been in post throughout the year. The Council of Governors and Board members were individually invited to comment on the performance of each Non-Executive Director. This information was part of the appraisal process led by the Trust Chair with support from the Lead Governor and a further governor member of the Nominations and Remuneration Committee. In addition, appraisal of the Trust Chair took place led by the Senior Independent Director and supported by the Lead Governor and a stakeholder governor. Guidance published by NHS England and NHS Improvement in September 2019 on the appraisal of NHS Chairs was adopted. All Governors, Board members and external stakeholders were invited to provide feedback on the Chair's performance which fed into the appraisal process.

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

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

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

3.1.16 Keeping informed of the views of governors and members

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

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

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

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

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

The Council of Governors also has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties. The Council of Governors did not exercise these powers during 2021/22.

3.1.17 NHS Improvement's well-led framework

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

3.1.18 Leadership capacity and capability

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

The Trust has a clear policy for the appraisal of its staff and monitoring of the appraisal of senior leaders within the organisation. Personal Development Review (PDR) rates are reported to the People Committee to oversee compliance. There is a clear leadership, accountability and governance structure within the organisation and through this assurance on quality and safety of the operational clinical services is provided to the Quality Assurance Committee.

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

Our strategic objectives enable us to achieve our vision. The business plan to deliver our strategic direction is refreshed each year and takes into account changes to the internal and external environment and the views of stakeholders. Through this process, strategic priorities, including quality priorities are identified and agreed. Any risks to the delivery of strategic objectives are recorded in the Trust Board Assurance Framework which is reviewed quarterly by the Board and by Board committees.

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

3.1.20 Culture of high quality, sustainable care

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

We endeavour to underpin all we do through the application of our values of working together (for service users), respect and kindness, everyone counts, commitment to quality and improving lives. We employ values-based recruitment for all staff and our Quality Improvement and Assurance Strategy supports a philosophy of continuous improvement and a model of co-production with our service users in the design and delivery of services.

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

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

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

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

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

3.1.22 Clear process to manage risk, issues and performance

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

In year, our internal auditors continued to audit our strategic governance processes, providing significant assurance. The Risk Management Strategy was approved by Board in May 2021.

3.1.23 Appropriate and accurate information being effectively processes, challenged and acted upon

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

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

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

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

- our Council of Governors
- engagement with our membership
- the work of our Engagement and Experience Team
- Microsystem (a methodology used to make quality improvements)
- formal consultations on service reconfigurations and change when required
- national patient survey
- Care Opinion
- quality of experience questionnaire
- Friends and Family Test
- our involvement in the South Yorkshire and Bassetlaw Integrated Care System
- our partnerships with commissioners
- membership and participation in local partnership boards
- membership and participation in local safeguarding boards
- engagement with Healthwatch Sheffield
- staff network groups
- Sheffield Flourish

Foundation Trust status enables us to engage governors and members, who represent the communities that we serve, in the development of our services and the improvement of care. You can find more detail on our approach to well-led services in the Annual Governance Statement in Section 3.7

3.1.25 Working with commissioners, partners and stakeholders

3.1.25.1 Our commissioners

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

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

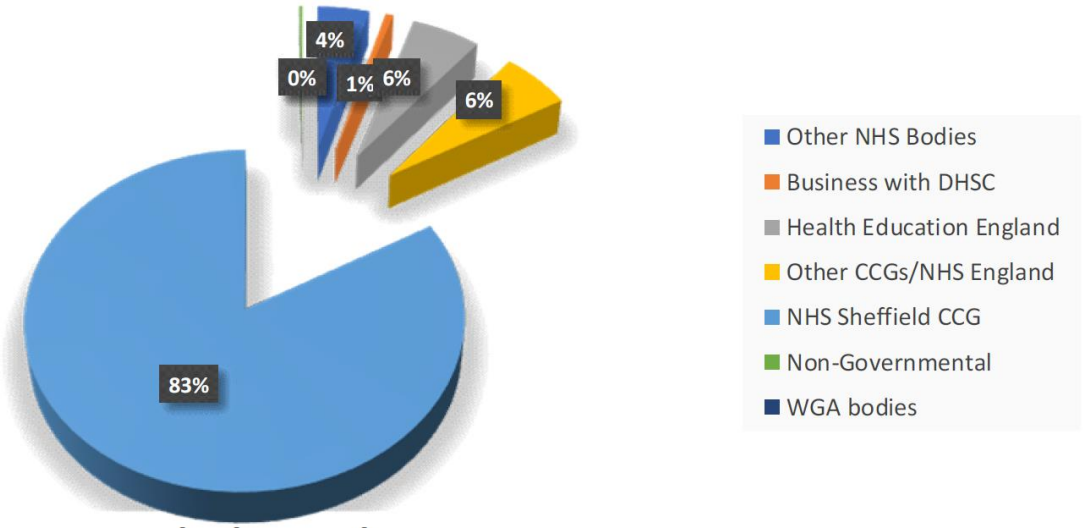
NHS England and NHS Clinical Commissioning Groups commission education, training, research and development from us.

3.1.25.2 How we work with our partners

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

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

3.1.26 Total income by commissioner



3.1.27 Consultations

3.1.27.1 Formal consultations we have completed

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

3.1.27.2 Formal consultations we have in progress

At the time of confirming this report there were no formal consultations in progress. However, we expect a formal consultation to be led by Sheffield City Council in the 2022/23 financial year on the future of social care provision in the city.

3.1.28 Council of Governors

3.1.28.1 The role of the Council of Governors

Governors play a vital role in governance arrangements of the Trust. They primarily carry out their role through the meetings of the Council of Governors of which there were seven in 2021/22. There are additional meetings put in place as required through engagement with constituencies.

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

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

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

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

- Holding the Non-Executive Directors both individually and collectively to account for the performance of the Board of Directors

- Holding the Board of Directors to account for the effective management and delivery of the organisation's strategic aims and objectives

- To be consulted by Directors on future plans, including any significant changes to the delivery of the Trust's business plan, and offer comment on those plans

- Receiving the annual accounts, any auditor report regarding the accounts, and annual report

- Deciding whether any private patient work undertaken by the Trust would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England, or performing the Trust's other functions

- Approving any proposed increases in non-NHS income of 5% or more in any financial year. Approval means that at least half of the Governors taking part in the vote agree with the increase

- Approving 'significant transactions'

- Approving an application by the Trust to enter into a merger, acquisition, separation or dissolution. In this case, approval means at least half the Governors taking part in the vote agree with the amendments

- Approving amendments to the Constitution

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

- Contributing to discussions on strategic issues
- Monitoring the activities of the Trust with a view to ensuring these are being carried out in a manner that is consistent with the Trust's Constitution and its terms of authorisation
- Representing the interests of members and partner organisations
- Providing feedback to members

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

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

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

3.1.28.2 Composition of the Council of Governors

As at 31 March 2022 the Council of Governors comprised 44 seats, 33 of which are elected from the membership. 11 of these seats were vacant as at 31 March 2022. Governors are elected for a three-year term and can hold this position for a total of three terms. 11 of the seats are for appointed Governors. These positions have a three-year term.

The Council of Governors was chaired by Mike Potts from April 2021 until 30 September 2021. From 1 October 2021 the Council of Governors is chaired by Sharon Mays who is also the Chair of the Board of Directors. It is the Chair's responsibility to ensure that Governors' views are represented at the Board of Directors and that information from the Board is fed back to the Council. The Chair fulfils this responsibility through regular communication with Governors as well as providing updates at each Council meeting. The Chair also gives Governors the opportunity to meet on a one-to-one basis.

It is a requirement of the regulator, NHS Improvement, that all Foundation Trusts have a Lead Governor. On 12 December 2019 Terry Proudfoot was elected as the Lead Governor with effect from 1 January 2020. In December 2021 the Council of Governors agreed, in a closed session, to defer election of the Lead Governor role and extend the term of the current Lead Governor to 30 June 2022 (end of Governor term).

Seven Council of Governors meetings took place during 2021/22 which included one extraordinary meeting. The individual attendance of each Governor is shown in the table below which also shows a breakdown of seats on the Council and associated Governors throughout the year, including their term of office.

Table 1

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Chris Digman	Public South East	Elected	01.08.2020	31.07.2023	5/7
Angela Barney	Public South West	Elected	01.07.2018	30.06.2021	2/2
Julie Kitlowski	Public South West	Elected	01.08.2021	31.07.2024	2/5
Ben Duke	Public South West	Elected	01.08.2020	31.07.2023	7/7
Steve Hible	Public North East	Elected	01.07.2019	30.06.2022	6/7
Ahmed Ibrahim	Public North East	Elected	01.07.2019	30.06.2022	1/7
Sylvia Hartley	Public North West	Elected	01.08.2020	31.07.2023	4/7
Margaret Spencer	Public North West	Elected	09.08.2019	08.08.22 (Resigned)	1/5
Adam Butcher	Service User	Elected	01.07.2016	30.06.2022	6/7
Nev Wheeler OBE	Service User	Elected	01.09.2020	31.08.2023	6/7
Nicola Hodson	Service User	Elected	01.08.21	31.07.2024	2/5
Lee Coxon	Service User	Elected	01.07.2018	30.06.2021	0/2
Jonathan Hall	Service User	Elected	01.07.2019	30.06.2022	6/7
Nick Hall	Service User	Elected	01.07.2018	30.06.2021	1/2
Rebecca Lawlor	Service User	Elected	01.09.2020	31.08.2023	5/7
Terry Proudfoot	Service User	Elected	01.07.2016	30.06.2022	7/7
Kate Steele	Service User	Elected	01.07.2018	30.06.2021	1/2
Joan Toy	Service User	Elected	01.07.2016	30.06.2022	1/7
Billie Critchlow	Carer	Elected	01.07.2016	30.06.2022	7/7
Liz Friend	Carer	Elected	01.07.2019	30.06.2022	3/7

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Sue Roe	Carer	Elected	01.07.2013	30.06.2022	4/7
Varria Russell-White	Carer	Elected	01.07.2019	30.06.2022 (resigned)	0/1
Natasha Wilson	Young Service User/Carer	Elected	01.08.2020	31.07.2023 (resigned)	0/3
Mark Goodwin	Staff Social Work	Elected	05.07.2019	04.07.2022	3/7
Liz Carthy	Staff Psychology	Elected	01.07.2018	30.06.2021	1/2
Catherine Draper	Staff Psychology	Elected	01.08.2021	30.06.2022	4/4
Julian Davis	Staff Nursing	Elected	01.07.2019	30.06.2022	2/4
Dr Nusrat Mir	Staff Medical	Elected	01.07.2018	30.06.2021	0/2
Adam Rodgers	Staff Clinical Support	Elected	01.08.2020	31.07.2023 (term ended)	0/5
Bradley Wass	Staff Central Support	Elected	01.07.2019	30.06.2022	3/7
Vyvyan Hopkinson	Allied Health Professionals	Elected	01.08.21	31.07.2024	0/4
Cllr Adam Hurst	Appointed – Local Authority	Appointed	05.09.2014	04.09.2023 (Term ended April 2021)	0/2
Cllr Josie Paszek	Appointed – Local Authority	Appointed	04.02.21	03.02.2024	2/7
Cllr Steve Ayris	Appointed – Local Authority	Appointed	10.09.2021	09.09.2023	3/7
Fay Colphon	Appointed – SACMHA	Appointed	24.04.2018	23.04.2021 (Term ended April 2021)	1/1
Celia Jackson-Chambers	Appointed – SACMHA	Appointed	01.05.2021	30.04.2024	4/6
Muhammad Ali	Appointed – PMC	Appointed	24.01.2020	23.01.2023	0/7

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Dave Swindlehurst	Sheffield MENCAP	Appointed	01.07.2020	30.06.2023	6/7
James Barlow	Appointed – Sheffield Carers Centre	Appointed	22.01.2022	21.01.2025	3/7
Mark Gamsu	Appointed – NHS Sheffield CCG	Appointed	15.05.2020	14.05.2023	4/7
Scott Weich	Appointed – University of Sheffield	Appointed	03.09.20	02.09.2023	7/7
Julie Marsland	Staff Side	Appointed	01.07.2020	30.06.2023	5/7
Susan Wakefield	Appointed – Sheffield Hallam University	Appointed	08.09.2016	07.09.2022	5/7

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

Table 2

Name	Title	Total
Mike Potts	Trust Chair	3/3
Sharon Mays	Trust Chair	4/4
Richard Mills	Non-Executive Director and Vice Chair	7/7
Sandie Keene CBE	Non-Executive Director and Senior Independent Director	5/5
Anne Dray	Non-Executive Director	5/7
Heather Smith	Non-Executive Director	7/7
Dr Olayinka Fadahunsi-Oluwole	Non-Executive Director	4/6
Professor Brendan Stone	Associate Non-Executive Director	4/7
Jan Ditheridge	Chief Executive	4/6
Phillip Easthope	Executive Director of Finance	0/6
Dr Mike Hunter	Executive Medical Director	2/6
Beverley Murphy	Executive Director of Nursing, Professions and Operations	2/6
Caroline Parry	Executive Director of People	3/7
David Walsh	Director of Corporate Governance	4/4
Susan Rudd	Director of Corporate Governance	3/3
Pat Keeling	Director of Strategy	5/6

*Executive Directors attend meetings to present papers as and when needed and attendance at all meetings is not a requirement of them.

3.1.28.3 Changes to the Council of Governors

In 2021/22 elections were held for 12 vacancies in nine constituencies. Further elections are planned to take place in 2022/23.

Constituency	Number of candidates	Successful candidates	Declarationdate	Term start date
Public Sheffield South East	1	0	25.06.21	N/A
Public Sheffield South West	1	Julie Kitlowski	25.06.21	01.08.21
Public Rest of England	1	0	25.06.21	N/A
Service Users	4	Nicola Hodson	25.06.21	01.08.21
Young Service User/Carer	1	0	25.06.21	N/A
Staff – AHP	1	Vyvyan Hopkinson	25.06.21	01.08.21
Staff – Clinical Support	1	0	25.06.21	N/A
Staff – Medical and Clinical	1	0	25.06.21	N/A
Staff - Psychology	1	Catherine Draper	25.06.21	01.08.21

3.1.28.4 Governor activities in 2021/22

3.1.28.4.1 Holding to account

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

The foundation of their success is dependent upon their relationship with the Board. The Board takes specific steps to cement its relationship with the Council of Governors in addition to the action it takes throughout the year to ensure that it fully understands the views of Governors. In 2021/22 Non-Executive Directors continued to share significant issues from Board committees and providing assurance as to how they are being addressed.

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

According to the Health and Social Care Act 2012, it is the role of the Council of

Governors to ensure that the Trust operates within its terms of authorisation. The Trust must furnish governors with sufficient information to give assurance on the safety, quality and cost effectiveness of its services. This is undertaken through a variety of methods including performance reports to every Council meeting, annual reviews with the Board of Directors and through regular dialogue with Non-Executive Directors and opportunities to engage directly with the Chair.

3.1.28.4.2 Forward plans

Governor's views on the Trust's forward plans are sought each year along with the views of staff, service users and other stakeholders. A session took place with governors in June 2021 to seek views on the Trust's strategic direction which helped to shape the Trust's refreshed aims and objectives.

3.1.28.4.3 Other activities

In addition to their statutory duties, governors were involved in a number of other areas of the Trust:

- A new Governor Development programme
- Governor Development Workshop
- Rainbow Badge training
- Clinical and Social Care Strategy Workshop
- Promoting and Ensuring Equality, Diversity and Inclusion Workshop
- South Yorkshire and Bassetlaw Integrated Care System Workshop
- Raising the Profile of Carers Workshop
- Service User Engagement and Experience Workshop
- Human Rights Workshop
- Board sub-committee observations
- Chair drop-in sessions

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

3.1.28.4.4 The Nominations and Remuneration Committee of the Council of Governors

The appointment of the Trust Chair and other Non-Executive Directors is the responsibility of the Council of Governors. The process of selecting suitable candidates to be recommended for appointment by the Council is delegated to a committee of the Council of Governors known as the Nominations and Remuneration Committee (NRC). In addition, the NRC has responsibility for monitoring the performance evaluation of the Trust Chair and the Non-Executive Directors.

It is the responsibility of the Council of Governors to both appoint and remove Non-Executive Directors. Termination requires the approval of three-quarters of the

members of the whole Council of Governors pending a formal process involving a number of rigorous elements.

Over the past 12 months the committee has met five times: on 13 April 2021; 2 August 2021; 10 November 2021; 1 February 2022 and 16 February 2022.

The Trust Chair presides over the meetings except in circumstances where there would be a conflict of interest or regarding the appointment of the Trust Chair in which case the Reserve Chair, who is a member of the Council and Lead Governor presides. Attendance of the Nominations and Remuneration Committee members is shown in the table below.

Table 3

Name	Position	Attendance
Mike Potts	Chair (left 30 September 2021)	2/2
Sharon Mays	Chair (started 01 October 2021)	3/3
Sandie Keene	Non-Executive Director and Senior Independent Director (left 31 December 2021)	2/3
Anne Dray	Non-Executive Director and Senior Independent Director (from 1 January 2022)	2/2
Terry Proudfoot	Lead and Service User Governor	4/5
Ben Duke	Deputy Lead Governor	2/5
Adam Hurst	Appointed Member	2/2
Sylvia Hartley	Public Governor	3/5
Adam Butcher	Service User Governor	4/5
Billie Critchlow	Carer Governor	5/5
David Walsh	Director of Corporate Governance (left October 2021)	2/2
Susan Rudd	Director of Corporate Governance (from November 2021)	3/3

3.1.29 Membership

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

3.1.29.1 Constituencies, eligibility criteria and membership numbers

There are three elected membership constituencies, each of which has a number of classes within. The table details each one and its eligibility criteria where applicable, the number of members in class as at 31 March 2022.

Constituency	Class	Number of members	Criteria
Public	South West	2,601	Must live in the following electoral wards: Gleadless Valley, Dore and Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief and Greenhill or Crookes.
Public	South East	2,342	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton or Woodhouse.
Public	North West	1,954	Must live in the following electoral wards: Stocksbridge and Upper Don, Stannington, Hillsborough, Walkley, Broomhill or Central.
Public	North East	2,386	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen and Brightside.
Public	Rest of England	534	Any area within England outside of the Sheffield electoral wards.
Service user	Service user	923	Must have received a service or services from the Trust within the last five years.
Service user	Carer	602	Must have cared for someone who has received a service from the Trust in the last five years.
Service user	Young service user or carer	77	A service user or carer but must be 35 years old or younger.
Staff	Allied Health Professional	154	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term.
Staff	Central support	266	

Constituency	Class	Number of members	Criteria
Staff	Clinical support	99	Must have either worked for the Trust continuously for at least 12 months or have acontract of no fixed term.
Staff	Medical and clinical	164	
Staff	Nursing	546	
Staff	Psychology	256	
Staff	Social work	26	
Staff	Support work	386	
Appointed	Stakeholder organisation: PMC	N/A	N/A
Appointed	Stakeholder organisation: SACMHA Health and Social Care		
Appointed	Stakeholder Organisation x2		
Appointed	Local Councillors x 3		
Appointed	Staff Side		
Appointed	Sheffield Hallam University		
Appointed	University ofSheffield		
Appointed	NHS SheffieldCCG		

At the end of March 2022 there were 11,419 members (excluding staff).

3.1.29.2 Developing a representative membership

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

As well as defining the membership, this strategy outlines how we plan to:

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

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

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

3.1.29.3 Membership recruitment and engagement

In line with the Trust's membership strategy to both recruit and engage members from across Sheffield, governors and staff participate in several community events, specifically targeting ones in areas of the city with a high ethnicity and targeting specific groups such as people with a learning disability. This was halted in 2020 due to restrictions in place from COVID-19 which continued into 2021.

The Trust held a successful online Annual Members' Meeting in 2021 which was livestreamed – which attracted more than 150 views of the live stream. The event provided an opportunity for members to learn more about the Trust and its services. The Lead Governor presented a report on behalf of the Council of Governors, on their activities to members.

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

3.1.30 Political or charitable donations we have made

The Trust did not make any political or charitable donation during the year 2021/22

as it is not permitted under the governance of NHS Foundation Trusts to make such donations.

3.1.31 Cost allocation and charging guidance

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

3.1.32 Income disclosures

In 2021/22, we met the requirement that income from the provision of goods and services for the purposes of the Health Service in England must be greater than its income from the provision of goods and services for any other purposes as defined under section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). All net income from the provision of goods and services for other purposes has been reinvested back into healthcare for the benefit of service users.

3.1.33 The Better Payments Practice Code

Better Payments Practice Code target is to pay all non-NHS suppliers within 30 days of receipt of goods/services or a valid invoice unless different terms have been agreed in advance. This disclosure is based on total bills paid over the financial year and excludes invoices in dispute.

The Trust achieved 100% compliance for NHS entities throughout 2021/22 by both number and value. Due to the small number of NHS entities paid, percentage compliance for NHS bodies is unreliable and sometime erratic. Performance for non-NHS bodies was 98% for invoice numbers and 99% for invoice values. In 2020/21 the Trust signed up to the Prompt Payment Code administered by the Chartered Institute of Credit Management of behalf of the Department for Business Innovation and Skills.

Signatories undertake to pay suppliers within agreed credit terms, give clear guidance to suppliers and encourage good practice through supply chains. Signatories also undertake not to exceed a 60-day limit for payments and settling payment disputes. There is no liability or charge in 2021/22 resulting from late payments.

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

3.2 Remuneration Report

3.2.1 Annual statement on remuneration

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

- Executive Director pay
- Appointment of Executive Director of Nursing, Operations and Professions (effective from 1 April 2021)
- Appointment of Director of Corporate Governance
- Interim arrangements for Director of Corporate Governance
- Director of Strategy post
- Succession planning

No significant changes to existing levels of executive pay were made beyond national recommendations. A new post of Director of Strategy was established with pay taking into account national benchmarking and modelling. The establishment of this role reflected organisational changes linked to improvements being made in the leadership of the Trust.

