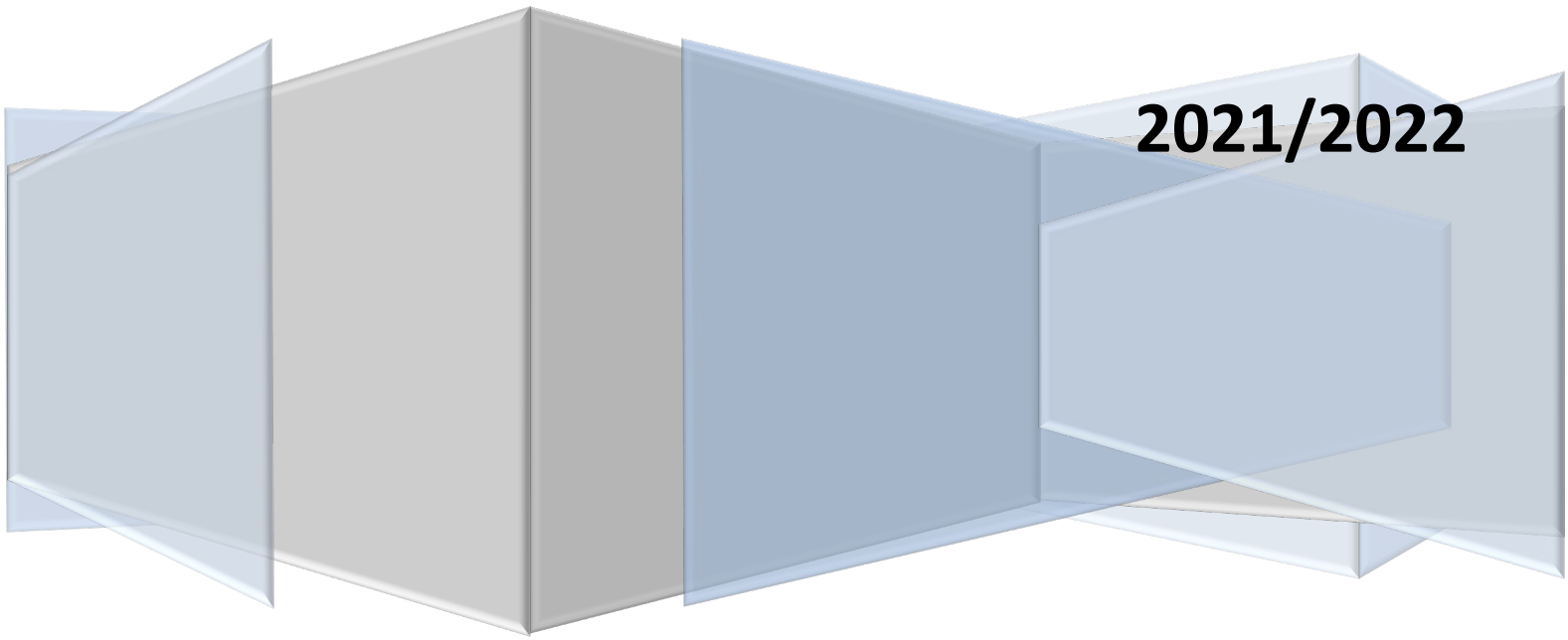
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2021/2022

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2021/2022

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

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Performance Report

Statement from the Chair

At the start of our fiscal year, April 2021, we were looking back at one of the most demanding 12 months in the history of the NHS.

#TeamSFH colleagues, like all those working across the health and care sectors, had met the challenges of Covid-19 with dedication and determination but I don't think many of us were expecting the next 12 months to be equally difficult.

It is only right I start by acknowledging everyone at #TeamSFH for continuing to show remarkable commitment to keeping patients and each other safe.

It will have taken a physical and mental toll on many of us, so it is important that we continue to support each other with civility, kindness, care and understanding.

The emergence of the Omicron variant in December 2021, sparked a new wave of Covid-19. More infectious than previous variants and coming at a time when we faced the usual winter pressures, colleagues responded brilliantly in the first weeks of 2022, increasing our bed capacity and developing new ways of working, keeping our patients and each other safe.

Covid-19 remains very much with us. The Vaccination Programme continues to be rolled out and we must remain vigilant as life slowly returns to normal.

We are also working hard for those patients waiting for operations and treatments. We are committed to reducing the backlog that built up during the early phases of the pandemic. It is worth noting that even during the height of the Omicron wave, we were able to maintain levels of elective care and were often running at higher that pre-pandemic levels.

I appreciate that the demands will have taken a toll and recognise that I, and the Trust Board, have an important role to play, ensuring our focus remains on doing the right thing, both for patients and colleagues. We need to make sure we all feel well supported so we can continue to make the right decisions.

New leadership positions for #TeamSFH executive and non-executive directors

This year has been a time of considerable change for the senior leadership team at Sherwood Forest Hospitals.

I was honoured and proud to be appointed Chair in October 2021 following the move by John McDonald to become Chair of University Hospitals Leicester (UHL). I would like to thank John for his leadership, support and friendship during his time as Chair.

I joined the Board in 2013 when Sherwood Forest was a very different place and I am immensely proud of everything our colleagues have achieved, including the delayed (due to Covid) announcement that we were the Health Service Journal's Acute Trust of the Year for 2020.

Paul Robinson, previously Chief Finance Officer and Deputy Chief Executive was appointed Chief Executive, following Richard Mitchell's move to UHL and we have since confirmed Phil Bolton and Rachel Eddie will be joining us as Chief Nurse and Chief Operating Officer, respectively.

Richard Mills, previously Deputy Chief Finance Officer, is currently Interim Finance Officer

Towards the end of the year, Director of People Clare Teeny also announced her departure and we have recruited successfully for the new position of Director of Strategy and Partnerships.

As well as these executive positions, we have been joined by our former Medical Director Dr Andy Haynes (as a specialist adviser to the Board), and non-executive directors Steve Banks, Dr Aly Rashid and Andrew Rose-Britton.

They join us at an exciting time as we continue to emerge from the Covid-19 pandemic, and we move into a new environment of system-wide working with our health and social care partners as part of the Integrated Care Partnership (ICP).

We said farewell to Tim Reddish, our Senior Independent Director and a member of the board since 2013, and Neal Gossage, a non-executive director for Sherwood Forest for the past seven years left us shortly after the end of the 2021/22 year.

The new landscape for health and social care services

We continue to develop our role within our health and care system and how we will work with our partners to improve the lives of our citizens.

The focus is on working together for what is best for our patients and communities. Our trust members, colleagues, patients, volunteers and governors remain an important source of information and views on how we will shape that future with the new Integrated Care Partnership, Provider Collaboratives and Place-based Partnerships and Forums, which are due to come into effect from July 2022.

We have played a leading role in shaping this new environment and will use our size, scale and reach to influence the health and wellbeing of our communities, particularly targeting those that we are not engaging with as well as we could.

We have continued to develop the care and services we offer, including the expansion of surgical procedures at Newark as part of our ongoing investment in the site and the opening of the Same Day Emergency Care (SDEC) Unit at King's Mill.

Ophthalmology patients are now benefiting from an improved service thanks to a new community diagnostic centre that has been set up at Ashfield Health Village. The service allows patients with

glaucoma and macular degenerative disease to access a range of diagnostics tests, including having a vision test, optic pressure measurements, optic nerve scans and field-of-vision tests.

By October, two new scanning units were able to deliver up to 800 diagnostic scans for conditions, such as cancer in the bowel, bladder, stomach, oesophagus, brain and bones. The extra capacity created is part of a national plan for Community Diagnostic Centres and will support our work to bring down waiting times for diagnostic tests and ensure more people can start treatment or receive reassurance promptly.

Another example of great patient and family-centred care is our new double cot for twins in our Neonatal Intensive Care Unit. The special cot, funded through Sherwood Forest Hospitals Charity, means we can keep new-born children together, just like in the womb.

Climate Action Team

To demonstrate our commitment to reducing the impact we have on our environment, we took the decisive step to declare a climate emergency – one of only eight NHS organisations to do so.

The Climate Emergency UK declaration recognises the affect climate change has on health and supports our Green Plan commitments, which include:

- An 80% reduction in carbon emissions by 2025
- A 25% cut in patient transport mileage by 2025 to improve local air quality and reduce the health impacts of air pollution
- Reducing fossil fuel use over the next five years, with the long-term goal of phasing it out before 2040
- Reducing overall waste volume by 7% per year
- Ceasing purchase of many single-use plastics by April 2022.

Climate change is one of the most pressing challenges facing our society today. There are implications for physical and mental health, both directly and indirectly, across the population and as an NHS Trust, we have a responsibility to ensure efficient use of resources. By recognising the climate emergency, we can raise awareness among colleagues, patients and our local area.

Maternity services in the spotlight nationally

Maternity services in other parts of the country have been under the spotlight, particularly with the publication of the Ockenden Report and subsequent media headlines. At a time when it may feel tough working in Maternity, we scored some significant successes.

We met Chief Midwifery Officer for England, Professor Jacqueline Dunkley-Bent, who singled out #TeamSFH's Maternity Service for praise. She thanked the team for their commitment to safety and care during her visit and was given an outline of our seven features of safety, which builds on strong governance structures and our Maternity and Neonatal Safety Champions. Professor Dunkley-Bent revealed that Sherwood Forest Hospitals is seen as an exemplar Trust and work being done here is being talked about across the country.

We also scored well in the Care Quality Commission's national survey of maternity experiences, which showed that new mothers rate our care highly, despite Covid-19 restrictions, which across the country

impacted overall scores for satisfaction. We did well in areas such as staff treating new mums with respect and dignity, supporting and speaking to them in a way that they understand and including them in decision-making and giving explanations and information they needed.

Thank you to every who supports us through our charity and by volunteering

So much of our activity is enhanced through our charity and our wonderful volunteers. The charity uses money from grateful members of the public and fund-raising to enhance patient care while our volunteers give up their time to do the same.

Working with our Family Liaison service during the early first phases of the pandemic and the lockdown, hundreds of links between patients and loved ones~~,~~ were made and maintained thanks to our volunteers and the Community Involvement Hub. They supported thousands of connections and engaged in hundreds of conversations each week between patients, their families and clinical teams, supporting many patients through one of the toughest aspects of lockdown when it was necessary to severely restrict hospital visiting.

One point of real satisfaction came from a wellbeing survey of our volunteers that revealed 97.5% of those who responded would recommend us as a place to volunteer.

During another unprecedented year for #TeamSFH, the NHS, and our communities, I am both humbled and proud of the bravery, commitment and dedication everyone at Sherwood Forest Hospitals has continued to show during the Covid-19 pandemic. Thank you.

Claire Ward
Chair

Statement from the Chief Executive

We began the year with the fantastic (albeit much-delayed) news that we were the Health Service Journal's 2020 Acute Trust of the Year.

To be singled out for the top award in the most prestigious awards in the health sector was welcome news after a gruelling 12 months of pandemic.

During the judging process, health sector leaders and experts recognised:

- How we put the wellbeing of all colleagues at the centre of our decision making
- Our community response to Covid
- The fact we are the most improved NHS Trust in the past five years.

This was a huge accolade for everyone at #TeamSFH, past and present, at all our sites and all our partners, including our remarkable volunteers, Skanska, Medirest, and our retail outlets.

You don't win awards like this overnight (and let's not forget we were also finalists in the Staff Engagement and the Digitising Patient Services Initiative categories). This is the result of commitment and dedication to improvement over many years and we are fully focused on ensuring our journey to excellence and outstanding care continues across #TeamSFH.

Responding to Covid-19

Covid-19 has~~,~~ once again dominated our year. In April inpatient and admission numbers were beginning to fall. Having peaked at around 220 the previous January, they were down to around 40.

Unfortunately, this would not be the last we would see of Covid-19 and after easing through the summer, numbers began to rise again and by the end of the year we were creating extra capacity in our hospitals to meet exceptionally high demand.

During earlier waves, much of our planned activity, such as elective surgery, had been paused. During the Omicron wave of December, January and February, colleagues showed incredible resilience, coping with the rise in Covid-19 patients while maintaining much of our elective and non-urgent activity.

Our three priorities were to:

- Safely reduce demand in critical care and support the wellbeing of colleagues who work there
- Minimise crowding in the Emergency Department, supporting timely ambulance turnarounds, while continuing to treat our most seriously ill, including those with cancer
- Continue to treat all other patients in as timely a way as possible.

This would have been remarkable at any time of year but to achieve all this during what are traditionally our busiest months of the year is a credit to all our colleagues. Well done.

While acknowledging the remarkable work of colleagues, I recognise that many patients have been waiting longer for treatment than anyone would like. I am sorry for this. We are working as hard as we can to treat people as quickly and as safely as possible according to clinical urgency.

Meanwhile the vaccination programme continued at pace as the offer of the Covid jab was extended to more and more cohorts of the population. The vaccine is still the best way we can protect ourselves from becoming seriously ill and I am proud of the contribution our vaccination team and the vaccination hub at King's Mill played in delivering well over 200,000 doses, since the start of the programme at the end of 2020. At times we were delivering more than 1,200 doses a day.

Creating a better work environment

We have made significant strides in developing our plans for better equality, diversity and inclusion. We closed 2020/21 with the unveiling of our Rainbow pedestrian crossing – a visible sign that we recognise and aim to offer a supportive environment to colleagues and visitors from the LGBT+ (Lesbian, Gay, Bisexual, Transgender and all other identities) community.

We took an active role in NHS Equality, Diversity and Human Rights week in May, celebrated Pride throughout July and joined the Nottingham and Nottinghamshire Integrated Care System's live virtual Pride extravaganza.

Through 2021/22 we co-produced a regional Workforce Race, Equality and Inclusion Strategy making a clear commitment to our staff and our communities that we are determined to take effective and impactful action to create an anti-racist working environment, culminating in the launch of our new anti-racism strategy in February 2022.

As part of our wider work to reduce aggression and discrimination, support a zero-tolerance approach to all unacceptable behaviours, we marked the International Day for the Elimination of Racial Discrimination with the unveiling of special One World, One #TeamSFH artwork celebrating and embracing our diverse workforce, who come from more than 80 countries around the world.

We cannot tolerate racism – whether it is discriminatory language or behaviour from patients, visitors or from our own staff. People from all parts of the community we serve, whether they are seeking treatment or visiting, must feel confident they will be welcomed.

Our workforce must also know that we will protect them from racism (and all other forms of aggression and abusive behaviour) so they can focus on delivering the best care and support for our patients and their loved ones. It is vital colleagues experiencing racism know we will work with them to combat racist behaviour.

Our strategy has been shared with the ICS (Integrated Care System) and it is anticipated it will support the implementation of an Anti-Racism Action Plan for our local health care system partners.

After more than two years of the Covid-19 pandemic, making #TeamSFH a better place for us all has never been more important and we continue to develop our health and wellbeing packages, so they are meeting the needs of all colleagues in a meaningful way, including the appointment of a new Lead Clinical Psychologist and a People Wellbeing Lead.

Through Trust-wide communication channels and face-to-face discussions, we have also worked hard to ensure staff have the confidence to speak to our Freedom to Speak Up Guardian Kerry Bosworth and #TeamSFH's Freedom to Speak Up Champions should they wish to raise issues while working in fast-changing and sometimes challenging environments.

Strong response to the NHS Staff Survey

Making life at #TeamSFH the best it can be for all our colleagues is important because we know it creates an environment where we can support each other to provide the best care and services for all our patients.

That is why such as strong response from colleagues to the NHS National Staff Survey is so important. With a response rate of 66%, we have the highest engagement rate of any acute and acute community trust in the Midlands.

The results, announced in March, give us rich data and a clear picture of how our colleagues are feeling about being part of #TeamSFH and what we need to do to make things even better. If we know about what can be improved, we can – and will – take action.

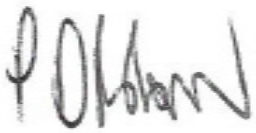
So, we know we must do more to improve our health and wellbeing support and to reduce aggression towards staff. We also need to address recruitment and retention as many colleagues tell us more people are needed to meet demands.

But the survey also tells us we are well-placed among our peers with almost three-quarters of our colleagues (74.9%) recommending #TeamSFH as a place to work and eight out of ten (81.7%) recommending our hospitals as places to receive treatment. For more detail on the NHS National Staff Survey see page 58.

Thank-you #TeamSFH

Just like the previous 12 months, 2021/22 was another unprecedented period and I would, like to pay tribute to the whole of #TeamSFH for continuing to deliver great care in such remarkable and demanding circumstances.

We began the year being recognised by our peers in the HSJ awards and we finished the year with confirmation that we continue to be a great place to work and to receive care. I hope all my colleagues are as proud as I am about everything we have achieved.



Paul Robinson
Chief Executive Officer

Overview of Performance

This section summarises our organisation's purpose, history, objectives and key risks.

Our History and Structure

Sherwood Forest Hospitals was formed in 2001 and gained Foundation Trust status in 2007. We provide outstanding healthcare across the community to 500,000 people in Mansfield, Ashfield, Newark, and Sherwood and parts of Derbyshire and Lincolnshire. We work with more than 5,000 colleagues in our three hospitals – King's Mill, Newark and Mansfield Community and at Ashfield Health Village. We have well-established relationships with partners in health and social care through the Nottingham and Nottinghamshire Integrated Care System (ICS) and the Mid-Nottinghamshire Integrated Care Partnership (ICP).

We have five clinical divisions: Urgent and Emergency Care, Medicine, Surgery, Women's and Children's, and Diagnostics and Outpatients. Each division benefits from clinical and managerial leadership and is supported by the corporate function.

Our Trust is managed by the Board of Directors, which is responsible for the management and performance of the organisation and for setting the future strategy. The Board ensures the quality and safety of healthcare services, education, training and research delivered by the Trust and applies the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies. It also makes sure that we exercise our functions effectively, efficiently and economically.

As a Foundation Trust we have a Council of Governors, which works with the Board of Directors and represents the interests of our members in the planning of services. The Council of Governors play an important role in the delivery of safe, high quality care. They are elected by our public and staff members or appointed to represent community partners, such as the local councils and commissioners.

King's Mill Hospital, where 90% of our services are based, is rated Outstanding by the Care Quality Commission and is the only Outstanding NHS hospital in the East Midlands. Newark Hospital and Mansfield Community Hospital are both rated Good and all 15 of our services are rated Good for Safety with five Outstanding services.

Safe, patient centred care is delivered by well supported people and in 2021 colleagues at Sherwood rated us as being the best place to work across all acute trusts in the Midlands region (second nationally) in the National Staff Survey. Overall, as an average across all the People Promise domains, the survey results for Sherwood placed us as the third best Acute or Acute Community Trust in the country.

In March 2021 the Trust was recognised as the Acute or Specialist Trust of the Year in the prestigious Health Service Journal Awards. The HSJ awards are the most coveted accolade in UK healthcare and Trust of the Year is the most prestigious category within these awards.

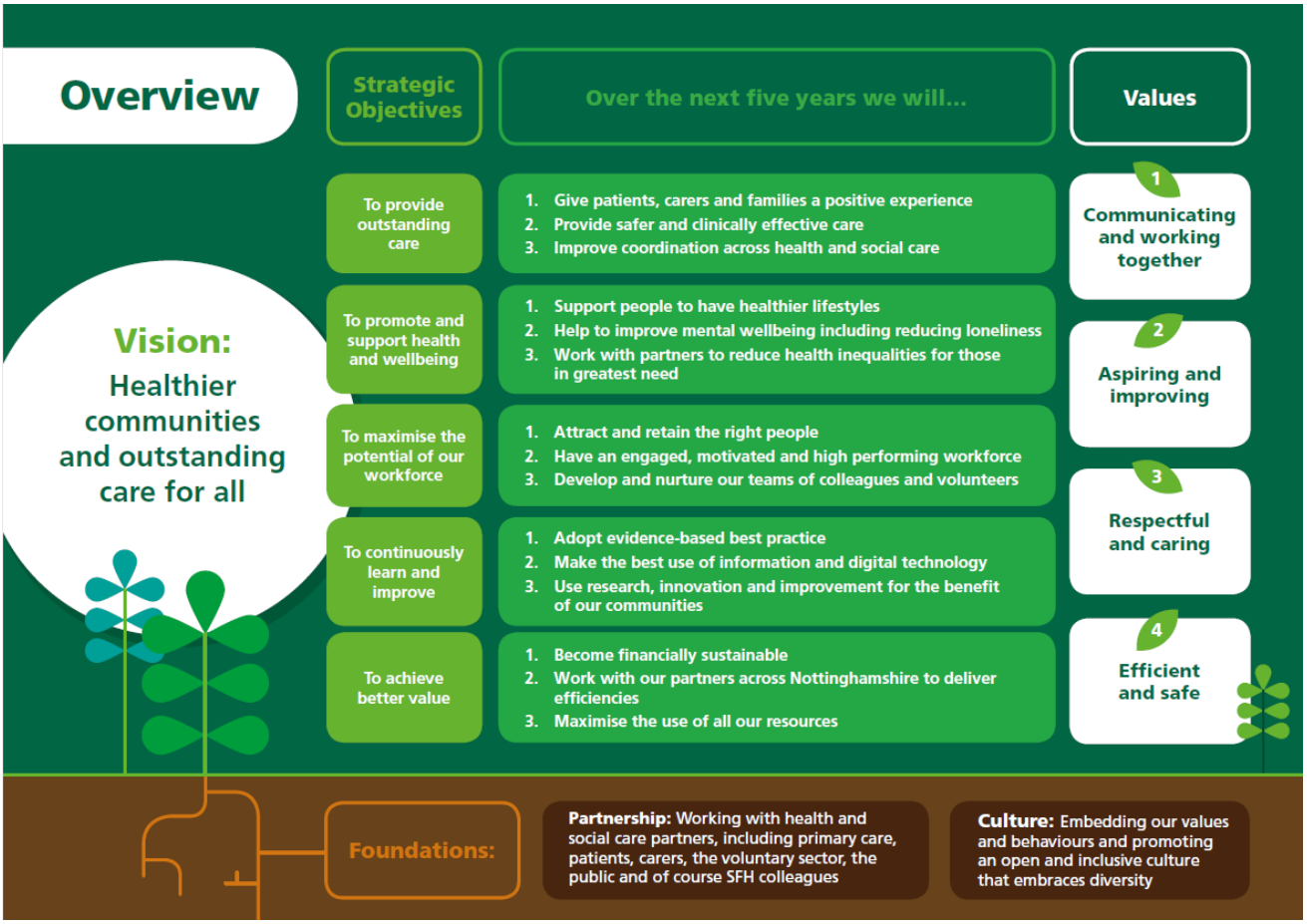
We play an active role in the Nottingham and Nottinghamshire Integrated Care System (ICS), which brings together local NHS services, councils and voluntary sector with the ambition for people living in Nottingham and Nottinghamshire to live longer, happier, healthier and more independent lives.

Our purpose and activities

Over the past year the NHS has continued to face extraordinary challenges and pressures relating to the pandemic. Covid-19 once again dominated our year. Our colleagues have continued to demonstrate remarkable commitment to keep our patients, and each other safe. We are working hard for those patients waiting for operations and treatments, while balancing the needs of those requiring emergency care, and we are doing all we can to treat people as quickly and as safely as possible according to clinical urgency.

Despite the challenges, the incredible commitment of our workforce has enabled us to continue to make progress on delivering our vision of Healthier communities and outstanding care for all.