Sharon Mays

Sharon Mays
Chair
Chair of Remuneration and Nomination Committee
Date: 29 June 2022

3.2.2 Executive Directors' remuneration

The Remuneration and Nominations Committee of the Board of Directors comprises the Non-Executive Directors. The committee is chaired by Sharon Mays, the Trust Chair. The committee is responsible for determining the remuneration and terms and conditions of service of the Executive Directors (including the Chief Executive) in order to ensure that they are properly rewarded having regard to the Trust's circumstances. The Chief Executive attends the committee's meetings by invitation in an advisory capacity. The Executive Director of People and the Director of Corporate Governance (Board Secretary) attend the committee's meetings to provide advice and professional support to its members. The committee met on two occasions during 2021/22 and members' attendance is as shown below:

Name	Position	Attendance
Mike Potts	Committee Chair and Trust Chair (to September 2021)	1/1
Sharon Mays	Committee Chair and Trust Chair (from October 2021)	1/1
Richard Mills	Vice-Chair and Non-Executive Director	2/2
Anne Dray	Non-Executive Director	1/2
Sandie Keene	Non-Executive Director (to December 2021)	1/1
Professor Brendan Stone	Associate Non-Executive Director	0/2
Heather Smith	Non-Executive Director	1/2
Dr Olayinka Fadahunsi-Oluwole	Non-Executive Director (from June 2021)	2/2

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

The committee is responsible for ensuring the Chief Executive and the Executives performance is monitored through the Trust appraisal process and taken into account if salary increase above national recommendations are being considered.

During 2021/22, the committee has delivered its key responsibilities as set out in the terms of reference, including:

- consideration of executive portfolios and executive appointments or exit arrangements, and remuneration thereof. This reflects the changes in staffing in the executive team, including the interim and substantive appointment of the Director of Corporate Governance and the appointment of a Director of Strategy.

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

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

Executive Director	**Date of substantive contract**
Jan Ditheridge	March 2020
Dr Mike Hunter	October 2016
Phillip Easthope	January 2016
Beverley Murphy	April 2021
Caroline Parry	January 2021
Pat Keeling (non-voting)	February 2022

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

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

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

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

with the salaries available to other staff. There is provision, on termination of the contract, for the payment of salary in lieu of outstanding leave.

Two members of the executive team attract a salary exceeding the £150,000 threshold warranting specific mention – these are the Chief Executive and the Executive Medical Director (this salary includes the medical consultant element of the role).

3.2.3 Non-Executive Directors' remuneration

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

It is the responsibility of the Council of Governors' Nominations and Remuneration Committee to ensure performance is monitored for the Chair and non-executive directors. The committee may, in appropriate cases, or, if specifically requested by the Council of Governors to do so, report its findings to the Council. Details of the activities of the Nominations and Remuneration Committee for the past year are reported on in Section 3.1.28.4.4 of this report.

Details of the remuneration paid to all of the Directors during 2021/22 are shown in Table A on the following page. The policies applied, and descriptions of these policies are included in Table B. The Non-Executive Directors' duration of office is reported in Section 3.1.9 of this report.

3.2.4 Directors' remuneration and pension entitlements

Executive directors are members of the NHS-defined benefit pension scheme managed by NHS Pension Authority. J Ditheridge is beyond the expected retirement age for the scheme.

Dr M Hunter re-joined the scheme in February 2022. Details are provided in the following tables.

Pension data for S Rudd was not available from Greenbury because of the length of her interim contract with the Trust. P Keeling opted out of the NHS Pension scheme on appointment to the Trust.

Table A – Salaries and allowances 2021/22

Name and title	Period 01.04.21 to 31.03.22							Period 01.04.20 to 31.03.21						
	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
M Potts, Chair (August 2020 – 31 September 2021)	20-25	-				-	20-25	25-30	-				-	25-30
S Mays, Chair (from 1 October 2021)	20-25	-				-	20-25							
R Mills, Non-Executive Director	10-15	-				-	10-15	10-15	-				-	10-15
S Keene CBE, Non-Executive Director (up to 31 December 2021)	10-15	-				-	10-15	10-15	-				-	10-15
H Smith, Non-Executive Director	10-15	-				-	10-15	10-15	-				-	10-15
A Dray, Non-Executive Director	10-15	-				-	10-15	5-10	-				-	5-10
Dr O Fadahunsi-Oluwole, Non-Executive Director (from 7 June 2021)	10-15	-				-	10-15							
Prof. B Stone, Associate Non-Executive Director	5-10	-				-	5-10	5-10	-				-	5-10

Name and title	Period 01.04.21 to 31.03.22							Period 01.04.20 to 31.03.21						
	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
J Ditheridge, Chief Executive	155-160	-				-	155-160	165-170	-				112.5-115.0	280-285
Dr M Hunter, Executive Medical Director	190-195	-	12,100			-	200-205	185-190	-	12,100			-	195-200
B Murphy, Executive Director of Nursing, Professions and Operations (from September 2020)	140-145	-				15-17.5	155-160	115-120	-				-	115-120
P Easthope, Executive Director of Finance, IMST and Facilities	120-125	-				32.5-35	155-160	120-125	-				22.5-25.0	145-150
C Parry, Executive Director of People	95-100	-				25-27.5	120-125	80-85	-				20.0-22.5	100-105
P Keeling, Director of Special Projects (from 01 February 2022)	15-20	-				-	15-20							
S Rudd, Interim Director of Corporate Governance (from 08 November 2021)	40-45	-				-	40-45							

Name and title	Period 01.04.21 to 31.03.22							Period 01.04.20 to 31.03.21						
	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary and Fees (bands of £5,000) £'000	Other Remuneration (bands of £5,000) £'000	Taxable Benefits (rounded to the nearest £100) £	Annual Performance Related Bonuses (bands of £5,000) £'000	Long Term Performance Report Bonuses (bands of £5,000) £'000	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
C Clarke, Deputy Chief Executive, Executive Director of Operations and Social Care Lead (up to September 2020)								55-60	-				15.0-17.5	70-75
M Fearon, Joint Executive Director of Operations and Social Care Lead (up to August 2020)								40-45	-				17.5-20.0	55-60
L Lightbown, Executive Director of Nursing, Professions and Care Standards (up to September 2020)								45-50	-				15.0-17.5	65-70
J Brown OBE, Chair (up to July 2020)								10-15	-				-	10-15
P Stanley, Non-Executive Director (up to October 2020)								5-10	-				-	5-10
D Gilderdale, Executive Director of Nursing, Professions and Care Standards (May 2020 to July 2020)								30-35	-				-	30-35

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 requires disclosure of remuneration numbers as shown in the table above.

Table B – Senior manager' remuneration – future policy table

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

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

One executive director leased a vehicle through the Trust's Car Lease Schemes (Dr M Hunter – Salary Sacrifice).

3.2.5 The Hutton Disclosure

	01 April 2021 to 31 March 2022	01 April 2020 to 31 March 2021
Band of highest paid director's total (remuneration £000)	200-205	195-200
Median total remuneration	31,201	30,615
Ratio of median remuneration to midpoint of the highest paid director's band	6.5	6.5

In line with the Hutton Review of Fair Pay, NHS organisations are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. The median table above reflects a ratio of 6.5 (2020/21 – 6.5) between the highest paid director and employees.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021-22 was £200,000-£205,000 (2020-20 - £195,000-£200,000). The highest paid director for both years was the Executive Medical Director whose pay was boosted by clinical and management awards. The change between years was 3% (reflected in tables below). There was a change in disclosure numbers for the Executive Medical Director to incorporate a benefit in kind that was omitted in 2020/21. This resulted in a change to reported pay multiples for the prior year but enabled comparison between years. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, nor employer pension and national insurance contributions, nor the cash equivalent transfer value of pensions.

For employees of the Trust, the range of remuneration in 2021-22 was £13,000 to £264,000 (2020-21 - £13,000 to £260,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 3% and is in line with the nationally agreed pay award. One employee received annualised remuneration that is more than the highest-paid director in 2021-22 of £264,000 (2020-21 - £260,000). Both years relate to a consultant seconded to the Trust and payment included high clinical excellence awards. For the 2021/22 reporting cycle NHS organisations were required, in line with the Hutton recommendations, to disclose the relationship between the remuneration of the highest-paid director against the 25th percentile, median and the 75th percentile of remuneration of the workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and the 75th percentile of salary components of the workforce. The relationship to the remuneration of the workforce is disclosed in the following table.

Fair pay table

	Pay data	25% employees v mid point highest paid director	50% employees v mid point highest paid director	75% employees v mid point highest paid director
2021-22				
Highest paid director				
Basic and allowances	109,789	109,789	109,789	109,789
Pay and benefit	**204,864**	**202,500**	202,500	202,500
All employees				
Basic and allowances	22,904	12,857	22,904	33,281
Total pay and benefit	**31,201**	**22,549**	**31,201**	**40,962**
Ratio (pay and benefits)		**9.0**	**6.5**	**4.9**
2020-21				
Highest paid director				
Basic and allowances	104,769	104,769	104,769	104,769
Pay and benefit	**199,216**	**197,500**	**197,500**	**197,500**
All employees				
Basic and allowances	22,628	13,720	22,628	32,542
Total pay and benefit	**30,615**	**22,434**	**30,615**	**40,245**
Ratio (pay and benefits)		**8.8**	**6.5**	**4.9**

Year movements %

Highest paid director	3.0%	3.0%	3.0%	3.0%
All employees	3.0%	1.0%	2.0%	2.0%

Highest paid director comparator

	2021/22	**2020/21**	**% change**
Salary and allowances	109,789	104,769	5.0%
Performance pay and bonuses	64,975	64,347	1.0%
All taxable benefits	30,100	30,100	0.0%
Total	204,864	199,216	3.0%

3.2.6 Directors and governors expenses

Expenses shown in £00s	**2021/22 £'00**	202/21 £'00
Aggregate sum of expenses paid to governors	**0**	0
Aggregate sum of expenses paid to directors	**2**	2
Total	**2**	2

	Number of individuals who held office at any point during the year		**Number who claimed expenses during the year**		**Amount claimed in total £00**	
	2021/22	2020/21	**2021/22**	2020/21	**2021/22**	2020/21
Governors	**43**	48	**0**	1	0	0
Directors	**15**	9	**2**	1	2	2

Table C – Pension benefits

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

Pension benefits 2021-2022

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2022 £000	Cash equivalent transfer value at 31 March 2021 £000	Real increase in cash equivalent transfer value £000
J Ditheridge, Chief Executive (from March 2020)	0	0	65-70	195-200	0	1,600	0
P Easthope, Executive Director of Finance, IMST and Facilities	2.5-5	0-2.5	30-35	55-60	490	451	19
B Murphy, Executive Director of Nursing, Professions and Operations	0-2.5	2.5-5	70-75	215-220	1,612	1,533	50
Dr M Hunter, Executive Medical Director	0-2.5	0	40-45	95-100	758	745	6
C Parry, Executive Director of People	0-2.5	0	5-10	0	90	62	13

Pension benefits 2020-2021

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2021 £000	Cash equivalent transfer value at 31 March 2020 £000	Real increase in cash equivalent transfer value £000
J Ditheridge, Chief Executive (from March 2020)	5.0-7.5	17.5-20.0	65-70	195-200	1,600	1,397	179
C Clarke, Deputy Chief Executive, Executive Director of Operations and Social Care Lead (up to September 2020)	0-2.5	0	35-40	90-95	823	768	42
P Easthope, Executive Director of Finance, IMST and Facilities	0-2.5	0	30-35	55-60	451	416	28
Dr M Hunter, Executive Medical Director							
B Murphy, Executive Director of Nursing, Professions and Operations (from September 2020)							
D Gilderdale, Executive Director of Nursing, Professions and Care Standards (from May 2020 to July 2020)	0	0	0	0	0	0	0
L Lightbown, Associate Executive Director of Nursing (up to September 2020)	0-2.5	2.5-5.0	50-55	160-165	1,191	1,110	62
C Parry, Executive Director of People (from May 2020)	0-2.5	0	0-5	0	62	39	23
M Fearon, Joint Executive Director of Operations and Social Care Lead (December 2019 to August 2020)	0-2.5	0-2.5	20-25	30-35	288	251	33

Most Trust employees' pensions are managed by NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practitioners, and other bodies under the direction of the Secretary of State, in England and Wales. It is, therefore, not possible for the Trust to identify its share of the underlying scheme assets and liabilities. A small number of staff (43) are members of South Yorkshire Pensions scheme. Further details can be found in the Annual Accounts in note 1.6 and notes 29 and 29.1.

It is important to note that NHS Pension Scheme have not adjusted their pension data to cater for potential legal challenges because of the McCloud judgement (age discrimination case raised over the way UK public service pension schemes introduced a CARE benefit scheme in 2015 for all but the older members of the scheme who were allowed to retain the Final Salary model). There is yet to be a full evaluation of the effects on funding and pension values due to the changes in the NHS Pension Scheme introduced in 2015.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to transfers of pension rights. The value derived does not represent value receivable individuals. It is only an estimation of the benefits accrued by being a member of the pension scheme. The pension benefit table provides further information on the pension benefits accruing to individuals and section 3.2.4 provides detail on directors who have opted out of the pension. Ms B Murphy was on secondment in 2020/21 and therefore pension information for that financial year is not included in the table.

3.2.7 Service contract obligations

There is a requirement to notify of any outside business interests, contracts or proposed contracts where there is a financial interest. Prior written consent is required for engaging in any other business, profession, trade or occupation. The intellectual property created during the course of employment belongs to the Trust and there is provision for payment to Trust for any remuneration which arises from such intellectual property.

3.2.8 Policy on payment for loss of office

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

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

3.2.9 Statement of consideration of employment conditions elsewhere in the Trust

The Remuneration and Nomination Committee took explicit account of the Agenda for Change pay award which was effective from 1 April 2018.

3.2.10 Senior manager remuneration policy

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

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

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

Some of our commitments to diversity and equal opportunity include:

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

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

3.3 Staff Report

3.3.1 Staff numbers and staff costs

Average number of employees (whole time equivalent basis)	Permanent number	Other number	2020/21 total number	2019/20 total number
Medical and dental	147		**147**	**157**
Administration and estates	428		**428**	**641**
Healthcare assistants and other support staff	1,003		**1,003**	**605**
Nursing, midwifery and health visiting staff	533		**533**	**510**
Nursing, midwifery and health visiting learners	-		**-**	**19**
Scientific, therapeutic and technical staff	322		**322**	**348**
Other		7	**7**	**-**
Total average numbers	**2,433**	**7**	**2,440**	**2,280**
Of which:				
Number of employees (WTE) engaged on capital projects	15		15	1

As of 29 March 2022 the gender ratio of staff is 74.76% female and 25.24% male (2591 total workforce).

Of our executive directors, four are female and two are male.

Of our other senior managers,52 are female and 20 are male.

	Permanent £000	Other £000	2021/22 Total £000	2020/21 Total £000
Salaries and wages	87,878		**87,878**	87,965
Social security costs	8,450		**8,450**	8,366
Apprenticeship levy	411		**411**	411
Employer's contributions to NHS pensions	14,790		**14,790**	14,790
Pension cost – other	159		**159**	55
Other post-employment benefits	0		**-**	-
Other employment benefits	0		**-**	-
Termination benefits	0		**-**	315
Temporary staff	0	5,899	**5,899**	4,721
Total gross staff costs	**111,688**	**5,899**	**117,587**	**116,623**
Recoveries in respect of seconded staff	-	-	**-**	**-**
Total staff costs	**111,523**	**5,899**	**117,587**	**116,623**
Of which				
Costs capitalised as part of assets	165		**165**	379
Total staff cost excluding capital costs	111,523	5,899	**117,422**	116,244

3.3.2 Sickness absence

The sickness absence rates for the Trust can be found on the NHS Digital website at digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

3.3.3 Supporting equality and inclusion

Our Equality Diversity and Inclusion Strategic Overview 2020 – 2024 includes our Equality Objectives and how these align with the NHS Equality Delivery System.

We publish a separate Annual Equality and Human Rights Report which includes information on our progress against these each year.

Our Annual Workforce Race Equality Standard (WDES) Report outlines our actions on race equality.

You can read these reports in full on our website at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

3.3.3.1 Supporting disabled employees

We continue to be a Disability Confident Employer including offering a guaranteed interview to disabled applicants who meet the essential requirements of the role.

We have a Disabled Staff Policy which sets out our policy approach which focuses on a social model of disability, we regularly include lived experience as an essential and desirable criteria in many of our roles.

Our policy supports the provision of adjustments and Disability Related leave.

Our 2021/22 Workforce Disability Equality Standard Report (WDES) provides details about our 2021/22 action on disability, this is co-produced with our Disabled Staff Network Group.

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

3.3.4 Staff engagement and involvement

We continue to build on our investment into staff experience and engagement. Our range of methods for keeping staff informed and connected as part of Team SHSC, through information giving, celebrating successes and sharing good practice include: weekly update from the Chief Executive, regular COVID-19 information briefings, weekly all staff newsletter, extranet where the latest news, events and documents are shared and visits (virtual and face to face) to clinical and corporate areas by senior colleagues.

In 2021 we launched a new Women's Staff Network Group and continued to regularly engage with each of our staff network groups on issues that are important to them.

We continue to invest in accessible leadership development as part of our commitment to delivering on our strategic priorities and being 'well-led'. Monthly leadership engagement meetings with the Chief Executive are delivered virtually which enables 60 plus leaders to regularly participate on the call. This gives an interactive opportunity to share good practice and to question and challenge ourselves and our senior leaders. Topics range from strategic updates, through to team leads sharing how they have dealt with operational challenges during COVID-19 and bitesize leadership skills such as Mindful Leadership.

In February 2022 we launched our internal leadership development programme 'Team SHSC: Developing as leaders' which aims to bring our current and future leaders together to challenge their thinking, learn and connect. It will help us develop as leaders that champion compassionate and inclusive leadership that delivers outstanding care and improves lives.

The outcomes of our 'Big Conversation' action during 2020-21 identified the need for proactive anti-racism activity and to support this an 'Anti-discrimination leadership' development programme was introduced facilitated by the King's Fund.

To further support our commitment to an inclusive and 'just and learning' culture we have had colleagues represent the Trust on the ICS 'Our Compassionate Leadership Footprint' programme and the Mersey Care NHSFT and Northumbria University 'Principles and Practice of Restorative Just Culture programme. Both areas will be key elements of culture development at the Trust going forward.

During 2021 we refreshed our values to reflect the world we are now working in. Wide reaching engagement included open staff sessions and liaison with Staff Side. With the temporary easing of COVID-19 restrictions in Autumn 2021 we were able to hold 'Team SHSC: Leadership Away Days' which provided interactive events for leaders to contribute to the refreshing of our values and help us ensure that we are championing values that reflect our staff priorities in our care of service users and their families and carers. Our refreshed values are now golden threads through engagement and leadership development activity.

As well as organisational efforts on getting 'back to good' and transformational projects, we have made sure that we don't lose sight of the individual. We have focused on the effective implementation of the Trust's commitment to agile working with managers briefings to enable hybrid working to be successful for all staff whose role allows this. We have provided extensive support for the relocation of the Trust's headquarters from Fulwood House to Centre Court and Distington House, and consulted at individual and team level to enable a comprehensive and inclusive approach to this major change.

To show our continued appreciation to our hard-working, committed and loyal staff, we have undertaken a range of 'thank you' activities, including:

- giving all staff the 'Gift of Time' - an extra day for staff to use as they wish to help support their health and wellbeing

- providing food trucks and coffee vans at sites
- hampers at Christmas and for staff engagement with the Staff Survey
- encouraging recognition through contributions from staff on the extranet 'Wonderwall'

We have been active across the South Yorkshire and Bassetlaw Integrated Care System (ICS), and health and wellbeing has been a particular focus taking part in the health and wellbeing trailblazer activity, Train the Trainer wellbeing conversations, training advocates as part of Menopause Awareness along with participation in the week-long virtual health and wellbeing festival in March 2022.

3.3.5 Staff consultation

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

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

This year we have continued to work closely in partnership with Staff Side supporting staff and responding to changes needed to keep staff safe during the pandemic. Staff Side have held a place on key working groups, including our Working Safely Group and supported local consultation forums.

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

We have further developed strong partnership relationships and worked together to support the review of our community mental health teams.

We now receive a case for change through JCF before consultation begins, and we are in the process of reviewing changes undertaken using our new approaches.

3.3.6 Education, training and development

3.3.6.1 Mandatory training

We have a dedicated education, training, and development department which commissions and delivers core mandatory, clinical skills and specialist training for our staff to ensure that they meet the essential training requirements for their roles. Our aim is to ensure we always have the staff with the rights skills at the right time to provide high quality, safe care to our services users. We have maintained excellent compliance with mandatory training with 23 subjects (two more subjects than the previous year) at 89.61% at the start of March 2022 down 0.3% on December 2021.

During 2021/22 the Mandatory Training team has supported the safe training of staff during the Covid Pandemic. Our aim for the year was to embed technological enhanced ways of working, enhancing the web-based programmes introduced in 2021 and to add as many programmes as possible to our Electronic Staff Record

(ESR) system. 5 subjects which had been moved to web-based assessments in 2021 have now been transferred over to e-learning. The team in conjunction with Senior leads and Subject experts have also added 11 new subjects to the Trust's mandatory training portfolio and have supported the roll out of the training packages. We look forward to moving to new Training premises in 2022/23 and will continue to move the remaining web based assessments on to our Electronic Staff Record (ESR) system.

3.3.6.2 Apprenticeships

We currently have 74 staff studying on 15 different apprenticeships within the trust with 16 starting on programme in 2021/2022 ranging from Level 3 to Level 7.

Apprenticeships are used to support recruitment and retention of Registered Nurses, Support Workers and Pharmacy Technician roles in a response to workforce shortages, as well as for new role development including Trainee Nursing Associates (TNA) and Clinical Associate Psychologist (CAP). In 2021 we had 100% completion rate of our first cohort of TNA Apprentices. We are the first trust within the South Yorkshire and Bassetlaw region to start the CAP Apprenticeship and to date have recruited 22 onto this programme. 2021/2022 also saw the introduction of two new apprenticeships – Advanced Clinical Practitioner (ACP) and the Occupational Therapist (OT) which has been used as a means of supporting staff retention and career progression. We also support apprenticeships in Estates, IT, Human Resources, Leadership and Management, Education and Training and Business Administration. The COVID-19 pandemic has had some impact on apprenticeships with delayed start dates, apprentices placed on pause and learners needing extra time, however, our retention rate has been unaffected.

3.3.6.3 Recovery Education Cognitive Behavioural Psychotherapy Education

The Trust had a long-standing contract with Health Education England (HEE) as a regional training provider for the provision of Cognitive Behavioural Therapy and Recovery Education programmes. In April 2020 HEE issued a contract termination notice to the Trust due to changes in their funding criteria and a refocus on key transformation priorities. The traditional process for HEE funding is no longer consistent with ICS workforce priorities which have been realigned to meet NHS Long Term Plan and mental health transformation aims. Some of the programmes previously delivered through this contract are now being delivered using the CPD funding for nurses and AHP staff who meet the criteria.

3.3.6.4 Induction

During 21/22 we started a monthly 'Welcome to Team SHSC' session facilitated on Microsoft Teams, providing new staff with an opportunity to meet the Chief Executive and Executive Director of Nursing, Professions and Operations, and discuss our culture and values.

New staff have a chance to learn more about our staff network groups and staff benefits, how to navigate our extranet, known as ‘Jarvis’, and are introduced to the learning platform on the electronic staff record (ESR). New starters are booked on to the session automatically as part of the recruitment process through the Trac system. Once we move into our new headquarters next year, we plan to run face to face sessions and extend the offer to include service users and other Trust services.

3.3.6.5 Nursing – pre-registration training and new role developments

3.3.6.5.1 Pre-registration mental health nursing

We were pleased to have 41 first year student nurses join the Trust in February 2022. They received a great welcome from our senior nursing colleagues and their placement teams.

Whilst we support the students who lost placement time through the pandemic placement capacity will remain at a premium across the SYB ICS. Through our membership of the SYB ICS Learning Environment and Placement (LEaP) programme board we have been able to link with our partners at South West Yorkshire Partnership Trust and Sheffield Hallam University to secure funds to pilot a new model of community placement delivery using technology. The model will incorporate all learners however our goal is to increase capacity to accommodate more nursing students in the coming years.

It is now a requirement for all Trust nurses to undertake e-learning Practice Supervisor Preparation. This has led to a significant increase in the number of supervisors available to the students. We have also been able to support 35 staff to undertake Practice Assessor Training at Sheffield Teaching Hospitals with a further 50 places secured for 2022-23.

3.3.6.5.2 Open University Registered Nurse Degree Apprenticeship (RNDA)

We currently have 18 apprentices with the Open University Registered Nurse Degree Apprenticeship programme, two of whom are our first trainees within learning disability services. All apprentices have been recruited internally and to date we have zero attrition from the programme.

We are pleased and excited to announce that our first two RNDA apprentices will register as a Registered Nurse Mental Health at the end of March and have secured Band 5 preceptorship posts with the Trust. Four more apprentices are on track to register in the autumn of this year, and all will be offered preceptorship posts in their preferred area of practice.

We are now starting to see applications to the RNDA from some of our Registered Nursing Associates who are motivated to continue their professional development to become a registered nurse. In recognition of the prior learning this can be achieved within two years.

Despite challenges across the placement circuit our apprentices have all been able to achieve the number of clinical placement hours required to enable them to progress through the apprenticeship.

3.3.6.5.3 Trainee Nursing Associates

Six staff successfully completed the Nursing Associate Apprenticeship in October bringing the total number of qualified Nursing Associates in the Trust to eight. We currently have 13 members of staff enrolled on the two year apprenticeship, two of whom are training for roles within our Learning Disability services. Over the year we have been able to recover placement time lost through the pandemic and keep all apprentices on track to complete on time whilst delivering on our commitments to provide alternative placements to our ICS partners.

3.3.6.5.4 Advanced Clinical Practice

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

3.3.6.6 Medical Education

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

Additionally, we run several recruitment initiatives to encourage students and doctors to consider psychiatry as a career and offer selected student-selected components. We have two undergraduate Clinical Tutors, a Patient Ambassador with lived experience and a Nurse Educator to support the development and improvement of undergraduate medical and physician associate education. We have a number of volunteer service users providing support to medical and physician associate students.

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

Psychiatry is considered a hard to fill training specialty and we have recruited Clinical Fellows on fixed term contracts over the last year to be able to overcome the

challenges of low recruitment. They are being supported to develop skills in psychiatry and three have now joined the training scheme.

We have also recruited 11 qualified Physician Associates (PA) to support the care of patients in our inpatient wards, learning disability and recovery services. Educational input for them is being provided by colleagues in the Medical Education department and we plan to recruit a lead PA tutor this year.

We are also supporting the educational needs of Advanced Clinical Practitioners as part of workforce development initiatives. We have received good feedback from the South Yorkshire and Bassetlaw Faculty of Advanced Practice in relation to our ACP and PA programmes.

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

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

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

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

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

Following the publication of ‘Supported and Valued’ by the Royal College of Psychiatrists, we host a quarterly Trainee Improvement Forum led by higher trainees to improve communication between trainees and senior management.

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

of clinical expertise in the region. We have recently been successful in our bid to continue delivery of this course for the next 3 years.

The Trust is soon to be become fully accredited with the Faculty of Medical Leadership and Management. Leadership and Management training are now featured heavily in the Psychiatry Training Course timetable as well as other training events.

3.3.6.7 Appraisal compliance

Appraisal compliance	Dec 2020	Dec 2021
% AfC Staff Appraisal Rate (12 Month Rolling or YTD as report to Board)	92.62%	92.03%
% Medical Staff Appraisal Rate (12 Month Rolling or YTD as report to Board)	91.3%	96.55%
% Mandatory Training Completed (12 Month Rolling or YTD as report to Board)	89.89%	90.30%

3.3.7 Health and safety

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

We have an established Health and Safety Committee with representatives from clinical and non-clinical representatives and trade unions, which is chaired by a director, and supported by the Health and Safety Manager.

The role of the committee is to provide the Trust with an overarching view of health and safety performance and to provide assurance that health and safety risks are identified and effective mitigation is put in place, to promote collaborative working throughout the Trust on all matters of health and safety and to monitor and escalate any significant health and safety compliance risks to the Quality Assurance Committee.

Work within the last year has included updating the “statement of intent”, introduction of safety walkabouts and audits.

3.3.8 Occupational health

Our approach to occupational health involves the following strands:

- Occupational health service, provided by People Asset Management (PAM) - We have now reached the end of the agreed contract with PAM and the tender for the occupational health service is in progress.
- Workplace Wellbeing – this is our own free, confidential staff counselling and consultation service which is available to both individuals and groups of staff as well as bespoke stress resilience sessions for teams. In addition, we have been able to access the South Yorkshire and Bassetlaw Integrated Care

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

- Health and wellbeing – we provide a dedicated page on our staff extranet which helps direct staff to a range of useful local, regional and national resources and tools to assist with promoting a healthy and active lifestyle, including the free access to the wellbeing apps such as Sleepio and Headspace.
- Training and interventions – we provide specific training on key health related areas such as back care, manual handling, stress awareness, dealing with conflict, coping with COVID-19 and this year all our staff were invited to the ICS Wellbeing festival 7 days of wellbeing in addition to the wellbeing training hub with a range of free training for all staff to access
- In addition to continuing to support risk assessments for COVID for vulnerable staff we have established a long covid support group.

Our flu campaign was combined this year with the COVID vaccinations:

- 74% of all substantive and bank received the flu vaccine 90% of staff were vaccinated with the COVID-19 booster who are currently eligible to receive it. There were 2,638 vaccinations given by the Trust in 2021/22.

Substantive staff uptake:	**Bank Only Uptake:**
Flu: 75.5%	Flu: 60.1%
Covid dose 1: 97%	Covid dose 1: 95.7%
Covid dose 2: 94.9%	Covid dose 2: 93.1%
Covid booster: 90%	Covid booster: 82.8%

3.3.9 Countering fraud, bribery and corruption

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

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

Staff are trained in fraud awareness and we actively promote the mechanisms for staff to report any concerns. All concerns of fraud, bribery and corruption at the Trust are referred to the Local Counter Fraud Specialist and addressed in accordance with

the Trust's Fraud, Bribery and Corruption Policy. The Local Counter Fraud Specialist reports annually on all work undertaken, including the outcome of investigations.

3.3.10 Gender Pay Gap

We have published our 2021 Gender Pay Gap this can be viewed through the Government Gender Pay Gap reporting portal https://gender-pay-gap.service.gov.uk

We publish a narrative report on our Gender Pay Gap and progress in reducing this this can be found www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

3.3.11 Staff Survey

The annual NHS Staff Survey is our key staff engagement and benchmarking tool. During 2021 we have also been supplementing this with the NHS People Pulse option, which allows us to take 'the pulse' of what is important to our staff at that time. We have held People Pulse surveys within the Trust in November 2021 and January 2022. The results have been aligned with the 2021 Staff Survey results.

Some key points from the Staff Survey 2021:

- Survey ran from September to November 2021
- 52% of staff filled in the survey (1,290 completed questionnaires). An increase of 11% on the year before.

The NHS Staff Survey is conducted annually. For the first time in 10 years the national survey has undergone a reporting transformation and now produces results for the first time against our NHS People Promise themes plus staff engagement and staff morale.

The three annual survey results preceding the 2021 survey grouped questions to give scores against theme areas such as team working, health and wellbeing and immediate manager.

Considerable change in their presentation has taken place, albeit teams see the results of the 111 questions asked in 2021 into very similar categories as they have in preceding years.

Teams with results can map question scores to each theme.

The indicator scores continue to be based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2021 was 52% (51.8%) rising from 41% in 2020 and 40% in 2019. Scores for each indicator together with that of the survey benchmarking group (mental health/learning disability) are presented below.

The table below shows our results for 2021 in the new reporting style.

People Promise theme	Benchmark average score	Organisation score
We are compassionate and inclusive	**7.5**	7.1
We are recognized and rewarded	**6.3**	6.0
We each have a voice that counts	**7.0**	6.5
We are safe and healthy	**6.2**	5.9
We are always learning	**5.6**	5.4
We work flexibly	**6.7**	6.5
We are a team	**7.1**	6.8
Themes		
Staff engagement	**7.0**	6.5
Staff morale	**6.0**	5.6

Below is the table that captures the survey results from 2018-2020.

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

The Trust's benchmark report is available online at www.nhsstaffsurveys.com/results

Our 2021 results indicate little positive change overall. Whilst COVID-19 has presented many challenges we cannot disregard the level of disengagement from staff who participated in the 2021 survey. We note that two People Promise themes 'we are flexible' and 'we are always learning' show a more positive level of

engagement and come closer to the average across our comparator group. Although marginally positive comparatively it was encouraging to see.

A refreshed approach to leading the NHS Staff Survey across the Trust was introduced throughout the latter part of 2020. This approach placed greater focus on outreach engagement with leaders, managers and teams, and this approach continues. Throughout the 2021 survey window, proactive engagement, including reaching out to teams and leaders to encourage greater participation took up pace.

Leader and team away days took place throughout 2021 to engage with staff on the Trust's strategy and values, and to encourage staff to complete the survey saw an 11% increase in participation rate.

The results were shared with the Board and Directors during the embargoed pre-release period, before being shared with staff in December 2021. Local team level data continues to be shared and explored.

Activity to engage around the results included:

- Full results shared with staff on the Trust's extranet
- Local team results shared with teams directly and acted on
- Board and Director staff engagement sessions
- A greater focus on cross team working alongside immediate teams, exploring the wellbeing of staff and how engagement impacts the delivery of care to those we serve, forming action plans with our Trust strategy and aims in mind at all times
- We refreshed our Staff Survey Steering Group, and have changed this to a Staff Engagement Steering Group, widening the lens, with engagement focussed discussion and action across the Trust, not specific to the survey in isolation

Our priorities for 2022/23 are:

- Managing directorate and team engagement plans, with accountability at senior manager level to inform on activity and impact via local monthly and quarterly performance reviews with the Board.
- Actions linked to Trust aims and business plans with an outcome-based focus and system thinking approach.
- Working in partnership with our Staff Side and staff Governors taking a 'big conversations' approach across the Trust on staff engagement. Engagement and wellbeing topics being widely discussed and explored as one team, aiming to create meaningful actions, share best practice and lessen duplication across systems
- Providing local team support extensively through the HR Business Partnering Team
- Work across the ICS to learn of experiences and approaches that have influenced positive people engagement

- Embed Trust-wide culture and leadership development programmes that began early 2022. Leadership development course based on the nine NHS leadership dimensions
- Continue to create consistent, safe and inclusive work environments where everyone can flourish and do their best work
- Staff survey and engagement work to be cognisant of our Trust strategy and aims, with our vision firmly embedded into our thinking and practice.

3.3.12 Trade Union Facility Time

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

The current reporting year is for the 12 months from 01 April 2020 to 31 March 2021. 'Facility time' is the provision of paid or unpaid time off from an employee's normal role to undertake trade union duties and activities as a trade union representative.

There is a statutory entitlement to reasonable paid time off for undertaking trade union duties. There is no statutory entitlement to paid time off for undertaking trade union activities.

3.3.12.1 Trade union representatives and full-time equivalents

Number of employees who were relevant union officials during the relevant period	19
Full-time equivalent employee number for the Trust	18.6

3.3.12.2 Percentage of time spent on facility time

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

Percentage of time	**Number of employees**
0%	4
1% - 50%	11
51% - 99%	4
100%	0

3.3.12.3 Percentage of pay bill spent on facility time

Total cost of facility time	**£156,319**
Total pay bill	£117,587,000
Percentage of the total pay bill spent on facility time	0.13%

3.3.12.4 Paid trade union activities

Of these representatives the hours spent on paid facility time were 5,208 and the hours spent on paid trade union activities were 462.

Time spent on paid trade union activities as a percentage of total paid facility time hours	3.56%

3.3.13 Expenditure on consultancy

In 2021/22 the Trust spent £1,196,000 on consultancy.

3.3.14 Off-payroll engagements

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

Table 1: For all off-payroll engagements as of 31 March 2022, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2021	**14**
Of which:	
Number that have existed for less than one year at time of reporting	14
Number that have existed between one and two years at time of reporting	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration, between 01 April 2020 and 31 March 2021	**16**
Of which:	
Number assessed as caught by IR35	13
Number assessed as not caught by IR35	3
Number engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022.

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	**1**
Number of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility', during the financial year. These figures should include both off-payroll and on-payroll engagements.	**16**

3.3.15 Exit packages

3.3.15.1 Staff exit packages

3.3.15.1.1 Reporting of compensation schemes - exit packages 2021/22

The tables below summarises the total number of exit packages agreed during the year and the previous financial year. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications.

The tables shows packages agreed in year, irrespective of the actual date of accrual or payment.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	2		**2**
£10,000 - £25,000			**3**
£25,001 - £50,000	3		**4**
£50,001 - £100,000			
£100,001 - £150,000	1		**1**
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	**6**		**10**
Total cost (£)	290		**290**

3.3.15.1.2 Reporting of compensation schemes – exit packages 2020/21

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

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

The table below discloses non-compulsory departures and values of associated payments. The table shows packages agreed in year, irrespective of the actual date of 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 table above which represents the number of individuals.

	2021/22		2020/21	
	Payments agreed number	**Total value of agreements £000**	**Payments agreed number**	**Total value of agreements £000**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Contractual payments in lieu of notice	2	7	1	49
Total	**2**	**7**	**1**	**49**
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

3.3.16 Staff turnover

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

3.3.17 Equality, diversity and inclusion

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

3.4 Code of Governance Disclosures

3.4.1 Our commitment to good governance

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance followed by all those who play a part in the conduct of the Trust's business. The Board recognises that the purpose of the NHS Foundation Trust Code of Governance (the Code), published by NHS Improvement, the independent regulator of NHS Foundation Trusts, is to assist NHS Foundation Trust Boards and their governors to improve their governance practices by bringing together the best practices from the public and private sectors. Sheffield Health and Social Care NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Code issued in 2012.

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

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

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

3.4.3 Compliance with the provisions of the Code

In 2021/22 the Trust complied with all relevant requirements of the Code with the exception of one provision, save that the organisation has retained an arrangement whereby non-executive directors serve a term of four years, rather than three as per the Code, as a review in 2019/20 found that this provided a greater degree of stability and continuity without compromising independence. It should also be noted that during 2021/22, the organisation has been embedding changes to governance arrangements, among other things, arising from an improvement programme developed in response to a Care Quality Commission inspection which took place in 2019/20.

3.4.4 Disclosure of corporate governance arrangements

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

A.1.1 Statements on how the Board of Directors and the Council of Governors operate, including high level statements of which types of decisions are to be taken by each one of them and which are to be delegated to the management by the Board of Directors, are contained in Sections 3.1.8 and 3.1.28 of this report. A statement describing how any disagreements between the Council of Governors and the Board of Directors will be resolved is contained in Section 3.1.28.

A.1.2 The names of the Chair, the Vice-Chair, the Chief Executive, the Senior Independent Director, Chairs and members of the Board of Directors' Remuneration and Nomination Committee, the Council of Governors' Nominations and Remuneration Committee and the Audit and Risk Committee are contained Sections 3.1.2, 3.1.3, 3.1.11 and 3.1.28.4.4 of this report. The number of meetings of the Board of Directors, its committees and the attendance by individual directors are shown in Sections 3.1.9 of this report.

A.5.3 The names of the governors, details of their constituencies, whether they are elected or appointed, the duration of their appointment and details of the nominated Lead Governor are contained in Section 3.1.28 of this report. The number of meetings of the Council of Governors and the individual attendance by governors and directors is also contained in Section 3.1.28.

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

I. Sharon Mays (Chair)

II. Anne Dray

III. Richard Mills

IV. Heather Smith

V. Dr Olayinka Fadahunsi-Oluwole

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

- None of them is employed by the Trust or has been in the last five years
- None of them has, or has had, within the last three years, a material business relationship with the Trust, either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust
- None of them has received or receives additional remuneration from the Trust apart from their director's fee. They do not participate in any

performance-related pay as no such scheme is run by the Trust nor are they a member of the Trust's pension scheme

- None of them has close family ties with any of the Trust's advisers, directors or senior employees
- None of them holds cross-directorships or has significant links with other directors through involvement (with those other directors) in other companies or bodies
- None of them is a member of the Council of Governors
- None of them has served on the Board of this NHS Foundation Trust for more than 10 years.

B.1.4 Contained in Sections 3.1.12 and 3.1.14 of this report is a description of each director's expertise and experience and a statement on the Board of Directors' balance, completeness and appropriateness. In addition, it also contains information about the length of appointments of the non-executive directors. Information about how non-executive director appointments may be terminated is contained in Section 3.1.28.4.4.

B.2.10 An explanation of the work of the Remuneration and Nomination Committee which oversees the appointment process of executive members of the Board can be found in Sections 3.1.10.2 of this report. The work of the Nominations and Remuneration Committee of the Council of Governors, including the process it has used in relation to Board appointments together with an explanation of whether a search consultancy was used in the appointment of the Chair or the non-executive directors, is contained in Section 3.1.28.4.4 of this report.

B.3.1 The Trust Chair's other significant commitments and any changes to them during the year are contained in the Directors' Register of Interests referred to in Section 3.1.14 of this report.

B.5.6 A statement about how the governors have canvassed the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the Trust's forward plan, including its objectives, priorities and strategy, and how their views were communicated to the Board of Directors is contained in Section 3.1.28.4 of this report.

B.6.1 A statement on how the performance of the Board, its committees and individual directors was evaluated is contained in Section 3.1.15 of this report.

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

An improvement programme arising from the 2019/20 CQC inspection of the organisation has been in place throughout 2020/21 and 2021/22, with significant monitoring and engagement of NHS Sheffield CCG and the CQC.

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

C.1.1 An explanation from the directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities is contained in Sections 3.1.5 and 3.6 of this report and the approach taken to quality governance is detailed in the Annual Governance Statement in Section 3.7.

C.2.1 A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls is contained in Section 3.1.11.1 of this report.

C.2.2 The Trust has an internal audit function. Information on how the function is structured and what role it performs is included in Section 3.1.11.1.2 of this report.

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

C.3.9 An explanation of the work of the Audit and Risk Committee can be found in Section 3.1.11.1 which includes any significant statements the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed, an explanation of how it has assessed the effectiveness of the Trust's external audit process and details of the Trust's external audit contract as well as information about any non-audit work that may have been commissioned.

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

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

E.1.5 Board members, and in particular non-executive directors, develop an understanding of the views of governors and members through their attendance at meetings of the Council of Governors. They are further informed of the activities of the Council of Governors through Trust Board meeting updates on the affairs of the Council of Governors and Trust's members. Board members are appraised of members' opinions at the Annual Members' Meeting where views are canvassed. Further details on how the Board canvass the views of governors and members can be found in Section 3.1.28 of this report.

E.1.6 The Board monitors membership and engagement through monthly reporting processes. Information on monitoring how representative the Trust's

membership is and the level and effectiveness of member engagement is contained in Section 3.1.29 of this report.

Detailed information regarding the Trust's membership constituencies and their eligibility, membership numbers, the Membership Strategy and steps taken in year to ensure a representative membership are detailed in Section 3.1.29.1.

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

A statement from the directors that the business is a going concern, together with supporting assumptions or qualifications as necessary, is contained in Section 2.2.6 of this report.

3.5 NHS England and NHS Improvement's NHS System Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs.

The framework looks at five themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

3.5.1 NHS System Oversight Framework Segmentation

The CQC, in their formal inspection report, received in April 2020, recommended to NHS England and NHS Improvement that the Trust should be placed in special measures for reasons of quality (System Operating Framework category 4). This recommendation was formally accepted by the NHS England and NHS Improvement Provider Oversight Committee (POC) on 12 May 2020.

In March 2022 the System Oversight Committee of NHS England and Improvement met and confirmed that the Trust will transition to System Oversight Framework category 3 and would no longer need the support of the Recovery Support Programme. The transition is made in recognition of the significant progress made.

This segmentation information is the trust’s position as at 31 March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website.

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Sheffield Health and Social Care NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Health and Social Care NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

3.7 Annual Governance Statement

3.7.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 SHSC ('the Trust') is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

3.7.2 The purpose of the system of internal control

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

3.7.3 Capacity to handle risk

3.7.3.1 Senior Leadership and Structure

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

The posts of Executive Director of Nursing and Professions, Executive Director of Finance, IMST and Performance, Executive Medical Director, Executive Director of People and the Director of Corporate Governance (Board Secretary), a non-voting board role, have remained in place throughout 2021/22.

The post of Director of Special Projects which had been in place since December 2020 was reviewed and became the Director of Strategy with the role successfully recruited to and an appointment made in February 2022 to strengthen our strategy development capacity.

An Improvement Director, appointed by NHS England and NHS Improvement has been in place for 2021/22 to support the organisation's regulatory status.

3.7.3.2 Risk management roles of leaders

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

3.7.3.3. Staff training

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

Overall compliance with mandatory training was at 89.79% by 31 March 2022.

Of the 31 subject areas:

- exceeded 95% compliance
- 10 exceeded 90% compliance
- 8 exceeded 85% compliance
- 6 exceeded 80% compliance
- 4 were below 80% - and have recovery plans in place.