This vision and strategy can be summarised as follows:



We remain committed to delivering on our strategic objectives, to make Sherwood Forest Hospitals an even better place to work and to receive care. Over the past year we have taken steps to progress against these objectives, with some examples highlighted below.

To provide Outstanding Care	• Launched the Carers Passport for patients and their carers during Carers' Week in June 2021. • Rollout of Covid Vaccination Programme to the local population, with our vaccination team delivering 200,000 plus, doses since the start of the programme and at times delivering more than 1,200 doses a day. • Expansion of services, including a new community diagnostic centre at Ashfield Health Village for Ophthalmology patients, additional scanning capacity from a Mobile Endoscopy Unit situated at King's Mill Hospital, and the expansion of surgical procedures at Newark Hospital. • Introduced our new double cot for twin babies in our Neonatal Intensive Care Unit, allowing us to keep new-born children together, just like in the womb. • Delivered full compliance against the ten safety actions set out by NHS Resolution to support the delivery of safer maternity care and been commended by the Chief Midwifery Officer for England as an exemplar Trust for our commitment to safety and care. • Introduced a pilot whereby QR code posters (linking to relevant Trust-approved patient information leaflets) have been produced, to further improve effective patient communication. • Strengthened our links with Primary Care, opening channels between GPs and the Trust, as part of the Integrated Care Board/Place-based Partnership Communications Group.
To promote and support health & wellbeing	• Successfully delivered a dedicated Health and Wellbeing campaign, under the brand Boost, capturing six different themes, and appointed a dedicated People Wellbeing Lead and a new Lead Clinical Psychologist. • Introduced 20 new Wellbeing Champions, with varied interests including physical activity, mental health, and menopause. • Developed and published a Mental Health Strategy with Nottinghamshire Healthcare NHS Foundation Trust. • Through 2021/22 we co-produced a regional Workforce Race, Equality and Inclusion Strategy and in February 2022 we launched our new anti-racism strategy, making a clear commitment to take effective action to create an anti-racist working environment. • Declared a climate emergency, being one of only eight NHS organisations to do so, to recognise the affect climate change has on physical and mental health.
To maximise the potential of our workforce	• Continued our progress to Pathway to Excellence accreditation. • Appointed a new Head or Learning an Organisational Development, to lead on the design and implementation of a Talent Strategy for the Trust. • Introduced a high impact action plan to address inequity in recruitment and development for those from ethnic minority backgrounds, alongside partners within the Nottinghamshire ICS.

	• Established a working group to launch a carers passport for staff who are unpaid carers and introduced a new staff network for carers in the organisation.
To continuously learn and improve	• Conducted a Continuous Improvement Maturity Assessment. • Furthered our digital maturity through the rollout of our Electronic Prescribing and Medicines Administration (EPMA) system and the development of a business case for a new Electronic Patient Record (EPR) system. • Commissioned Grant Thornton to undertake an external Well-Led Review of the organisation, assessing us against the framework set out by NHS England and NHS Improvement and providing recommendations to improve. • Strengthened system coordination through the development of a Provider Collaborative and Placed Based Partnerships.
To achieve better value	• Delivered Financial Improvement Programme savings of £5.8m in 2021/22. • Launched a three-year Transformation and Efficiency Programme, with an ambition to deliver savings of more than £30m over the period. • Contributed to the development of a Provider Collaborative Office, to initiate and coordinate projects and workstreams that will identify and deliver opportunities for improvement. • Launched a System Costing Group. Which will support clearer understanding of costs to deliver services across the Nottinghamshire health and care system.

In the coming year we will look to accelerate our progress against these strategic objectives. We will do this through the launch of new Strategic Workforce and Talent Management strategies, a refreshed Quality Strategy and further partnership working through the Provider Collaborative, Integrated Care System and Place Based Partnerships. We will look to advance our digital strategy, improving access to our services through using digital technology more effectively and accelerating the implementation of initiatives that have been paused due to the pandemic.

During the year we plan to revisit and refresh our vision, strategic priorities and values, enabling us to move into to 2023/24 with a clear direction to support our delivery of the national NHS priorities.

We recognise that as well as being an outstanding provider of care, we have a unique opportunity and a responsibility to support our local population to become healthier. This is not something we can achieve on our own. It is a partnership involving everyone in our community, including those who work and volunteer in health and social care across Nottinghamshire, those who use our services and those who may need our services in the future.

Risks to delivery of objectives

Our vision, values and strategic objectives express our ambition to see healthier communities and outstanding care for all. Our ability to fully realise all our objectives is linked to the ongoing level of healthcare demand from Covid-19. Our goal is to increase the number of people we treat and care for

in a timely way but we know that securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff.

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of Covid-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs.

Through our risk and control framework the Board of Directors regularly scans the horizon for emergent opportunities or threats and considers the nature and timing of the response required to ensure risk is always kept under prudent control.

The most significant strategic risks facing us continue to be: (i) the maintenance of sufficient numbers of skilled employees to deliver our full range of clinical services; (ii) financial sustainability due to the requirement to increase activity while substantial cost pressures remain; and (iii) demand that overwhelms our capacity to deliver care effectively.

These risks are interrelated and incorporated into the Board Assurance Framework (BAF). It is not envisaged these risks will change over the coming year. The Internal Audit Plan and Counter Fraud Plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF.

Working in partnership through the Integrated Care System, our Provider Collaborative and Placed Based Partnerships is a fundamental mitigation to our risks. Our continued focus is on improving our internal working processes and practices to ensure patients receive high quality care in a timely manner, while also using our size, scale and reach to influence the health and wellbeing of our communities, particularly targeting those that we are not engaging with as well as we could.

Further detail about our risk management approach is included in the Annual Governance Statement, later in this report.

How we are using our FT status to develop services and improve patient care

We are dedicated to realising our vision of healthier communities and outstanding care for all. This vision statement includes our commitment and ambition to excel and continually improve the quality of our services. Our four core values underpin this and describe the way in which we will operate:

Communicating and working together,

Aspiring and improving,

Respectful and caring,

Efficient and safe.

We develop our services and improve patient care based on evidence. We proactively seek and use feedback from patients and staff, as well as analysing data that benchmarks the performance of our services against other Trusts. It is vital that our culture engenders a desire to improve and innovate. That is why we train colleagues in our improvement methodology. This supports them to take a systematic approach to improvement, empowering colleagues to turn good ideas into sustainable reality.

Going concern

The going concern concept is further covered in IAS 1 – 'Presentation of Financial Statements'. IAS 1 requires management to assess, as part of the account's preparation process, the Trust's ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. If a Foundation Trust is dissolved by NHS England and NHS Improvement (NHSE&I) any property or liabilities of the Trust may be transferred to another Foundation Trust, an NHS Trust, or the Secretary of State, and therefore, as services will continue to operate, the Trust is considered to be a going concern in line with the guidance outlined in Practice Note 10. Practice Note 10 is the guidance issued by the Financial Reporting Council (FRC) to help public sector organisations consider going concern in financial statements.

Significant changes continued to the funding streams as a result of the pandemic and in year block contract rather than activity-based payments were received. In addition, for the half year period to September 2021 (H1) additional top up money was received and a break-even position expected, across the NHS. This was in line with NHSE strategy to meet all reasonable costs associated with the vaccination programme and Covid-19.

For the second half year ending March 2022, (H2) a control total was agreed for both the Trust and the Integrated Care System (ICS) as a whole, with NHSE.

As part of the continued change in monitoring of spend there was no requirement to have a formal financial efficiencies plan in H1, but there was a requirement in H2, however, the trust has continued to review pay, non-pay and income throughout the year to ensure that outturn is in line with plan and in year is reporting financial efficiency delivery of (£5.8m). The Project Management Office has been working to identify and risk rate identified schemes for 2022/23 and is forecasting delivery of (£11.73m) in the financial year 2022/23.

For the year ending 2021/22 the Trust is reporting a deficit of (£1.25m), which includes the impact of gains on the valuation of buildings. Removing this impairment gain, which was (£11.737m) and other non-control items, we are reporting a deficit of (£13.18m). This is above our agreed control total for H2; however, it is in line with the forecast outturn total agreed with NHSE/I. In year the trust received £23.20m in respect of covid and vaccination money which are included in the reported outturn position.

No revenue support was requested in year however, due to PFI Private Finance Initiative (PFI) liabilities, depreciation does not self-fund the capital expenditure. Capital of £10.85m was agreed with NHSE and drawn down in the form of Public Dividend Capital to support the capital programme.

As previously disclosed all Interim revenue and Capital loans, were repaid in 2020/21. The impact of these repayments means that the Trust now has a positive Statement of Financial Position (SOFP). There is, however, still a significant liability in respect of the PFI which will reduce over the remaining term of the contract. In year the Trust paid (£0.68m) in Public Dividend Capital (PDC) based on 3.5% of the net average value of assets.

The financial framework for 2022/23 has been issued and in line with this guidance a draft Financial Plan, which includes capital, was submitted on 17th March 2022 and a final plan was submitted on 28th April 2022. The plan submitted was agreed with the ICS partners and indicates a surplus/deficit of (£13.76m) and a capital programme of (£19.46m). As detailed above the plan includes forecast efficiencies of (£11.73m)

In applying the Trusts accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

Performance Analysis

Performance in 2021/22 continued to be affected by the Covid-19 pandemic as the NHS remained in Level 4 National incident.

- Whilst elective care was reduced in the previous year, as the vaccination programme has gained momentum and the numbers of patients being hospitalised on emergency and ventilated pathways for Covid 19 symptoms have reduced, the trust has been able to restart surgery and outpatients in a planned way. The aim of the Trust is to reduce the number of patients waiting for operations beyond two years to zero by the end of June 2022.
- The Trust Covid 19 pandemic plan is still in use and there have been surges of patients attending hospital either due to covid symptoms or with incidental Covid symptoms over the year. The result of this is the continued use of areas within the hospital outside of their normal function, to keep patients safe.
- Infection Prevention and Control measures are still in place and the trust is adhering to the rules of segregation and social distancing that have been in place throughout the pandemic.
- The winter months have been particularly pressured as the country returned to a level of normality, with the trust accommodating both Covid 19 patients and those with the usual ailments, injuries and illnesses that we would generally see over the winter. This led to further bed capacity being opened as part of the winter plan and this capacity remains open.
- The trust maintained its positive track record in terms of access for patients to emergency care provided in a safe and timely way, and its position as a provider of one of the lowest emergency care waiting times in the Midlands and the country, reducing the risk of Covid 19 cross infection in an overcrowded emergency department. The trust also ensured that ambulances were not held up at the Kings Mill Emergency Department (ED) enabling East Midlands Ambulance Service (EMAS) crews to hand over patients quickly and effectively.

Performance Analysis

Emergency Department (ED) 4-hour performance

The Trust has some of the lowest waiting times in the NHS through its Emergency Department and Newark Urgent Treatment Centre and was regularly ranked in the top 12 (out of 117 Trusts) within the NHS. While maintaining the low waiting times at Newark, as with the rest of the NHS, there has been a lengthening in waiting times in ED. This is related to COVID spikes in activity and the stark impact on social care staffing capacity for care home placements and packages of care.

Accident and emergency attendances

Accident and Emergency attendances increased overall in 2021/22 in comparison to 2019/20.

Ambulance arrivals

We measure handover performance, which is the time taken from the moment the ambulance crew arrives, to the safe handing over of the patient to the team in the Emergency Department. Despite spikes in attendances, handover times (when measured as a percentage over 30 minutes) are the lowest in the East Midlands Ambulance Service region.

Relevant metrics are monitored in real-time within the department and reviewed at all bed meetings, which take place throughout the day. We escalate issues and take timely actions to mitigate concerns when we foresee a potential delay.

Emergency admissions from the Emergency Department

Emergency admissions overall and admissions from ED have increased significantly when compared to 2019/20; this has mainly been for admission to medical specialties. A lot of this growth has been managed using new models of care, particularly 'Same Day Emergency Care' via the Ambulatory Emergency Care unit, but there has also been growth to bedded care. The Trust continues to work with partners to reduce admissions, ensuring patients get into the right service to meet their needs which may be an alternative to a hospital stay.

Referral to Treatment

The NHS Constitution sets out that (as a minimum) 92% of our patients should wait no longer than 18 weeks from GP referral to treatment (RTT), however reporting on this has been paused since the start of the Covid-19 pandemic, due to the pause in elective treatments as a part of the national Level 4 incident actions in 2020/21. The waiting list and times have increased, and we have worked hard as an organisation to reduce this backlog and have reduced the number of patients waiting more than two years to just six at the end of 2021/22. We have plans in place to reduce this further by the end of the coming year to ensure that no one waits beyond 18 months. We regularly clinically review patients who are waiting to ensure they remain safe and well enough for treatment. In 2022/23, we have plans to increase the availability of alternatives to face-to-face appointments to further reduce the length of time patients wait for treatment.

Diagnostics

This national target means that 99% of all diagnostic tests relating to physiology, radiology and endoscopy need to be completed within six weeks of referral. As a result of the pause of elective activity due to the national Level 4 Incident this deteriorated over 2020/2021. It is the aim of the trust to return to pre-pandemic levels as soon as possible and certainly in line with the national NHS planning guidance of 99% of diagnostic tests within six weeks by 2025.

Cancer standards

Cancer Waiting Times standards monitor the length of time patients with cancer or suspected cancer wait to be seen and treated in England. We know it is better for the vast majority of patients to be seen, diagnosed and treated for cancer as soon as possible. Throughout the Covid-19 pandemic we have prioritised the diagnosis and treatment of patients with suspected cancers when other less urgent surgery was paused. The effect of staff sickness due to Covid-19, the nationally prescribed testing regime for patients attending for surgery and reporting capacity for diagnostic tests had an adverse effect on our ability to meet the performance standards in 2021/22. We remain focussed on actions to support earlier diagnosis or ruling out of cancer and are working closely with tertiary providers and system partners to systematically deliver national optimal pathways and improve outcomes for our patients.

King's Mill Hospital Vaccination Hub

The King's Mill Covid Vaccination Hospital Hub gave the first vaccine on Tuesday 8th December 2020 and has had tremendous success delivering over 209,000 vaccine doses, operating a 7-day service.

The Hub has been reactive to both national and local strategic direction and has offered vaccines to all cohorts eligible for vaccination, aging from 5-year-old children to 106-year-old.

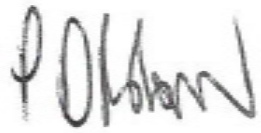
Nationally as the vaccination programme has developed, the hub has continued to achieve regional assurance to offer the multiple vaccines approved to some of the most vulnerable citizens in our local population.

The service has continued to review and improve the service delivery maximising capacity ensuring the best use of resource including both staff and vaccine supply in order to reach the maximum population within all cohorts. The SFH workforce bureau have continued to support the staffing in the Hub and Vaccination Sites in Nottinghamshire, recognising the increase of staff who are first time employees in the NHS who have now successfully taken up permanent contracts with SFH.

In November 2021, the Hub celebrated winning the SFH Staff Excellence award for The Healthier Communities category, recognising the positive contribution to our staff and our local population.

A newly refurbished Hub is planned for Spring 2022 offering a more permanent home for the Vaccination Hub located on the ground floor of the TB3 building on the King's Mill site. The ICS commissioned the service along with other sites and out of all the sites in the Midlands region, the Hospital Hub is the best performing vaccine hub.

SFH have committed to support the vaccination system longer-term, supporting the vaccination of staff and local citizens as the National Vaccination Programme confirm the Autumn Booster Programme



Paul Robinson
Chief Executive Officer **17th June 2022**

Accountability Report
Directors' Report

Board of Directors

The Board of Directors is the team responsible for the management and performance of the organisation and for setting the future strategy. Our Board has overall responsibility for the preparation and submission of the Annual Report and Accounts; the Board considers the Annual Report and Accounts, taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy.

The primary responsibility of our Board of Directors is to promote the long-term success of the organisation by creating and delivering high quality services within the funding streams available. Our Board seeks to achieve this through setting strategy, monitoring strategic priorities and providing oversight of implementation by the Executive Management Team. In establishing and monitoring its strategy, our Board considers, where relevant, the impact of its decisions on wider stakeholders including staff, partners and the environment.

So far as the Directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware, and the Directors have taken all the steps that they ought to have taken as Directors to make themselves aware of any relevant audit information and to ensure the NHS Foundation Trust's auditor is aware of that information.

The individuals who served at any time during the financial year as directors were as follows:

Name	Job Title	Commenced in post	Seconded to another role	Termination date
John MacDonald	Chair	01/03/2017	19/04/2021	31/07/2021
Claire Ward	Deputy Chair	01/05/2013		19/04/2021
	Interim Chair	20/04/2021		30/09/2021
	Substantive Chair	01/10/2021		
Tim Reddish	Senior Independent Director	08/07/2013		31/10/2021
Barbara Brady	Non -Executive Director	01/10/2018		
	Senior Independent Director	01/11/2021		
Neal Gossage	Non-Executive Director	10/05/2015		
Graham Ward	Non-Executive Director	01/12/2015		
Manjeet Gill	Non-Executive Director	01/11/2018		
Steve Banks	Non-Executive Director	01/12/2021		

Dr Aly Rashid	Non-Executive Director	10/01/2022		
Dr Andy Haynes	Specialist Advisor	18/04/2021		
Richard Mitchell	CEO	01/07/2017		01/10/2021
Paul Robinson	Chief Finance Officer	23/03/2015		30/09/2021
	Interim CEO	01/10/2021		31/03/2022
	Substantive CEO	01/04/2022		
Dr David Selwyn	Executive Medical Director	09/12/2019		
Julie Hogg	Chief Nurse	09/12/2019		
Shirley Higginbotham	Director of Corporate Affairs	04/04/2013		
Emma Challens	Director of Culture and Improvement	09/12/2019		
Simon Barton	Chief Operating Officer	01/01/2018		
Clare Teeney	Director of People	02/09/2019		
Richard Mills	Interim Chief Finance Officer	01/10/2021		
Lorna Branton	Director of Communications	06/11/2020	30/10/2021	
Marcus Duffield	Associate Director of Communications	20/10/2021		

The balance, completeness and appropriateness of our Board membership is reviewed periodically and upon any vacancies arising among either the Executive or Non-Executive Directors. The balance of skills is appropriate to the requirements of the organisation. Board Directors are required to declare any interests that are relevant and material on appointment, or should a conflict arise during their term. A register of Board members' interests is maintained by the Company Secretary and is published annually as covered later in this Annual Report. Board Directors are also required to meet the Fit and Proper Persons Test, and this is evidenced in their individual personal files.

The Chair, John Macdonald is also the Independent Chair of Joined up Care Derbyshire (STP). He undertook a secondment to University Hospitals Leicester until July when he was appointed as their substantive chair and left Sherwood Forest Hospitals NHS Foundation Trust.

The Chair, Claire Ward is also Chief Executive of the Institute for Collaborative Working, a not-for-profit organisation, Governor on the Board of the University of Hertfordshire and owns Capewells Limited, a consultancy company which acts for several pharmacy and pharmaceutical companies and organisations.

Attendance at Board meetings

	Public		**Private**	
Name	Actual	Possible	Actual	Possible

John MacDonald	1	1	1	1
Richard Mitchell	5	6	6	7
Paul Robinson	12	12	13	13
Dr David Selwyn	11	12	12	13
Julie Hogg	12	12	13	13
Clare Teeney	10	12	10	13
Simon Barton	11	12	12	13
Shirley A Higginbotham	12	12	13	13
Emma Challans	12	12	12	13
Lorna Branton	5	7	6	8
Richard Mills	6	6	6	6
Marcus Duffield	5	5	5	5
Tim Reddish	6	7	7	8
Neal Gossage	9	12	10	13
Claire Ward	12	12	13	13
Graham Ward	12	12	13	13
Barbara Brady	12	12	12	13
Manjeet Gill	10	12	11	13
Steve Banks	4	4	4	4
Dr Aly Rashid	2	2	2	2
Dr Andy Haynes	10	11	8	11

Register of Interests

The Register of Interests for all members of our Board is reviewed regularly and published annually on our website. https://www.sfh-tr.nhs.uk/about-us/register-of-interests/. The register is maintained by the Company Secretary, who is based at Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton-in-Ashfield, Nottinghamshire, HG17 4JL.

All members of our Board and Council of Governors must disclose details of company directorships or any other positions held, in general and more specifically with organisations who may trade with the organisation.

We maintain NHS Litigation Authority insurance, which gives appropriate cover for any legal action brought against our directors to the extent permitted by law.

Cost allocation

We have complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2022.

Better Payment Practice Code

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code.

Due to the monthly prepayment of block contract sums in 2021/22 payments were made earlier than in previous years which is reflected in the level of compliance with the 95% targets in year.

Our performance against this metric is shown as follows:

	2021/22		2020/21	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	81,942	272,225	70,794	228,825
Total non-NHS trade invoices paid within target	75,430	260,346	64,079	219,807
Percentage of non-NHS trade invoices paid within target	92%	96%	91%	96%
Total NHS trade invoices paid in the year	2,463	30,115	2,640	28,251
Total NHS trade invoices paid within target	2,151	29,494	2,202	27,424
Percentage of NHS trade invoices paid within target	87%	98%	83%	97%

Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust paid £9,500 in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2021/22 would be £2,160. (2020/21 £10,120) There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

All of this relates to non-NHS invoices, and none relates to NHS healthcare contracts.

Income Disclosures

We have met the requirement under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the 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 purpose. Other income generated by us was used to support the provision of our health services.

Well-Led Framework

During the year we commissioned Grant Thornton to undertake an external Well-Led Review of the organisation. The organisation was assessed against each of the eight questions identified in the NHSI Well-Led framework.

The Board reviewed the final report, received in January 2022. The report noted of the 15 recommendations, three rated as medium priority and 12 rated as low priority. Actions have been developed to address the recommendations made and these, together with the executive owner and deadline for completion was reported to the Board in April 2022. A progress report on these actions will be presented to board in each quarter of 2022/23.
The Care Quality Commission inspected us during 2020 and assessed our overall Trust Well-Led score as Good, and King's Mill Hospital Outstanding.

Patient Care

Our journey to outstanding is the driving force behind our approach to the culture of continuous improvement now well embedded throughout the organisation. This is supported by our values of:

Communicating and working together

Aspiring and improving

Respectful and caring

Efficient and safe.

We have robust systems and processes in place to enable colleagues to celebrate where we provide excellent, safe, high-quality care, but also quickly identify areas of focus for further improvement.

Building on the previous quality improvement programmes we continued to work towards our agreed Quality Strategy for 2018/21. This was the vehicle for progressing improvement work, monitoring improvement initiatives, and providing evidence of achievement to our patients and staff. During 2021/22 the strategy was under review and a refreshed version will be agreed in 2022/23.

Quality Strategy 2018-21 Summary

After extensive consultations our new Quality Strategy is scheduled to be approved by the Board in the summer of 2022, therefore the principles and direction of the 2018-21 strategy remain in place.

Following the success of the Quality Improvement Plan (2015/16) and the Advancing Quality Programme (2016/18) the three-year Quality Strategy was approved by the Board of Directors in April 2018.

We believe that we can demonstrate outstanding care and be one of the best providers of healthcare in the country. Our Quality Strategy gave us the road map to get there. It reflected our quality priorities and took account of national, local and independent reports and enquiries.

Improving the quality of care we deliver, is about making our care safe, effective, patient-centred, timely, efficient and equitable. It is intended that we use quality priorities to monitor service improvement, to demonstrate that high quality care and services are being provided and to highlight areas where further improvements are required. The quality priorities for 2018/21 were sub-divided into four improvement campaigns:

Campaign One: A positive patient experience: We aim to:

- Change behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide.