Mandatory training is kept under continuous review with floor to Board reporting and monitoring in place. The Board sees data on overall compliance; individuals and managers receive reminders throughout the year and can see their own data, with managers being able to see data for their teams.

3.7.3.4 Learning from good practice

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

These have included:

- Quality Assurance Committee meetings and Flash Reports for the Board of Directors
- Preventing Future Deaths reports
- Quality Improvement Forum
- Daily Incident Huddle (review and follow up of all incidents with services)
- Weekly Investigation Panel (all clinical investigations to track, support and review)
- Safeguarding supervision (group)
- Bitesize safeguarding online open sessions
- Safeguarding Conferences (6 monthly with partners)
- Culture and Quality Visits
- Fundamental standards clinical reviews PICU and acute wards
- Lessons Learnt Staff Bulletin (Quarterly)
- `Talking Heads` online patient safety focussed groups
- Lived Experience Reports
- Care Opinion and Friends/Family Test
- Team and clinical directorate governance meeting reports and events
- Acute care forum
- Lessons learned events
- Service based development forums
- Clinical Quality and Safety Group
- Least Restrictive Practice Conference and Restrictive practice learning events
- Leadership Forum
- 48hr reports leading to Significant Event Analysis Reports with reflective learning
- Commissioned patient safety and staff safety reviews (external)
- Serious Incident Reports
- Mortality Reviews and Structured Judgement Reviews
- Blue light alerts
- Section 42 enquiries (safeguarding investigation)
- System learning panels (Firshill review)
- Clinical Executive Panel (monthly review with directorates of patients whose needs are not being well met by the system)
- Trust review and response to national reports e.g. Out of Sight review, Ockenden Report
- Board development learning e.g. Ockenden and Firshill
- Bespoke learning events e.g. Human Factors and System Thinking (RCA) Quality Summit approach on the Firshill inspection looking at this from a system, Place and organisation perspective
- Suicide Reference Group (Sheffield wide)
- Complaints thematic review
- Claims thematic review

3.7.4. The risk and control framework

3.7.4.1 Risk Management Strategy

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

Risks are assessed using a stepped approach which identifies and analyses the risk, identifies the control measures in place and how effective these are and the actions that need to be taken to reduce/mitigate/remove the risk. Risks are graded according to their severity and likelihood of recurrence, using a 5x5 risk grading matrix based upon guidance produced by the former National Patient Safety Agency.

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

Risks on the Corporate Risk Register (CRR) are overseen by lead Directors, received and monitored through the Board sub committees, and received at each public Board meeting.

As at 31 March 2022, there were 21 risks on the Corporate Risk Register. There is one high risk with a current risk score of 16:

- Risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at the Trust

  Mitigations:
  - The Community Intensive Support team and Community Learning Disability team are working closing with services users and providers to support into the community and to support admissions avoidance.
  - Learning Disability Multi-Disciplinary Team will in-reach into the wards to provide specialist support and training to mental health staff.

- Standard Operating Procedure for emergency admission avoidance/admissions has been developed.
- List of CQC rated Good ATS inpatient settings across the country was to be used if admission cannot be avoided (if available)
- Risk action plans include ongoing work with the Learning Disability Programme Board and the development of a new community enhanced model for Sheffield; and discussion with regional Commissioners about future planning for Learning Disability beds at and Integrated Care system and regional level.

There were 5 risks with a current risk score of 15:

- Risk to patient safety arising from the quality and safety of the ward environments across Trust hospital sites, including access to ligature anchor points.

  Mitigations:

  - Policies and Standard Operating procedures are embedded, including ligature risk reduction, observation and risk management.
  - Inpatient environments have weekly health and safety checks.
  - The ward works on all adult acute wards is continuing in line with the programme.
  - 14 commissioned beds are in place to mitigate the reduced bed base whilst refurbishment work to remove Ligature anchor points is progressed.

- Risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.

  Mitigations:

  - All referrals are triaged within a 24hr period to determine need and urgency.
  - Customer Service Improvement Programme Manager in post to improve response time and caller experience.
  - Written information and advice on accessing help in a crisis given to services users waiting assessment.
  - Waiting time trajectory is reported to Quality Assurance Committee. Voluntary, Community and Social Enterprise (VCSE) offer went live in February 2022 and will be evaluated in April 2022.

- Risk that there are insufficient beds to meet service demand;caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city.

Mitigations:

- Clinical Director and Executive Director (out of hours) approval for out of are authorisation.
- Crisis Resolution and Home Treatment team support for ward discharges and gatekeeping of admissions.
- Additional 12 acute beds and additional 6 PICU beds procured.

- Risk to patient safety, caused by key clinical documents being deleted resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g., missed appointments.

Mitigations:

- New Electronic Patient Record (EPR) programme which will deliver a new EPR allowing Insight to be fully recovered is the full mitigation for this risk.
- Improved backup infrastructure is in place to provide faster recovery of deleted documents.
- Hourly snapshots of data in place to reduce volume of data that could be lost in an incident.
- Standard Operating Procedure in place to handle document deletion incidents with oversight from Digital Information Governance Group (DIGG).
- Quarterly planning overseen by IMST Senior Management Team (SMT).
- Information Security Group within IMST for planning of security and governance actions.

- Risk that complaints will not be responded to in a timely manner which will give rise to breaches of contractual standards and dissatisfaction from service users, carers and families.

Mitigations:

- Complaints Manager and Complaints officer employed to support the administration and processing of complaints.
- Quality Directorate provides oversight.
- Rapid improvement plan developed and monitored through Quality Assurance Committee.

All risks on the Corporate Risk Register have a defined ‘monitoring group’ (assurance committee) and each of the risks described above are closely managed through the Ulysses system and receive scrutiny through the Quality Assurance Committee and Finance and Performance Committee. This scrutiny includes controls, assurances and any gaps in controls and assurance aligned to the actions being taken to achieve the target risk score.

The Trust Board reviews its risk appetite annually, aligning it to revised strategic objectives and determines whether an individual risk or a specific category of risks

are considered acceptable or unacceptable based on the circumstances and situation facing the Trust. The risk appetite is included in the Risk Management Strategy and reflected in the Board Assurance Framework (BAF) and Corporate Risk Register.

The Board will review risk appetite when the BAF for 2022/23 is agreed. The Trust's approach is to minimise exposure to risk that impacts on patient safety and the quality of our services. However, the Trust accepts and encourages an increased degree of risk relating to innovation, providing the innovation is consistent with the achievement of patient safety and quality improvements.

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

Training has been put in place to support risk owners in updating their risks and support is available on an ongoing basis.

The Trust has commissioned a review of its systems processes, capacity and capability around risk to support ongoing improvement and the outcome of this review is due for receipt through our Back to Good monitoring structure, Audit and Risk Committee and Board in June 2022.

3.7.4.2 Board Assurance Framework (BAF)

Assurance is provided to the Audit and Risk Committee every quarter that risks are being addressed and actions completed through updates to the Corporate Risk Register and Board Assurance Framework.

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

The BAF was reviewed at each Audit and Risk Committee meeting and each Board committee also received and reviewed the element of the BAF relevant to their remit. The Board received the BAF on a quarterly basis which was informed by the committee reviews.

A clear link between papers and the BAF is required on each report to demonstrate how they provide assurance to the Board and its committees that risks are being managed and mitigated and support and training has been provided to report authors to support their understanding around the level of detail required generally in the Board reporting structures.

At the start of 2021/22 financial year, the Trust had nine BAF risks to the delivery of the strategic objectives. A further risk was added during the year ‘risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs’ and is monitored by the Board.

A separate COVID-19 risk register is maintained with reporting through the Command structure and the Quality Assurance Committee and to Board.

The Trust is compliant with its CQC registration and will be declaring compliance against Provider licence risk requirements.

The trust has published on its website a register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS’ guidance. Work is underway to call in declarations of interest below Board level with this process expected to complete by the end of Q2 2022/23.

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 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. A new appointment has been made for a Human Rights lead and the EDI and Human Rights teams strengthened in 2021/22.

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

The Trust Board has approved the ‘Green Plan’ as part of its sustainability strategy and commitment to this agenda.

3.7.4.3 Public stakeholder involvement in managing risks

The Trust works to continuously improve its approach to engaging service users, carers, governors and partners to learn from individuals’ experiences and enable continuous quality improvements in all areas of our business this has included particularly effective partnerships with organisations such as Flourish to broaden engagement with our communities.

Service users, carers, governors and partners engage in the Trust’s governance structures and actively take part in groups across the organisation to contribute to planning and service improvement.

The number of service user and carer networks, co-led by service users and carers, continues to develop, enabling services to improve their care in line with service user and carer experience feedback.

Staff networks were strengthened significantly in 2021/22 providing invaluable insight in a wide range of areas.

Partnership working has continued through the Sheffield Accountable Care Partnership (ACP), NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield City Council.

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

There is a Governors Development Programme in place which in 2021/22 included workshops on:

- Integrated Care Systems
- human rights
- raising the profile of carers
- service user engagement and experience
- engagement
- Clinical and Social Care Strategy
- Rainbow badge training.

In addition to this Chair drop in sessions were established and governor observation of Board sub committees was introduced.

The Council of Governors were also provided with externally supported consultants provided two Governor development workshops around induction, roles and responsibilities, holding the Board to account, the Health and Social Care Bill and the Trust's Strategy.

3.7.4.4 Quality governance arrangements

A 'Back to Good' programme has been in place throughout the year and was developed to identify the must-do and should-do actions arising from the CQC inspection. These have been monitored monthly through a Back to Good Board and reported to Quality Assurance Committee and Board.

During the year, governance arrangements across the organisation were in place to monitor progress against quality improvement actions following CQC inspections. Senior leaders have engaged with regional NHS colleagues and the CQC to report on improvement.

The Well-Led development programme agreed in 2020 was incorporated into the 'Back to Good' programme in 2021 and continued to be reflected in the Board Development Programme.

There has been significant focus on senior leadership activity with a comprehensive Board development programme, a governor development programme, non-executive director development programme, executive development programme and leadership programmes in place and being implemented across the organisation.

Additional activity has included a listening programme of service visits by both the executive team as a whole and Board members (in pairs of one non-executive and one executive member) with actions captured and followed up with the teams visited. This supports triangulation of reports and information received at Committee and Board.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level. During 2021/22 a performance framework has been in place, with continuing development of the Integrated Performance and Quality report. This is reporting at board committees and also to the Board. The schedule of meetings for the year ensures all data can progress from the point of availability to reporting upwards via the necessary groups. This quality assurance step ensures the quality of data received. Service performance reviews have taken place regularly, chaired by the Director Finance and attended by the Chief Executive, engaging all members of the executive leadership to positively challenge performance in clinical and corporate services across the organisation.

In 2021 a number of internal controls led to the Director of Nursing sharing serious concerns with the CQC regarding the quality of care at Firshill Rise Assessment and Treatment Service. This led to a number of actions to improve the service but following an unannounced visit by the CQC (although this was expected by the organisation), this resulted in the service being rated as inadequate and a condition and a requirement to stop new admissions until a number of conditions were met.

A number of learning events were undertaken to understand the root causes of the findings of the report. One of the outcomes of these learning events was that the Trust made the decision to support the safe transfer of the service users in the unit with the support of system partners and then take the opportunity to redesign the model of care with an emphasis on a strengthened community offer. The unit remains closed while the system agrees a new model of care.

Progress has been made in services previously inspected by CQC and rated as inadequate:

- In May 2021 the CQC carried out a follow up inspection of the acute wards and psychiatric intensive care unit, mental health wards for older people, and crisis and health-based places of safety, due to these being rated inadequate at the previous inspection. At this inspection, two services (mental health

wards for older people, and crisis and health-based places of safety), improved their rating to requires improvement.

- At this time the acute wards and psychiatric intensive care unit remained rated inadequate because further improvement was required however in December 2021, a follow up CQC visit took place with the report published in February 2022 and an improved rating for these services from inadequate to requires improvement.
- The well-led question was also inspected as part of this due to this previously having been rated inadequate and was re-rated as requires improvement.

In February 2022 the CQC confirmed that the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed.

These improvements led to an overall rating for the Trust of Requires Improvement and a national and regional decision to move from SOF4 to SOF3.

3.7.4.5. Information governance and data security

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

Following our 2020/21 Data Security and Protection Toolkit (DPST) submission, a plan was agreed with NHS Digital to address those areas identified as requiring improvement but the requirement to submit the outcome was subsequently dropped so our attainment level is recorded as 'Approaching Standards'.

The Trust continues to work to implement further improvements to enhance our performance against DPST requirements. An Information Security Group meets monthly and is focussed on the requirements of the toolkit to support the organisation to be 'audit ready' in all areas. A phishing exercise was undertaken by internal audit which identified fragilities in the organisation's IT security and as a result changes were made to strengthen our arrangements. This continues to be an area of focus.

Information governance training is included as part of the core training for new starters and all staff are required to undertake annual information governance training. Other specific training sessions have been provided to staff.

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

During 2021/22 four incidents were reported to the ICO. One related to a service writing to a service user at the wrong address; one related to an allegation by a service user that an external interpreter had shared their information inappropriately

(although this was not verified); one occurred when a temporary member of staff shared information about a service user who was known to them; and one related to out of date details being used resulting in a former carer of a service user being contacted. In each of these cases processes were reviewed and updated where appropriate and the ICO has taken no further action. These are reflected on the risk register and the Electronic Patient Record project will be a significant contributor to mitigating the risks with other safeguards also in place.

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

The Trust has a robust committee governance structure which was refreshed during 2020/21.

The following committees report into the Board:

- Audit and Risk Committee
- Finance and Performance Committee
- Quality Assurance Committee
- People Committee
- Mental Health Legislation Committee (newly established in 2021)
- Remuneration and Nominations Committee

Terms of Reference for all committees have been approved by the Board, and are undergoing regular annual review processes, alongside the reviews of effectiveness for the committees.

The Trust continued to review its operational efficiency metrics throughout the year, as described earlier through the Integrated Performance and Quality Report and Performance Framework.

The organisation has reviewed and continues to review its leadership at various levels as shown by the introduction of the Director of Strategy post. An internal leadership development programme was launched in February 2022 aiming to bring current and future leaders together to challenge their thinking, learn and connect.

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

Improvement in triangulation of data has taken place across the Board sub committees with escalation taking place between committees and Board members placed on a range of committees to support cross fertilisation in discussion and around challenge. There has been an improvement in our recovery plans and continuous improvement around monitoring with a more systematic approach to challenge and improvement in place.

As part of well led improvement, finance reviews by NHSE/I continued to take place with CQC/NHSE/I oversight of our Quality Improvement journey continued

throughout the year which provided an opportunity for extended challenge and verification resulting in the Trust moving from SOF 4 to SOF 3 at the end of the financial year.

3.7.6. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the 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 and I met with internal and external audits periodically (planned) throughout the year. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and its assurance committees as described in this statement, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Committees provide ‘Alert, Advise, Assure’ reports, alongside the minutes, after each meeting on the significant matters for consideration, these may include issues of specific interest, but will also include control issues or areas where there are gaps in assurance.

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

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

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

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

The Mental Health Legislation Committee provides assurance to the Board of Directors on statutory and regulatory compliance in respect of Mental Health and Human Rights legislation.

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

The Non-Executive Directors sit on more than one committee to increase integrated discussions on quality and resource assurance with issues escalated between committees and the Board kept informed through the Alert, Assure and Advise (AAA) reports. The integrated approach is also provided through the Integrated Performance and Quality Report (IPQR) received at Committees and Board.

Our 'Back to Good' programme provides assurance focussed on or related to areas identified for improvement through our CQC report. There is a programme board in place which activity monitors progress and provides regular reports to our assurance committees and directly to the Board. The Quality Oversight Board led by regional partners and attended by CQC, provides oversight of our 'Back to Good' journey.

The clinical audit programme also supports my review of the effectiveness of internal control. A full internal review of each clinical audit is undertaken with actions identified to address any identified risks and to improve quality of care.

The role of the assurance committees in maintaining and reviewing the Trust's systems of internal control are described above.

The internal audit programme overseen at the Audit, Risk and Compliance Committee provides a further mechanism for supporting this. 360 Assurance, our internal auditors, identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker and reviewed frequently both internal by the Executive Team and with our auditors.

In 2021/22 performance in our in-year audits improved with the in-year position moving from limited to significant assurance. The Board Assurance Framework and Corporate Risk audit remained 'moderate' although it was recognised work to continue to embed these had been made.

The following reports were received with Limited Assurance:

- Procurement
- Waiting List Data Quality and Management with one high risk finding identified
- Quality of Performance Development Reviews (PDRs) with one high risk finding identified – note this report is from the 2020/21 audit programme.

The following reports were received with Significant Assurance:

- Incident Management
- General Ledger and Financial Reporting Arrangements

- Strategic Governance
- Policy Management
- Transformation and Project Management
- Health and Wellbeing
- Payroll.

At the time of writing testing was in progress for the 2021/22 reports for Safeguarding Adults and Children; and Recruitment reviews. The Health and Safety audit was also ongoing with the final draft awaiting sign off.

There have been some delays with implementing some of the recommendations during the financial year (predominantly low or medium risks) and as a result of this the overall opinion remained 'moderate'. However, I recognise this is an area which requires improvement and I am assured systems to address and improve are being put in place to improve the position in 2022/23.

In summary areas of progress across the year include stable executive leadership team and operational leadership arrangements with the right skills and expertise:

- Robust Board development plan alongside executive development, non-executive development, governor development and staff leadership programmes
- Embedding of the revised governance structure that was introduced in 2020/21 with assurance reporting to the Board of Directors via a new Alert, Assure Advise (AAA) report from Committee Chairs to Board placing the previous significant assurance reports
- Increased reporting and scrutiny of the BAF with challenge at committee level
- Embedding of the Performance Framework and the performance management reviews
- The work of the Back to Good Board ensuring that improvement actions are completed in time and escalating if appropriate
- We have retained external support in our development work throughout the year which will continue into 2022/23 and has been of significant benefit
- Support has continued to be provided to report authors to improve the quality of reports received at Committees and Board with further work planned in the coming year
- Triangulation of data and performance information with Board and Executive visits and through cross reporting from the Board sub committees has improved across the board
- Work has been identified to support our continuing proramme of improvement
- Movement of our overall CQC rating from Inadequate to Requires Improvement and movement in the following services/areas from inadequate to requires improvement
    - Mental health wards for older people
    - Crisis and health-based places of safety

    - Acute wards for adults of working age and psychiatric intensive care unit
    - Well Led
- Previous Section 29A enforcement notice closed
- Movement of the organisation from SOF segment rating 4 to SOF rating 3 with recovery support no longer required
- We have had a number of significant assurance internal audit reports in the year which provides assurance around our improving systems and controls; and whilst we had a small number of reports with limited assurance only two contained high risk recommendations.

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

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

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

Head of Internal Audit Opinion

I am providing an opinion of moderate assurance that there is a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.

Whilst I have concluded an overall moderate assurance, we recognise that the Trust has continued on its improvement journey and the CQC inspections demonstrate that, although there is still work to do, the Trust is on a positive trajectory.

In providing our opinion we consider the three areas outlined below.

Strategic risk management: moderate assurance

Our opinion considers strategic risk management arrangements over the course of 2021/22. Across the year we have identified a number of findings in relation to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and the Trust agreed actions to strengthen arrangements, including updating and refining the BAF and strengthening the controls for extending BAF/CRR action due dates. Our review of the BAF which was presented to Board in March 2022 confirms steps have been taken to improve the BAF. However the Trust recognises it is a work in progress – work has been done to improve the content, but this is continuing. The Trust feels that discussions have improved and are becoming more focused on

managing the Trust's risks. It is important that the improvements continue into 2022/23 and the Trust can demonstrate these are embedding to ensure the BAF is a robust tool the Trust can use to manage its strategic risks.

Internal Audit plan outturn: significant assurance

We are providing significant assurance for this segment. It should be noted that there have been three limited assurance opinions issued during the year (for the Quality of PDRs, Procurement and Waiting List Data Quality and Management audits).

Follow up of Internal Audit actions: moderate assurance

Whilst we acknowledge the external factors which may impact on the Trust's ability to respond to internal audit actions (e.g. COVID-19 and the CQC), progress has been slow throughout the year, in particular the first follow up rate is low (46%). The Trust's overall implementation rate for actions in 2021/22 is 72%. This just falls within the 'moderate assurance' category for follow up. The Trust's ability to implement agreed actions has been raised in the previous four Head of Internal Audit Opinions.

This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.

Conclusion

In my opinion, notwithstanding issues noted in this report and the substantial progress made in addressing the previous significant internal control issues,

I recognise there were significant internal control weaknesses identified in the early part of this financial year given the concerns raised about the Assessment and Treatment Service (ATS) at Firshill Rise with the following condition placed upon us:

- The registered provider must not admit any service user to the Assessment and Treatment Service (ATS) at Firshill Rise, without the prior written agreement of the CQC

Having identified the issues at Firshill Rise, we recognised the opportunity to modernise the service with greater community focus. This requires system support the approach to which is being led by the Trust. The unit will remain closed until that modernisation programme is completed.

I am assured around the work in place to address areas of weaknesses in control noted by our Internal Auditors and acknowledgement from them of the improvements made in continuing to demonstrate we remain on a positive and demonstrable trajectory of improvement.

In conclusion whilst significant internal control weaknesses existed in 2021/22, these have been addressed, with significant progress recognised by the CQC in addressing the previous internal control issues identified in 2019/20. New internal control issues identified in 2021/22 have been addressed; in this financial year our CQC rating was re-rated from 'inadequate' to 'requires improvement' and our System Oversight Framework segmentation improved from SOF4 to SOF3.

To the best of my knowledge, no further significant internal control issues over and above those identified in this report, have been identified within 2021/22.

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

3.8 Equality Report

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

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

Our values are:

- Working together for our service users
- Respect and kindness
- Everyone counts
- Commitment to quality
- Improving lives.