Campaign Two: Care is safer: We aim to:

- Focus on frailty and learning disability adapting to meet the healthcare needs of an increasingly elderly patient population and, by delivering 'better basics', reduce exposure to harm or complications of care.

Campaign Three: Care is clinically effective: We aim to:

- Ensure patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Campaign Four: We stand out: We aim to:

- Be a leader in the delivery of high-quality, safe healthcare, striving for excellence on our journey to outstanding.

The progress made was monitored and reviewed each month by the Medical Director and Chief Nurse. Progress was reported to the Quality Committee and routinely as part of the cycle of business for the Board of Directors, this will continue for the refreshed strategy. Each Campaign comprised specific improvements workstreams, examples of which are illustrated in Diagram 1.

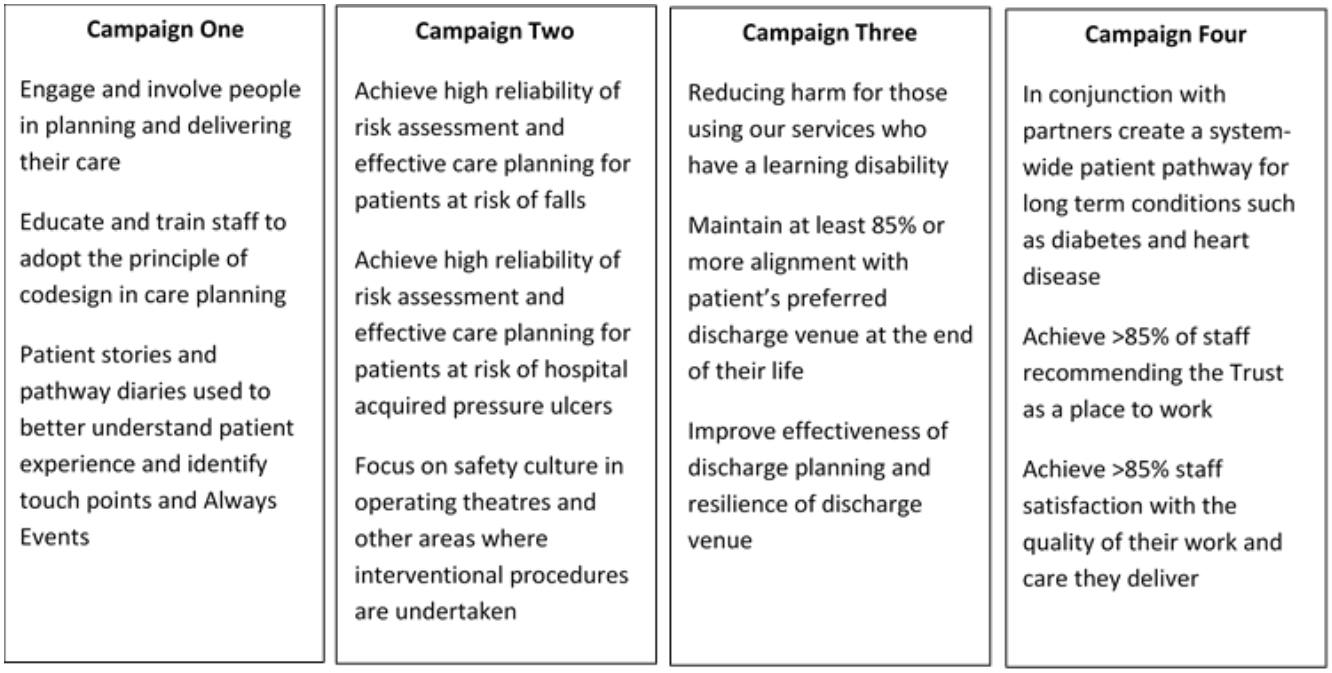


Diagram 1.

As our improvement journey has matured, colleagues have gained confidence in implementing small changes and improvements within their areas. These have positively contributed to the current position where we are recognised regionally and nationally for exemplar practice, benchmarking above the regional or national average in a significant number of indicators.

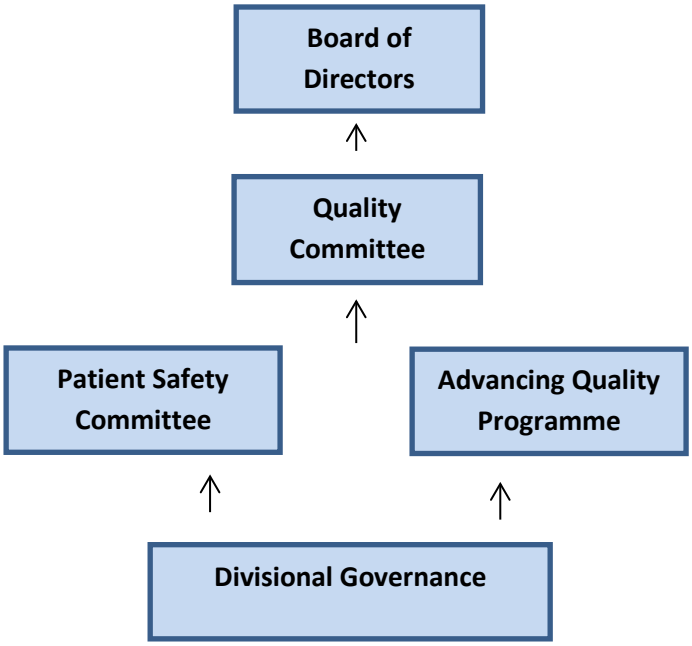
We continue to robustly monitor progress of our improvement work through our safety and quality governance framework, including working much more closely with other improvement processes across the organisation and wider health and social care footprint.

An example of the above is demonstrated in our Nottinghamshire-wide training approach to Quality Improvement (QI), which is delivered jointly between us, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust. This uses the nationally accredited QI training approach, Quality, Service Innovation and Re-design (QSIR) as the platform to build capabilities, networks and a common QI language across traditional organisational boundaries. This has been recognised as national best practice by NHS Improvement's Act Academy.

We launched our QI approach in July 2018 - the Sherwood Six Step – which is underpinned by the globally recognised Institute of Healthcare Improvement's Model for Improvement.

Improvements in Quality Governance

We continue to build on the robust governance structures implemented in 2015, with the continuation of the Patient Safety Committee (formally the Quality Assurance Safety Cabinet) and the Advancing Quality Programme, both jointly chaired by the Executive Medical Director and Chief Nurse. The reporting structure from 'ward to board' provides the required assurances that our patients receive the high quality, safe care they deserve. The reporting structure is illustrated in Diagram 2:



The Patient Safety Committee (PSC) is overseen by the Executive Team, and meets monthly, providing a reporting and assurance role to the Trust Board's Quality (Assurance) Committee. PSC drives the patient safety and quality agenda across the organisation, being the vehicle to monitor the effectiveness of governance in its widest sense and hold defined specialist areas and the clinical divisions to account.

The Advancing Quality Programme (AQP) is overseen by the Executive Team and meets every other month and like PSC provides a reporting and assurance role to the Trust Quality Committee. AQP drives the strategic quality agenda across the Trust by assuring actions from external programmes such as the Care Quality Commission (CQC) and Get It Right First Time (GIRFT) are agreed and managed appropriately.

The PSC and AQP Annual Work Plans are aligned to that of the Quality Committee. Sub-groups ensure that timely and accurate accounts of quality standards are presented, good practice is recognised and rewarded, risks to the safety of patient care are identified and remedial action taken where required. Most importantly, the sub-groups ensure that lessons are learned and shared across the organisation.

Local governance processes have been strengthened, with effective and constructive discussion at specialty and divisional level common place. Performance and quality metrics have been aligned to

avoid duplication and to provide further assurance that the safety and quality of care is not compromised with the need to meet all necessary activity and financial standards.

Involvement of Governors

Our Council of Governors plays an important role in the delivery of safe, high-quality care. Members of the Governing Body act as observers on the Board committees and are also members of our Forum for Patient Involvement. Governors normally take an active role in our formal and informal visits to wards and departments, and provide an invaluable, impartial and observational perspective on how we conduct business. The Covid-19 pandemic has led to the suspension of these in 2021/22; We have a clear plan to reintroduce these in 2022/23. They have continued to support our Quality Committee ensuring a vital link between the organisation, our members and local communities, and support our engagement and communication activities.

Patient Care: Improvements in patient/carer information

The patient information service continues to provide specific and tailored information, education and support. Information is evidence-based, clinically accurate, up-to-date and written in a way to enable patients and their families/carers to better understand their care and treatment.

Leaflets are stored in an easily accessible patient information library on the Trust's website. Accessibility tools and information on interpreting and translation are available.

The patient information leaflet section on our intranet site helps colleagues in their production of patient information leaflets for their respective specialties/services. As well as a policy and instructions on how to create a new/reviewed leaflet, accessible information and health literacy (including a literacy checker) pages are available to further educate colleagues.

To tackle health equalities, mainly poor health and digital literacy among the local population, we signed the Patient Information Forum (PIF) Health and Digital Literacy Commitment Charter in 2020. Aspiring to become health and digital literacy friendly, accredited training sessions were put in place for Trust staff to learn how to implement techniques to enhance approaches and practice that effectively support people with low levels of health and digital literacy.

To further improve effective patient communication, a pilot is currently in place whereby QR code posters (linking to relevant Trust-approved patient information leaflets) have been produced.

The aim is to get the information patients need directly on to their digital devices where they can access it more easily. These posters will not completely replace direct website downloads or paper copies of leaflets (due to poor digital literacy), they will enhance the service, while also supporting the Trust's Green Plan commitments by reducing use of paper.

Complaint Handling

The Trust is committed to resolving any concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the team. The Patient Experience Team (PET) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/service directly, or where they have done so but their concern remains unresolved. The PET aims to resolve any concerns that are raised with them quickly and informally.

The Trust operates a centralised complaints service, which ensures that a patient-centred approach is taken to the management of complaints and that all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt.

In addition to the valuable learning and improvements that result from individual concerns or complaints, data is analysed to identify any themes and the intelligence generated is shared across the organisation to drive necessary improvements.

Complaint management was paused during the first wave of Covid-19 following guidance from NHSE to pause for three months. There were additional pauses at the start of 2021 and 2022 due to increase in clinical pressures from the rise in Covid-19 cases. These pauses were to allow staff to concentrate on front-line duties and responsiveness to Covid-19. During these times all complaints were acknowledged and reviewed for any patient safety concerns, safeguarding issues, etc. Where concerns were identified, action was taken in accordance with the complaints policy.

During 2021/22 we received 299 complaints, showing a 17% increase from 2020/21. In the same reporting period, we responded to 39% within the agreed 25 days; in some cases, due to Covid-19 pressures and complexities of the complaint investigations, a revised timescale of 40 working days was agreed with the complainant.

During 2021/22 there were 60 re-opened complaints where there further dialogue was required following an initial response, this is approximately 35% higher than in the same reporting period in 2020/21. Two applications were received from the Parliamentary and Health Service Ombudsman (PHSO) during 2021/22; four cases were not accepted by the PHSO; two were upheld/partly upheld and action plans and learning has been completed. The PHSO currently have five on-going investigations at the time of writing this report. Due to the pause on the acceptance of new health complaints in March 2020, the Trust is aware the PHSO has a significant backlog and therefore anticipate a substantial increase in new PHSO complaints over the next year.

Stakeholder relations

We continue to develop our role within our health and care system and how we will work with our partners to improve the lives of our citizens. We play a leading role in the Nottingham and Nottinghamshire Integrated Care System (ICS), which brings together local NHS services, councils and the voluntary sector with the ambition for people living in Nottingham and Nottinghamshire to live longer, happier, healthier and more independent lives.

The Health and Care Bill, which intends to put Integrated Care Systems on a statutory footing and create Integrated Care Boards (ICBs) as new NHS bodies, is expected to take effect from 1st July 2022. This will enable ICBs to be legally and operationally established.

Under the new legislation all statutory NHS providers are required to be involved in at least one provider collaborative. The Trust has actively supported the development of the Nottinghamshire Provider Collaborative and we are currently working to establish a Provider Collaborative Office, to co-ordinate and drive forward the work of the collaborative and to realise benefits for our patients.

In June 2022 we will welcome our new Director of Strategy and Partnerships, who will help us to develop our partnership working within the ICB and Provider Collaborative, as well as with Place Based Partnerships and Primary Care Networks. Through collaboration we will be able to improve patient care and the health of everyone we serve.

This role will build on strong foundations already in place, as the Trust has a number of senior managers and executives already working regularly with system partners through established forums. We have embraced closer system working and welcome a greater level of transparency and consistency between organisations.

The challenges of the past two year have necessitated further joint working between organisations, particularly in relation to the rollout of the Covid-19 Vaccination Programme. The Trust has taken a lead role in the successful deployment of the programme in Nottinghamshire, providing payroll, IT and rostering support for 2,417 colleagues working in vaccination centres.

We are committed to improving patient experience through responding to stakeholder feedback.

Consultation with local groups and organisations

It has been more important than ever to engage with our communities and stakeholders in 2021-22, to keep them informed and engaged while the Trust has been managing our response to the Covid-19 pandemic.

Many traditional forms of face-to-face engagement haven't been available to us. We have had to be flexible and innovative, relying more on digital channels to stay in contact with groups that we have been actively encouraging to stay away from our hospital sites.

Staying in contact with these groups has been vital though, to help them understand what life has been like at our hospitals, to inform services and to communicate essential public health messages.

We continue to work towards the Trust's Healthier Communities, Outstanding Care for All strategy and this year have continued to engage our citizens and partners through a number of channels.

Through the #TeamSFH website, social media accounts and close working with local digital, print and broadcast media we have continued to keep patients and the wider public informed about what is happening at our hospital sites and supporting everyone to keep safe.

We have continued to use these same channels to celebrate our successes and to share important information about service developments at all our sites.

We have also strengthened our links with Primary Care with regular attendance in each other's key meetings opening channels between GPs and the Trust and we are now part of the Integrated Care Board/Place-based Partnership Communications Group, which meets to share information, knowledge, and best-practice to communicate and engage with the public more effectively.

The Forum for Public Involvement continues to meet virtually each month. The group has more than 40 members and sits across the Mid-Nottinghamshire Integrated Care Partnership footprint. It develops and agrees its own agenda and as a result hears regularly from teams across the Trust, for example, Patient Experience and HR. The group also contributes to key Trust documents.

As a Foundation Trust we have an active and effective Council of Governors. Opportunities for Governors to engage with patients and the public have been limited due to Covid-19 restrictions but as part of wider engagement and through the Mid-Nottinghamshire Place-based Partnership, our Chair of Governors Sue Holmes has been leading efforts to establish more links with community groups with a focus on Priority Places (areas of high deprivation and traditionally low engagement with NHS and social care services).

Starting with the Bellamy Road Estate in Mansfield, this work will help us to better understand these communities' needs and reduce barriers to accessing our services – helping us to deliver outstanding care and, ultimately, leading to healthier communities.

During February we opened nominations for people to become Governors.

As a foundation trust, Governors represent our members' and the public's interests and have a statutory duty to hold the Non-Executive Directors to account for the performance of the Trust Board. They bring valuable perspectives and ensure the Trust is publicly accountable for the services it provides.

We had vacancies for 12 public governors covering the different areas we serve. We also had vacancies for three staff governors – one for Newark and two for King's Mill and Mansfield Community Hospitals.

We also have a public Trust Membership of 14,500, which we communicate with monthly, through an e-newsletter which features key news and developments at SFH. We also invite members to take part in key events such as the Annual Meeting and share news through social media.

We continued our focus on engaging and recruiting more young members to the membership, establishing links with our local further education colleges and developing a communications and engagement strategy.

Our Patient Experience Team is often the first point of call for patients with both negative and positive experiences of our services, and they work closely with our divisions to ensure we respond appropriately to individuals. The service has a clear governance process for reporting themes or concerns for oversight and action via our Patient Safety Committee. We respond to comments made via Care Opinion, and regularly share both positive and negative comments on social media, encouraging patients to share their feedback to help us improve.

We continue to meet with our MPs, local politicians and other partners and stakeholders, including district council leaders and Healthwatch representatives.

We are the largest employer in our area by a significant margin and we know that by engaging effectively with our staff (evidenced by our Staff Engagement performance among other measures) we are, by extension, also communicating effectively with our service users and community.

We communicate and engage with #TeamSFH colleagues using a range of channels, including staff briefings across all sites, blogs, a weekly e-newsletter, WhatsApp and a closed Facebook group with more than 3,200 members. Specific networks for ethnic minority disabled and LGBTQ+ colleagues has also all been strengthened.

Paul Robinson
Chief Executive Officer **17th June 2022**

Remuneration Report

Scope of the report

The Remuneration Report summarises our remuneration policy and, particularly, its application in connection with the executive directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS FT Code of Governance, in sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ('the Regulations') as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations and elements of the Foundation Trust Code of Governance.

Annual Statement on Remuneration from the Chair of the Remuneration Committee

The Remuneration Committee met seven times during the year and key decisions made included the interim arrangements for the Chief Executive and Chief Finance Officer/Deputy Chief Executive, the agreement to ensure the consistency of payments in lieu of notice clause across all employee contacts, the annual review and approval of the Terms of Reference for the committee, the establishment of a Director of Strategy and Partnerships to replace the role of Director of Communications, the recruitment process and timeline for the substantive CEO, Chief Nurse, Chief Operating Officer and Director of People. And the cessation of the agreement to share a Director of Corporate Affairs with Nottinghamshire Healthcare NHS Foundation Trust.

Senior managers' remuneration policy

We must attract, develop and retain executive directors and senior managers of a high calibre to ensure the organisation is well led and able to deliver its strategy and vision.

Executive directors and senior managers receive an annual appraisal, in accordance with our performance management framework. This ensures the performance of the executive directors and senior managers is based on the delivery of objectives as defined within the annual plan.

There are, however, no contractual provisions for performance-related pay for executive directors and senior managers and, as such, no performance related payments were made relating to 2021/22.

Our approach to remuneration is modelled on guidance in The NHS Foundation Trust: Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health).

The key principles of the approach are that pay and reward are firstly assessed relative to the financial performance of the Trust as a whole, and secondly in line with available benchmarks, including NHS Providers, the NHSE published pay ranges and the wider pay policies of the NHS.

Executive appointments to the Board of Directors continue under permanent contracts.

Governance for the approval of remuneration packages, in line with the policy, is in place through the Remuneration Committee, which considers pay on an individual basis attributed to scope and remit of role. Through the Remuneration Committee, the Board assures itself that salaries are commensurate with other organisations of similar size and complexity. It also considers the nature of the patient, quality and safety challenges to provide assurance that any given salary reflects the degree of responsibility and accountability.

Senior manager remuneration

Set out below are the components of the senior managers' remuneration package. All substantive senior managers receive basic pay and business expenses. They also receive the employer's contribution to the NHS pension scheme where they are eligible to join it.

Relocation expenses are paid in accordance with the Trust's general relocation policy, where an appointee is required to maintain two properties or move their primary residence to take up their position.

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	All senior managers receive a basic pay element to their remuneration, which is pro-rata for part time staff	The Trust pays employer contributions for all senior managers who are enrolled in the NHS pension scheme. This is a % of pay set by NHS Pensions Authority	Reimbursement of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Up to £5,000 is available to newly appointed senior managers in accordance with the terms of the Trust's general relocation scheme	Payment is only applicable to the Medical Director and is in accordance with the local and national scheme	The Trust pays remuneration to senior managers who have additional system / duties above the expressed duties in the contract of employment. For 2021/22 this relates to the Chief Nurse for support offered to Shrewsbury and Telford NHS Trust with their maternity improvement, the Acting Chief Executive in relation to the additional responsibility associated with undertaking the acting Chief Executive Role, and the Acting Chief Finance Officer in

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
						relation to the additional responsibility associated with undertaking the acting Chief Finance Officer role.
How the component supports short-term and long-term objectives of the Trust	Set at point of recruitment, reviewed using pay benchmarking and other relevant information. Recruiting high-calibre senior managers is crucial to the delivery of the Trust's objectives. Benchmarking takes into consideration other similar medium-sized acute district general hospitals to	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	ensure salary levels are competitive, but also represent value for money					
How the component operates	Standard monthly pay	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme	Reimbursed as incurred, paid via monthly payroll	Reimbursed as incurred on appointment	Determined by local and national policy	Determined by guidance for approval of senior pay
Maximum payment	Basic pay	Contributions are made in accordance with the NHS Pension Scheme	Expenses incurred on official duties reimbursed	£5,000	Determined by local and national policy	£17,500
Framework used to assess performance	Trust appraisal system	N/A	N/A	N/A	N/A	N/A
Performance measures	Individual objectives agreed as part of appraisal process	N/A	N/A	N/A	N/A	N/A
Performance Period	Annual Appraisal	N/A	N/A	N/A	N/A	N/A

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
Amount paid for minimum level of performance and any further levels of performance	No performance-related payment arrangements	N/A	N/A	N/A	N/A	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered in accordance with Trust Policy. A performance-related clawback of up to 10% arrangement is in place	N/A	N/A	N/A	N/A	N/A

The senior manager remuneration policy does not provide for automatic annual inflation-related increases. Any such increase needs to be expressly approved by the Remuneration Committee.

The Trust does not have any executive directors or senior managers who are members of a different pension scheme who receive an employer contribution from the Trust as part of their remuneration.

From 1st April 2021, the Committee approved: one director received a 5% pay increase following a review of objectives and recognising national influence, while a further Director received a 10% pay increase associated with undertaking a dual role with a neighbouring NHS organisation. None of these increases exceeded or further exceeded the £150,000 threshold.

In accordance with the NHSE letter to Chairs of all NHS Trusts and NHS Foundation Trusts dated 8th September 2021, there was no annual pay award for Very Senior Managers (VSMs) in 2021/22. In summary the letter recognised that NHS Trusts may from time to time use their discretion to make exceptional pay awards to acknowledge exceptional performance. The advice from the NHS People Officer is that if local Remuneration Committees are considering making exceptional pay awards any money spent on non-consolidated awards must come from existing budgets, and these should not exceed 2% of the VSM pay bill. In addition, the letter identified individuals should not receive a non-consolidated pay award which exceeds 5% of their reckonable pay pot and organisations must be mindful of the constraints on the Agenda for Change framework with the cap at 3%. The letter also clarified that if any VSM pay exceeds £150,000 or further exceeds the £150,000 threshold following a pay review ministerial comment/approval is required. Following a benchmarking exercise, the Remuneration Committee recommendation was that the executive directors did not receive an annual pay increase in 2021/22.

During the year Non-Pensionable Personal Responsibility payments have been paid to directors where they have taken on additional responsibilities over and above their substantive role and usually outside of their employing organisation

Senior managers paid more than £150,000 per annum

Where a senior manager is paid more than £150,000 per annum, the Remuneration Committee has taken robust steps to provide assurance that this remuneration is reasonable. This is done by applying the principles of good corporate governance as described in the NHS FT Code of Governance, in Sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) (the Regulations) as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations. In addition, benchmark information is used, particularly that appertaining to the NHS, such as remuneration surveys conducted and supplied by NHS providers and NHSEI's published pay ranges.

The Remuneration Committee also seeks approval from HM Treasury, NHSE-I, the Department of Health and the Minister of State for Health for salaries that exceed £150,000 per annum, as required by NHS Improvement's guidelines on pay for very senior managers in NHS Trusts and Foundation Trusts.

Since June 2015, any salary approved in excess of £150,000 is subject to a 10% earn-back in the event of under-performance of the post-holder.

Non-Executive Directors' remuneration

Fee	Car allowance	Pension	Business expenses	Relocation Expenses
All Non-Executive Directors received a fee	Not applicable	Not applicable	Refund of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Not applicable

The remuneration for Non-Executive Directors has been determined by the Council of Governors and is set at a level to recognise the significant responsibilities of non-executive directors in NHS Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

Non-Executive Directors each have terms of no more than three years and can serve two concurrent terms (no more than six years), dependent on formal assessment and confirmation of satisfactory on-going performance. Non-executive directors can apply for a third term if the Council of Governors is in agreement.

Their remuneration framework, as agreed previously by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2021/22 has been consistent with that framework. Benchmarking is provided via the NHS provider annual remuneration survey. There were no cost-of-living increases applied for non-executive directors during 2021/22.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and expenses incurred while on Trust business and are not entitled to any termination payments. The Council of Governors as a whole determines the terms and conditions of the Non-Executive Directors.

The Trust does not make any contribution to the pension arrangements of Non-Executive Directors. Fees reflect individual responsibilities, including chairing the committees of the Board, with all Non-Executive Directors otherwise subject to the same terms and conditions.

The balance of the Board complies with the Code of Governance, which requires that at least half the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent, and our constitution, which states the number of executive Directors is less than the number of Non-Executive Directors. There are six Non-Executive Directors, excluding the Chair, and five voting Executive Directors including the Chief Executive.

Termination payments for senior managers and policy on payment for loss of office

Termination payments for senior managers are contained in the contract of employment regarding notice periods. Notice periods set out under senior managers' substantive employment contracts are in line with statutory requirements. Interim contractors and fixed-term senior managers have a notice period of one month.

Entitlements to severance payments are in line with those of other employees within the Trust, namely those provisions contained in section 16 of Agenda for Change: National NHS terms. This is based on length of continuous and reckonable NHS service and basic pay. The basic pay element had a salary cap of £80,000 during 2021

Statement of consideration of employment conditions elsewhere in the Foundation Trust

We do not consult with employees when setting our senior manager remuneration policy. The pay and conditions of other Trust employees, however, were considered. All other national NHS terms are mirrored for Trust senior managers, including annual leave and sick pay.

In accordance with the policy on diversity and inclusion the remuneration committee ensures that in terms of the constitution of the board and with regards to pay and remuneration decisions are made in accordance with the principles of this policy. This links to the Trust's strategy in terms of recruiting and retaining the right people.

Annual Report on Remuneration (not subject to audit)

Senior manager remuneration

Name	Title	Start Date	Expiry	Notice Period
Richard Mitchell	Chief Executive	01/07/017	01/10/2021	6 months
Paul Robinson	(Acting) Chief Executive	02/10/2021	31/03/2022	6 months
Paul Robinson	Chief Financial Officer	23/03/2015	02/10/2021	6 months
Simon Barton	Chief Operating Officer	01/01/2018		6 months
Shirley A Higginbotham*	Director of Corporate Affairs	04/04/2013		6 months
Lorna Branton**	Director of Communications	16/11/2020		3 months
Marcus Duffield	Interim Associate Director of Communications	20/10/2021		3 months
Clare Teeney*	Director of People	02/09/2019		6 months

Emma Challans	Director of Culture & Improvement	09/12/2019		6 months
Julie Hogg	Chief Nurse	09/12/2019		6 months
Dr David Selwyn	Medical Director	09/12/2019		6 months
Richard Mills	Interim Chief Finance Officer	01/10/2021		3 months

*Joint appointment with Nottinghamshire Healthcare NHS Foundation Trust.
** On external secondment

Non-Executive Directors' remuneration

Service Contracts

Senior managers' service contracts do not contain any obligation on the Trust.

Name	Title	Start Date	Expiry	Notice Period
John MacDonald	Non-Executive Director (Chair)	01/03/2017	31/07/2021	1 month
Claire Ward	Non-Executive Director (Chair)	01/10/2021	30/09/2024	1 month
Claire Ward	Non-Executive Director	01/05/2013	30/09/2021	1 month
Tim Reddish	Non-Executive Director	08/07/2013	31/10/2021	1 month
Neal Gossage	Non-Executive Director	10/05/2015	30/04/2022	1 month
Graham Ward	Non-Executive Director	01/12/2015	30/11/2022	1 month
Barbara Brady	Non-Executive Director	01/10/2018	30/09/2024	1 month
Manjeet Gill	Non-Executive Director	01/11/2018	31/10/2024	1 month
Steven Banks	Non-Executive Director	01/12/2021	30/11/2024	1 month
Dr Aly Rashid	Non-Executive Director	10/01/2022	09/01/2025	1 month
Dr Andrew Haynes	Specialist Non-Executive Advisor to the Board	19/04/2021	18/04/2022	1 month

Major decisions on senior managers' remuneration

The remuneration of senior managers was reviewed in 2021/22 as there were a number of changes in senior manager appointments and the roles of senior managers.

Substantial changes to senior managers' remuneration during the year and the context for these

Changes in remuneration were made as a consequence of extended duties outside of the organisation and relevant benchmarking data was considered when making these payments.

Payments for loss of office

No payments for loss of office were made during 2021/22.

Payments to past senior managers

No payments to past senior managers were made during 2021/22, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Remuneration and Nominations Committees

We have two remuneration and nominations committees: one which serves as a committee of the Board and is responsible for recruiting and appointing the Chief Executive and executive directors; and the other which serves as a committee of the Council of Governors and is responsible for recruiting and appointing the Chair and Non-Executive Directors and approving the appointment of the Chief Executive.

Our Board appoints the Remuneration and Nominations Committee, its membership comprises only Non-Executive Directors. The committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation, including the framework of executive and senior manager remuneration.

The following Non-Executive Directors have served on the committee, which has met seven times during the year:

Name	**Meetings attended out of possible total**
Graham Ward (Chair of Committee) from May 2021	7/7
Claire Ward (Chair of Committee) to May 2021	1/1
Barbara Brady	5/6
Manjeet Gill	5/7
Neal Gossage	1/1
Dr Aly Rashid	1/2
Steve Banks	1/1

The committee also invited the assistance of our Chief Executive (Richard Mitchell) and (Paul Robinson), the Company Secretary (Shirley A Higginbotham), Director of People (Clare Teeney) and the Deputy Director of People (Rob Simcox). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

Our Council of Governors appoints the Remuneration and Nominations Committee, its membership comprises of the Chair and public, staff and appointed governors. The Committee meets to determine, on behalf of the Council of Governors, the remuneration for the Chair and Non-Executive Directors, the composition of the Board regarding skills and experience, and to agree the recruitment process for the Chair and Non-Executive Directors.

During the year, the following have served on the Committee, which has met five times:

Name	Meetings attended out of possible total
Sue Holmes (Lead Governor)	5/5
Martin Stott (Public Governor)	5/5
Roz Norman (Staff Governor)	4/5
Lawrence Abrams (Public Governor)	3/5
Philip Marsh (Public Governor)	5/5
Michael Brown (Appointed Governor)	0/1

The Committee also invited the assistance of our Company Secretary (Shirley A Higginbotham) our Senior Independent Director (Tim Reddish) and our Chair (Claire Ward). Neither they, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

The Committee successfully recommended the following to the Council of Governors for approval the:

- Re-appointment of Non-Executive Directors who had reached the end of their tenure,
- Chair's appraisal and objectives
- Objectives for the interim Chair
- Process for the recruitment of a substantive chair and Non-Executive Directors
- Renewal of the specialist advisor role to the Board
- Objectives for the Non-Executive Directors
- Appointment of the Vice Chair

Disclosures required by Health and Social Care Act

Governor and Director Expenses

During the year the total number of Directors who served on our Board was 21 and the number of Governors serving on our Council of Governors totalled 27 during the year. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		**Total paid 2021/2022 £'00**	**Total paid 2020/2021 £'00**
John MacDonald	Chair	6.70	9.80
Claire Ward	Non-executive director	0	0
Tim Reddish	Non-executive director	0	0
Neal Gossage	Non-executive director	0	0.30
Graham Ward	Non-executive director	0	0
Barbara Brady	Non-executive director	0	1.00
Manjeet Gill	Non–executive director	0	0
Steve Banks	Non–executive director	0	N/A
Dr Aly Rashid	Non–executive director	0	N/A
Richard Mitchell	Chief Executive	21.85*	66.51*
Julie Hogg	Chief Nurse	0	0
Clare Teeney	Director of People	0	0
Emma Challans	Director of Culture and Service Improvement	0.60	4.74
Simon Barton	Chief Operating Officer	0	0
Dr Andrew Haynes	Medical Director	0	0
Dr David Selwyn	Medical Director	0	0
Paul Robinson	Chief Financial Officer / Deputy CEO - Chief Executive Officer	1.30	0.90
Shirley Higginbotham	Director of Corporate Affairs	0	0
Robin Smith	Head of Communications	0	0
Marcus Duffield	Interim Associate Director of Communications	0	0
Lorna Branton	Director of Communications	0.10	0
	TOTAL	**30.60**	**83.30**

*includes items for staff health and wellbeing

Governors	Constituency	Area	Total 2021/22 £'00	Total 2020/21 £'00
Ann Mackie	Public Governor	Newark and Sherwood	No claim	No claim
Ian Holden	Public Governor	Newark and Sherwood	No claim	No claim
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	N/A
John Wood	Public Governor	Mansfield	No claim	No claim
Kevin Stewart	Public Governor	Ashfield	No claim	No claim
Martin Stott	Public Governor	Newark and Sherwood	No claim	No claim
Roz Norman	Staff Governor	King's Mill and Mansfield	No claim	No claim
Susan Holmes	Public Governor	Ashfield	No claim	0.08
Valerie Bacon	Public Governor	Derbyshire	N/A	No claim
Belinda Salt	Public Governor	Mansfield	N/A	No claim
Ben Clarke	Staff Governor	King's Mill and Mansfield	No claim	No claim
Brian Bacon	Public Governor	Derbyshire	N/A	No claim
Craig Whitby	Appointed Governor	Mansfield District Council	No claim	No claim
David Walters	Appointed Governor	Ashfield District Council	No claim	No claim
Dean Whelan	Public Governor	Mansfield	No claim	No claim
Gerald Smith	Public Governor	Mansfield	No claim	0.20
Jacqueline Lee	Staff Governor	Newark	No claim	No claim
Jayne Revill	Staff Governor	King's Mill and Mansfield	No claim	No claim
Lawrence Abrams	Public Governor	Rest of East Midlands	0.70	No claim
Michael Brown	Appointed Governor	Newark and Sherwood District Council	No claim	No claim
Nikki Slack	Appointed Governor	West Notts College	No claim	No claim
Philip Marsh	Public Governor	Ashfield	No claim	No claim
David Ainsworth	Appointed Governor	Local Commissioning Group	No claim	N/A
Linda Davies	Appointed Governor	Newark and Sherwood District Council	No claim	N/A
Richard Boot	Staff Governor	Newark	No claim	No claim
Maxine Huskinson	Public Governor	Ashfield	No claim	N/A
Nadia Whitworth	Appointed Governor	Sherwood Forest Hospitals Volunteers	No claim	N/A
TOTAL			**0.70**	**0.28**

Annual Report on Remuneration (subject to audit)

Senior Managers Disclosure

	2021/22						2020/21					
Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total
	£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors												
Mr R Mitchell (Chief Executive Officer) (1)	105 - 110	2,200	0	0	0	105 - 110	180 - 185	6,700	0	0	48 - 50	235 - 240
Mr P Robinson (Chief Executive Officer) (2)	165 - 170	100	0	0	0	165 - 170	100 - 105	100	0	0	0	100 - 105
Ms J Hogg (Chief Nurse) (3)	135 - 140	0	0	0	0	135 - 140	130 - 135	0	0	0	0	130 - 135
Mr S Barton (Chief Operating Officer)	135 - 140	0	0	0	35 - 37.5	170 - 175	135 - 140	0	0	0	23 - 25	155 - 160
Dr D Selw yn (Executive Medical Director) (4)	165 - 170	0	0	0	52.5 - 55	220 - 225	160 - 165	0	0	0	0	160 - 165
Mr R Mills (Acting Chief Financial Officer) (5)	65 - 70	0	0	0	32.5 - 35	95 - 100	N/A	N/A	N/A	N/A	N/A	N/A
Non voting members												
Ms S Higginbotham (Director of Corporate Affairs) (6)	110 - 115	0	0	0	20 - 22.5	130 - 135	110 - 115	0	0	0	20 - 22.5	130 - 135
Ms C Teeney (Director of People (HR) (7)	15 - 20	0	0	0	10 - 12.5	25 - 30	15 - 20	0	0	0	35 - 37.5	50 - 55
Ms E Challans (Director of Culture and Improvement) (8)	110 - 115	100	0	0	0	115 - 120	110 - 115	500	0	0	0	110 - 115
Ms L Branton Head of Communications) (9)	30 - 35	0	0	0	5 - 7.5	35 - 40	30 - 35	0	0	0	20 - 22.5	50 - 55
Mr M Duffied (Head of Communications) (10)	40 - 45	0	0	0	2.5 - 5	45 - 50	N/A	N/A	N/A	N/A	N/A	N/A
Mr R Smith Acting Head of Communications) (11)	N/A	N/A	N/A	N/A	N/A	N/A	40 - 45	0	0	0	25 - 27.5	65 - 70
Mr P Wozencroft (Director of Strategic Planning and Commercial Development) (12)	N/A	N/A	N/A	N/A	N/A	N/A	75 - 80	0	0	0	0	75 - 80
Ms Kerry Beadling-Barron (13)	N/A	N/A	N/A	N/A	N/A	N/A	25 - 30	0	0	0	5 - 7.5	30 - 35
Non-Executive Directors												
Mr J MacDonald (Chair) (14)	0 - 5	0	0	0	0	0 - 5	50 - 55	1,000	0	0	0	50 - 55
Ms C Ward (Chair) (15)	45 - 50	0	0	0	0	45 - 50	N/A	N/A	N/A	N/A	N/A	N/A
Mr T Reddish (16)	5 - 10	0	0	0	0	5 - 10	15 - 20	0	0	0	0	15 - 20
Ms C Ward	0 - 5	0	0	0	0	0 - 5	10 - 15	0	0	0	0	10 - 15
Mr G Ward	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr N Gossage	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Ms B Brady	10 - 15	0	0	0	0	10 - 15	10 - 15	100	0	0	0	10 - 15
Ms M Gill	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Dr A Rashid (17)	0 - 5	0	0	0	0	0 - 5	N/A	N/A	N/A	N/A	N/A	N/A
Mr S Banks (18)	0 - 5	0	0	0	0	0 - 5	N/A	N/A	N/A	N/A	N/A	N/A
Dr A Haynes (Specialist Advisor to the Board) (19)	10 - 15	0	0	0	0	10 - 15	N/A	N/A	N/A	N/A	N/A	N/A

Notes (2021/22)

1 - Mr R Mitchell CEO Resigned 3rd Oct 21 (Chair of the East Midlands Cancer Alliance, 2 days per month from Nov 19). Chose not to be covered by the pension arrangements during the reporting year
2 - Mr P Robinson (Acting) CEO from 4th Oct 21, CFO to 3rd Oct 21 (Interim Director of Finance, Nottinghamshire ICS 2
3 - Ms J Hogg Appointed Chief Nurse 9th Dec 2019. Chose not to be covered by the pension arrangements during the
4 - Dr D Selwyn Appointed Medical Director 9th December 2019. 2 programme activities per week for the Royal College of
5 - Mr R Mills (Acting) CFO from 4th Oct
21
6 - Ms S Higginbotham (Director of Corporate Affairs / Company Secretary dual role with Nottinghamshire Healthcare NHS Foundation Trust from 1st Oct 2020. Total salary across both organisations £121,100
7 - Ms C Teeney Appointed Director of People (HR) 2nd Sep 2019 dual role with Nottinghamshire Healthcare NHS foundation Trust. Total salary across both organisations £146,300.
8 - Ms E Challans Chose not to be covered by the pension arrangements during the reporting year
9 - Ms L Branton seconded to NHS Digital 1st Nov 21
10 - Mr M Duffield Appointed Head of Communications 20th Oct 21
11 - Mr R Smith, Acting Head of Communications from 1st May 2019 to 30th Nov 20.
12 - Mr P Wozencroft, Retired 30th Sep 20. (Incl Arrears and Lieu of notice)
13 - Ms K Beadling-Baron assigned to work for Nottinghamshire ICS from 1st May 2019 and resigned 31st Jul 20.
14 - Mr J MacDonald, Seconded to University University Hospitals of Leicester 17th Apr 21 & Chair of Joined up Care Derbyshire ICS. Resigned as Chair for Sherwood Forest Hospitals NHS Foundation Trust 17th Jun 21
15 - Ms C Ward, Appointed Chair for Sherwood Forest Hospitals NHS Foundation Trust 17th April 21
16 - Mr T Reddish, Resigned Non Executive Director 31st Oct 21
17 - Dr A Rashid, Appointed Non Executive Director 10th Oct 21
18 - Mr S Banks, Appointed Non Executive Director 1st Dec 21
19 - Dr A Haynes Appointed Specialist Advisor to the Board 19th Apr 21. Chose not to be covered by the pension arrangements during the reporting year

Expenses relate to travel/subsistence claims which may be taxable dependent on value/type

Pensions-related benefit is disclosed for each senior manager based on their time in post as Director.

Notes (2020/21)

1 - Mr R Mitchell (Chair of the East Midlands Cancer Alliance, 2 days per month from Nov 19).
2 - Mr P Robinson (Director of Finance, Nottinghamshire ICS 2 days per week from 12th Dec 19).
3 - Ms J Hogg appointed Chief Nurse 9th Dec 2019. Opted out of the Pension scheme 31st Jan 2020
4 - Dr D Selwyn Appointed Medical Director 9th December 2019. 2 programme activities per week for the Royal College of
5 - Ms S Higginbotham (Director of Corporate Affairs / Company Secretary dual role with Nottinghamshire Healthcare NHS Foundation Trust from 1st Oct 2020. Total salary across both organisations £110,200
6 - Ms C Teeney appointed Director of People (HR) 2nd Sept 2019 dual role with Nottinghamshire Healthcare NHS foundation Trust. Total salary across both organisations £119,200.
7 - Ms L Branton appointed Director of Communications from 16th Nov 20 & lead for the mid-Notts Integrated Care Partnership
8 - Mr R Smith, Acting Head of Communications from 1st May 2019 to 30th Nov 20.
9 - Mr P Wozencroft, Retired 30th Sep 20. (Incl Arrears and Lieu of notice)
10 - Ms K Beadling-Baron assigned to work for Nottinghamshire ICS from 1st May 2019 and left 31st Jul 20.
11 - Ms S Banks Retired 31st Dec 2019.
12 - Dr A Haynes appointed to Nottinghamshire ICS (Executive Medical Director) 9th Dec 19 .
13 - Ms J Bacon, Retired 31st Dec 19 (Incl Arrears and Lieu of notice)
14 - Mr J MacDonald, Chair for Sherwood Forest Hospitals NHS Foundation Trust & Chair of Joined up Care Derbyshire ICS)

Expenses relate to travel/subsistence claims which may be taxable dependent on value/type
Pensions-related benefit is disclosed for each senior manager based on their time in post as Director.

Pension disclosure

Name and Title		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Executive Directors		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mr R Mitchell	***	0	0	0	0	0	0	0	0
Ms J Hogg	**	0	0	0	0	0	0	0	0
Mr S Barton	*	3 - 5	0 - 2.5	35 - 40	60 - 65	556	27	605	0
Dr D Selwyn		3 - 5	7.5 - 10	70 - 75	210 - 215	1658	0	0	0
Mr R Mills	*	0 - 2.5	0 - 2.5	20 - 25	30 - 35	203	17	254	0
(nee Clarke)	*	0 - 2.5	0	25 - 30	0	362	7	405	0
Ms C Teeney	*	0 - 2.5	0	60 - 65	0	812	18	870	0
Ms L Branton	*	0 - 2.5	0	10 - 15	0	106	1	121	0
Mr M Duffield		0 - 2.5	0	0 - 5	0	41	0	52	0

2020/21

Name and Title		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
Executive Directors		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mr R Mitchell	*	3 - 5	-3 - 0	40 - 45	70 - 75	516	25	567	0
Ms J Hogg	**	0	0	0	0	0	0	0	0
Mr S Barton	*	0 - 2.5	-3 - 0	30 - 35	60 - 65	514	16	556	0
Dr D Selwyn		-3 - 0	-3 - 0	65 - 70	200 - 205	1602	11	1658	0
(nee Clarke)	*	0 - 2.5	0	20 - 25	0	318	16	362	0
Ms C Teeney	*	0 - 2.5	0	60 - 65	0	711	35	812	0
Ms L Branton	*	0 - 2.5	0	10 - 15	0	61	12	106	0
Mr R Smith		0 - 2.5	0	0 - 5	0	26	3	40	0
Mr P Wozencroft	*	-5 - -3	-15 - -13	30 - 35	65 - 70	824	-4	648	0
Ms K Beadling-Barron	*	0 - 2.5	0 - 2.5	15 - 20	25 - 30	169	20	219	0

Notes

* These members' pension entitlements relate to the total values under two different NHS schemes

** Ms J Hogg chose not to be covered by the pension arrangements during the reporting year. Involvement in the NHS pension scheme terminated from Feb 20

*** Mr R Mitchell chose not to be covered by the pension arrangements during the reporting year. Involvement in the NHS pension scheme terminated from Jan 21

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 a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Fair Pay Multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Foundation Trust in the financial year 2021-22 was £205,000 - £210,000 (2020-21 was £205,000 - £210,000. This is a change in salary between years of 0.0%. No employees (2020-21, 0) received remuneration in excess of the highest-paid director.

For all employees of the trust as whole the remuneration ranged from £8,603 to £207,600 (2020-21, £8,320 to £206,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2.84%.

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

The median remuneration is based on annualised, full-time equivalent remuneration of all employees as at the reporting date. This has been calculated excluding any enhancements or overtime payments. This calculation does not include the impact of payments made to agency staff in post at year end. We are working on collating this information to include in the disclosure in future years.

There were no agency Board members at 31 March 2022.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the

highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021/22	25th Percentile	Median	75th Percentile
Salary Component of Pay	20,330	27,780	39,027
Total benefits excluding pension benefits	20,330	27,780	39,027
Pay and benefits: Pay ratio for highest pay director	10.3	7.5	5.3

Related party transactions

No related party transactions have been identified from a review of the register of interests.

Compliance statement

In compliance with the UK Directors Remuneration Report Regulations 2002, the auditable part of the remuneration report comprises executive Director's remuneration and Non-Executive Directors fees.

Paul Robinson
Chief Executive Officer **17th June 2022**

Staff Report

The largest group employed by us is nursing, midwifery and health visiting staff, followed by administration and estates staff, then healthcare assistants and other support staff, and medical and dental staff. The smallest group is those employed as healthcare science staff.