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

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

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

3.8.1 Equal opportunity and dignity statement

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

3.8.2 Key achievements over the past 12 months

- Recruited a Human Rights Officer to lead on our work to ensure the rights of our service users are protected
- We introduced a new Inclusion and Equality Group to oversee our approach to equality, diversity and inclusion
- We agreed our organisation Anti Racist Commitment
- We provided leaders training on anti racism
- We joined Phase 2 of the national Rainbow Badge initiative

- We piloted a new approach to supporting staff experiencing hate incidents in our services
- We took part in the NHS Flex for the Future programme
- We developed digital stories focused on disability in partnership with Sheffield Flourish following a successful bid to the Workforce Disability Equality Standard Innovation Fund
- We introduced an Equality Diversity and Inclusion (EDI) Engagement Lead post for the Workforce Race Equality Standard
- We introduced an EDI administrative role focused on supporting EDI work and our staff networks
- We introduced an EDI Health Inequality (Staff) role
- We celebrated LGBT History Month with a series of workshops and celebrated the introduction of our rainbow crossings on a number of our sites
- We held our annual Working Together conference

3.8.3 Find out more

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

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

3.9 Sustainability Report

In 2020/21 the Trust developed a Board approved Sustainability Strategy known as the ‘Green Plan’. The Green Plan sets out the our commitments and approach to transitioning to a net zero carbon organisation. In addition, the Green Plan will create a framework to allow the Trust to minimise our environmental impact, improve the mental, physical and social wellbeing of people in our communities and ensure our services are adapted to the growing impacts of climate change.

The Green Plan reflects the national Greener NHS Programme priorities laid out in the ‘Delivering A Net Zero National Health Service Report’. However, in term of timescales, the Trust has made a commitment to be ambitious, going beyond the national net zero carbon targets for the emissions under our control. We aim for the emissions we control directly (our carbon footprint) to be net zero by 2030, this brings the national Greener NHS target forward by 10 years and aligns the Trust to our partners across the city.

Climate change is likely to impact health in Sheffield in different ways including heatwaves, worsened cold weather, storms and floods. Our work directly and indirectly contributes to the causes of climate change, reduced air quality and the associated health impacts. For instance, air pollution alone is linked to 500 deaths a year in Sheffield, with many of the most polluted communities being not only the most deprived, but the ones closest to Sheffield’s large hospitals. As well as physical health impacts there will be mental health impacts directly affecting how we deliver our services with an increasing number of studies concluding climate change events increase presentations of Post-Traumatic Stress Disorder (PTSD) and anxiety among the general population. The Trust acknowledges it is often the health of marginalised and deprived communities that are impacted the most therefore we must ensure our actions avoid accentuating existing health inequalities.

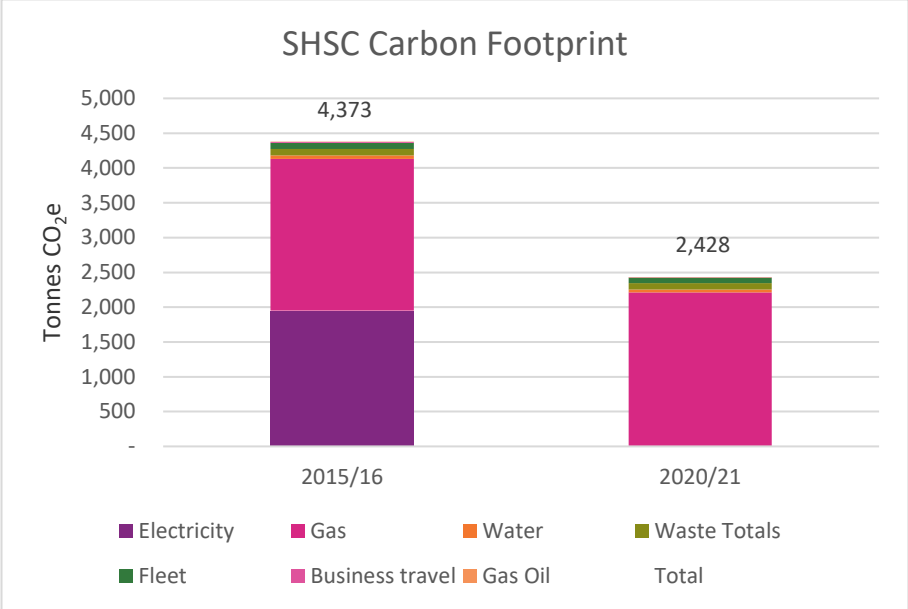
3.9.1 Our carbon footprint

Our day to day work generates carbon emissions and consequently we are contributing to the climate health crisis.

Developing our Green Plan included calculating the Trust’s carbon footprint (using the National NHS carbon Footprint format) for two years, 2015/16 and 2020/21.

We will continue to calculate this annually and report our progress.

Our carbon footprint includes emissions that are in our direct control, indirectly under our control and those emissions which are out of our control but we can influence.



Our carbon footprint analysis demonstrates we have reduced carbon emissions from the baseline year of 2015/16 to 2020/21 by 44%. Reductions have been achieved across all emissions sources, with the exception of natural gas, which has increased by 1%.

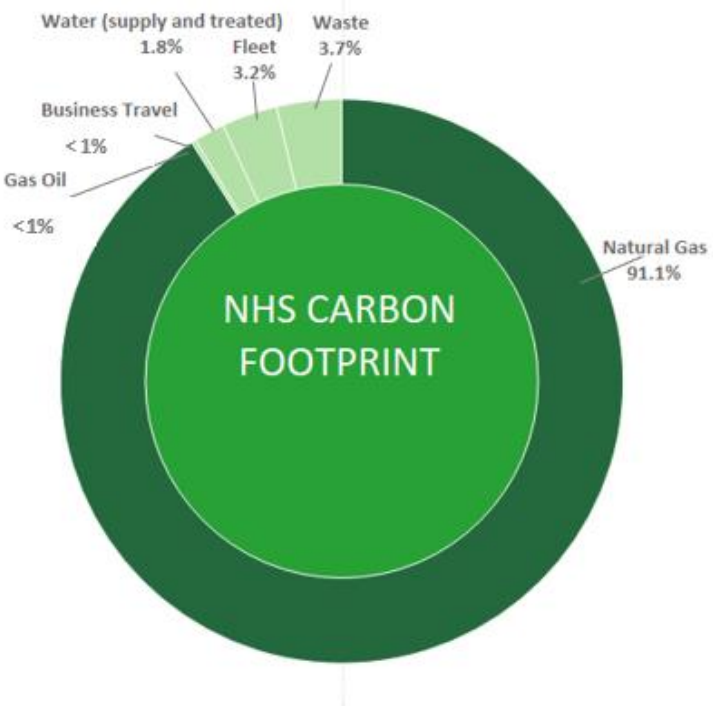
We must review our emissions figures with caution due to the impact of the COVID-19 pandemic when assessing the 2021/22 performance.

tCO_2e	**2015/16**	**2020/21**	**% change (2015/16 vs 2020/21)**
Grid electricity	1,949	0	-100%
Natural gas	2,180	2,211	+1%
Gas oil	1	0.4	-68%
Water	52	43	-18%
Waste	92	90	-2%
Fleet	89	78	-13%
Business travel	10	6	-43%
Total	**4,373**	**2,428**	**-44%**

The 44% reduction in our carbon emissions reflects our investment in a zero-carbon REGO-backed electricity tariff from April 2020 onwards.

Our ratios in respect to where we impact on carbon emissions we control are shown below in the NHS Carbon Footprint format.

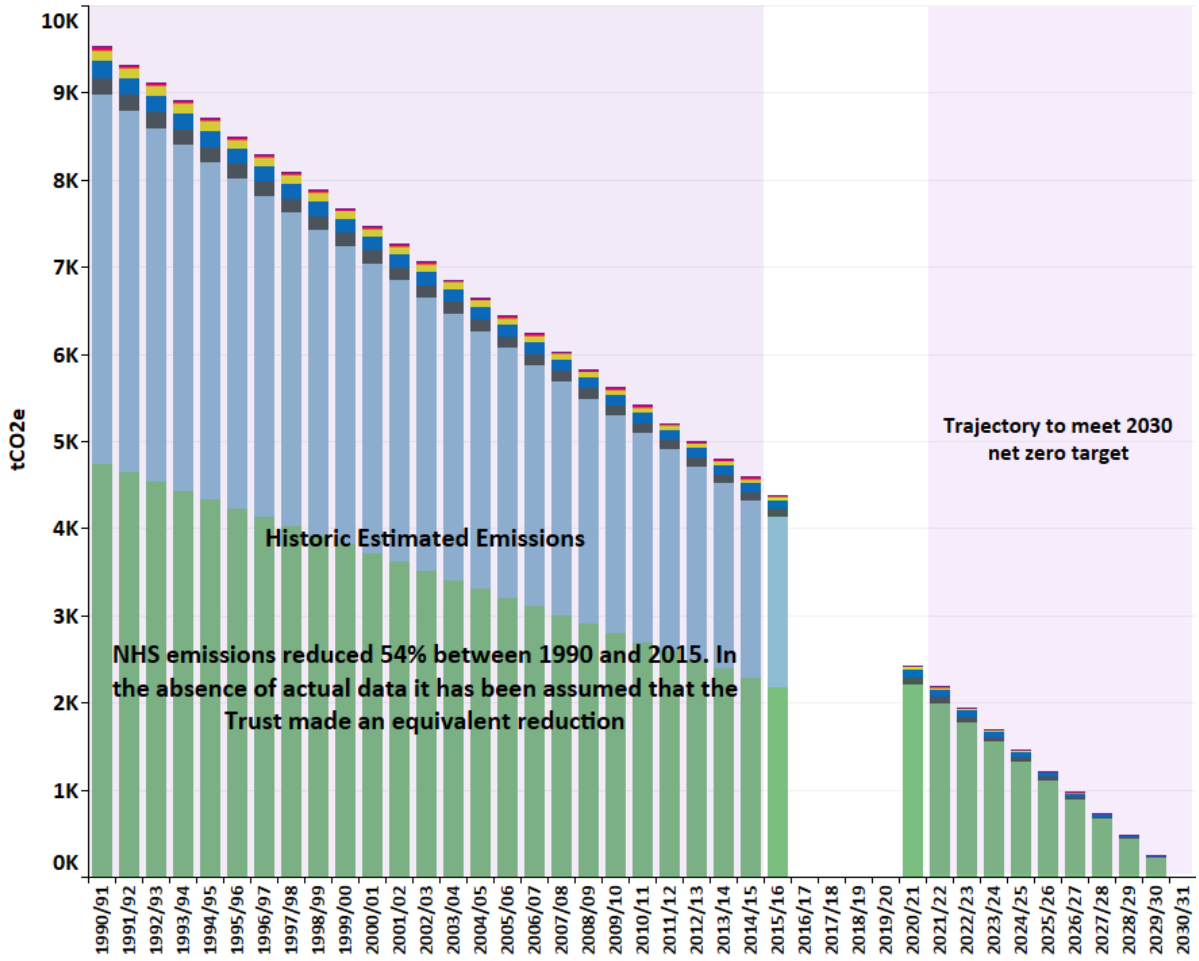
As a Trust we do not use anaesthetic gas therefore we have a different distribution of emissions, very heavily weighted towards the use of natural gas to heat our sites. To achieve our net zero carbon target by 2030 it is vital we prioritise the decarbonisation of our Estate in order to reduce our natural gas consumption.



To commit to carbon reduction, we must also commit to monitoring our carbon emissions. Each year we will calculate our carbon footprint annually and report to the Trust's Board.

We will develop and publicise an Annual Sustainability Report and share this with staff, patients, visitors, the local community and other stakeholders.

The table below shows the emissions reductions that are required to achieve the Trust's net zero target by 2030 for carbon emissions within our control.



In order to establish our 1990/91 baseline, we have calculated our NHS Carbon Footprint for 2015/16 which NHS England has published an overall reduction in emissions of 54% since 1990.

Based on this we would extrapolate our emissions in 1990/91 as 9,719 tCO2e. This makes our overall current reduction in emissions since 1990/1 approximately 7,150 tCO2e, a reduction of 74%.

This places us in a good position, but the incremental effort required to reduce each additional tonne of carbon equivalent increases significantly, so we cannot be complacent.

SHSC 1990/91 carbon baseline calculations	1990	2010	2015	2019	2020	2024
Climate Change Act - Carbon Budget Target		25%	31%		37%	
NHS Carbon Footprint (MtCO2e)	16.2	8.7	7.4	6.1		
NHS Carbon Footprint as a % Reduction on 1990		46%	54%	62%		
SHSC Carbon Footprint (tCO2e)	9,719		4,471		2,565	1,539
SHSC Carbon Footprint as a % Reduction on 1990			54%		74%	84%
NHS Carbon Footprint Plus (MtCO2e)	33.8	28.1	27.3	25		
NHS Carbon Footprint Plus as a % Reduction on 1990		17%	19%	26%		

To be on target for our net zero 2030 goal we need to reduce our emissions to 1,539 by the end of our current Green Plan in three years' time, a reduction of 1,026 tCO2e.

3.9.2 The Green Plan: our aims

The scale of the challenge faced by the Trust to change working practices and behaviours is broad and diverse and a rapid response will be needed at every level of our organisation to both mitigate and adapt to the challenges of climate change.

We have established key aims for our Green Plan:

- For the emissions we control directly (our carbon footprint) to be net zero by 2030 and for the emissions we can influence to be net zero by 2045.
- To provide sustainable services through ensuring value for money, reducing wastage and increasing productivity from our resources
- Continuously developing our approach to improving the mental, physical and social wellbeing of the communities we serve through innovation, partnership and sharing
- We will promote a culture of collaboration, supporting our people and suppliers to work together to make a difference
- We will innovate and transform to provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing

Th Green Plan will identify the enabling actions required to reduce our carbon footprint and enhance sustainability for example by:

- Creating the Leadership and Governance structure to drive change
- Engaging and training staff to embed sustainability

- Developing Sustainable Models of Care
- Reducing the carbon impact of the medicines we prescribe

The Trust has set up a Sustainable Development Group, chaired by Phillip Easthope, Executive Director of Finance, and Board level net zero lead for the organisation. The group reports into the Finance Performance Committee on a quarterly basis and membership includes representation from across all directorates who will each be a workstream lead for the nine areas of focus identified within the Green Plan.

The nine areas of focus are:

- Estates and facilities
- Digital transformation
- Adaptation
- Medicines
- Food and nutrition
- Supply chain and procurement
- Travel and transport
- Workforce and system leadership
- Sustainable models of care

One of the first priorities of the group will be to produce a Green Plan Action Plan with SMART (Specific, measurable, attainable, realistic and timebound) targets using the outcome of the Sustainable Development Assessment Tool (SDAT) completed to support the development of the Green Plan.

The SDAT was created to help NHS organisations to benchmark their sustainability performance, measure progress and develop aims and objectives to improve the application of the principles of sustainable development across an organisation. Our Green Plan Action Plan so far contains 274 statements, aligned to each area of focus within the Green Plan. For each statement we have stated how we will target achieving the outcome of the statement over the next three years, responding as either:

- Already achieved and we can sufficiently evidence we are already doing this as a Trust
- Targeted action to be achieved within Green Plan period
- Target in progress where we are in the planning or implementation phase to achieve our target and can evidence the planning/ progress towards achieving target
- Not targeted for those statements which are either not relevant to our Trust or targets which have dependencies on linking targets being achieved first so will not be prioritise during this Green Plan period.

The table below demonstrates the number of actions aligned to each focus are of the Green Plan.

Green Plan area of focus	Green Plan actions				Total actions
	Already achieved	Targeted	In progress	Not targeted	
Adaptation	6	5	6	8	25
Digital Transformation	3	1	0	0	4
Estates and Facilities	2	25	14	3	44
Food and Nutrition	2	5	4	0	11
Supply Chain and Procurement	4	20	13	5	42
Sustainable Models of Care	2	8	10	3	23
Travel and Transport	3	14	6	4	27
Workforce and System Leadership	9	55	26	8	98
Medicines	*No statements within current version of SDAT*				274

Our targeted performance at the end of this Green Plan period reflects an intended effort to increase the pace of change we are working at over the next three years. In 2021/22 we will focus our efforts to embed sustainable development into everything we do.

We need to spend the next three years targeting actions that will enable the Trust to build our knowledge on the topic, increase pathways to measure and monitor our sustainable development performance and carbon reductions and to train and engage our staff to support our Green Plan goals. We will need to demonstrate leadership and an established drive for improvement both within the Trust and across the SYB ICS region.

3.9.3 Our priorities

We will prioritise actions that reduce carbon emissions, improve sustainability performance and the health of our region. Some initial priorities are detailed below:

- To create a Sustainable Buildings Action Plan to inform our estate rationalisation
- To ensure sustainability is an area our leadership are focussed on by training our Board and providing enhanced CPD training to our Board leads and senior Sustainability personnel
- To procure a new EPR (Electronic Patient Records) System

- To train and engage our staff on sustainability to support the goals of our Green Plan
- To assess the potential routes to introduce a Travel and Transport Co-ordinator role to the Trust
- To write a Climate Change Risk Assessment for each site, to add to our Sustainable Buildings Action Plan
- To create the following policies with sustainability in mind:
    - Capital projects
    - Sustainable procurement
    - Sustainable travel
- To write the following strategies with sustainability in mind:
    - Green space and biodiversity
    - Nutrition and hydration
    - Waste
- To assess the results of our Scope 3 emissions study and engage with our supply chain to understand their current net zero targets and publicise our Green Plan to them
- To focus on meeting our obligations under the NHS Standard Terms and Conditions around sustainability
- To set up the governance structures to enable reporting the key performance indicators of our sustainability targets to the board on a regular basis.

Section 4.0 Auditor's Report

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

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sheffield Health and Social Care NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.1

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries.

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

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included postings by the Director of Finance, unusual debit and credit entries to cash and material post close journals.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Testing of accruals in order to assess the existence and accuracy of accruals recorded in the financial statements.

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

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

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

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

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

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

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

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

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

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

Other information in the Annual Report

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

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

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion the Annual Report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 98, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

The Trust has been responding to historic issues following an inadequate rating of CQC in April 2020. Despite significant progress being made during the year, there is evidence that statutory/regulatory requirements have not been met throughout the year. For instance, for the majority of the financial year the previous Section 29A enforcement notice was in place (closed in February 2022) and the Trust was in SOF4 until March 2022. We also note during 2021-22 Trust management reported their concerns to CQC over the Assessment and Treatment Service, which led to a CQC visit in April 2021 that concluded the service was inadequate and CQC placed a condition on the Trust that they must not admit any service user to this service without the written permission of CQC.

Consequently, our judgement is that the Trust had significant weaknesses in its arrangements for improving economy, efficiency and effectiveness in respect of ensuring statutory and regulatory requirements throughout the year.

We have not raised a recommendation as a recommendation was made during 2020/21 which the Trust has now implemented. Further details are available in the Auditor's Annual Report.

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

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

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

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

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

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

1 July 2022

Section 5.0 Annual Accounts

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by Sheffield Health and Social Care NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

After making enquiries and reviewing independent evaluations, the Directors have a reasonable expectation that the services provided by Sheffield Health and Social Care 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.

Jan Ditheridge

Jan Ditheridge
Chief Executive (as Accounting Officer)
Date: 29 June 2022

The Accounts of Sheffield Health and Social Care NHS Foundation Trust for the period ending 31 March 2022 follows the four primary statements:

- the Statement of Comprehensive Income (SOCI)
- the Statement of Financial Position (SOFP)
- the Statement of Changes in Taxpayers' Equity (SOCITE)
- the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.

These statements are followed by supporting notes to the accounts and relevant disclosures as required by financial standards.

Note 1 outlines Sheffield Health and Social Care NHS Foundation Trust's accounting policies and procedures. Subsequent notes provide further details and disclosures explaining some of the main items reflected on the four primary statements above. The notes are cross referenced on the relevant statements.

The financial statements (accounts) were approved by the Board on Wednesday 29 June 2022 and signed on its behalf by:

Jan Ditheridge

Jan Ditheridge
Chief Executive
Date: 29 June 2022

Statement of Comprehensive Income

	Note	2021/22 £'000	2020/21 £'000
Operating income from patient care activities	3	130,481	118,174
Other operating income	4	21,368	35,537
Operating expenses	6, 8	(149,667)	(149,813)
Operating surplus/(deficit) from continuing operations		**2,182**	**3,898**
Finance income	11	29	1
Finance expenses	12	(25)	(22)
PDC dividends payable		(1,765)	(1,374)
Net finance costs		**(1,761)**	**(1,395)**
Other gains / (losses)	13	(1)	(20)
Surplus / (deficit) for the year from continuing operations		**420**	**2,483**
Surplus / (deficit) for the year		**420**	**2,483**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(516)	(259)
Revaluations	15	5,946	7,510
Other recognised gains and losses		-	(521)
Remeasurements of the net defined benefit pension scheme liability / asset	29	2,407	(118)
Other reserve movements		(394)	1
Total comprehensive income / (expense) for the period		**7,863**	**9,096**

Statement of Financial Position

	Note	31-Mar-22 £'000	31-Mar-21 £'000
Non-current assets			
Intangible assets	14	1,363	1,062
Property, plant and equipment	15	55,238	57,810
Receivables	21	4,434	4,554
Assets held for Sale	34	8,050	
Total non-current assets		**69,086**	**63,426**
Current assets			
Inventories	20	81	67
Receivables	21	8,034	6,350
Assets held for Sale	34	3,950	-
Cash and cash equivalents	22	58,757	62,075
Total current assets		**70,822**	**68,492**
Current liabilities			
Trade and other payables	23	(13,037)	(13,493)
Provisions	25	(762)	(613)
Other liabilities	24	(865)	(291)
Total current liabilities		**(14,664)**	**(14,397)**
Total current assets less current liabilities		**56,158**	**54,095**
Non-current liabilities			
Provisions	25	(984)	(774)
Other liabilities	24	(3,301)	(5,265)
Total non-current liabilities		**(4,285)**	**(6,039)**
Total assets employed		**120,959**	**111,482**
Financed by			
Public dividend capital		41,181	39,567
Revaluation reserve		25,786	20,355
Income and expenditure reserve		53,993	51,560
Total taxpayers' equity		**120,959**	**111,482**

The notes on pages 142 to 194 form part of these accounts.

Jan Ditheridge

Jan Ditheridge
Chief Executive (as Accounting Officer)
Date: 29 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£'000	£'000	£'000	£'000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**39,567**	**20,355**	**51,560**	**111,482**
Surplus/(deficit) for the year	-	-	420	420
Impairments	-	(516)	-	(516)
Revaluations	-	5,946	-	5,946
Transfer to retained earnings on disposal of assets	-	-	-	-
Other recognised gains and losses	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	2,407	2,407
Public dividend capital received	1,614	-	-	1,614
Other reserve movements	-	-	(394)	(394)
Taxpayers' and others' equity at 31 March 2022	**41,181**	**25,786**	**53,993**	**120,959**

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

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

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a public sector equity finance transferred from NHS predecessor organisations.

The dividend (finance charge) paid to the equity fund is calculation on a ratio of assets over liabilities at the end of the financial year. Additional funds from the public sector equity may also be issued to trusts by the Department of Health and Social Care to finance capital projects or working capital.

The dividend charge to the Trust is reflected in the financial statement of the year and calculated as shown below:

	2021/22 £'000
Opening Net assets at 1 April 2021	110,598
Closing Net Assets at 31 March 2022	117,722
	228,320
Average Net Assets 2021/22	**114,160**
Average Daily cash balance 2021/22	(63,762)
Final average relevant net assets	50,398
PDC dividend rate charged on relevant assets	3.5%
Calculated PDC dividend	**1,764**

Revaluation reserve

Increases in value of assets arising from revaluations are recognised in revaluation reserves unless the increase reverses previous impairments. In that case the previous impairment is recognised in operating income and any valuation over that impairment is processed to revaluation reserves. Reductions in value of asset (impairments) arising from revaluation are charged to revaluation reserves if previous gains were recognised on the affected assets. If the reduction in value represents a clear consumption of economic benefit or a reduction in service potential, then the impairment is charged against operating income.

Income and expenditure reserve

The Income and Expenditure reserve represents the accumulation of surpluses or deficits in the Trust’s operations over the years

Statement of Cash Flows

	Note	2021/22 £'000	2020/21 £'000
Cash flows from operating activities			
Operating surplus / (deficit)		2,182	3,898
Non-cash income and expense:			
Depreciation and amortisation	6	2,980	3,406
Net impairments	7	911	3,152
Non-cash movements in on-SoFP pension liability		443	378
(Increase) / decrease in receivables and other assets		(1,779)	1,358
(Increase) / decrease in inventories		(14)	46
Increase / (decrease) in payables and other liabilities		503	1,598
Increase / (decrease) in provisions		368	255
Other movements in operating cash flows		(428)	(312)
Net cash flows from / (used in) operating activities		**5,166**	**13,779**
Cash flows from investing activities			
Interest received		29	9
Purchase of intangible assets		(599)	(432)
Purchase of PPE and investment property		(7,977)	(5,151)
Proceeds from sales of property, plant and equipment and investment property		183	-
Net cash flows from / (used in) investing activities		**(8,364)**	**(5,574)**
Cash flows from financing activities			
Public dividend capital received		1,614	4,062
PDC dividend (paid) / refunded		(1,733)	(1,210)
Net cash flows from / (used in) financing activities		**(119)**	**2,852**
Increase / (decrease) in cash and cash equivalents		**(3,318)**	**11,057**
Cash and cash equivalents at 1 April - brought forward		62,075	51,018
Cash and cash equivalents at 31 March	22	**58,757**	**62,075**

Notes to the Accounts

Note 1.1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts should meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), that are agreed with HM Treasury.

This financial statement has, therefore, been prepared in accordance with the DHSC Group Accounting Manual (GAM) 2021/22 dated 12 May 2021, issued by the Department of Health and Social Care (DHSC) and in line with the amendments to the GAM issued in January 2022.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected.

The policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to these accounts.

Sheffield Health and Social Care NHS Foundation Trust ("SHSC") achieved foundation trust status on 1 July 2008 and have been operating as a going concern since then.

Note 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 1.1.2 Accounting period
The accounts of the Trust have been drawn up for the year from 1 April 2021 to 31 March 2022.

Note 1.1.3 Acquisitions and discontinued operations
Activities are 'acquired' only if they are taken from outside the public sector. Activities are 'discontinued' only if they cease entirely. They are not considered 'discontinued' if they transfer from one public sector body to another.

Note 1.2 Going concern
The Trust’s annual report and accounts have been prepared on a going concern basis, as approved by the Board. There is reasonable assumption that the Trust can continue in existence into the foreseeable future.

Note 1.3 Interest in other entities

NHS charitable funds

Sheffield Health and Social Care NHS Foundation Trust (SHSC) is related to Sheffield Hospitals Charitable Trust, under the umbrella registration of 1059043-3. The Trust is not a corporate trustee of the charity. The Trust assessed its relationship to the charitable trust and determined that it is not a subsidiary because The Trust does not have powers to govern the financial and operational policies of the charitable trust to obtain benefits from its activities for its stakeholders. Because of this relationship the Trust will not be consolidating the Sheffield Hospitals Charity into their accounts. The Department of Health and Social Care corresponds directly with NHS charities who are independent of their linked trust (with independent trustees) to obtain the information they require to consolidate into Department of Health and Social Care group. Sheffield Hospitals Charity is one such charity. During 2021/22 the Trust did not receive any donations through the charity.

Subsidiaries

Subsidiaries are entities where the Trust has power to exercise control. The Trust has control when it can affect the variable returns from the other entity through its power to direct relevant activities. Their accounts should then be consolidated into the Trust's. The income, expenses, assets, liabilities, equity, and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not coterminous. Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'. In 2015/16 the Trust established a wholly owned operating company, 7 Hills Care and Support Ltd. The company was closed and taken off the register of companies on 5 April 2022 (post this financial statement).

Associates

Associates are entities where the Trust can exercise significant influence to obtain economic or other benefits. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the Trust from the associate. Associates which are classified as held for sale are measured at the lower of their carrying amount and "fair value less costs to sell". The Trust did not have any recognised Associates during financial year 2021/22.

Joint arrangements

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement/activity/entity. A joint arrangement is either a joint operation or a joint venture. A joint operation exists where the parties that have joint

control have rights to the assets, and obligations for the liabilities relating to the arrangement/activity/entity.

Where the Trust is a joint operator, it recognises its share of, assets, liabilities, income, and expenses in its own accounts. During 2021/22 the Trust did not have any joint arrangement/activity/entity.

Note 1.4 Critical judgements and key sources of estimation uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The Trust confirms that it has not used any key assumptions concerning the future or had any key sources of estimation uncertainty at the end of the reporting period that have risk of causing material adjustments to the carrying amounts of assets and liabilities within the next financial year that need to be disclosed under IAS1.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Based on existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in Note 16.1.

Note 1.4.1 Critical judgements in applying accounting policies
The main area of estimation uncertainty within the Trust is the carrying value of the property portfolio and the assumptions used in the determination of fair value at the Statement of Financial Position date. To minimise the risk of material misstatement, a full property valuation was commissioned by the Trust for 31 March 2022. Provisions have been calculated after recognising obligating events during the year and include estimates and assumptions relating to the carrying amounts and timing of anticipated payments. Litigation provisions are based on estimates provided through NHS Resolution and injury benefit provisions calculated on figures from NHS Business Services Authority. Refer to Paragraph 1.15 for further details.

Further areas of estimation are around net liability to pay pensions in respect of staff who transferred to the Trust from Sheffield City Council. This estimation depends on judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in the retirement ages, mortality rates, and expected returns on pension fund assets. Consulting actuaries, Hymans Robertson, engaged by the South Yorkshire Pensions Authority, provide the Trust with expert advice on assumptions applied in the valuation of these pensions.

The Trust's standard policy is to carry out full revaluation of lands and buildings every five years, with a provision for a tabletop revaluation during the third year. A full revaluation was undertaken in March 2022 to align with the take of leased assets under IFRS 16 and to measure the impact of the U.K. exit from Europe on asset values. A full review of existing assets and lease additions will be considered within the financial statement and reported under a separate note.

Most of the Trust's fixed assets are specialised assets, used to deliver healthcare services for the Trust, except Wardsend Road (office space). The Specialised assets were revalued at their "depreciated replacement cost" or fair value for those that were added to the portfolio of assets. This technique involves assessing all the costs of providing a modern equivalent asset using pricing at the valuation date. In making these judgements, the Trust is aware that the Royal Institute of Chartered Surveyors (RCIS) issued in April 2020, a valuation practice guidance to valuers where valuers must declare material uncertainties attached to valuations considering impact of COVID-19 on markets. The Trust obtained a valuation report for 2021/22 which considered possible deviances coming from both the impact of COVID-19 and the U.K. exit from the European Union. Given the judgements explained above in preparing the financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation to which a materiality uncertainty might be attached.

Note 1.5 Transfers of functions

As public sector bodies operate under DHSC regulations and control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the DHJSC Group Accounting Manual (GAM) requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gains or losses resulting are recognised in the Statement of Comprehensive Income and are disclosed separately from operating income and expenditure.

Note 1.6 Revenue

In the application of IFRS 15 several practical expedients offered in the standard have been employed. These are:

- The Trust does not disclose information regarding performance obligations of contracts that have a duration of one year or less
- The Trust does not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application
- The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. At year end, the Trust accrues income relating to performance obligations satisfied in that year but not invoiced. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue

- Where income is received for a specific performance obligation that is to be satisfied in following years, that income is deferred into the corresponding year. The method adopted to assess progress towards the complete satisfaction of a performance obligation is the input method, i.e. the measure of resources consumed to deliver services.

Other income
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.

Note 1.7 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages, and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is accrued in the financial statements only for those employees permitted to carry-forward leave into the following period. In all other cases such leave is forfeited and lost at the end of the financial year.

Pension costs

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

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

An outline of these follows:

a) **Accounting valuation**
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability

as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

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 employee entitlements post-employment. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Local Government Pension Scheme
Some Trust employees who were transferred from Sheffield City Council elected to remain with the Local Government Pension Scheme, administered by the South Yorkshire Pensions Authority, which is a defined benefit pension scheme. The assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. These postings are mostly countered by the terms of the current partnership agreement. The terms of the current partnership agreement with Sheffield City Council ('the Council') provide that any long-term pension liability arising from the scheme will be funded by the Council, except for any pension changes which relate to salary increases more than any local government grading agreements. The impact on the current and prior year Statement of Comprehensive Income and Statement of Changes in Taxpayers' Equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is mostly negated by the inclusion of a corresponding non-current receivable with the Council. For further information see Note 27 and 27.1.

Note 1.8 Expenditure on other goods and services
Expenditure on goods and services is recognised when they are received in full. The value is normally the fair or agreed value of those goods and services. Expenditure is recognised in operating expenses except where it is for the acquisition of a non-current asset such as property, plant and equipment, furniture and fitting, or long-term intangible asset.

Note 1.9 Property, plant and equipment

Note 1.9.1 Recognition
Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of £5,000 or more inclusive of value added tax, or
- collectively, items have a cost of £5,000 with each individual item having a cost of £250 or more. The grouped assets should be functionally interdependent, have broadly the same purchase dates, are anticipated to have similar economic lives and are in use or controlled by one department.

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

Note 1.9.2 Measurement

Valuation
All property, plant and equipment are initially measured 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 to. When such assets are revalued, their value is adjusted to those determined by the valuers and their useful cost.

Assets held for their service and still in use (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that held for their service potential but are surplus with no plan to bring them back into use, are measured at fair value. If there are no restrictions to the sale of such assets at the reporting date, and such assets do not meet the definitions of investments, they are classified as “assets held for sale” in the financial statements.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. These valuations are carried out by professionally qualified valuers in accordance with Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Fair values are determined as follows:

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

A full revaluation was undertaken as at 31 March 2022 and are reflected in these financial statements.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties under construction for service or administration purposes are carried at cost in this financial statement. Cost will include professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences in the following quarter when the assets are brought into use.

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

Subsequent expenditure
Subsequent expenditure relating to items of property, plant and equipment is recognised as increases in the value 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 capital expenditure recognition above. Its value is added to the cost of the existing asset and the replacement de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, are charged as expenditure to the Statement of Comprehensive Income in the period they occur.

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

Property, plant and equipment reclassified as ‘held for sale’ ceases to be depreciated upon reclassification. Assets under construction are not depreciated until they are brought into use.

Revaluation gains and losses
Revaluation gains are recognised in revaluation reserve, except where they are a reversal of revaluation decreases (impairments) that have previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

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

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

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

Note 1.9.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the following conditions 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 i.e:
    - 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 abandoned, 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. Assets are de-recognised when all material sale contract conditions have been met. The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the income statement. On disposal, the balance for the asset on the revaluation reserve, donated asset reserve or government grant reserve is transferred to retained earnings. The Trust will transfer the revaluation excess on Fulwood site (£11.6 million).

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 with an adjusted useful life in line with the expected period before scrapping or demolishing. The asset is de-recognised when scrapping or demolition occurs.

Assets held as "Excess to Requirements" or Surplus Assets are valued at fair value and depreciated as part of operational assets. Such assets, if not sold, will retain the status of operating assets until they are either disposed of, sold, or brought back into operation. Fulwood land was classified as surplus assets for the financial year 2020/21.

Note 1.9.4 Donated assets and Government grant funded assets
Donated non-current assets are capitalised at current value in existing use, if they are held for their service potential, or at fair value on receipt, with a matching credit to income. They are valued, depreciated, and impaired as other purchased assets above. Gains and losses on revaluations, impairments and sales are treated in the same way as purchased assets.

Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Note 1.9.5 Investment property
Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure. Only assets held solely to generate commercial returns are classified as investment properties. Where an asset is held, in part, to support services, then it should be classified as part of the general assets and rental charged for the part being leased out. Properties occupied by employees, whether they pay rent at market rates, are not classified as investment properties.

	Minimum life - years	Maximum life - years
Buildings, excluding dwellings	15	50
Plant and machinery	5	15
Transport equipment	3	7
Information technology	3	7
Furniture and fittings	7	10

Freehold land, assets under construction or development, investment properties, and assets held for sale are not depreciated. Depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives.

The estimated economic useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss. Intangible assets not yet available for use are tested for impairment annually at the financial year end. Several Trust properties are due for useful life reviews in 2022/23 in line with the Estates Strategy.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above. This note is likely to change with the implementation of IFRS 16 in 2022/23.

Note 1.10 Intangible assets

Note 1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow, or services be provided to the Trust and where the cost of the asset can be measured reliably and when the cost is £5,000 and above inclusive of VAT.

Internally generated intangible assets

Software

Software that is integral to the operation of hardware like operating systems, is capitalised as part of the related item of property, plant and equipment. Software that is not integral to the operation of hardware like most application software, is capitalised as intangible assets.

Expenditure on research is not capitalised but is recognised as an operating expense in the period it occurs. Internally developed software is recognised when the following conditions have been met:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the Trust intends to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial, and other resources to complete the intangible asset and sell
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Note 1.10.2 Measurement

Intangible assets acquired separately are recognised at cost. The amount recognised for internally developed intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally developed intangible asset can be recognised, the expenditure is recognised in the period in which it occurs.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market. Where no active market exists, they are valued at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

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

Note 1.10.3 Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.10.4 Economic lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The Trust’s range of useful lives are shown below:

	Minimum life - years	Maximum life - years
Information technology	3	7
Software licenses	3	7
Licenses and trademarks	3	7
Other (purchased)	3	7
Goodwill	3	7

Note 1.11 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Cash and cash equivalents
Cash resources cover cash in hand (including petty cash), and cash deposits with financial institutions available on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of investment and that are readily convertible to cash but carry some 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or issue another financial instrument in compensation. The GAM the definition of such contractual obligations includes legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

Note 1.13.2 Classification and measurement
Financial assets and financial liabilities are measured at fair value plus or minus directly attributable transaction costs or through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by other fair valuation techniques.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, SHSC recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of estimated future cash flows discounted at the financial asset’s original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

For 2021/22 financial year, the Trust did not have any investments or obligation under financial instruments.

Note 1.14 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 SHSC as lessee

Finance leases
Property, plant and equipment held under finance leases are recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

During 2021/22 the Trust had no finance leases.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land and building component are separated and individually assessed as to whether they are operating or finance leases.

Treatment of operating leases will change in 2022/23 with the full implementation of IFRS16.

Note 1.14.2 SHSC as lessor

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

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

The note on leases will change with the implementation of IFRS 16 in 2022/23.

Note 1.15 Provisions
Provisions are recognised in the financial statement when the Trust has a present legal or constructive obligation for compensation or payment relating to past actions, commitments, or legal charges. Provisions are processes for these when reliable and measurable estimates to settle the obligations can be obtained. These may require adjustment for the value of time. Where a provision is adjusted for the time value of fund using cash flows estimated to settle the obligation, the carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 1.30% (2020-21: negative 0.95%) in real terms.

Note 1.16 Clinical negligence costs
NHS Resolution operates a risk pooling scheme (insurance) under which the Trust pays an annual contribution to them to cover all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in Note 24.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of claims are charged to operating expenses as and when they become due.

The Trust provided £184,000 in their financial statement as possible excess costs for pending cases of public liability and employer liability.

Note 1.17 Contingencies
Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the SHSC's control. These are not recognised as assets but are disclosed in a note to the accounts where an inflow of economic benefits is probable.

SHSC had no contingent assets at 31 March 2022.

Contingent liabilities are:

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

Contingent liabilities are not recognised in the accounts but are disclosed in a note in the accounts unless the probability of a transfer of economic liability is remote. The Trust did not have any contingent liabilities to disclose for the financial year 2021/22.

Note 1.18 Public dividend capital (PDC) and PDC dividend
Public dividend capital are funds issued by the Department of Health and Social Care (DHSC) to fund public sector equity. This represents the DHSC's investment in the Trust. HM Treasury has recognised the investment as being issued under statutory authority rather than under contract, so PDC is not a financial instrument within the meaning of IAS 32. The Secretary of State has rights to issue new PDC or require repayments of PDC to and from the Trust at any time.

PDC capital is recorded in these accounts at the value received.

A periodic charge reflecting the cost of PDC capital utilised by the Trust, is paid to the Department of Health and Social Care as dividends. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, taking out:

i. donated and grant funded assets
ii. 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 short-term working capital facilities
iii. any PDC dividend balance receivable or payable
iv. capital scheme contributions through MOUs supported through public bodies
v. Capital support offered for COVID-19 related schemes.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant

net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the Trust’s group accounts (i.e including subsidiaries) but excluding consolidated charitable funds.

Note 1.19 Value added tax
Most of the activities of the Trust are outside the scope of Value Added Tax (VAT) so output tax does not generally apply and input tax on purchases is also normally not recoverable. Irrecoverable VAT is charged to expenditure or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax
The Finance Act 2004 amended Section 519A of the Income and Corporation Taxes Act 1998 to empower HM Treasury charge corporation tax on non-core activities of the Trust where profits exceed £50,000 per annum. This covers activities that fall outside healthcare provision and are not in support of any activities that add viability to the core functions of the Trust. These activities are subject to regular review.

The Trust carried the review of corporation tax liability of its non-healthcare activities for the financial year 2021/22 and no activities ancillary to patient and health care earned £50,000 or more in income for the year.

Note 1.21 Foreign currencies
The Trust’s functional currency and presentational currency is pound sterling, and numbers in these accounts are presented in thousands of pounds unless expressly stated otherwise. Transactions that are denominated in foreign currency are translated into the functional currency at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

Note 1.22 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. These are, however, disclosed in a separate note to the accounts in line with the requirements of HM Treasury’s FReM.

Note 1.23 Losses and special payments
Losses and special payments are payments that arise outside the normal business of health care provision. These payments are subject to special control procedures compared with most payments. The payments are categorised, and the governance is different.

Losses and special payments are normally covered by insurance with the excess charged to revenue as and when the cases are reported. Cases that are not paid through the normal insurance cover are charged to revue in the year they occur.

Note 1.24 Gifts
Gifts or voluntary donations, with no preconditions and without expectation of any return are treated by the Trust as charitable donations. These gifts include transactions economically equivalent to free and unremunerated transfers, such as the loan of assets over their expected useful life, and the sale or lease of assets to the Trust at below market value. All these gifts and conations, both tangible and intangible, are recorded as donated assets in the Trust's asset registers and depreciated in line with normal asset depreciation policy.

Note 1.25 Early adoption of standards, amendments, and interpretations
No new accounting standards or revisions to existing standards have been adopted in 2021/22.

Note 1.26 Standards, amendments, and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following Standards and Interpretations to be applied in 2021/22. These standards are still subject to HM Treasury FReM adoption, with IFRS16 being deferred for implementation until year 2022/23, and the government implementation date for IFRS17 still subject to HM Treasury consideration:

- IFRS 16 Leases – The standard is effective 1 April 2022, as adapted and interpreted by the FReM
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust has considered the above new standards, interpretation, and amendments to published standards that are not yet effective and concluded that IFRS 17 is currently not relevant to the Trust or would not have a significant impact on the Trust's financial statements, apart from some additional disclosures. However, the future implementation of IFRS 16 "Leases" was assessed in line with HM Treasury and NHSI guidance to understand its impact on capital expenditure, finance cost and depreciation.

Leases will be incorporated as part of the Trust's assets from 1 April 2022 and incorporated as part of the five-year Long Term Financial Model.

The anticipated impact on the Trust's Balance Sheet is shown in the table below.

Estimated impact on 1 April 2022 statement of financial position	**Estimated future impact of IFRS16** **£'000**
Additional right of use assets recognised for existing operating leases	7,949
Additional lease obligations recognised for existing operating leases	(4,406)
Changes to other statement of financial position line items (excluding reserves)	(3,542)
Estimated impact on net assets on 1 April 2022	**1**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	**(565)**
Additional finance costs on lease liabilities	**(39)**
Lease rentals no longer charged to operating expenditure	**540**
Other impacts on income / expenditure	**(206)**
Estimated impact on surplus / deficit in 2022/23	**(270)**

Note 2 Operating Segments

The Trust has one operating segment, the provision of health and social care. All its revenues are derived from within the United Kingdom.

Details of operating income by classification and type are provided under Note 3 below.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income is recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)

	2021/22	2020/21
	£'000	£'000
Mental health services		
Block contract / system envelope income	118,430	106,458
Clinical partnerships providing mandatory services (including S75 agreements)	1,174	1,168
Other clinical income from mandatory services	6,199	5,659
All services		
Private patient income	-	-
Additional pension contribution central funding**	4,508	4,505
Other clinical income	170	384
Total income from activities	**130,481**	**118,174**
Of which:		
Related to continuing operations	130,481	118,174
Related to discontinued operations	-	-

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

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
	£'000	£'000
NHS England	9,636	10,829
Clinical commissioning groups	113,302	100,134
Local authorities	7,373	7,211
Non-NHS: other	170	-
	130,481	**118,174**

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Research and development	1,286		**1,286**	1,128	-	**1,128**
Education and training	8,410		**8,410**	7,389	-	**7,389**
Non-patient care services to other bodies	7,487		**7,487**	8,423	-	**8,423**
Provider sustainability fund (2019/20 only)	-		**-**	-	-	**-**
Reimbursement and top up funding	5		**5**	10,375		**10,375**
Income in respect of employee benefits accounted on a gross basis	3,721		**3,721**	6,048		**6,048**
Charitable and other contributions to expenditure	-	63	**63**	-	973	**973**
Rental revenue from operating leases	-		**-**	-	-	**-**
Other income	396		**396**	1,201	-	**1,201**
Total other operating income	**21,305**	**63**	**21,368**	**34,564**	**973**	**35,537**
Of which:						
Related to continuing operations			21,368			35,537
Related to discontinued operations		-				-

Charitable and other contributions to expenditure is related to free items received from DoHSC in response to COVID-19 pandemic.