Our average workforce numbers from 1 April 2021 to 31 March 2022 are:

Average number of persons employed (Whole Time Equivalent) Subject to Audit

		2021/22		2020/21
	Total	Permanent	Other	Total
Medical and dental	**707**	634	73	**673**
Ambulance	**2**	2		**4**
Administration and estates	**1,150**	1,150		**1,086**
Healthcare assistants and other support staff	**1,017**	1,017		**1,035**
Nursing, midwifery and health visiting staff	**1,483**	1,299	184	**1,336**
Nursing, midwifery and health visiting learners	**26**	26		**0**
Scientific, therapeutic and technical staff	**391**	373	18	**394**
Healthcare science staff	**147**	147		**129**
Other	**37**	37		**10**
Total average numbers	**4,960**	**4,685**	**275**	**4,667**
Of which:				
Number of employees (WTE) engaged on capital projects	**2**	2		**1**

Although only two full time members of staff are employed to permanently manage capital, other staff costs have been incurred and capitalised relating to specific 2021/22 capital projects.

The permanent WTEs numbers disclosed are based on the average number of monthly employees. This is different to the methodology set out in the FT ARM which is calculated based on weekly numbers.

Breakdown of staff (actual headcount at 31 March 2022)

	Male	Female	Total
Director	8	6	14
Other Senior Manager	86	177	263
Employee	1012	4223	5235
Grand Total	**1106**	**4406**	**5512**

Staff Costs- Subject to audit

	Total	Permanent	Other	Total
	31-Mar-22	31-Mar-22	31-Mar-22	31-Mar-21
	2021/22	2021/22	2021/22	2020/21
Salaries and wages	218,926	218,926	0	197,025
Social security costs	23,021	23,021	0	20,409
Apprenticeship levy	1,102	1,102	0	972
Pension cost - employer contributions to NHS pension scheme	23,655	23,655	0	21,133
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	10,342	10,342	0	9,089
Pension cost - other*	179	179	0	0
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	16,885		16,885	15,160
TOTAL GROSS STAFF COSTS	**294,110**	**277,225**	**16,885**	**263,788**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	0
TOTAL STAFF COSTS	**294,110**	**277,225**	**16,885**	**263,788**
Included within:				
Costs capitalised as part of assets	231	308	0	308

Sickness absence

Information regarding our sickness absence data is published by NHS Digital at: **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates**

Health and Safety at Work 2021/22

The Trust recognises the importance of ensuring the health, safety and well-being of all Trust employees as enshrined in the NHS Constitution. The Trust strives to provide all colleagues with a healthy and safe working environment.

The Trust's health and safety team works collaboratively with different organisations, line managers, specialist teams and individuals to secure the health and safety of staff, patients, visitors and contractors. This is in keeping with the ethos of the Health and Safety at Work etc. Act 1974, which recognises that everybody needs to play their part in ensuring that all who come in to contact with the work activities of the Trust are kept safe.

The Trust encourages divisional management teams and staff-side representatives to work in partnership to ensure that all parties are engaged in health and safety management across the organisation.

The Trust's Health and Safety Group acts as the main mechanism for consultation on work-related health and safety matters. This forum reports to the Risk Committee which is chaired by the Chief Executive. The Health and Safety Group also works closely with the Health and Wellbeing group, the Estates Governance Group and the Infection Prevention and Control Committee to ensure that the full range health and safety related risks are properly identified, and suitable and sufficient controls are put in place.

In line with other services 2021/22 has been a very busy year with the spotlight on keeping colleagues as safe as reasonably practicable from the SARS-Cov2 Virus. The Health and safety Team has been working closely with colleagues and the staff-side on issues such as Respirator fit testing, PPE specification, risk assessments, signage and cleaning practices.

In August 2021 HSE inspectors spent three days at the Trust conducting a proactive inspection of the Trust's management arrangements for reducing the risk of staff suffering injury due to violence and aggression or from musculoskeletal disorders (MSDs. The inspectionwas comprehensive, and all parties involved gained valuable learning from the inspection. HSE did not take any enforcement action against the Trust.

The Trust uses a range of both reactive and proactive measures to monitor health and safety performance. One measure adopted is the rate of non-fatal injuries occurring that require reporting to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

In 2021/22 The Trust reported 14 staff injuries (17 in the previous year) and zero patient injuries under the reporting requirements of RIDDOR. On average the Trust headcount for 201/22 was 5,402 (5,308 in previous year) excluding bank and agency staff. The Trust's rate of RIDDOR reportable non-fatal injury per 100,000 employees was 259 against a reported latest national average rate for the human health activities sector of 314 non-fatal injuries per 100,000 employees. The Trust's rate of injuries in 2020/21 was 320 against a national average of 350 non-fatal injuries per 100,000 health care workers.

In line with both local and national health and safety priorities the work plan for the coming year will focus on improving staff wellbeing, with a focus on work-related musculoskeletal disorders, and the prevention of work-related violence and aggression.

Staff policies and actions applied during the financial year

We follow a clear governance structure for the approval and ratification of policies and procedures for matters relating to current and prospective staff members. Each policy document has a complete Equality Impact Assessment covering all relevant equality strands. This ensures that we are able to mitigate any possible areas of direct or indirect discrimination as part of the approval and ratification process.

The associated people related policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training, and ensuring development to support career progression. Our policies also establish minimum expectations in relation to conduct, behaviour and performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

We continue to operate fair recruitment practices to ensure equal access to employment opportunities for all. We have been awarded 'Disability Confident Employer' status which supports the Trust to make the most of the talents disabled people can bring to the workplace.

This is used on our recruitment material to show we encourage applications from applicants with disabilities. As an employer this status means we are committed to the following:

- Interviewing all applicants with a disability who meet the essential criteria for a job vacancy
- Supporting and empowering staff on an annual basis to declare any disabilities via wellbeing conversations to support development and use abilities at work.
- Making every effort when employees become disabled to make sure they stay in employment
- Taking action to ensure that all employees develop the appropriate level of disability awareness
- Reviewing these commitments every year and assessing what has been achieved, planning ways to improve on them and letting employees and Jobcentre Plus know about progress and future plans

We continue to be a signatory to the Charter for Employers who are Positive about Mental Health, reflecting the general philosophy of the Mindful Employer Charter which helps us to support staff who experience mental ill health. This has also been supported through the embracing the Time to Change agenda with focus of supporting employees with the opportunities to talk about the mental health.

Information to be published under Regulation 8 revised Trade Union (Facility Time Publication Requirements) Regulations 2017

Table 1: Relevant union officials

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

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
41	**34.37**

Table 2: Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	**23**
1-50%	**15**
51%-99%	**0**
100%	**3**

Table 3: Percentage of pay bill spent on facility time

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

First Column	Figures
Provide the total cost of facility time	99,918.12
Provide the total pay bill	277,225,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.36%

Table 4: Paid trade union activities

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

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	5.1%

Expenditure on consultancy

Consultants have been used where specific expertise is required which is not available in- house or where the capacity to complete a time limited exercise does not exist. Consultancy has been used in year for one Executive level appointment. We spent £0.187m on consultancy during the year, (2020/21 £0.125m).

Off-payroll engagements

The following tables disclose the number of staff with a significant influence over the management of the organisation where payment has been made directly to these staff or their companies, rather than via the Trust payroll.

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 2022	0
Of which...	
No. that have existed for less than one year at time of	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. 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 1 April 2021 and 31 March 2022, for more than *£245* per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust'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 1 April 2021 and 31 March 2022	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0

Process for off-payroll arrangements

Our policy is to avoid the use of off-payroll arrangements for engaging highly paid employees. The only event in which they are used, exceptionally, is where there is a business need to secure skilled expertise we do not currently have for a specific short-term purpose within a defined timescale, and where for whatever reason it is not feasible to engage someone as a direct employee. We have robust recruitment processes in place, including exploring framework providers in the first instance, to minimise any potential need for off payroll requirements.

Should appointments be made, they will be retained only for the minimum possible time until the requirement for the work is concluded, or a permanent recruitment has been secured. Any off-payroll engagement is subject to approval by a board member based on a clear case of need and is followed up to ensure that the arrangement has been concluded within the expected timescale.

Exit packages (subject to audit)

	2021/22			2020/21		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band
<£10,000	0	0	0	0	0	0
£10,001 - £25,0000	0	0	0	0	5	5
£25,001 - £50,000	0	1	1	2	1	3
£50,001 - £100,000	0	0	0	0	1	1
£100,001 - £150,000	1	0	1	0	0	0
£150,001 - £200,000	0	0	0	0	1	1
>£200,000	0	0	0	0	0	0
Total number of packages by type	1	1	2	2	8	10
Total resource used	135	37	172	70	338	408

	2020/21		2019/20	
	Agreements Number	**Total Value of Agreements £000**	**Agreements Number**	**Total Value of Agreements £000**
Voluntary redundancies including early retirement	0	0	2	70
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	2	172	6	298
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval	0	0	2	40
Total	2	172	10	408
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

Staff Survey

National Staff Survey

Staff Experience and Engagement

During 2021/22 Covid-19 continued to challenge our people. As part of our response, the HR, training and education, wellbeing, engagement, and organisational development teams have worked closely to deliver collaborative support to teams across the organisation. Based upon the NHS People Plan and NHS People Promises, a three-year joint People, Culture and Improvement Strategy has been developed for 2022/23 onwards. The work undertaken in 2021/22 has helped to shape this strategy and identified key priorities around staff engagement and support, with a view that the new strategy will further develop and improve our organisational culture. We want empower our people by giving them the knowledge, skills and tools to improve our culture and provide high quality care to our patients.

Each year the Trust Cultural Improvement action plan is refreshed and has specifically focused on improving themes from our annual staff survey and quarterly Pulse Surveys (previously Staff Friends and Family Tests). Evidence from our National Staff Surveys, quarterly Pulse Surveys, Freedom to Speak Up Guardian and HR workforce data indicates that many of our HR, Improvement, People Development and Organisational Development (OD) initiatives have contributed to improving our culture.

Engagement with staff and wellbeing offers were strengthened during the Covid-19 pandemic. This included regular communication updates with colleagues (sometimes even daily), the creation of a wellbeing den across each site, psychological support services and wellbeing road shows. We undertook a Learning From Covid exercise which helped to make further improvements in our organisational engagement; wellbeing; leadership development; and colleague experience offers.

Further organisational engagement initiatives have been introduced in 201/22, such as leading remotely and virtually trough on-line toolbox talks, using MS Teams to deliver training online, significant expansion of e-learning programmes and bespoke organisational development team interventions. In addition to this, we have actively continued to raise the profile of our Civility, Respect and Kindness programme at a Trust and system level, hosting a successful system wide learning event in September 2021.

The Trust culture improvements include:

- Despite the challenges of the past year, colleagues would still strongly recommend the Trust as a great place to work (74.8% compared to 59.4% national comparator average)
- Colleagues feel more valued than the average for our peer group (126 Acute and Community Trusts) with our National Staff Survey score nearly 10% above the national average
- Colleagues want to stay at this Trust, in part because of the way we support and develop them (National Staff Survey score for this question is 10% more than the national average)

- Launching breakaway training to support areas experiencing high incidents of physical violence from patients/public to staff
- Continuing to improve our on-boarding experience for new starters to ensure that it is a personal experience that is slick, informative, and effective
- Improved communication and engagement through the Covid-19 pandemic
- Continued to support agile working with more colleagues working flexibly between home and site
- Successful virtual ward initiative to support bank workers to join the Trust in a supportive and clear way
- Continued to grow and define our health and wellbeing offers and resources, including recruiting a wellbeing lead and staff clinical psychologist
- Continued to support wellbeing dens across all three sites
- Created online engagement sessions with local schools and colleges and themed career sessions to support succession planning.
- Supported more than 195 staff to undertake apprenticeships with 91 starting in 2021/22
- Employed new Head of Learning and OD with focus on leadership development and talent management
- Carried out wellbeing 'checking in, not checking up' visits in partnership between OD and the wellbeing team
- Delivered system wide Civility and Respect learning event
- Delivered a two-day Proud2bAdmin engagement event with Proud2bAdmin network launch and recognition event in line with World Admin Day in April 2022
- Built on our successful Sherwood Forest Virtual Exercise Group aimed to increase colleague morale, and physical and emotional wellbeing. This has grown from under 300 members to now more than 700 members

NHS Staff Survey

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

The response rate to the 2021 survey among trust staff was 66.4% (2020 61.1%).

For the fourth year running the Trust scored the highest engagement score as the best acute trust to work at in the Midlands and was the overall third best acute or acute/community trust in England, which is a fantastic achievement.

It is important to note that nationally all trusts in our comparator group (acute and acute community trusts) have seen an overall deterioration in their results as, a result of the immense pressure our workforce has been under for the past two years We sit favourably against other comparator organisations when benchmarked but we have declined in a number of scores.

Therefore, a strong people recovery plan is underway alongside service recovery in 2022/23 and beyond.

2021/22

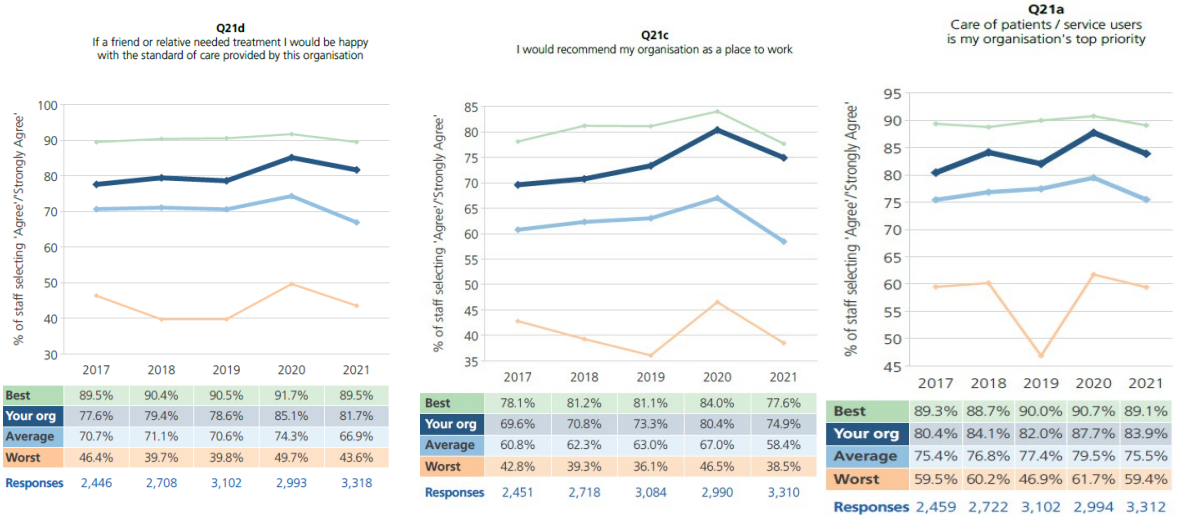
Scores for each indicator together with that of the survey benchmarking group (acute and acute community trusts) are presented below.

Table

Indicators ('People Promise' elements and themes)	**Trust Score**	**Benchmarking Group Score**		
People Promise	**Score**	**Score**	**Regional Position**	**National Position**
We are compassionate and inclusive	7.6	7.2	2nd	4th
We are recognised and rewarded	6.2	5.8	2nd	4th
We each have a voice that counts	7.1	6.7	Joint 1st	3rd
We are safe and healthy	6.2	5.9	Joint 1st	3rd
We are always learning	5.8	5.2	2nd	3rd
We work flexibly	6.5	5.9	Joint 1st	3rd
We are a team	7.0	6.6	Joint 1st	4th
Staff Engagement	7.3	6.8	1st	4th
Morale	6.4	5.7	1st	2nd

Sherwood Forest Hospitals sits above the national average for our comparator peer group in all nine themes and we are within 0.2 points of the highest achieving organisation in seven out of these nine themes. Please note, these are new indictor themes for 2021 and therefore cannot be compared to previous years.

The graphs below summarise the Trust 2021 National Staff Survey results for our three key questions.



2019/20 and 2020/21

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

Table:

	2019/20		2020/21	
	Trust Score	Benchmarking Group Score	Trust Score	Benchmarking Group Score
Equality, Diversity and Inclusion	9.3	9.0 Average 9.4 Best	9.3	9.1 Average 9.5 Best
Health and Wellbeing	6.1	5.9 Average 6.7 Best	6.4	6.1 Average 6.9 Best
Immediate Managers	7.1	6.8 Average 7.4 Best	7.2	6.8 Average 7.3 Best
Morale	6.5	6.1 Average 6.7 Best	6.7	6.2 Average 6.9 Best
Quality of Care	7.7	7.5 Average 8.1 Best	7.9	7.5 Average 8.1 Best
Safe environment – bullying and harassment	8.1	7.9 Average 8.5 Best	8.3	8.1 Average 8.7 Best
Safe environment – violence	9.3	9.4 Average 9.6 Best	9.3	9.5 Average 9.8 Best
Safety Culture	6.9	6.7 Average 7.2 Best	7.2	6.8 Average 7.4 Best
Staff Engagement	7.2	7.0 Average 7.5 Best	7.4	7.0 Average 7.6 Best
Quality of Appraisals	5.8	5.6 Average 6.6 Best	Not an indicator group in 20/21	
Team Working	6.9	6.6 Average 7.2 Best	6.9	6.5 Average 7.1 Best

Key Areas for Improvement

- Strengthened recruitment and retention focus underpinned by a clear workforce strategy, to improve responses to “enough staff in the organisation to do my job properly”.
- Reduce variation of experience of colleagues with protected characteristics, and foster closer partnership working with our growing staff networks
- Focus on further improvements in how we treat each other; Civility, Respect, Kindness, Diversity, Equality, and Inclusion
- Continue to support colleagues experiencing and reporting physical violence from patients/service users and families, provide additional training and link into zero tolerance communication campaigns with public/patients at a system level
- Reduce variability of management capability through targeted leadership and management training and development
- Increase visibility and support from our executive and senior leadership teams, particularly across the Newark and Mansfield sites.
- Further develop our talent management approach and offer to support succession planning. Specific programme of work to be developed around fairness in career development
- Review appraisal process and documentation to ensure appraisals are adding value
- Refresh our reward and recognition offer to ensure it is equitable and person centred
- Better inform the Trust about cultural improvements made at a Trust and local level through the development of a new active Staff Engagement Culture Collaborative model, and our “You Said, Together We Did” rolling communications campaign
- Focus our people and improvement coaches to better support colleagues in an inclusive and compassionate manner
- Continually evaluate and improve our well-being and resilience offer to colleagues, as part of our Wellbeing Strategy.

Actions and Monitoring

The results have been communicated to colleagues in a number of ways including electronic and face-to-face briefings. Some of the positive results also feature in our recruitment campaigns.

The reports are analysed including a review of the anonymous comments that were captured in the free text as these provide further important context. Analysis is also undertaken by staff group, division, department, and site. Our Culture and Improvement Cabinet will consider the themes and comments in detail and maintain oversight of Trust cultural improvements, with regular updates to the Trust People, Culture, and Improvement Committee.

Our divisions are sent a copy of the Trust report, their divisional results and the free text anonymous comments. They then actively explore the themes further with their teams and develop improvement initiatives pertinent to their division to address areas of concern. This also applies to corporate areas. We will undertake engagement sessions with divisional triumvirate

leadership teams for them to present their reflections on their findings and to identify what support they need to improve the culture within their divisions.

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce Key Performance Indicators (KPIs) and Speaking Up concerns. This enables more targeted actions and interventions to be identified, supported by our OD Team and HR business partners. New for 2021/22 we have designed an in-house survey explorer tool hosted on the intranet to allow any leader or individual in the organisation to review their own area's results.

The diversity and inclusivity results will be scrutinised by our staff networks and overarching People and Inclusion Committee and appropriate actions incorporated into its work programme. The performance of the programme is reported through to the People Culture and Improvement Committee. Such performance and activity is reviewed in light of key priorities associated with the Trust's requirements under the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Equality Delivery System (EDS).

Future Priorities and Targets

Priority Area	**Executive Lead**	**Timescales**
To build on what we do well	**Director of Culture and Improvement**	
To engage with the Divisions on a regular basis using the newly designed in-house culture insights approach to celebrate successes and focus collaborative support to areas in need		Monthly
To develop a Trust engagement calendar with values-based campaigns each month/quarter sponsored by relevant Executive Directors		May 22 onwards
Address the violence experienced from patients, carers and visitors	**Chief Nurse**	Sept 22
Violence and Aggression Working Group to continue, and reframe areas of focus in-light of most recent results		May 22
Continue to roll out breakaway and clinical holding skills training course to better protect staff		Ongoing
Focussed programme of work to attract and retain people to work at Sherwood	**Director of People (DoP) / Director of Culture and Improvement (DCI)**	Sept 22
Develop robust workforce strategy to maximise recruitment and retention opportunities	DoP	May 22
Refresh reward and recognition offer to ensure staff feel valued and recognised	DCI	April 22
Continue to provide a people focussed employee support service to reduce absence from work	DoP	Ongoing

Reduce variation of experience (where you work/what role you do)	**Director of Culture and Improvement**	
Civility, Respect and Kindness working group to continue, and reframe areas of focus in light of most recent results		April 22
Increase offer of Civility Saves Lives toolbox talk and include in managers induction		May 22
Support career development and talent recognition across all services and SFH workforce, including review of appraisal process and documentation		June 22
Improve sense of belonging across the administration professional group through a Proud2bAdmin movement		April 22
Tackle issues of poor Equality Diversity and Inclusion experience	**Director of People**	
'Ready to talk, ready to listen' approach rolled out to 'get underneath' the numbers and hear lived experiences		Start April 22
To continue to engage with EDI Staff Networks to feedback Staff Survey Results and co-create actions for improvement		June 22
Further embed Trust anti-racism strategy and continue targeted zero tolerance campaigns		Ongoing
Focussed work on improving the experience of colleagues with a disability		September 22

Equality Reporting

Last year the Trust launched a new Equality Diversity and Inclusion strategy that was aligned to the objectives of the Trust and the NHS People Plan and People Promise. Since then, the Trust has responded to the regional Midlands NHSE-I strategy (launched in May 2021) with the addition of a six high impact action plan to address inequity in recruitment and development for those from ethnic minority backgrounds. As part of a system approach, we worked with partner organisations within the Nottingham and Nottinghamshire ICS to produce a system 6 high impact action plan.

In response to the call for action against racism and the continuing evidence from our Staff Survey showing disparity in abuse against ethnic minority colleagues compared to colleagues from a white background (2020 results), the Trust has also developed an Anti-Racism Strategy to complement the existing EDI strategy and 6 high impact action plan. Launched in February 2022, the strategy outlines the actions the Trust will take in the upcoming 18-24 months, including colleagues being empowered to refuse to treat a patient who is racist towards them, celebrating diversity within the trust and providing education Trust-wide to embed Anti-Racism in our workplaces.

Mandatory Reporting
The Trust has met its obligations to report on Gender Pay, the Workforce Race Equality Standard and the Workforce Disability Equality Standard and the results of these are published on our website. The results are examined and appropriate action plans to address any disparity are put in place.

Gender Pay Gap
Sherwood Forest Hospitals has complied with the expectations associated with the gender pay regulations. Our response for 2021/22 can be viewed at the following link: Gender pay gap for Sherwood Forest Hospitals NHS Foundation Trust - GOV.UK - GOV.UK (gender-pay-gap.service.gov.uk)
WRES and WDES
Our reports for 2020/21 can be accessed via our website:
Sherwood Forest Hospitals (sfh-tr.nhs.uk)

We also meet our obligation to report our compliance with the Public Sector Equality Duty through our annual EDI Activity Report which is published in June each year.

Staff Networks:
We have continued to promote staff networks throughout the Trust and encourage colleagues to be involved with the activities of the networks. Like the previous year, engagement has been difficult for colleagues due to continued pressure from Covid-19 and winter pressures.