Other income includes business with Primary Care Sheffield (non-NHS) in relation to the "Clover GP Practice".

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22 £'000	2020/21 £'000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	199	25
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31-Mar-22	31-Mar-21
	£'000	£'000
within one year		291
after one year, not later than five years		-
after five years		-
Total revenue allocated to remaining performance obligations	**-**	**291**

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:

	2021/22 £'000	2020/21 £'000
Income from services designated as commissioner requested services	130,481	118,174
Income from services not designated as commissioner requested services	20,924	35,537
Total	**151,405**	**153,711**

Note 5.4 Profits and losses on disposal of property, plant and equipment
The Trust did not dispose of any Property, Plant and Equipment in 2021/22. The contract for the sale of Fulwood land and adjacent leased car park was signed in December 2021 and deposit receipted. The property was reclassified as “held for sale” and the sale value of £12 million.

Note 5.5 Fees and charges
HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

No material fees and charges to service users to report at 31 March 2022.

Note 6.1 Operating expenses	2021/22 £'000	2020/21 £'000
Purchase of healthcare from NHS and DHSC bodies	34	367
Purchase of healthcare from non-NHS and non-DHSC bodies	9,674	7,782
Staff and executive directors costs	112,489	113,869
Remuneration of non-executive directors	119	117
Supplies and services - clinical (excluding drugs costs)	414	1,574
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID-19 response	63	
Supplies and services - general	2,568	1,032
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	965	850
Inventories written down	11	99
Consultancy costs	1,196	704
Establishment	748	601
Premises	6,325	6,819
Transport (including patient travel)	1,186	1,187
Depreciation on property, plant and equipment	2,779	3,252
Amortisation of intangible assets	201	154
Net impairments	911	3,152
Movement in credit loss allowance: contract receivables / contract assets	(30)	(131)
Increase/(decrease) in other provisions	388	200
Change in provisions discount rate(s)	97	29
Audit fees payable to the external auditor	-	
audit services- statutory audit	99	95
other auditor remuneration (external auditor only)	-	-
Internal audit costs	107	85
Clinical negligence	693	683
Legal fees	402	224
Insurance	66	137
Research and development costs	1,351	1,279
Education and training	4,755	1,760
Net operating lease expenditure	594	
Rentals under operating leases	-	1,281
Redundancy	-	315
Car parking and security	183	164
Hospitality	28	5
Losses, ex gratia and special payments	64	211
Other services, e.g. external payroll	156	158
Other	587	1,759
Total	**149,223**	**149,813**
Of which:		
Related to continuing operations	149,223	149,813
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2021/22 £'000	2020/21 £'000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Due to COVID-19 the Quality Report was removed from Trust accounts nationally from 2020/21. There were, therefore, no audit fees related to quality accounts in 2021/22.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work was £1 million (2020/21: £1 million).

Note 7.1 Impairment of assets

	2021/22 £'000	2020/21 £'000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	3,383
Changes in market price	911	(231)
Total net impairments charged to operating surplus / deficit	**911**	**3,152**
Impairments charged to the revaluation reserve	516	259
Total net impairments	**1,427**	**3,411**

The Trust carried out a full revaluation of their lands and buildings, including leased land and building in preparation for IFRS16. There were huge reductions in market valuation for Wardsend Road and the Michael Carlisle Centre due to renovation works that had taken place at both sites. The value of the Michael Carlisle Centre was affected by the scheduled plans to dispose of the property within the next five years. Total adjustment for impairment for the year was £911k which included a sizeable shift in the value of the Longley Centre.

Note 8 Employee benefits

	Permanent	Other	2021/22 Total	2020/21 Total
	£'000	£'000	£'000	£'000
Salaries and wages	87,878		**87,878**	**87,965**
Social security costs	8,450		**8,450**	**8,366**
Apprenticeship levy	411		**411**	**411**
Employer's contributions to NHS pension scheme	14,790		**14,790**	**14,790**
Pension cost - other	159		**159**	**55**
Other post-employment benefits	0		**0**	**-**
Other employment benefits	0		**0**	**-**
Termination benefits	0		**0**	**315**
Temporary staff	0	5,899	**5,899**	**4,721**
Total gross staff costs	**111,688**	**5,899**	**117,587**	**116,623**
Recoveries in respect of seconded staff				
Total staff costs	**111,688**	**5,899**	**117,587**	**116,623**
Of which				
Costs capitalised as part of assets	165		165	379
Total Staff Cost excluding Capital Costs	**111,523**	**5,899**	**117,422**	**116,244**

*Apprenticeship Levy introduced in May 2017 aimed at encouraging organisations to take on more apprentices by financing their training. It is a tax applied to all employers whose annual salary bill is above £3 million. The levy is 0.5% of the total salary bill and can only be used for apprentice training and assessment, and not salaries. The Trust utilised £441,000 of the levy in 2021/22 and is in the process of registering as a formal apprenticeship training centre.

There was provision of £54,000 towards the Flowers payment for 2021/22.

Note 8.1 Directors and Non-Executives Remunerations

	2021/22 Total £000	2020/21 Total £000
Fees to Non-Executive Directors*	97	105
Executive Directors – Salaries **	932	854
Executive Directors – Benefits (NHS Pension scheme)	69	88
	1,098	**1,047**

* Excludes National Insurance contributions.
** Further information about the remuneration of individual directors and details of their pension arrangements is provided in the Remuneration Report.

Note 8.2 Retirements due to ill-health
During 2021/22 there were nine early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2021). There were no additional pension liabilities on ill-health retirements in the year.

Note 9 Pension costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

An outline of these follows:

a) **Accounting valuation**
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

Note 9.1 NEST Pension Scheme
The Trust is a member of the National Employment Savings Trust (NEST) pension scheme that is defined contribution scheme. The Trust pays contributions into NEST but have obligation to make additional 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 limited to the amount agreed as its contribution to the fund on behalf of employees and place actuarial and investment risk on them as members of NEST. The amount recognised on the financial statements is the contribution paid on behalf of members.

	2021/22 £000	2020/21 £000
Employer's Contributions	159	55

The number of members at the end of 2021/22 was 155 (159 for 2020/21).

Note 10 Operating leases

Note 10.1 Sheffield Health and Social Care NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Sheffield Health and Social Care NHS Foundation Trust is the lessor.

The Trust received rental income from Primary Care Sheffield (Highgate Centre) and National Probation Services (1 Sydney Street). The Trust recovered utility and capital costs for properties occupied by Sheffield Teaching Hospitals (Longley Centre and Rivermead Collective) and from several sites occupied by assets for the National PowerGrid.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	29	29
Total	**29**	**29**

Note 10.2 Sheffield Health and Social Care NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sheffield Health and Social Care NHS Foundation Trust are the lessee.

The Trust holds operating leases mainly from other DoHSC bodies £594,000. These operating leases are for premises for patient care services.

	2021/22 £'000	2020/21 £'000
Operating lease expense		
Minimum lease payments	594	1,281
Less sublease payments received	-	-
Total	**594**	**1,281**

	31-Mar-22 £'000	31-Mar-21 £'000
Future minimum lease payments due:		
- not later than one year;	564	566
- later than one year and not later than five years;	1,776	1,858
- later than five years.	5,306	5,411
Total	**7,646**	**7,835**
Future minimum sublease payments to be received	-	-

Note 11 Finance income
Finance income represents interest received on assets and investments over the period.

	2021/22 £'000	2020/21 £'000
Interest on bank accounts	29	1
Total finance income	**29**	**1**

The reduced interest income reported in 2021/22 was due to no availability of cash investment opportunities caused by uncertainty on the market and the withdrawal of the United Kingdom from the EU.

Note 12 Finance expenditure
Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2021/22 £'000	2020/21 £'000
Unwinding of discount on provisions	(9)	(6)
Other finance costs	34	28
Total finance costs	**25**	**22**

Note 13 Other gains/(losses)
No liability accruing in year 2021/22 under this legislation because of late payments.

	2021/22 £'000	2020/21 £'000
Gains/(losses) on disposal of assets	(1)	(20)
Other Gains/(Losses) on disposal of assets	(1)	-
Total gains / (losses) on disposal of assets	**(2)**	**(20)**

Note 14.1 Intangible assets – 2021/22

	Software licences	Intangible assets under construction	Total
	£'000	£'000	£'000
Valuation / gross cost at 1 April 2021 - brought forward	**1,224**	**194**	**1,418**
Additions		502	**502**
Impairments			**-**
Reclassifications	417	(417)	**-**
Valuation / gross cost at 31 March 2021	**1,641**	**279**	**1,920**
Amortisation at 1 April 2021 - brought forward	**356**	**-**	**356**
Provided during the year	201		**201**
Amortisation at 31 March 2021	**557**	**-**	**557**
Net book value at 31 March 2022	**1,084**	**279**	**1,363**
Net book value at 1 April 2021	**868**	**194**	**1,062**

Note 14.2 Intangible assets – 2020/21

	Software licences	Intangible assets under construction	Total
	£'000	£'000	£'000
Valuation / gross cost at 1 April 2020 - brought forward	**716**	**925**	**1,641**
Additions	-	531	**531**
Impairments	(754)	-	**(754)**
Reclassifications	1,262	(1,262)	**-**
Valuation / gross cost at 31 March 2021	**1,224**	**194**	**1,418**
Amortisation at 1 April 2020 - brought forward	**202**	**-**	**202**
Provided during the year	154	-	**154**
Amortisation at 31 March 2021	**356**	**-**	**356**
Net book value at 31 March 2021	**868**	**194**	**1,062**
Net book value at 1 April 2020	**514**	**925**	**1,439**

Note 15.1 Property, plant and equipment – 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Valuation/gross cost at 1 April 2021 - brought forward	**17,794**	**34,686**	**3,439**	**739**	**227**	**3,447**	**54**	**60,386**
Additions			7,689					**7,689**
Impairments		(2,275)						**(2,275)**
Reversals of impairments		848						**848**
Revaluations	5,053	(1,298)						**3,755**
Reclassifications		3,129	(4,473)	69	349	791	135	**(0)**
Transfers to / from assets held for sale	(12,000)							**(12,000)**
Disposals / derecognition				(43)	(32)	(1,315)	(15)	**(1,405)**
Valuation/gross cost at 31 March 2022	**10,847**	**35,090**	**6,655**	**765**	**544**	**2,923**	**174**	**56,998**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**448**	**-**	**302**	**179**	**1,631**	**17**	**2,577**
Provided during the year		2,218		73	20	464	4	**2,779**
Impairments								**-**
Reversals of impairments		(2,191)						**(2,191)**
Disposals / derecognition				(43)	(32)	(1,315)	(15)	**(1,405)**
Accumulated depreciation at 31 March 2022	**-**	**475**	**-**	**332**	**167**	**780**	**6**	**1,760**
Net book value at 31 March 2022	**10,847**	**34,615**	**6,655**	**433**	**377**	**2,143**	**168**	**55,238**
Net book value at 1 April 2021	**17,794**	**34,238**	**3,439**	**438**	**48**	**1,816**	**37**	**57,810**

Note 15.2 Property, plant and equipment – 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Valuation/gross cost at 1 April 2020 - brought forward	**11,185**	**35,163**	**5,964**	**580**	**216**	**2,068**	**19**	**55,195**
Additions	-	-	6,828	-	-	-	-	**6,828**
Impairments	-	(3,783)	-	-	-	-	-	**(3,783)**
Reversals of impairments	10	(4,797)	-	-	-	-	-	**(4,787)**
Revaluations	6,630	880	-	-	-	-	-	**7,510**
Reclassifications	-	7,665	(9,353)	250	24	1,379	35	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(31)	(442)	-	(91)	(13)	-	-	**(577)**
Valuation/gross cost at 31 March 2021	**17,794**	**34,686**	**3,439**	**739**	**227**	**3,447**	**54**	**60,386**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**3,833**	**-**	**324**	**167**	**1,272**	**17**	**5,612**
Provided during the year	-	2,818	-	50	25	359	-	**3,252**
Impairments	-	(4)	-	-	-	-	-	**(4)**
Reversals of impairments	-	(5,909)	-	-	-	-	-	**(5,909)**
Disposals / derecognition	-	(290)	-	(72)	(13)	-	-	**(375)**
Accumulated depreciation at 31 March 2021	**-**	**448**	**-**	**302**	**179**	**1,631**	**17**	**2,576**
Net book value at 31 March 2021	**17,794**	**34,238**	**3,439**	**438**	**48**	**1,816**	**37**	**57,810**
Net book value at 1 April 2020	**11,185**	**31,330**	**5,964**	**256**	**49**	**796**	**2**	**49,583**

Note 15.3 Property, plant and equipment financing – 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net book value at 31 March 2022								
Owned - purchased	10,847	33,746	6,655	433	377	2,143	168	**54,369**
Owned - donated/granted		869						**869**
TOTAL NBV	**10,847**	**34,615**	**6,655**	**433**	**377**	**2,143**	**168**	**55,238**

Note 15.3 Property, plant and equipment financing – 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net book value at 31 March 2021								
Owned - purchased	17,794	33,394	3,439	436	47	1,817	36	**56,963**
Owned - donated/granted	-	845	-	-	-	-	-	**845**
TOTAL NBV	**17,794**	**34,239**	**3,439**	**436**	**47**	**1,817**	**36**	**57,808**

Note 16 Donated Property, Plant and Equipment
There were no donations of Property, Plant and Equipment in 2021/22. Small items of equipment were received from the Department of Health and Social Care to assist with vaccination reference COVID-19.

Note 17 Revaluations of property, plant and equipment
All property, plant and equipment are measured at cost on acquisition, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value without depreciation charged if they are not in use. Assets that are Held for Sale are held at the fair value or market value if that is established. Assets held for sale are not subject to depreciation and should be fully decommissioned before transfer to “asset held for sale”.

Land and buildings still if use at the Trust are valued at their revalued cost on the Statement of Financial Position. This would be their fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Full revaluations at the Trust are scheduled every five years with a desk top revaluation every three years. Revaluation may be carried out where management feels there is a marked shift in asset valuations due to external factors. These valuations are carried out by professionally qualified valuers in accordance with Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

There was a full revaluation carried out on the Trust’s land and buildings and the values are reflected in the Statement of Financial Position. The revaluation excluded Highgate House whose contract with Primary Care Sheffield (PCS) was under negotiation over the year-end period. Fulwood freehold land was transferred to Assets Held for Sale after the signing of the sale contract in December 2021. Fulwood was sold inclusive on the adjacent leasehold car park. The Car park will be handled under IFRS16 in 2022/23.

Note 18 Investment Property

	2021/22 £'000	2020/21 £'000
Carrying value at 1 April - brought forward		
Acquisitions in year		
Reclassifications to/from PPE		
Disposals		
Carrying value at 31 March	**-**	**-**

No investment in properties for SHSC for 2021/22. Investment in 7 Hills Care Support Ltd was dormant to the end of 2021/22 with an application to close the company submitted into Companies House (company was struck off register on 5 April 2022).

Note 19 Disclosure of interests in other entities

Subsidiaries are entities where the Trust has power to exercise control. The Trust has control when it can affect the variable returns from the other entity through its power to direct relevant activities. Their accounts should then be consolidated into the Trust's. The income, expenses, assets, liabilities, equity, and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not coterminous. Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

In 2015/16 the Trust established a wholly owned operating company, 7 Hills Care and Support Ltd. The company was dormant through 2021/22 and an application was made to Companies House to have the company closed and taken off the register of companies. The application was passed on 5 April 2022 (post this financial statement).

Note 20 Inventories

	31-Mar-22 £'000	31-Mar-21 £'000
Drugs	81	67
Consumables		-
Other		-
Total inventories	**81**	**67**
of which:		
Held at fair value less costs to sell		-

Inventories recognised in expenses for the year were £965,000 (2020/21: £1,609,000). Additional inventories accounted for in the year's consumption were supplied through the Department of Health and Social Care to tackle the COVID-19 pandemic.

Note 21.1 Receivables

	31-Mar-22 £'000	31-Mar-21 £'000
Current		
Contract receivables	6,274	4,610
Capital receivables	275	183
Allowance for impaired contract receivables / assets	(59)	(89)
Prepayments (non-PFI)	1,033	1,036
Interest receivable	-	-
PDC dividend receivable	7	39
VAT receivable	484	543
Clinician pension tax provision reimbursement funding from NHSE	20	
Corporation and other taxes receivable	-	28
Total current receivables	**8,034**	**6,350**
Non-current		
Prepayments (non-PFI)	468	594
Clinician pension tax provision reimbursement funding from NHS England	101	
Other receivables*	3,865	3,960
Total non-current receivables	**4,434**	**4,554**
Of which receivable from NHS and DHSC group bodies:		
Current	2,854	4,791
Non-current	101	-

* Other non-current receivables are governed by IAS 19 (Employee Benefits), and it is related to the LGPS "back-to-back" funding agreement with Sheffield City Council.

Note 21.2 Allowances for credit losses

	2021/22 Contract receivables and contract assets £'000	2020/21 Contract receivables and contract assets £'000
Allowances as at 1 April - brought forward	**89**	**472**
New allowances arising	25	145
Reversals of allowances	(55)	(276)
Utilisation of allowances (write offs)		(252)
Allowances as at 31 Mar 2022	**59**	**89**
Loss / (gain) recognised in expenditure	**(30)**	**(383)**

The Trust had small amounts of receivable that required credit losses to be recognised. Receivables are impaired when there is no likelihood of the debt being recovered in full. The impairment maybe based on legal advice, insolvency of debtors, or other economic factors. Impaired receivables are written off only when all available means of recovery have been exhausted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

Note 22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22 £'000	2020/21 £'000
At 1 April 2021	**62,075**	**51,018**
Net change in year	(3,318)	11,057
At 31 March 2022	**58,757**	**62,075**
Broken down into:		
Cash at commercial banks and in hand	49	90
Cash with the Government Banking Service	58,708	61,985
Total cash and cash equivalents as in SoFP	**58,757**	**62,075**
Total cash and cash equivalents as in SoCF	**58,757**	**62,075**

Note 22.2 Third party assets held by the Trust

Sheffield Health and Social Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients and in which the Trust has no beneficial interest. This was excluded from the cash and cash equivalents reported on the Statement of Financial Position.

	31-Mar-22 £'000	31-Mar-21 £'000
Bank balances	50	47
Monies on deposit	-	-
Total third-party assets	**50**	**47**

Note 23 Trade and other payables

	31-Mar-22 £'000	31-Mar-21 £'000
Current		
Trade payables	1,805	2,298
Capital payables	1,984	2,369
Accruals	5,617	5,168
Social security costs	1,220	1,242
Other taxes payable	975	908
Other payables	1,436	1,508
Total current trade and other payables	**13,037**	**13,493**
Non-current		
Non-current trade and other payables at 31 March 2022		
Of which payables from NHS and DHSC group bodies:		
Current	536	358
Non-current		-

Note 24 Other Liabilities

	31-Mar-22 £'000	31-Mar-21 £'000
Current		
Deferred income: contract liabilities	865	291
Total other current liabilities	**865**	**291**
Non-current		
Net pension scheme liability (LGPS)	3,301	5,265
Total other non-current liabilities	**3,301**	**5,265**

Changes in LGPS are the result of independent professional actuary valuation commissioned by South Yorkshire Pension.

Note 25 Provisions for liabilities and charges analysis (ref table below)
Provision of £707,000 relates to Injury Benefits. These are payable to current and former members of staff who suffered injury at work. These cases that were adjudicated by the NHS Pensions Authority. £707,000 is the payments due to claimants at the end of 2021/22 payable over their expected life. The figures are adjusted for inflation and any increase in life expectancy (in 2020/21 was £646,000).

Legal claims relate to claims brought against the Trust for Employer's Liability or Public Liability. These cases are handled by NHS Resolution, who provide estimates of the Trust's probable liability. Actual costs incurred are subject to the outcomes of

court cases or legal out of court agreement. Settlement costs and legal costs may vary from the provisions put through the accounts. NHS Resolutions cover costs that are more than £10,000 for Employer's liability cases, and £3,000 for Public Liability cases.

Restructuring and redundancy provisions cover on-going staff redeployment and structural changes. Staff movements to Sheffield City Council was expected to cost the Trust £220,000 in restructuring and redundancy costs. Provisions were also made for redundancies expected from relocating of the Trust’s headquarters from Fulwood House.

Provisions were also made for employment tribunal cases brough directly against th Trust which cannot go through NHS Resolution due to their nature. Dilapidation provisions were put in for property rented by the Trust that required restructuring and redesign to suit the Trust’s operational needs and standards.

Note 25 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Re-structuring	Redundancy	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2021	**646**	**96**	**242**	**97**	**307**	**1,388**
Change in the discount rate	97	-	-	-	-	**97**
Arising during the year	14	297	220	-	171	**702**
Utilised during the year	(41)	(99)	(242)	(21)	-	**(403)**
Reversed unused	-	(28)	-	-	-	**(28)**
Unwinding of discount	(9)	-	-	-	-	**(9)**
At 31 March 2021=2	**707**	**266**	**220**	**76**	**478**	**1,747**
Expected timing of cash flows:						
- not later than one year;	43	266	220	76	157	**762**
- later than one year and not later than five years;	179	-	-	-	15	**194**
- later than five years.	485	-	-	-	306	**791**
Total	**707**	**266**	**220**	**76**	**478**	**1,747**

Note 26 Clinical negligence liabilities

A provision of £5,430,000 was included in the accounts of SHSC for clinical negligence cases through NHS Resolution (31 March 2021: £4,992,000).

Note 27 Contingent assets and liabilities

	31-Mar-22 £'000	31-Mar-21 £'000
Value of contingent liabilities		
NHS Resolution legal claims	(184)	(22)
Employment tribunal and other employee related litigation	(169)	
Redundancy	(76)	
Other	-	-
Gross value of contingent liabilities	**(429)**	**(22)**
Amounts recoverable against liabilities		
Net value of contingent liabilities	**(429)**	**(22)**
Net value of contingent assets		

Legal claims contingent liabilities represent the consequences of losing all current third-party legal claim cases. The contingent liabilities are based on the estimations provided by NHS Resolution for cases with a possibility of an outflow of resources of 50% or above.

Note 28 Contractual capital commitments

	31-Mar-22 £'000	31-Mar-21 £'000
Property, plant and equipment	1,753	2,239
Intangible assets	0	130
Total	**1,753**	**2,369**

£1,753,000 value of capital commitments, mostly to cover the ligature anchor replacements, were made before the end of the financial year.

Note 29 Defined benefit pension schemes

South Yorkshire Pensions Fund – Retirement Benefit Obligations

Some Trust employees who were transferred from Sheffield City Council elected to remain with the Local Government Pension Scheme, administered by the South Yorkshire Pensions Authority, which is a defined benefit pension scheme. The assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the

Statement of Comprehensive Income as an item of ‘other comprehensive income’. These postings are mostly countered by the terms of the current partnership agreement. The terms of the current partnership agreement with Sheffield City Council (‘the Council’) provide that any long-term pension liability arising from the scheme will be funded by the Council, except for any pension changes which relate to salary increases more than any local government grading agreements. The impact on the current and prior year Statement of Comprehensive Income and Statement of Changes in Taxpayers' Equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is mostly negated by the inclusion of a corresponding non-current receivable with the Council.

The total defined benefit pension loss for 2021/22 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £404,000 (31 March 2019 gain £639,000).

A pension deficit of £5,669,000 was included in the Statement of Financial Position as at 31 March 2022 (31 March 2021 - £5,265,000).

The impact on the current and prior year statement of consolidated income and taxpayers’ equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is adjusted by a corresponding non-current receivable with the Council of £3,865,000 (2021/22 - £3,960,000).

Estimation of the net liability to pay pensions depends on several complex judgements. A firm of consulting actuaries is engaged by South Yorkshire Pensions Authority to provide expert advice about the assumptions made, such as mortality rates and expected returns on pension fund assets.

Pension increases or revaluations for public sector schemes are based on the Consumer Prices Index ("CPI") measure of price inflation.

The main actuarial assumptions used at the date of the statement of financial position in measuring the present value of defined benefit scheme liabilities are:

	2022	2021
	%	%
Rate of inflation	**3.85**	2.7
Rate of increase in salaries	**4.20**	4.4
Rate of increase in pensions and deferred pensions	**3.20**	2.8
Discount rate	**2.70**	2.1

Other assumption for valuations 2021/22
Life expectancy is based on the S3PA, S3DA and S3IA tables (with appropriate weighting) with improvements in line with the CMI 2018 model an allowance for smoothing of recent mortality experience and long-term rates of 1.75% p.a. for males and females.

Based on these assumptions, the average future life expectancies at age 65 are summarised below:

	Male	**Female**
Current Pensioners	22.4 years	25.1 years
Future Pensioners	23.8 years	27.0 years

* Figures assume members aged 45 as at the last formal valuation date.
Life expectancies for the prior period end are based on the S3PA, S3DA and S3IA tables with appropriate weighting.

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme Assets 2022		**Scheme Assets 2021**	
	£'000	**%**	**£'000**	**%**
Equities	**16,418.0**	63	**12,403**	49.17
Government Bonds	**4,097.9**	15	**2,690**	10.67
Other Bonds	**1,213.5**	4	**2,779**	11.02
Property	**4,558.2**	17	**2,284**	9.06
Cash / Liquidity/Other	**311.4**	1	**5,065**	20.08
Total fair value of assets	**26,599.0**	100	**25,221**	100.00
Present value of defined benefit obligation	**(29,900.0)**		**(30,486)**	
Net retirement benefit deficit	**(3,301.0)**		**(5,265)**	

IAS19 mean that rather than recognising the expected gain during the year from scheme assets in finance income and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities recognised in finance costs; the net interest cost during the year is presented within finance costs. Actuarial gains and losses are not presented; rather the re-measurements of the defined benefit plan are disclosed and recognised in the income and expenditure reserve.

Movements in the present value of the defined benefit obligations are:

	2021/22 £'000	2020/21 £'000
Present value of the defined benefit obligation at 1 April	**(30,486)**	**(26,325)**
Current service cost	(441)	(367)
Interest cost	(639)	(625)
Contribution by plan participants	(72)	(72)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	1,184	(3,727)
Benefits paid	554	630
Past service costs	-	-
Present value of the defined benefit obligation at 31 March	**(29,900)**	**(30,486)**

Movements in the fair value of the scheme's assets were:

	2021/22 £'000	2020/21 £'000
Plan assets at fair value at 1 April	**25,221**	**21,556**
Interest income	533	512
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets		
- Actuarial gain / (losses)	1,223	3,609
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling		
Contributions by the employer	104	102
Contributions by the plan participants	72	72
Benefits paid	(554)	(630)
Plan assets at fair value at 31 March	**26,599**	**25,221**
Plan surplus/(deficit) at 31 March	**(3,301)**	**(5,265)**

The net pension expenses recognised in operating expenses in respect of the scheme are:

	2021/22 £0	2020/21 £0
Current service cost	(441)	(367)
Interest expense / income	(106)	(113)
Administration costs		(6)
Past service cost	-	-
Total net (charge) / gain recognised in SOCI	**(547)**	**(486)**

Remeasurement gains and losses are recognised directly in the Income and Expenditure reserve. However, most of the gains and losses are covered by the back-to-back agreement with Sheffield City Council (further information is provided at Note 1.7.

The history of the scheme for the current and prior year is:

	31-Mar-22	31-Mar-21
	£'000	£'000
Present value of the defined benefit obligation	(29,900)	(30,486)
Plan assets at fair value	26,599	25,221
Net defined benefit (obligation) / asset recognised in the SoFP	**(3,301)**	**(5,265)**
Fair value of any reimbursement right	3,865	3,690
Net (liability) / asset after the impact of reimbursement rights	**564**	**(1,575)**

Note 29.1 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	2021/22 £'000	2020/21 £'000
Plan assets at fair value at 1 April	**25,221**	**21,556**
Interest income	533	512
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets		
- Actuarial gain / (losses)	1,223	3,609
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling		
Contributions by the employer	104	102
Contributions by the plan participants	72	72
Benefits paid	(554)	(630)
Plan assets at fair value at 31 March	**26,599**	**25,221**
Plan surplus/(deficit) at 31 March	**(3,301)**	**(5,265)**

Note 29.2 Amounts recognised in the SoCI

	2021/22	2020/21
	£0	£0
Current service cost	(441)	(367)
Interest expense / income	(106)	(113)
Administration costs		(6)
Past service cost	-	-
Total net (charge) / gain recognised in SOCI	**(547)**	**(486)**

Note 30 Financial instruments

Note 30.1 Financial risk management

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the period in creating or changing the risks faced by the Trust. Because of the continuing service provider relationship that the Trust has with NHS Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by other businesses. The Trust has limited powers to borrow or invest surplus funds on their own 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 within the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors.

Currency risk

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

Credit risk

As the majority of the Trust's income comes from contracts with NHS Clinical Commissioning Groups and public sector bodies, they have low exposure to credit risk. The maximum exposure at the end of the financial year would be in receivables from customers, as disclosed in the receivables note.

Liquidity risk

Most of the Trust's operating costs are incurred under contracts with NHS Clinical Commissioning Groups, local authorities and other government bodies which are financed from resources voted annually by Parliament. The Trust finances capital expenditure from funds from their cash reserves or through loans and funds from the PDC. Because of this, the Trust's exposure to liquidity risk is minimal.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£'000	£'000	£'000
Trade and other receivables excluding non-financial assets	10,355	-	**10,355**
Cash and cash equivalents	58,757	-	**58,757**
Total at 31 March 2022	**69,112**	**0**	**69,112**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£'000	£'000	£'000
Trade and other receivables excluding non financial assets	8,664	-	**8,664**
Cash and cash equivalents	62,075	-	**62,075**
Total at 31 March 2021	**70,739**	**0**	**70,739**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£'000	£'000
Trade and other payables excluding non-financial liabilities	10,842	**10,842**
Total at 31 March 2022	**10,842**	**10,842**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£'000	£'000
Trade and other payables excluding non-financial liabilities	11,331	**11,331**
Total at 31 March 2021	**11,331**	**11,331**

Note 30.4 Maturity of financial liabilities

	31-Mar-22 £'000	31-Mar-21 £'000
In one year or less	10,842	11,331
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**10,842**	**11,331**

The fair value of the Trust's financial assets and financial liabilities at 31 March 2022 equates to book value.

Note 31 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£'000	Number	£'000
Losses				
Bad debts and claims abandoned	7	4	21	255
Stores losses and damage to property	61	62	56	126
Total losses	**68**	**66**	**77**	**381**
Special payments				
Compensation under court order or legally binding arbitration award			2	15
Overtime corrective payment - Flowers			1	203
Ex-gratia payments	4	1	11	3
Total special payments	**4**	**1**	**14**	**221**
Total losses and special payments	**72**	**67**	**91**	**602**
Compensation payments received			2	333

The prior year value has been restated to include a £203,000 special payment for nationally agreed overtime corrective payments (Flowers judgement) as required by new NHS Improvement guidance to aid the national preparation of consolidated provider accounts. The costs were accrued in the 2020-21 accounts but not disclosed as a special payment

Over 2020/21 a total of £67,000 (2020/21 - £399,000) was paid out in losses and special payments.

The number of cases also went down from 90 in 2020/21, to 72 in 2021/22.

In 2020/21 the Trust wrote off £234,000 in bad debts most of which were owed by Sheffield City Council.

Note 32 Gifts
No gifts to report for financial years 2020/21 and 2021/22.

Note 33 Related parties
Sheffield Health and Social Care NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

During the year the Trust had transactions with several organisations with which key employees or directors of the Trust have some form of relationship. These are detailed below:

Related Party (Register of interest 2021/22)	2021/22 Receipts from Related Party	Payments to Related Party	2021/22 Amount due from related party	Amount owed to related party
	£'000	£'000	£'000	£'000
South Yorkshire Housing Association	2,405	402	416	1
Sheffield Flourish	-	161	-	-
South West Yorkshire Partnership NHS Foundation Trust	689	1	79	-
Nottingham City Care Partnership	-	2	-	-
	3,094	**567**	**494**	**1**

The relationships are:

- One Non-Executive Director undertakes unpaid consultancy for South Yorkshire Housing Association
- One Non-Executive Director is a board member Sheffield Flourish
- One Non-Executive Director is a board member of Nottingham City Care Partnership
- Executive Director for South West Yorkshire Partnership NHS Foundation Trust is seconded from Sheffield Health and Social Care NHS Foundation Trust.

Amounts owed to related parties are unsecured, interest-free and have no fixed terms of repayment. The balances will be settled in cash. No guarantees have been given or received. No expenses are recognised in year in respect of bad or doubtful debts due from related parties.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial results may have been influenced by related parties. The Trust deals directly with the organisations listed above without any influence from the individuals that sit within their positions of influence.

There were no direct payments to related parties for 2021/22 (2020/21 £nil). Details of directors' remuneration and pensions is on Note 8.1. Further details of Executive and Non-Executive Directors' salaries and pensions can be found in the Remuneration Report in the Annual Report.

Other related parties
The value of SHSC's transactions with other related parties during the year is given below:

	2021/22		2020/21	
	Income £000	**Expenditure £000**	**Income £000**	**Expenditure £000**
Department of Health and Social Care	830	-	741	-
Other NHS bodies	132,477	1,620	130,257	1,944
Other WGA	305	794	735	1,633
Other bodies	7,748	384	7,703	377
Total	**141,360**	**2,798**	**139,436**	**3,954**

The value of receivables and payables balances held with related parties at 31 March 2022 was:

	2021/22		2020/21	
	Receivables £000	**Payables £000**	**Receivables £000**	**Payables £000**
Department of Health and Social Care	383	136	113	0
Other NHS bodies	2,454	716	3,018	358
Other WGA	501	3,631	1,030	3,658
Other bodies	2,745	651	96	321
Total	**6,083**	**5,134**	**4,257**	**4,337**

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2021 have been raised where deemed appropriate.

The Department of Health and Social Care ("the Department") is regarded as a related party.

During the year, the Trust had material transactions with the Department, and other entities for which the Department is regarded as the parent Department.

These entities are listed below:

- NHS Sheffield Clinical Commissioning Group
- Health Education England
- NHS England - Yorkshire and the Humber Local Office
- NHS England - Yorkshire and the Humber Commissioning Hub
- NHS Barnsley Clinical Commissioning Group
- NHS Derby and Derbyshire Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Doncaster Clinical Commissioning Group
- Derbyshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- NHS Litigation Authority
- NHS Business Services Authority.

The Trust also had several transactions with central government departments and local government bodies.

Most of these transactions have been with HM Revenue and Customs (including National Insurance Funds), NHS Pension Scheme and South Yorkshire Pension Scheme (in conjunction with Sheffield City Council).

Note 34 Assets Held for sale
The contract to sell Fulwood land and adjacent leasehold car park was signed in December 2021.

Contracts to relocate headquarters were signed in March 2022. Fulwood land was assigned as an asset held for sale for the financial year ending 31 March 2022.

Note 35 Prior period adjustments
No prior period adjustments reported at 31 March 2022.

Section 6.0 Glossary

Accounts Payable (Creditor)

A supplier who has delivered goods or services in the accounting period and has invoiced the Trust, but has not yet been paid.

Accounts Receivable (Debtor)

An organisation which has received a service from the Trust in the accounting period and has been invoiced by the Trust, but has not yet paid.

Amortisation

Depreciation of Intangible Assets.

Annual Governance Statement (AGS)

A statement about the controls the Foundation Trust has in place to manage risk.

Annual Accounts

Documents prepared by the Trust to show its financial position.

Annual Report

A document produced by the Trust which summarises the Trust's performance during the year, including the annual accounts.

Asset

Something which is owned by the Trust. For example, a building or a piece of equipment, some cash or an amount of money owed to the Trust.

Audit Opinion

The auditor's opinion of whether the Trust's accounts show a true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Available Held for Sale (AHFS)

Assets are classed as available for sale if they are held neither for trading nor to maturity. An example of this would be an investment without a maturity date such as an ordinary share.

Budget

Represents the amount of money available for a service in a period of time and is compared to actual spend for the same period.

Capital Expenditure

Money spent on buildings and valuable pieces of equipment such as major computer purchases.

Cash and cash equivalents

Cash includes cash in hand and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straight away.

Cash Equivalent Transfer Value (Pensions)

This is the total value of the pension scheme benefits accrued (i.e. saved up) which are the contributions paid by a member of staff and the Trust over the period of employment.

These funds are invested and valued at a point in time by an actuary. The cash equivalent transfer value is the amount which would be transferred, if a staff member moved to work for a different organisation.

Control Total

An agreed financial control total for all NHS Providers, calculated on a Trust-by-Trust basis and designed to ensure the NHS provider sector achieves financial balance in 2018/19.

Access to the Provider Sustainability Fund is dependent on agreement and delivery of the control total.

Corporation tax

A tax payable on a company's profits. Foundation Trusts may have to pay corporation tax in the future. The legislation introducing corporation tax to Foundation Trust has been deferred and 2011/2012 was the first year that Government introduced corporation tax to Foundation Trusts.

Care Quality Commission (CQC)

The independent regulator of all health and social care services in England.

CQUINs

Commissioning for Quality and Innovation payments framework were set up in 2009/10 to encourage care providers to continually improve how care is delivered.

Current Assets

These are assets, which are normally used or disposed of within the financial year.

Current Liabilities

Represents monies owed by the Trust that are due to be paid in less than one year.

Deferred Income

Funding received from another organisation in advance of when we will spend it.

Depreciation

An accounting charge which represents the use, or wearing out, of an asset. The cost of an asset is spread over its useful life.

EBITDA

Earnings Before Interest, Tax Depreciation and Amortisation – this is an indicator of financial performance and profitability and indicates the ability to pay the dividends due to the Government in respect of the 3.5% return on assets the Trust is expected to achieve.

External Auditor

The independent professional auditor who reviews the accounts and issues an opinion on whether the accounts present a true and fair view.

Finance lease

An arrangement whereby the party leasing the asset has most or all of the use of an asset, and the lease payments are akin to repayments on a loan.

Financial statements

Another term for the annual accounts.

Foundation Trust Annual Reporting Manual (FT ARM)

The guidance document, published annually by NHS Improvement, sets out the accounting requirements for Foundation Trust's Annual Report. Previously included technical guidance on the Accounts, which is now provided within the Department of Health and Social Care (DHSC) Government Accounting Manual.

Going concern

The accounts are prepared on a going concern basis which means that the Trust expects to continue to operate for at least the next 12 months.

DHSC Government Accounting Manual (GAM)

Provides the accounting guidance for all NHS bodies, now including Foundation Trusts. Guidance specific to Foundation Trusts in respect of the Annual Report is still included in the Foundation Trust Annual Reporting Manual (FT ARM).

IFRS (International Financial Reporting Standards)

The professional standards organisations must use when preparing the annual accounts.

Impairment

A decrease in the value of an asset.

Income and Expenditure Reserve

This is an accumulation of transfers to / from the Revaluation Reserve as well as the cumulative surpluses and deficits reported by the Trust, including amounts brought forward from previous years.

Intangible asset

An asset which is without substance, for example, computer software.

Inventories

Stocks such as clinical supplies, medical equipment, pharmacy stock.

Liability

Something which the Trust owes, for example, a bill which has not been paid.

Liquidity ratio

Liquidity is a measure of how easily an asset can be converted into cash. Bank deposits are very liquid, debtors less so. The liquidity ratio is a measure of an entity's ability to meet its obligations, in other words how well it can pay its bills from what it owns.

MEA (Modern Equivalent Asset)

This is an instant build approach, using alternative site valuation in some circumstances.

Net Book Value

The net book value is the lower of the cost to the business to replace a fixed asset or the recoverable amount if the asset was sold (net of expenses).

NHS Improvement (NHSI)

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. From 01 April 2019, NHS England and NHS Improvement came together to act as a single organisation. Their aim is to better support the NHS and help improve care for patients.

NICE

National Institute for Health and Care Excellence. NICE provide independent, evidencebased guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

NIHR

National Institute for Health Research. The NIHR is a large, multi-faceted and nationally distributed organisation, funded through the Department of Health and Social Care to improve the health and wealth of the nation through research.

Non-current assets held for sale

Buildings that are no longer used by the Trust and declared surplus by the Board, which are available for sale.

Non-current asset or liability

An asset or liability which the Trust expects to hold for longer than one year.

Non-Executive Director

These are members of the Trust's Board of Directors, however they do not have any

involvement in the day-to-day management of the Trust. Their role is to provide the Board with independent challenge and scrutiny.

Operating lease

An arrangement whereby the party leasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

Payment By Result/Payment by Outcomes

A national tariff of fixed prices that reflect national average prices for hospital procedures. Already in use in acute trusts and currently being developed for mental health and learning disabilities services.

POMH

The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice.

Primary statements

The four main statements that make up the accounts: the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers' Equity; and Statement of Cash Flows.

Provisions for Liabilities and Charges

These are amounts set aside for potential payments to third parties, which are uncertain in amount or timing, for example, claims arising from litigation.

Provider Sustainability Fund (PSF)

PSF replaces the 'Sustainability and Transformation Fund' (STF) from year 2018/19 and it is the additional funding administered by NHS Improvement, which is intended to incentivise Trusts to achieve their Control Totals. It breaks down into three areas – Finance, General Distribution and Bonus.

Public Dividend Capital (PDC)

This is a type of public sector equity finance based on the excess of assets over liabilities at the time of the establishment of the predecessor NHS Trust. It is similar to a company's share capital.

Public Dividend Capital Payable (PDC Payable)

This is an annual amount paid to the Government for funds made available to the Trust.

Reference Cost

The costs of the Trust's services are produced for the Department of Health for comparison with other similar Trusts.

Revaluation Reserve

This represents the increase or decrease in the value of property, plant and equipment over its historic cost.

Service Line Reporting (SLR)

A system which identifies income and expenditure and then produces gross profit across defined 'business units', with the aim of improving quality and productivity.

Single Oversight Framework

The Single Oversight Framework is designed to help NHS providers attain, and maintain, ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right. It applies from 01 October 2016 and replaces the Monitor Risk Assessment Framework and the NHS Trust Development Authority Accountability Framework.

South Yorkshire and Bassetlaw Integrated Care System (ICS)

Integrated Care Systems are a way of working, collaboratively, between a range of health and social care organisations, to help improve people's health. South Yorkshire and Bassetlaw ICS is a group of local Organisations that embrace similar aims in the provision of the broad spectrum of healthcare.

Statement of Cash Flows (SOCF)

Shows the cash flows in and out of the Trust during the period.

Statement of Changes in Taxpayers' Equity (SOCITE)

This statement shows the changes in reserves and public dividend capital during the period.

Statement of Comprehensive Income (SOCI)

This statement was previously called 'Income and Expenditure Account'. It summarises the expenditure on pay and non-pay running costs less income received, which results in a surplus or deficit.

Statement of Financial Position (SOFP)

A year-end statement which provides a snapshot of the Trust's financial position at a point in time. The top half shows the Trust's total net assets (assets minus liabilities). The bottom half shows the Taxpayers Equity or investment in the Trust.

Third Sector Organisations

This is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

True and fair

It is the aim of the accounts to show a true and fair view of the Trust's financial position, that is they should faithfully represent what has happened in practice.

UK GAPP (Generally Accepted Accounting Practice)

The standard basis of accounting in the UK before international standards were adopted.

Unrealised gains and losses

Gains and losses may be realised or unrealised. Unrealised gains and losses are gains or losses that the Trust has recognised in its accounts but which are potential as they have not been realised. An example of a gain that is recognised but unrealised is where the value of the assets has increased. This gain is realised when the assets are sold or otherwise used.

Use of Resources Metric

The new approach replacing the previous Financial Sustainability Risk Rating. The Use of Resources rating measures 5 metrics; Capital Service Cover, Liquidity, I&E Margin, I&E Variance from Plan and Agency spend, with equal weightings (1 being the highest overall score). The Financial Sustainability Risk Rating previously only measured the first four on equal weightings.

Section 7.0 Contacts

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Communications

If you have a media enquiry, require further information about our Trust or would like to request copies of this report please contact the Communications Team.

Email: communications@shsc.nhs.uk

Telephone: 0114 2264082

Membership

If you want to become a member of the Trust or want to find out more about the services we provide, please contact the Board Secretary on 0114 2718825.

Contacting members of the Council of Governors

The Governors can be contacted by emailing governors@shsc.nhs.uk or by phoning 0114 2718825.

Freedom of Information

To make a Freedom of Information Act request, please email FOI@shsc.nhs.uk

For more information or if you would like this document provided in a different language or large print please contact:

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