Despite difficulties, staff networks have contributed to key activities including Black History Month, International Day of Persons with Disabilities and Pride. This year we held a march at Newark Hospital for the very first time and Kings Mill Hospital colleagues also took part in a

march around the boundary of the hospital in our Pride march this year; Kings Mill Hospital's march was also featured on the national NHS Pride event.

Following the successful launch of the Carers Passport for patients and their carers during Carers Week in June 2021, the Trust established a working group to launch the passport for staff who are unpaid carers. As a result, a new staff network has been established for Carers in the organisation.

Sherwood Forest has also supported the organisation of, and participation in events for the Nottingham and Nottinghamshire Integrated Care System.

Policy

We have recently updated our EDI policy and have produced a guidance document for all staff for the first time which aims to support all colleagues in contributing to an inclusive workforce for all.

Modern Slavery

This section outlines the Trust's responsibilities and responses to line with section 54 of the Modern Slavery Act 2015, it sets out the steps that the Trust has taken, and is continuing to take, to make sure that modern slavery and/or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. We have has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguarding against any form of modern slavery taking place within our business or our supply chain.

We publish assurance on our Trust website that we do not support commissioning of any services linked to Modern Slavery and engage with any reviews locally and nationally where our patients may have been subject to modern slavery.

All our staff have a personal responsibility for the successful prevention of modern slavery and human trafficking, with the Procurement Department taking a lead responsibility for compliance in the supply chain.

During 2021/22 procurement and the safeguarding team have continued to work in collaboration to actively ensure all staff within the procurement team are aware of the risk of modern slavery and the responses required where this is suspected.

Our Policies on Slavery and Human Trafficking

We are aware of our responsibilities towards patients, carers, employees and the local community and expects all suppliers to adhere to the same ethical principles. Our supply chain includes procurement of agency staff, medical services, medical and other consumables, facilities maintenance, utilities and waste management. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently all awarded suppliers sign up to our terms and conditions of contract which provide provision to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chain; and that they conduct their business in a manner that is consistent with Trust policies.

We operate several internal policies to ensure that we are conducting business in an ethical and transparent way. These include the following:

Recruitment Policy: We operate a robust recruitment policy and under due diligence to identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Complete pre-employment checks on staff we employ, confirming their identities and right to work in the United Kingdom.

- Ensure agencies are on NHS improvement nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguarding against human trafficking or individuals being forced to work against their will.

- Follow NHS Agenda for Change Terms and Conditions to ensure that staff receive fair pay rates and contractual terms.

- Consult with Trade Unions on any proposed changes to employment terms and conditions.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with legal and regulatory frameworks. These include terms and conditions of employment, mandatory Equality, Diversity and Inclusion training for all staff and access to further training and development.

Safeguarding Policies: We adhere to the principles inherent in our Think Family Safeguarding Adult and Safeguarding Children policies. These are compliant with Nottinghamshire multiagency arrangements and provide clear guidance to support our staff if they are raising safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Speaking Up (Raising Concerns) Policy: We operate a Speaking Up Policy to support all employees to be able know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisal

Employment policies (including Policy and Procedure for Disclosure and Barring Service (DBS) Checks, Employment Records and Information Policy and Procedures, Professional Registration Policy, Induction Policy). These policies explain our vetting and barring procedures, including conducting eligibility to work in the UK checks for all employees to safeguarding against human trafficking, or individuals being forced to work against their will. The Trust adheres to the National NHS employment Checks/Standards including employee's UK address, their right to work in the UK and obtaining suitable references

Working with Suppliers

Sherwood Forest Hospitals will work to identify and mitigate risk and put in place contractual terms allowing the Trust to gain assurance that slavery and human trafficking have no place in

our business. We will work with suppliers to ensure that they treat their obligations towards modern slavery with the same importance that we do.
Suppliers are vetted through a robust Selection Questionnaire process before being appointed to any framework agreement.

All contracts are awarded under the NHS Terms and Conditions which contain clauses giving Sherwood Forest Hospitals the right to terminate a contract for failure to comply with labour laws.

When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

The staff of Sherwood Forest Hospitals must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Where it is verified that a subcontractor has breached child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulation 2015. The Trust will require that the main contractor substitute a new subcontractor.

The Procurement team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

Training
Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding adults and children training programmes, safeguarding policies and procedures, and the Trust safeguarding team. It is also discussed at our mandatory safeguarding induction day for staff starting employment with Sherwood Forest Hospitals. It also forms part of the training for our Safeguarding Champion Network.

We are continuously looking at ways to increase awareness across the organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

- We will know the effectiveness of the steps we are taking to ensure that modern slavery and/or human trafficking is not taking place within our business or supply chain if:

- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices are operational within our organisation.

- We monitor referrals to the Social Care and will actively refer any cases we identify through the delivery of our services that may indicate any of our service users have been victim to modern day slavery, whilst in the community.

- We report quarterly and annually via our safeguarding reporting mechanisms data relating to any safeguarding issues, along with trends and themes.

Valuing our Members

Membership information at 31 March 2022

Public breakdown by constituency

Mansfield	4,431
Ashfield	4,429
Newark & Sherwood	3,301
Rest of East Midlands	2,208
Rest of England	124

Public membership breakdown

	Number of members	Membership profile	Population profile
Age (years)			
0-16	2	0.01%	19.70%
17-21	32	0.22%	5.97%
22+	13, 294	92.38%	74.33%
Not stated	1,062	7.38%	0.00%
Ethnicity			
White	12,658	87.96%	85.42%
Mixed	28	0.20%	1.9%
Asian	83	0.57%	6.46%
Black	29	0.21%	1.8%
Other	8	0.06%	0.56%
Not stated	1,424	9.90%	0.00%

Gender			
Male	5,122	35.59%	49.49%
Female	9,072	63.04%	50.51%
Not stated	196	1.36%	0.00%

Membership activity, events and communication

As with the previous years, the Governor's Membership and Engagement Committee has continued to focus on how best to engage with members. We have continued to issue a monthly e-newsletter, Trust Matters, which includes a digital event.

Annual General Meeting / Annual Members' Meeting

This year's AGM was held via Microsoft Teams on Tuesday 28 September 2021. The link to the event was shared with all public and staff members, stakeholder and members of the general public to allow them to view the event.

We will continue to work closely with our members to help us to be truly accountable for the quality of the services we provide to our local communities.

Members can contact their governors either through our website or by contacting the Director of Corporate Affairs, Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, NG17 4JL or by emailing sfh-tr.governors@nhs.net.

Valuing our Governors

As an NHS Foundation Trust, we are accountable to the Council of Governors, which represents the views of members. The two key statutory duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- To represent the interests of our members and of the public.

In addition, the Council of Governors, among other matters, is responsible for making decisions regarding the appointment or removal of the Chair, the Non-Executive Directors and our External Auditors.

Our Constitution makes clear the process to appoint or remove the Chair and the other Non-Executive Directors, including the Governors' role in deciding the remuneration and allowances and other terms and conditions of office of the Non-Executive Directors.

The Council met a number of times during the year (see table). The meetings were well attended, with debate across several areas of interest.

One of the key roles of the Governors is engagement with their constituencies to gain feedback and report to the Council and subsequently the Board of Directors. Our governors achieve this by holding regular 'Meet Your Governor' events across all three hospital sites and in the community. At these events new members are recruited and patients, visitors and staff can discuss their views of the services provided. Due to the pandemic these haven't taken place this year. Governors have continued to feedback where possible comments, from patients and the public on an ad hoc basis.

The Governors continue to observe Board Committees to fulfil their statutory duty of holding the Non-Executive Directors to account. This enables the governors to gain assurance regarding how the Non-Executive Directors hold the executive to account and how strategic objectives are progressed and implemented. The observers then report their observations from the meetings back to the quarterly Council of Governors meetings, this year all Council of Governors meetings have been held via video conferencing due to the pandemic.

We held Governor elections in March 2022, to fill vacancies across the Public Constituencies of Ashfield, Newark and Sherwood and Rest of East Midlands constituencies, and the staff Constituencies of Kings Mill Hospital and Mansfield Community Hospital and Newark Hospital. The new Governors will take up their roles from May 2022. We have also appointed new governors from our partner organisations, Newark and Sherwood District Council, and Nottinghamshire County Council. The Council of Governors have remained incredibly proactive in undertaking all their statutory and non-statutory duties, during very challenging circumstances. External development is offered and undertaken through an expressions of interest process where the Governors who attend share their learning with other Governors and regular internal development is undertaken through quarterly workshops - the topics of which are suggested and agreed by the Governors.

Attendance at Council of Governor meetings

There have been four general Council meetings and two extra-ordinary Council meetings during the year. The following table details the Governors, the constituency they represent, their attendance and the date elected/appointed.

Attendance at Full COG (scheduled meetings)

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	TERM ENDS
			11/05/2021	10/08/2021	09/11/2021	08/02/2022			
Ann Mackie	Newark & Sherwood	Public	P	P	X	X	3	01/05/19	30/04/22
Ben Clarke	King's Mill Hospital	Staff	X				3	01/09/19	31/08/22
Councillor Craig Whitby	Mansfield District Council	Appointed	P	A	P	P	4	21/05/19	31/05/23
Councillor David Walters	Ashfield District Council	Appointed	P	P	P	P	1	23/04/20	31/05/21
Councillor Kevin Rostance	Nottinghamshire County Council	Appointed	X					15/10/20	31/05/21
Councillor Linda Dales	Newark & Sherwood District Council	Appointed				A	1	15/07/21	31/05/22
Councillor Michael Brown	Newark & Sherwood District Council	Appointed	X				1	18/05/20	31/05/21
David Ainsworth	Mansfield & Ashfield CCG	Appointed	P	A	X	A	N/A	20/02/20	N/A
Dean Whelan	Mansfield	Public	X				3	01/09/22	31/08/22
Gerald Smith	Mansfield	Public	P	A	X	X	3	01/05/19	30/04/22
Ian Holden	Newark & Sherwood	Public	P	P	P	P	3	01/05/19	30/04/22
Jacqueline Lee	Newark Hospital	Staff	P	P	X	A	3	01/05/19	30/04/22
Jayne Revill	King's Mill Hospital	Staff	X	A	X	X	3	01/05/19	30/04/22
John Wood	Mansfield	Public	P	P	P	P	3	01/05/19	30/04/22
Kevin Stewart	Ashfield	Public	P	P	P	P	3	01/05/19	30/04/22
Lawrence Abrams	Rest of East Midlands	Public	P	A	A	A	3	01/05/19	30/04/22
Martin Stott	Newark & Sherwood	Public	P	A	P	P	3	01/05/19	30/04/22
Maxine Huskinson	Ashfield	Public	X	P	P	X	3	01/11/20	31/10/23
Nadia Whitworth	Volunteers	Appointed		P	A	A	3	10/05/21	10/05/24
Nikki Slack	Vision West Notts	Appointed	A	A	A	A	N/A	17/07/19	N/A
Paul Baggaley	Newark & Sherwood	Public	P				3	01/11/20	31/10/23
Philip Marsh	Ashfield	Public	P	P	A	P	3	01/05/19	30/04/22
Richard Boot	Newark Hospital	Public	P	X	X	X	3	01/05/19	30/04/22
Roz Norman	King's Mill Hospital	Staff	P	P	P	P	3	01/05/19	30/04/22
Sue Holmes	Ashfield	Public	P	P	P	P	3	01/11/20	31/10/23

Attendance at Extraordinary COG meetings

NAME	AREA COVERED	CONSTITUENCY	EO COG 21/09/2021	EO COG 14/03/2022	TERMS OF OFFICE	DATE ELECTED	TERM ENDS
Ann Mackie	Newark & Sherwood	Public	P	X	3	01/05/19	30/04/22
Ben Clarke	King's Mill Hospital	Staff			3	01/09/19	31/08/22
Councillor Craig Whitby	Mansfield District Council	Appointed	X	P	4	21/05/19	31/05/23
Councillor David Walters	Ashfield District Council	Appointed	P	P	1	23/04/20	31/05/21
Councillor Kevin Rostance	Nottinghamshire County Council	Appointed				15/10/20	31/05/21
Councillor Linda Dales	Newark & Sherwood District Council	Appointed			1	15/07/21	31/05/22
Councillor Michael Brown	Newark & Sherwood District Council	Appointed			1	18/05/20	31/05/21
David Ainsworth	Mansfield & Ashfield CCG	Appointed	P	P	N/A	20/02/20	N/A
Dean Whelan	Mansfield	Public			3	01/09/22	31/08/22
Gerald Smith	Mansfield	Public	X	A	3	01/05/19	30/04/22
Ian Holden	Newark & Sherwood	Public	P	A	3	01/05/19	30/04/22
Jacqueline Lee	Newark Hospital	Staff	P	P	3	01/05/19	30/04/22
Jayne Revill	King's Mill Hospital	Staff	X	X	3	01/05/19	30/04/22
John Wood	Mansfield	Public	P	P	3	01/05/19	30/04/22
Kevin Stewart	Ashfield	Public	P	P	3	01/05/19	30/04/22
Lawrence Abrams	Rest of East Midlands	Public	P	A	3	01/05/19	30/04/22
Martin Stott	Newark & Sherwood	Public	P	P	3	01/05/19	30/04/22
Maxine Huskinson	Ashfield	Public	A	P	3	01/11/20	31/10/23
Nadia Whitworth	Volunteers	Appointed	P	A	3	10/05/21	10/05/24
Nikki Slack	Vision West Notts	Appointed	X	A	N/A	17/07/19	N/A
Paul Baggaley	Newark & Sherwood	Public			3	01/11/20	31/10/23
Philip Marsh	Ashfield	Public	P	P	3	01/05/19	30/04/22
Richard Boot	Newark Hospital	Public	X	X	3	01/05/19	30/04/22
Roz Norman	King's Mill Hospital	Staff	A	A	3	01/05/19	30/04/22
Sue Holmes	Ashfield	Public	P	P	3	01/11/20	31/10/23

Key:

P= Present

A= Apologies

X= Did not attend

Not in post

Non-Executive Director Attendance at Council of Governors

NAME	FULL COG AND EXTRAODRINARY MEETING DATES					
	11/05/2021	10/08/2021	21/09/2021	09/11/2021	08/02/2022	14/03/2022
Tim Reddish	P	P	P			
Neal Gossage	P	P	P	P	P	A
Graham Ward	P	P	P	P	P	A
Claire Ward	P	P	P	P	P	P
Barbara Brady	P	P	A	P	P	P
Manjeet Gill	P	P	A	A	P	A
Steve Banks					P	A
Dr Aly Rashid					P	A

Lead Governor Report 2021-2022

And so it has continued……vain hopes that we would be 'back to normal' this year. Governors' statutory duties have been restricted particularly regarding engaging with the public and patients. We did manage a few 'Meet Your Governor' sessions outside the main front door of Kings Mill in the summer when we heard overwhelming praise and thanks for our staff who have worked so well and tirelessly during these very difficult two years, I hope they know how much they are appreciated by the people we talk to. Some governors have recently visited Food Clubs to ask the views of the wider public about our services and I do hope that this will be extended in the coming months.

The 15 steps programme has not taken place for two years now but hopefully will be starting again in late spring.

Governors have still been able to 'Hold the Non-Executive Directors to account as all of the meetings we observe have been held via Microsoft Teams, as have Board meetings.
Once again, the Young Members scheme has been stalled but I have great hopes again for this year that it will finally get up and running.

After Governor Elections which were held in March/April, we have many new Governors scheduled to formally start in post in May 2022: -

Ashfield Public Governors

Newly elected	Liz Barrett
	Jane Stubbings
Not due for election	Sue Holmes
	Maxine Huskinson

Mansfield Public Governors

Newly elected	Janice Bramley
	Michael Longdon
	Ruth Scott
Re-elected	John Wood

Newark and Sherwood Public Governors

Newly elected	Keith Blundell
Re-elected unopposed	Ian Holden
	Anne Mackie
One Vacancy	

Rest of the East Midlands Public Governors

No nominations
Two vacancies

Staff Governors

Kings Mill Hospital and Mansfield Community Hospital

Newly elected Vickram Desai
Justin Wyatt

Newark Hospital

No nominations
One Vacancy

I look forward to welcoming and working with the new governors. I am quite sure t they will find it a very interesting, positive and at times challenging experience.

Sadly, we lose Martin Stott, Public Governor for Newark and Roz Norman, Staff Governor who have both completed the maximum three terms in office. I thank them both for the considerable work they have done over the past nine years during some very challenging times – seeing us move from 'Special Measures' to Good as a Trust and 'Outstanding' for Kings Mill Hospital.

Philip Marsh and Kevin Stewart (both Ashfield) have also made great contributions to the Council of Governors but sadly were not re-elected – there always is great competition in Ashfield, and Gerald Smith (Mansfield), Lawrence Abrams (Rest of the East Midlands) and Jackie Lee (Staff Governor – Newark Hospital) did not stand for re-election. We owe thanks to them all for the contributions.

I cannot finish without recognising our wonderful clinical staff for the way they have continued to provide excellent care and treatment during unprecedented times. Our back-office staff – the hundreds of people who make it all possible also deserve recognition – they are often the unsung heroes. Our volunteers too – the heart of our hospitals, are also back on site now and it is so good to see them out and about again.

The vaccination hub has been highly successful – indeed singled out for mention by the Prime Minister. I am personally grateful to have received all my vaccinations there. Congratulations to them.

We all continue to be very proud of our hospitals and can only hope that 'this time next year…….'

Sue Holmes
Lead Governor

NHS Foundation Trust Code of Governance

Sherwood Forest Hospitals 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 Governance Code issued in 2012.

Relating to	***Code of Governance* reference**	**Summary of requirement**	**Reference Page numbers**
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	75 -7 6 90 - 92
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.	22 - 23 47 - 48 87
Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	75 - 76

Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	77 - 79
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	22 - 23
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Sherwood Forest Hospitals (sfh-tr.nhs.uk)
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	43 - 44
Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	45 - 46
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	45 - 46
Chair / Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise and included in the next annual report.	23
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	75 - 76

Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012).	N/A
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	35 46 87 95
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	16 26
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.93.	97 - 98
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	97 - 98 110 - 111

Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	91 – 92 124
Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/A
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that 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 external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	90 - 92
Board / Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors,	75 - 76

		develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	
Board / Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	74 - 75
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	75
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership. • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	74 - 75
Board / Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.	24

Our Board of Directors is focused on achieving long-term success for the organisation and our vision of becoming an outstanding organisation, through the application of sound business strategies and the maintenance of high standards in corporate governance and corporate responsibility. The following statements explain our governance policies and practices and provide insight into how the Board and management run the Trust for the benefit of patients, carers, the community and our membership.

Our Board of Directors brings a range of experience and expertise to its stewardship of the organisation and continues to demonstrate the vision, oversight and encouragement required to enable our organisation to thrive and improve on a continuous basis. During the past year we welcomed new members to the Board, each bringing excellent skills and expertise to the organisation and providing crucial stable leadership.
At the end of the year the Board comprised seven Non-Executive Directors including the Chair (holding majority voting rights), six Executive Directors (voting), including the Chief Executive, two corporate Directors (non-voting) and one specialist advisor (non-voting)

The Chair is responsible for the effective working of the Board, for the balance of its membership subject to Board and Governor approval, and for making certain that all Directors play their full part in setting and delivering our strategic direction and ensuring effective and efficient performance. The Chair conducts annual appraisals of the Non-Executive Directors as well as the Chief Executive.

The Chief Executive is responsible for all aspects of the management of the organisation. This includes developing appropriate business strategies agreed by the Board, ensuring that related objectives and policies are adopted throughout, the effective setting of budgets, and monitoring performance. The Chief Executive is also responsible for conducting the annual appraisals of the executive and corporate Directors of the Board.

The Chair, with the support of the Director of Corporate Affairs ensures the Directors and Governors receive accurate, timely and clear information. Directors are encouraged to update their skills, knowledge and familiarity with the organisation's business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with Governors.

There is an understanding that any Non-Executive Director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Director of Corporate Affairs at the organisation's expense.

Our Non-Executive Directors offer a wide range of skills and experience and bring an independent perspective on issues of strategy, performance and risk through their contribution at Board and committee meetings. The Board considers that, throughout the year, each Non-Executive Director has been independent in character and judgement and met the independence criteria set out within Monitor's (now part of NHS Improvement) Code of Governance. Non-Executive Directors have ensured they have sufficient time to carry out their duties. During the year, time has been spent with Governors to help understand external views of the organisation and our

strategies, and all Chairs of Board committees and the Chief Executive attend the Council of Governors meetings.

Several key decisions and matters are reserved for the Board's approval and are not delegated to management. Our Board delegates certain responsibilities to its committees, to assist it in carrying out its function of ensuring independent oversight. The Board of Directors has a formal schedule of matters reserved for its decisions and has in-date and relevant terms of reference for all Board committees. Monthly updates on our performance are discussed at the Board of Directors meetings. The Board delegates the management of overall performance to the Chief Executive who leads the setting of clear priorities so that the organisation is managed efficiently to the highest quality standards and in keeping with our values.

The Board committees report annually on their effectiveness and review their Terms of References and work plans to ensure alignment with the organisation's priorities and the Board work schedule.

Our engagement policy outlines the mechanisms by which the Council of Governors and Board of Directors communicate with each other to support engagement, ensure compliance with the regulatory framework and specifically provide for any circumstances where the Council of Governors may raise concerns about the performance of the Board of Directors, compliance with the Trust's Provider Licence, or other matters related to the overall wellbeing of the organisation.

Counter fraud

Our Board of Directors attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by the local counter fraud specialists in liaison with NHS Counter Fraud Authority (NHSCFA). All investigations are reported to the Audit and Assurance Committee.

Functional Standard Summary:

Functional Standard 013: Counter Fraud ("the functional standard") was applied to the NHS for the first time from April 2021. It contains 12 components with 13 requirements (component 1 having 2 separate requirements). Requirements **1A** and **9** are scored **GREEN** or **RED**. The remaining requirements are scored **GREEN**, **AMBER** or **RED**.

The table below shows how the Trust scored itself for each component as part of the 2021 Counter Fraud Functional Standard Return (CFFSR), and the projection for the 2022 CFFSR.

Functional Standard Requirement	2021 CFFSR	Projected 2022 CFFSR
Component 1A: Accountable individual	G	G
Component 1B: Accountable individual	G	G
Component 2: Counter fraud, bribery and corruption strategy	G	G
Component 3: Fraud, bribery and corruption risk assessment	R	G
Component 4: Policy and response plan	G	G
Component 5: Annual action plan	A	G
Component 6: Outcome-based metrics	A	G
Component 7: Reporting routes for staff, contractors and public	G	G
Component 8: Report identified loss	R	G
Component 9: Access to trained investigators	G	G
Component 10: Undertake detection activity	A	G
Component 11: Access to and completion of training	G	G
Component 12: Policies and registers for gifts and hospitality and COI	G	G

In respect of fraud risks and social media, our digital communications team issued awareness raising advice on this in their bulletin in November 2021. They will be shortly following up with further awareness in upcoming communication bulletins in respect of cyber security, phishing emails and social media security. The Local Counter Fraud Service (LCFS) has delivered training sessions on social engineering and social media and this will continue in the new financial year and has been incorporated into the work plan for future events.

We continue to work to maintain an anti-fraud culture and we have in place a range of policies and procedures to minimise risk in this area. Colleagues have access to counter fraud awareness training which forms part of employee induction training and several bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. In November 2021 we took part in Fraud Awareness Month and several alerts were issued to employees, for example, online fraud, telephone scams and a counter fraud staff survey. We also disseminate the counter fraud newsletter 'Fraudulent Times' which helps raise awareness of fraud cases and how to identify where and how fraud can occur.

NHS Resolution

Our CNST premium has increased by £2.57m in 2021/22 (£12.75m to £15.32m). This represents a 20.1% increase. Note the premiums are the net charge including the rebate received in respect of the maternity incentive scheme

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2021/22 these committees included:

- The Audit and Assurance Committee, the principal purpose of which is to enhance confidence in the integrity of the Trust's processes and procedures relating to internal control and corporate reporting.

- The Quality Committee, which enables the Board to obtain assurance regarding standards of care and to ensure that adequate and appropriate clinical governance structures, processes and controls are in place.
- The Finance Committee, which oversees the development and implementation of our strategic financial plan and the management of the principal risks to achieving that plan.
- The People, Culture and Improvement Committee's principal purpose is to provide scrutiny and assurance of the development, delivery and impact of the Trust's workforce strategy and plan, together with providing assurance concerning organisational development activity undertaken to promote and embed an effective organisational culture.
- The Remuneration and Nomination Committee ensures the remuneration packages are sufficient to attract, retain and motivate Executives and senior officers (Directors) of the highest quality.

Audit and Assurance Committee

The Audit and Assurance Committee was chaired by Non-Executive Director Graham Ward, who is a fellow of the Chartered Institute of Management Accountants and has extensive financial expertise. The Committee's Terms of Reference make it clear that membership exclusively comprises Non-Executive Directors, with executives and others considered being 'in attendance'. Attendance of Non-Executive members at meetings is detailed below:

Graham Ward	7/7
Barbara Brady	6/7
Manjeet Gill	3/5
Steve Banks	2/2

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, KPMG, and the internal auditors, 360 Assurance, on the work they had undertaken in reviewing and auditing the control environment.
The Committee works with the Local Counter Fraud Service and Trust colleagues to actively promote, raise awareness and encourage people to raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Local Counter Fraud Service has a standing invitation to all meetings, with relevant policies readily available on our intranet. The Audit and Assurance Committee routinely receives financial information, including cash and liquidity and the going concern status of the organisation, as well as operational information.

Principal review areas
The five key duties of the Committee as set out in the terms of reference.

1. <u>Governance and internal control</u>

The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit opinions (Financial and Quality Accounts) and other appropriate independent assurances and

consider that the AGS is consistent with the Committee's view on the Trust's system of internal control.
The Committee has received update reports on Information Governance and members were pleased to note that the Data Security Protection Toolkit compliance had been maintained.

2. Internal audit

Through the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has also in year:

- Reviewed and approved the internal audit operational plan and more detailed programme of work initially and then on an on-going basis to consider the impact of the Covid-19 pandemic, while ensuring the provision of the internal audit service continued to be sufficient in supporting the Committee in fulfilling its role

- Considered the major findings of internal audit and are assured that the Head of Internal Audit Opinion and AGS reflect any significant internal control issues

- Invited lead directors of any internal audit reports issued with Limited Assurance to attend Committee meetings, present the report and provide assurance that actions will be implemented within agreed timescales

- Worked with colleagues internally and externally to address deteriorating performance regarding the provision of evidence and the achievement of internal audit actions, and the impact of the pandemic on timely completion of actions

- Held regular review of outstanding audit actions, and are assured that a robust progress monitoring process is in place

3. Counter Fraud Service

The Committee received regular progress reports on activity conducted as part of the agreed Counter Fraud Work Plan, including:

- Annual Report
- Updates on investigations
- Conflicts of Interest Policy and Declarations of Interest Register review
- Risk assessment in line with Counter Fraud Functional Standards

4. External audit

The Committee reviewed and agreed external audit's annual plan, noting that the Trust's main risk remains to be the valuation of land and buildings and that KPMG's audit focus this year is the implementation of IFRS 16 (leases) transition.
The Committee reviews and comments on reports prepared by external audit and welcomes their advice on areas of specific expertise.

5. Management

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling managers to account when considered necessary to obtain relevant assurance.

Standards of business conduct

The Board of Directors recognises the importance of adopting the organisation's Standards of Business Conduct. These standards provide information, education and resources to help colleagues make well-informed business decisions and to act on them with integrity.

Internal audit (360 Assurance)

The Audit Plan for 2021/22 was developed in line with the mandatory requirements of the Public Sector Internal Audit Standards. 360 Assurance, an external service, has worked with us to ensure the plan was aligned to the risk environment. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or under way. All audits with Limited Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate Board committee; however, our Audit and Assurance Committee receives a report stating which reports have been reported to other committees. Outstanding recommendations from internal audit are reported to our Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the organisation. Where owners of recommendations have not completed the actions by the implementation date they are invited to Audit and Assurance Committee to report on progress.

External audit service

The External Audit contract was retendered during 2020/21 and the Council of Governors, supported by the Chair of the Audit and Assurance Committee, subsequently appointed KPMG as our external auditors, for a period of three years, starting with the 2020/2021 Annual Accounts and Report.

We incurred £117,875 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12-month period to 31 March 2022 (£105k net of VAT for the period to 31 March 2021). Non-audit services amounted to £Nil net of VAT (£Nil net of VAT for the period to 31 March 2021) in respect of the Quality Report.

KMPG has not provided any non-audit services to the Trust during the year, and this is the second year of their appointment.

Remuneration and Nomination Committee

As at 31 March 2022 and on-going, membership of the Remuneration and Nomination Committee comprises Graham Ward as Chair and Barbara Brady, Manjeet Gill and Dr Aly Rashid, all Non-Executive Directors. The attendance of Non-Executive Directors is detailed within the Remuneration Report.

The primary role of the Committee is to recommend to the Board the remuneration strategy and framework, giving due regard to the financial health of the organisation and to ensure the executives are fairly rewarded for their individual contributions to the organisation's overall performance. The Remuneration Report is set out in its own section of this report.

Remuneration and Nomination Committee of the Council of Governors

The Council of Governors' Remuneration and Nominations Committee comprises Claire Ward as Chair and representatives from the public, staff and appointed Governor classes. The role of this Committee is to ensure that appropriate procedures are in place for the nomination, selection, training and evaluation of Non-Executive Directors and for succession plans. The Committee is also responsible for setting the remuneration of Non-Executive Directors, including the Chair. It considers Board structure, size and composition, thereby keeping under review the balance of membership and the required blend of skills, knowledge and experience of the Board.

Compliance with the Code of Governance

The purpose of the Code of Governance is to assist the Board in improving governance practices by bringing together best practice in public and private sector corporate governance. The Code is issued as best practice advice, but also imposes some disclosure requirements.

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2022, the Board considers that it was fully compliant with the NHS Foundation Trust Code of Governance with the following exceptions, where we have alternative arrangements in place.

In March 2020, NHSE/I issued guidance regarding 'Reducing burden and releasing capacity at NHS providers to manage the Covid-19 pandemic'. The Board reviewed its own processes to provide assurance to the Board that Corporate and Financial Governance continued to comply with guidance, our own assurance processes and the scheme of delegation. We continued with this process during 2021/22, deferring items on workplans as required as the impact of the pandemic peaked and fell during the year, all Board and Committee meetings continue to be carried out online and the public board is broadcast as a live event.

The agendas consisted of all essential items, including year-end performance against access and quality standards and updates from committees. The Finance Committee focused on financial governance.

It was agreed any urgent decisions or approvals required outside of the Board or Committee meetings would be undertaken by:

- CEO and Chair for corporate decisions
- Chair, Members of Quality Committee, Medical Director and Chief Nurse for all patient safety decisions
- Chair, Members of Finance Committee and CFO for all financial decisions.

All decisions and approvals made in this way were to be ratified at the next meeting of the Committee or Board, whichever is first in the meeting calendar.

In common with the health service and public sector, we are operating in a fast-changing and demanding external environment. We recognise the need to deliver significant increases in efficiency while maintaining high quality care at a time when budgets are tight and demand is high. We will continue to build on the improvements made to date in responding to these challenges, working through our exceptional and dedicated members of #TeamSFH.

The roles and responsibilities of the Council of Governors are described in our Constitution, together with details of how any disagreements between the Board and Council of Governors would be resolved. The types of decisions taken by the Council of Governors and the Board, including those delegated to committees, are described in the approved Terms of Reference.

We have a detailed scheme of delegation which is regularly reviewed. This sets out, explicitly, those decisions reserved to the Board, those which may be determined by standing committees and those which are delegated to managers.

The Chair, the Chairs of all Board Committees and the Chief Executive are invited to attend all public meetings of the Council of Governors; other Executive Directors are invited to attend as appropriate to specific agenda items. There has been limited scope during the year for Governors and Non-Executive Directors to take part in internal assurance visits to clinical areas across our sites due to the restrictions imposed by the pandemic. It is expected these will resume in spring 2022.

In an NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Council of Governors. The appraisal of the Chair is therefore carried out for and on behalf of our Council of Governors by the senior independent director, supported by the lead Governor. Together they review the Chair's performance against agreed objectives and discuss any development needs before reporting the outcome of the appraisal to the Nomination and Remuneration Committee of the Council of Governors. This Committee in turn reports to the Council of Governors.

The directors of the Board are appraised by the Chief Executive who, in turn, is appraised by the Chair. The Council of Governors does not routinely consult external professional advisers to market test the remuneration levels of the Chair and other Non-Executive Directors. The recommendations made to the Council of Governors are based on independent advice and benchmarking as issued from time to time by national body NHS Providers.

NHS Oversight Framework

NHSEI NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national 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.

Segmentation

As at March 2022, the latest information published on the NHS Improvement website from November 2021 places Sherwood Forest Hospitals Foundation Trust in segmentation 2, and the Nottinghamshire Integrated Care System in segmentation 3.

The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Foundation Trust License

There are no additional conditions on our Foundation Trust Licence.

Statement of the Chief Executive's responsibilities as the Accounting Officer of Sherwood Forest Hospitals NHS Foundation Trust

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

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

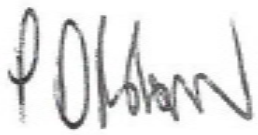
In preparing the accounts and overseeing the use of public funds the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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



Paul Robinson
Chief Executive Officer **17th June 2022**

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Regulation

The Care Quality Commission (CQC) undertook a full announced inspection of our Core Services during February 2020 including a well-led review and use of resources assessment; the final report was received in May 2020. We improved our overall rating of Good and King's Mill Hospital improved its rating to Outstanding

	Safe	Effective	Caring	Responsive	Well Led	Overall
King's Mill Hospital	Good	Good	Outstanding	Good	Outstanding	Outstanding
Newark	Good	Good	Good	Good	Good	Good
MCH	Good	Good	Outstanding	Good	Good	Good
Overall	Good	Good	Outstanding	Good	Good	Good

An extract from the Final CQC report states:

Our rating of the trust stayed the same. We rated it as good because:

We rated safe, effective, responsive and well-led as good and caring as outstanding for core services, the trusts well led was rated as good. We rated eight of the trust services as good and one, which was end of life care at Newark hospital as requires improvement overall. We rated well led for the trust as good overall.

We are fully compliant with the registration requirements of the Care Quality Commission.

The Trust has regular engagement meetings, involving the Medical Director and Chief Nurse with the Trust CQC Relationship Manager and the regional CQC Inspection Manager. The meetings are held every six to eight weeks and include a discussion on a wide range of issues ranging from examples of good practice in addition to areas of concern.

To demonstrate on-going compliance the Trust undergoes inspections by the Care Quality Commission of all core service areas across the Trust providing further opportunity to ensure the Trust continues to meet the requirements of its registration.

Capacity to handle risk

Our Board of Directors provides leadership on the overall governance agenda. On the Board's behalf our Risk Committee has maintained and kept under review a policy for the management of risk. Our Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Audit and Assurance Committee, Finance Committee, Quality Committee and People, Culture and Improvement Committee. Our Risk Committee is an executive committee focussing on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. Our Risk Committee is chaired by our Chief Executive (CEO) and comprises the Executive Team and selected members of the Senior Leadership Team. Senior managers and specialist advisers routinely attend each meeting. We have kept under review and updated risk management policies during the year. The output of the Risk Committee's work is reported to our Board and the CEO also ensures the Risk Committee works closely with front line divisional teams and all Committees of the Board to anticipate, triangulate and prioritise risk, working collectively to continuously balance and enhance risk treatment.

Training is provided to relevant colleagues on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for employee training required to control key risks as part of the requirements for essential training.

Incidents, complaints, claims, patient feedback and audit findings are routinely analysed to identify risks and single points of failure and learn from them. Lessons for learning are disseminated to colleagues using a variety of methods including customised briefings, bulletins, and personal feedback where necessary.

All significant risk exposures are reported to the Board of Directors and Risk Committee at each formal meeting. All new significant risks are escalated to the Chief Executive and subject to

validation by the Executive Team and Risk Committee. The residual risk score determines the escalation of risk and this is clearly established and embedded.

The Board of Directors regularly scans the horizon for emergent opportunities or threats and considers the nature and timing of the response required to ensure risk is kept under prudent control at all times.

The risk and control framework

The risk management process is set out in six key steps as follows:

1. **Determine priorities**
   The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

2. **Risk Identification**
   Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work-related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation.

3. **Risk Assessment**
   Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

4. **Risk Response (Risk Treatment)**
   For each risk, controls are established, documented, and understood. Controls are implemented to *avoid risk*; *seek risk* (take opportunity); *modify risk*; *transfer risk* or *accept risk*. Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk and expressed its appetite in the form of target risk ratings in the Board Assurance Framework.

5. **Risk Reporting**
   Significant risks are reported at each formal meeting of the Board of Directors and Risk Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and the Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management and Assurance Policy. The Audit and Assurance Committee and Board of Directors lead the acquisition and review of assurances, in line with the Board Assurance Framework, to keep risk under prudent control. The Board of Directors has in place an up-to-date and continually reviewed Board Assurance Framework.

6. **Risk Review**

   Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. In addition, risk profiles for all Divisions remain subject to detailed scrutiny as part of a rolling programme by the Risk Committee. The purpose of the rolling programme of review is to track how the risk profile is changing over time; evaluate the progress of actions to treat risk; ensure controls are aligned to the risk; ensure risk is managed in accordance with the Board's appetite; check resources are reprioritised where necessary; and ensure risk is escalated appropriately.

Incident reporting and investigation is recognised as a vital component of risk and safety management and is critical to the success of a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and routine mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

The most significant strategic risks facing us continue to be: (i) the maintenance of sufficient numbers of skilled employees to deliver our full range of clinical services; (ii) financial sustainability due to the requirement to increase activity while substantial cost pressures remain; and (iii) demand that overwhelms our capacity to deliver care effectively. These risks are inter-related and incorporated into the Board Assurance Framework (BAF). Should one or more of these risks materialise, or any other risk captured in the BAF, it may trigger a compound effect upon the safety/quality of care and/or financial sustainability. Our Board of Directors has focused throughout the year on delivering sustainable improvements in the quality and safety of clinical services, and strengthening our ability to meet demand, supported by refreshed recruitment and retention strategies and prudent financial management.

Standards of safety and care are perpetual risks, as are financial sustainability, working closely with local health and care partners and the potential for major disruptive incidents. Capacity and demand for care, and workforce capacity are expected to remain for the foreseeable future, and strategic partnerships will further develop over the coming months and years.

A breakdown of the risks addressed in the BAF, and how those risks are being mitigated, is captured in table 1 below.

Table 1: Clinical, Operational and Financial Sustainability Risks

Potential Risk	How the risk might arise	How the risk is being mitigated	How are the outcomes assessed
Significant deterioration in standards of safety and care.	This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality in the governance of Sherwood Forest Hospitals.	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety Committee and other sub-groups. This includes safety and quality indicators, incident investigations and key performance indicators.
Demand that overwhelms capacity.	This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease.	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward.	Progress and outcome are monitored through the Quality Committee, supported by the Patient Safety Committee. This includes safety and quality indicators, incident investigations and key performance indicators.
A critical shortage of workforce capacity and capability.	Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges to be significant.	The People, Culture and Improvement Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce, we aim to make Sherwood Forest Hospitals the employer of choice.	Progress and Outcomes are monitored through the People, Culture and Improvement Committee, supported by the People and Inclusion Cabinet. This includes vacancy levels, training and development progress.
Failure to achieve the Trust's financial strategy.	*The delivery of high-quality* care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk may	A local and system-wide Financial Improvement Plan is specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-	Frequent assessment of performance and forecast trajectories is monitored through the Finance Committee.

	arise if the trust is not able to secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals.	even (no surplus or deficit at the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Medical Director and Chief Nurse.	
Inability to initiate and implement evidence-based improvement and innovation.	This risk may arise if there is a lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care.	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's improvement agenda; striving for excellence and challenging unsatisfactory performance regarding organisational development; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	In addition to the Trust's Improvement Strategy, frequent correspondence and discussions with our partners and commissioners to ensure focus is maintained on quality and systems improvement, whilst maintaining compliance with regulatory requirements.
Working more closely with local health and care partners does not fully deliver the required benefits.	*This risk, which is currently being mitigated, may arise where strategic partners are unable to balance competing demands and/or work collaboratively across the whole health and social care system.*	Active participation and engagement with all ICS and ICP stakeholders to ensure effective planning, implementation and governance at a system level. We Continue to play a leading role in the Integrated Care System.	Frequent review of progress through ICS and Place Based Partnership engagement to monitor the effectiveness of system planning and project implementation.
A major disruptive event.	This risk, which is currently being mitigated, may arise where there is an expected or unexpected event which could lead to rapid operational instability and put safety and quality at risk. Such events include fire, cyber security and prolonged loss of utility (water, gas, electricity supplies).	This risk is mitigated through planned preventative maintenance, proactive inspection, regular testing of business continuity arrangements and horizon scanning.	This is monitored through the Risk Committee, supported by various sub-groups. Includes reporting of emerging risks and events to ensure effective management and mitigation.
Failure to deliver sustainable reductions in the Trust's impact on climate change.	This risk may arise if the Trust's vision to further embed sustainability, through actions outlined in our Green Plan, are not achieved.	This risk is mitigated through management of the action plan, engagement and awareness campaigns (internal/external stakeholders) and Environmental Sustainability Impact Assessments built into project implementation processes.	This is monitored through the Risk Committee, supported by various sub-groups. It includes reporting of progress and emerging risks to ensure effective management.

It is not envisaged these risks will change over the coming year. The Internal Audit Plan and Counter Fraud Plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF. The Audit and Assurance Committee uses the reports of management and internal audit to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

Clinical Audit 2021/22

The Covid-19 pandemic has continued to impact the clinical audit programme in 2021/22 in terms of both clinical engagement in the face of organisational challenges, staff deployment, and in collating and communicating outcomes and learning.

Nevertheless, there have been gains; there is now a programme in place, led by the Chief Clinical Registrar and the Improvement team, to coach trainee doctors in audit activities earlier in their rotation, so that they can benefit from guidance and support to lead improvement. We also have a transparent and accessible digital Audit platform in place, where Trust-wide outcomes and learning can be viewed by any colleagues participating in clinical audit.

1. **National clinical audits 2021/22**
   During **2021/22**, Sherwood Forest Hospitals NHS Foundation Trust participated in 52 national clinical audits and three National Confidential Enquiries into Patient Outcomes and Death (NCEPOD).

   Total Number of audits in the 2021/22 plan: = 365
   Number of local / other audits: = 313
   Number of national audits, including NCEPOD: 55
   Number of audits fully completed: = 142
   Percentage of completed audits = 38%

   Some of the key learning from National Audits during 2021/22 is as follows:

   The Sentinel Stroke National Audit Programme (SSNAP) has reported that we have achieved the standard for 24 of the 30 standards of care criteria that they audit against. We have shown strong performance against the criteria (100%) for patients starting Thrombolysis where eligible, the percentage of applicable patients receiving a joint health and social care plan on discharge and the percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation.

   Epilepsy 12 National Clinical Audit - the results of the audit show that 86% of our children and young people had an input to their care from an Epilepsy Nurse Specialist which is favourable against the national figure of 63%. The audit also found that 90% of patients had input into their epilepsy care from a paediatrician with expertise in epilepsy.

This learning has been made visible across the organisation through a poster, and this approach is being considered for other audits in terms of raising visibility and sharing organisational outcomes and learning.

The Society for Acute Medicine Benchmarking Audit (SAMBA) 2021 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 17th June 2021. Sherwood Forest Hospitals met the key performance indicators in more than 90% of the metrics. 92% (National average 77.4%) of patients had an early warning score recorded within 30 minutes of arrival to hospital. 96% (National average 87.4%) of unplanned admissions were seen by a tier 1 clinician within four hours of arrival to hospital. 98% (National average 67.8%) of unplanned admissions who required a medical consultant review were seen within the target time.

National Lung Cancer Audit (NLCA) Sherwood Forest Hospital (79.8%) is above the national average (75% in 2020) for the percentage of patients that are seen by a Cancer Nurse Specialist. It also displays a favourable median time from diagnosis to treatment for patients of 13 days compared to the national figure of 27 days in 2020.

National Emergency Laparotomy Audit (NELA) - Year 7 The report shows that Preoperative input by a consultant surgeon when there's a documented risk of death of more than 5% has improved from 74.6% of cases in Year 6 to 100% in Year 7. In addition, the results also show that we achieved a high score regarding consultant surgeon and anaesthetist presence in theatre when risk of death of more than 5%.

Looking forward to 2022/23 we aim to:

Strengthen both the assurance and visibility of clinical audit within the organisation via the Improvement in Clinical Audit Group, Advancing Quality Programme and by learning from, and sharing activities on key Trust-wide themes. This has started via the 'Antimicrobial Stewardship Quality Improvement Group' which has brought together different teams working in silos, into one cohesive project team.

To further connect audit to the continuous improvement and learning cycle; this will focus on process outcomes by being more directly involved as a team at Divisional Governance level, to influence more locally and to pull forward learning and good practice across the organisation.

Continue our focus on developing and progressing the QIP Club for trainee doctors, sharing this development both inside and outside the organisation.

To align to and contribute to Trust strategies; People, Culture and Improvement Strategy, the Continuous Improvement Strategy, the Quality Strategy and to support the nursing's Pathway to Excellence approach.

Workforce

Our workforce plan is linked to the national NHS People Plan and associated People Promise. This strategy was nationally introduced in July 2020 and is underpinned by an annual implementation plan, with progress regularly reported to our Board and associated Committees. A key part of the implementation plan has been to respond the challenges faced during the global pandemic of Covid-19 and the recovery of our workforce.

Our workforce strategy and plan reflect our numerical and skill mix requirements and is aligned with the Integrated Care System People and Culture Strategy. It focused on supporting the workforce during the global pandemic of Covid-19. It is consistent with our financial, quality and activity plans and supports the Developing Workforce Safeguards recommendations as it is the result of a structured cross-trust approach. However, it is noted that due to the pandemic our workforce strategy for 2021/22 was focused on the recovery and restoration of services and a new three-year Workforce Strategy will be introduced for 2022-2025 to achieve local, regional, and national priorities.

During 2021/22 the planning arrangements were paused, and as a result our plans have been carried over, however, the work we have undertaken on restoration and recovery has moved forward our workforce plans. We are developing a strategic workforce plan for 2022/2023 which is being co-designed with divisional colleagues, and is linked to the wider ICS workforce plan.

In relation to workforce plans our divisional teams are supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver on projected activity levels, in the short, medium and longer term. This bottom-up approach to ensuring we have safe and adequate staffing levels is supported by our executive-led People and Inclusion Cabinet.

Regular, staffing establishment reviews are also carried out and we have invested in E-Rostering, E-Job Planning and Clinical Activity Manager system. These all help better align our staffing to our activity and acuity levels.

We have expanded our temporary staffing offer as well as the governance around the processes. Additionally, we have had a programme of recruiting to vacancies; as such we have seen our Trust vacancy level reduce over the past 12 months.

Part of our approach to workforce planning is to ensure that we optimise our existing workforce. E-Rostering and E-Job Planning are key parts of our strategy and they are already well embedded in the organisation for both nursing and medical colleagues.

Key risks concerning workforce capacity and capability are contained in the Board Assurance Framework and were regularly reviewed by the People, Culture and Improvement Committee during 2021/22. They will continue to be reported in 2022/23. New roles are being developed to support our medium-term and longer-term workforce requirements, which will be linked to the Strategic Workforce Plan.

Over the past 12 months the Board has prioritised supporting staff with their health and wellbeing. Areas of focus over the past 12 months have been advertising and embedding the wellbeing support through an Employee Assistance Programme (EAP), supporting physical and emotional wellbeing, implementation of rest and recuperation zones and signposting to wellbeing offers available internally and externally. In addition, the Trust has implemented an additional onsite Clinical Psychology Service to provide extra support to staff who experience trauma within their work, and we have invested in our in-house Occupational Health service.

The Trust has embedded a Just and Restorative Culture focussing on why issues have arisen and what has contributed to errors or concerns rather than apportioning blame. This piece of work links into our wider civility work. This approach has resulted in a significant decline in the number of employee relation incidents.

We will continue to work closely with Health Education East Midlands (HEEM) and be guided by the People and Culture Board and national policy. We continued to work with partners such as East Midlands Leadership Academy (EMLA), and Regional NHS England / Improvement (NHSI/E) Teams to develop the existing workforce.

The Apprenticeship Levy continues to be an effective tool in supporting workforce transformation across our organisation and the wider ICS. We intend to develop and grow year-on-year the number of apprenticeships we support. We are determined to achieve an appropriate balance of clinical and non-clinical apprenticeships. The levy is also being used to support leadership development with levy funded Masters and MBA Programmes.

International recruitment of both doctors and nurses is a key part of our workforce strategy. We have also assessed the risk associated with European Union nationals in our workforce. The impact of Brexit on our workforce supply has been minimal, due to our limited reliance on EU staff.

As an NHS employer the Trust ensures, staff entitled to membership of NHS Pension Scheme are offered the scheme and measures are in place to ensure Scheme regulations are complied with regarding relevant deductions and contributions. The Trust also ensures that in accordance with Scheme rules records are accurately kept and updated in accordance with Regulation timescales.

Under the review of the Trust's People, Culture and Improvement Committee assurance is provided regarding the Trust's obligations to ensure equality, diversity, inclusion and human rights legislation are complied with.

We have adopted the NHS Improvement Workforce Safeguards (2018), and these are reported to the People, Culture and Improvement Committee. These standards ensure our staffing governance processes are informed, safe and sustainable, these includes:

- Embedding the National Quality Board standards
- Ensuring safe staffing processes include evidence-based tools, professional judgement and outcomes

- Receiving assurance from the Chief Nurse and the Medical Director that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable
- Having an effective workforce plan that is updated annually and signed off by the Board of Directors.

Compliance with NHS Foundation Trust Condition 4 (Foundation Trust governance)

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework, on an annual basis. The licence requires providers to self-certify they have:

a) Complied with governance arrangement (condition FT4)

Our self-certification was approved by the Board in May 2021. The self-certification process requires a response to the following five questions:

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time .

3. The Board is satisfied that the Licensee has established and implements:
   (a) Effective board and committee structures
   (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees
   (c) Clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

   a. To ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively
   b. For timely and effective scrutiny and oversight by the Board of the Licensee's operations
   c. To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board, and statutory regulators of health care professions
   d. For effective financial decision-making, management, and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)
   e. To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making
   f. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence
   g. To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery
   h. To ensure compliance with all applicable legal requirements.

5. The Board is satisfied that there are systems and /or processes referred to in paragraph 4 (above) that should include but not be restricted to systems and processes to ensure:
    a. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided
    b. That the Board's planning and decision-making processes take timely and appropriate account of quality-of-care considerations
    c. The collection of accurate, comprehensive, timely and up to date information on quality of care
    d. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
    e. That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders
    f. That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

The Board considered the risks to each element of the self-certification and confirmed evidence of compliance with condition 4; the key elements are noted below.

During the year due to the pressure on the organisation due to the pandemic our governance processes were reviewed and slimmed down to ensure the key items remained the focus with some items being deferred to later in the year.

Our governance committee structure has provided our Board of Directors with assurance during the year regarding quality, including compliance with the CQC standards and finance, particularly regarding specific issues raised by NHS Improvement in terms of loans and working capital facility.

During the year, our Board has received assurance regarding the performance through the Single Oversight Framework Integrated Performance Report and supporting exception reports for indicators rated as red on the performance dashboard, bringing together performance metrics and information relating to workforce, quality priorities, staffing and finance.

Reports to Board from the Board committees provide further assurance to the Board on the effectiveness of risk management and internal control, including the reporting of incidents through either Quality Committee for clinical incidents and Audit and Assurance Committee for Information Governance incidents. Reports from internal and external audit are reported to Board through the committee structure with any escalations being highlighted in the committee chair's report to Board.

We are registered to provide healthcare on the following hospital sites – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital and Ashfield Health Village. The registration requirements are reviewed on an annual basis with our CQC Local Team. In response to the rollout of the Covid-19 vaccination programme the Trust applied under set regulations the extension of its registration to the following vaccination sites – The Mansfield Vaccination Centre, Newark Showground, King's Meadow Campus, Richard Herrod Centre, Gamston Community Hall and Forest Recreation Ground. The Trust also provides vaccination centres at King's Mill Hospital and Ashfield Health Village, this falls under the Treatment of Disease, Disorder, and Injury condition of our current registration.

The Chief Executive, Medical Director, Chief Nurse, and the Deputy Director of Governance and Quality Improvement facilitate a regular engagement meeting every six weeks with our CQC Relationship Manager and the Lead Inspector. This meeting provides an opportunity for us to demonstrate on-going improvements in care but also an opportunity for CQC colleagues to gain assurance that timely and appropriate actions are in place to address issues raised through incident reporting, complaints and patient experience feedback. Since July 2017 CQC colleagues have visited a specialty area during the engagement meeting to enable them to meet SFH colleagues and further understand about the care we provide to our patients. These visits have been received very positively by both parties and have provided additional assurance that we understand where we provide excellent care and where there is further work to do. The success of this approach negated the need for additional staff focus groups and individual meetings during the most recent CQC Inspection resulting in a more streamlined visit.

We are fully compliant with the registration requirements of the Care Quality Commission.

We have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (band 7 and above) within the past 12 months, as required by the Managing Conflicts of Interest in the NHS guidance.

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

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

The foundation 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. We ensure our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

Our Board of Directors performs an integral role in maintaining the system of internal control, supported by the Board Committees and internal and external audit.

The internal audit plan is agreed by the Audit and Assurance Committee and is focused on key risk areas, identified through our Board Assurance Framework and via escalation processes from other board committees. Follow up audits are also included in the plan to ensure that actions are implemented, and improvements sustained.

The Board receives regular updates and assurance on the economic, efficient and effective use of resources, including:

Finance Committee - the Finance Committee receives detailed financial operating and outturn information, including historical and forecast pay and non-pay spending analysis, monitoring of the underlying financial position and assurance about financial control. A regular update on the financial position of the ICS is presented to the Finance Committee.

Risk Committee - this Committee receives assurance regarding the risks on the Board Assurance Framework, with divisional risks reviewed on a cyclical basis. The risks reviewed include those relating to workforce recruitment and retention, organisational sustainability and financial performance.

Trust Board - the Board receives assurance from its committees mentioned above. The main element of performance reporting is the Single Oversight Framework (SOF) which provides the Trust Board with key operational performance indicators on a monthly basis. For each of these indicator's standards and thresholds are agreed up front to help drive when indicators are flagged for specific follow up. The SOF highlights performance in different domains in line with the Trust's strategy and draws out key areas for improvement within each domain.

Transformation and Efficiency Cabinet - the Cabinet leads on the delivery of longer-term strategic change on behalf of the Trust Board with a nominated executive lead supporting the programme leads. The cabinet meets monthly to review progress to deliver transformational change that will improve services for the local population and deliver financial efficiencies.

Incident Control Team (ICT) - since the onset of the pandemic the Trust has had in place an Incident Control Team, chaired by the Trust's Accountable Emergency Officer (the Chief Operating Officer). The group meets weekly (or more regularly as required by the pandemic) and decisions made are ratified in the following Executive meeting.

People and Inclusion Cabinet - the People and Inclusion Cabinet provides scrutiny and assurance of the development, delivery and impact of the Trusts People and Inclusion strategy and plan. This includes the review of associated BAF risks, to provide assurance that those risks are being effectively mitigated or managed in a controlled way, and to provide assurance that suitable

structures, systems and processes are in place and functioning to support colleagues to deliver high-quality patient care.

PFI contract management is overseen by a contract management team, who ensure the outputs in the PFI specifications are met. Due to the contribution of the scheme to the wider underlying deficit the Trust has engaged with PFI specialists to review the nature of the contract. A monthly report is taken to Trust Board to update on PFI-related issues.

In response to the Covid-19 pandemic an interim financial framework was introduced across the NHS for the financial year 2020/21. This framework continued in 2021/22 and under this framework the Trust has largely been funded through fixed allocations. During the first half of the financial year (H1) these fixed allocations were supplemented with additional retrospective funding to match costs and to ensure a balanced health service position. These ceased in the period October 2021 to March 2022 (H2) where control totals were agreed with organisations, with the intention of still ensuring break even across the NHS.

Throughout the financial year, income and expenditure has been reviewed on an actuals basis and changes to run rate are reviewed and explained as part of the monthly reporting process. The Trust has also worked closely with our Counter Fraud Specialist and Internal Auditors throughout the pandemic.

We have ended the year with a deficit of £1.25m. Adjusting for asset impairments and other non-control total items gives a control total basis deficit of £13.18m. This value is aligned with the forecast outturn agreed between the Nottinghamshire ICS and NHSEI for the financial year 2021/22. Details relating to this position are included elsewhere in this report. Although the financial outturn is consistent with the agreed position we remain in a financially challenged position with a significant underlying deficit.

The Trust's Standing Financial Instructions have remained in place throughout the pandemic. Covid related expenditure is only incurred following approval (except for some pay costs for covering Covid-related absences, which are reviewed through month-end processes). All non-Covid costs are reviewed monthly against the financial plan and forecast, with a variance analysis completed on any significant movements. In addition, the Trust continues to report an underlying financial position the Finance Committee on a monthly basis.

During 2021/22 the Trust has not accessed additional interim revenue support in the financial year, however, capital of £10.85m was agreed with NHSEI and drawn down in the form of Public Dividend Capital.

The pandemic has continued to lead to significant changes in working practices and presented challenges in relation to recruitment and retention of employees. We have continued to actively recruit to our employee establishment and have been successful in reducing our number of vacant posts, although recruitment difficulties continue in the nursing and medical workforce. Changing demands and unprecedented levels of staffing absence rates, including those directly

related to Covid-19, have necessitated the requirement for additional temporary staffing during the year.

This has influenced an increase in agency expenditure to £16.89m in 2021/22, compared to a notional ceiling for the year of £12.66m. Although the formal agency expenditure ceiling was relaxed for 2021/22 the Trust has maintained controls to manage agency usage and costs.

The use of bank employees has been particularly important in the past year and the Trust has continued to grow this resource, with over 6,975 staff now on the Trust's bank. In addition, the Trust has taken on responsibility for the roster management of the Covid Vaccination Programme in Nottinghamshire. This has significantly increased pay costs, but; these costs are matched by funding from NHSEI.

The Transformation Team is responsible for supporting the Trust to deliver the overall Financial Improvement Programme (FIP). Identification of FIP schemes is led by the Transformation Team and supported by divisional teams and finance. The Trust uses benchmarking information from the Model Hospital and other sources including the Trusts Patient Level Information and Costing System (PLICS) to help to identify opportunities. For 2021/22 the Trust has reported efficiency savings of £5.8m. Development of the FIP plan for 2022/23 has started with a planned FIP of £11.7m. An Internal Audit of the Financial Improvement Plan and Programme Management Office, received a limited assurance audit opinion, there were three recommendations in the report two medium and one low, all three have been completed and evidence provided to Internal Audit who have approved the completion.

Despite the revised financial frameworks that have been in place since 2020/21 the Trust continues to operate at a recurrent underlying deficit and faces future uncertainty regarding future contracting and income arrangements. Close working with Nottinghamshire ICS partners to manage resource allocations at a system level will be crucial in ensuring financial sustainability.

The Nottinghamshire ICS has strengthened governance arrangements over the past year, which has supported closer system working and encouraged a greater level of transparency and consistency between organisations. The introduction of an ICS Transformation Cabinet and an ICS Finance Committee will facilitate the sustainable recovery and transformation of services. It is currently expected that the ICS will become a legislated body from Q2 which will be responsible for managing resources and ensuring delivery of the ICS agreed control totals in 2022/23.

These conditions indicate that there is uncertainty which may cast doubt about the Trust's ability to continue as a Going Concern, however, the assurance provided by the immediate continuing provision of healthcare services and improved access to funding through changes in the NHS financing regime significantly mitigates this and under the existing guidance as issued by the Financial Reporting Council, Practice Note 10, the accounts have been prepared on a going concern basis.

The Board of Directors has taken steps to ensure that this remains the case for the next 12 months.

A detailed going concern paper was reviewed and approved by the Audit and Assurance Committee in support of this assessment and is subject to an external audit review as part of the annual accounts process.

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs, who is also our Senior Information Risk Owner (SIRO) and the Medical Director who is our Caldicott Guardian. The SIRO is supported by a network of information asset owners, who ensure the integrity of, and monitor access to, the systems for which they are responsible. The Director of Corporate Affairs as SIRO and the Caldicott Guardian share the chair of the IG Committee. A working group also operates as part of the IG structure. The reporting and management of risks relating to data and security are safeguarded by ensuring all our employees are reminded of their data security responsibilities through education, at induction and through mandatory training requirements. More than 4,000 colleagues received mandatory IG training in 2021/22, and regular reminders are shared via internal communications. Near misses and lessons learned are used to inform the training programme, ensuring that the programme remains dynamic and reflects current and meaningful issues to facilitate greater employee engagement and ownership of IG processes.

Work continues to raise the profile of IG using a variety of mediums to ensure that incidents and lessons learned are brought to the attention of all employees.

Reports are shared at appropriate divisional and corporate meetings and colleagues are notified about updates to policies and guidelines via the Bulletin as soon as they are published on the intranet.

Risk Management and Assurance

As part of ensuring continued compliance with the IG agenda, we review the Terms of Reference for the IG Committee on an annual basis. The group has a strategic focus to ensure effective policies, processes and management arrangements are in place covering all aspects of information governance, including:

- Information security
- Data quality
- Digital continuity
- Records management
- Information disclosure
- Information sharing
- Legal and regulatory compliance.

This strategically focused group meets on a bi-monthly basis and is supported by the IG Working Group, which reviews Data Impact Assessments, as part of the wider stakeholder engagement.

This is to assess the level of risk and consider both the likelihood and the severity of any impact on individuals' rights and freedoms. The group also reviews national guidance to inform both strategy and policy development together with implementation plans and processes.

The IG Committee monitors the completion of the Data Protection Security Toolkit (DPST) submission, data flow mapping, and information asset registers. We have implemented the DPST requirements achieving 110/110 standards by the June 2021 deadline We are on target to achieve the same for 2021/22

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2021/22 to refresh skills and awareness of legislative changes.

Data Flow Mapping

Data from and to SFH is mapped and reviewed on an annual basis. The data flow mapping template has been updated in line with GDPR legal basis Article 6 and Article 9, which now includes categories of data subject / personal data, categories of recipients, information transferred overseas, whether data is retained or disposed of in line with polices, if not why not, and whether there is a data sharing agreement in place.

The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. During 2021/22 we have undertaken an annual review of information flow mapping to ensure we are assured information flows into and out of the organisation are identified, risk assessed and addressed. This is then expanded to ensure we have assurance all information is stored securely and appropriately and any partners in delivery of either shared care or information storage achieve the same high levels of information governance assurance. Information flows that have been provided have been reviewed and approved by the SIRO.

Serious Incidents Requiring Investigation (SIRI)

As part of the Annual Governance Statement, we are required to report on any Serious Incidents (SIRIs) or Cyber Incidents which are notified on the DSPT reported through to either the ICO or NHS Digital.
To date there has been one incident that required reporting to the Information Commissioners Office (ICO). We have had no further action from the regulators after investigation. The incident consisted of a compromise of the integrity of information.

Information Sharing

The IG department is actively involved in developing meaningful partnership working with neighbouring healthcare providers. The intention being to ensure the sharing of patient data is protected in line with national guidance in a seamless, robust and effective way across partner organisations.

Freedom of Information (FOI)

During 2021/22 the Trust processed a total of 600 FOI requests. This function is managed by the Information Governance Team and the activity is demonstrated in the table below.

Total	Breached timeframe of 20 days	Escalated to ICO
600	138	0

Any breaches in the 20-working day statutory response timeframe are due to complex requests that require input from multiple teams or due to an issue with a gap in the process, which has now been addressed and we will ensure where possible full compliance. The Impact of the ongoing Covid-19 pandemic has also affected compliance rates; several the FOIs are assigned to departments who are inundated with Covid-19 related work, such as the infection control team and information services.

Of the requests, 527 are currently completed, five on hold waiting further information and 68 still in progress. Of the requests completed 355 have been completed within 20 days which show a compliance rate of 67.3%.

Subject Access Requests (SARs)

The Trust has received 2,846 requests for access to patient records. Most cases are processed in line with national guidance which is exemplary given some of these cases represent hundreds of pages of information and require methodical attention to detail to ensure information is released appropriately.

There have been no complaints to the Information Commissioner – any requests for review of content of records by patients have been handled locally and achieved satisfactory resolution for patients.

From July 2021 the access team at KMH has been processing all the SAR requests for the trust.

April 21 to March 22 Total		Completed within 21 days	Completed 21-30 days	Completed more than 30 days
Kings Mill	2,731	2638	93	0
Newark	99	94	4	1
IG – Staff	16	10	4	2

Horizon Scanning

Data security will continue to have an increased focus over the next few years. It is impossible to eradicate human error in our work practices and therefore we will begin to see more clinical systems being digitised. While providing a more efficient and safe way of working, introduces a greater cyber-attack landscape. We are currently seeing more sophisticated phishing attacks and hackers are exploiting more vulnerabilities within our systems, which poses a high risk to the data we hold.

Data portability for patients will become increasingly common practice and we need to ensure data can be moved from one IT environment to another in a safe and secure manner. The introduction of the ICS is crucial to ensure data portability is progressed. The new Health and Social Care Bill which received Royal Assent in April 2022 aims to reform how health and care services begin to work together and data will need to be moved across geographical boundaries.

Legislation will need to be up-to-date and relevant in the digital age and we are already seeing some updates, which could have an impact on the Trust as we become more aware of ethics and human rights, the UK GDPR will need to be updated to reflect these changes.

Biometric controls are already in place in many of our personal lives with fingerprint unlocking on devices and voice activated smart assistants and this is set to become more widely used in healthcare settings.

Data Quality and Governance

SOP – Quality Assurance and sign off process

In accordance with the NHS Standard Contract, the Trust is required to participate in a range of national audits and clinical outcome reviews. In addition, the Trust is required to make routine information submissions to NHS Digital, NHSEI, Unify and the CCG. These submissions are quality assured and signed off before submission for the following reasons:

- **Quality assurance of data pre-submission** – to ensure the data has integrity and can be used in confidence to inform decision making and service development
- **Sign off data pre-submission** – to ensure that data are a true and accurate reflection of the Trust's position.

A comprehensive list of routine external submissions, together with the relevant operational and Executive Director leads is maintained. Quality assurance of National Audits is provided by clinical lead and head of service before signing off by the Clinical Chair and Executive Medical Director. Information requirements for example elective waiting time data is quality assured pre submission by the Divisional General Manager before signing off by the relevant Executive Director.

The relevant Executive Director may delegate responsibility for frequent, routine submissions, such as the daily situation report, but the Executive Director will remain the accountable officer for the submission.

The Trust assures the quality and accuracy of its Audit and Information requirements (for example elective waiting time data), and mitigates risks to the quality and accuracy of this data through the quality assurance and sign off procedure above and the work of the Data Quality Team which covers the following areas:

- **Validation** – in response to known areas of data quality concern (as identified through reporting or operational processes), we will:
    - Actively validate data sets to ensure decision making is based on accurate information
    - Ensure operational/clinical teams are informed to enable necessary action to be taken in cases where patient care is affected.

- **Addressing errors** – where data errors are identified, in addition to informing operational/clinical teams to enable the patient impact to be understood and addressed, we will:
    - Identify the root cause
    - Correct the information, as necessary
    - Ensure feedback is provided to the originator of the root cause (for example user, system provider, etc.)
    - Ensure action is taken to reduce or prevent repetition of the issue

- **Reporting** – use of key performance indicators (KPIs) to:
    - Monitor levels of data quality
    - Identify improvements or deterioration in data quality
    - Identify areas for validation, corrections, training, process improvements or ad hoc audits

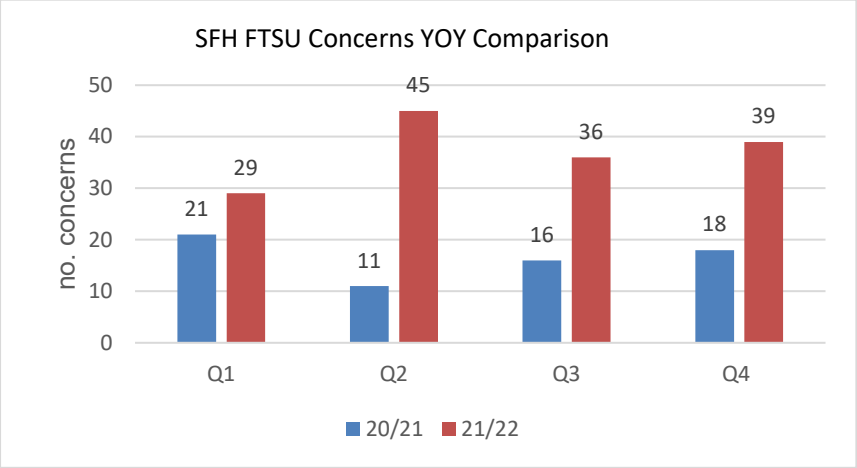
- **Auditing** – delivery of an audit programme to:
    - Systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback
    - Allow for ad hoc audits in response to suspected Data Quality weaknesses

- **Training** – delivery of Data Quality training for relevant members of staff. In addition, we provide targeted training in response to themes or repeated errors, as identified through:
    - Audit
    - Reporting
    - Operational issues

- **Process improvements** – where necessary, we systematically change operational processes to maximise data quality. Any such process changes are:
    - Clinically and operationally owned, designed and supported
    - Underpinned by procedural documents
    - Not be to the detriment of patient care
    - Reviewed once implemented

Freedom to Speak Up

During the year 2021/22 , 149 cases were raised to the FTSU Guardian compared with 69 cases raised the previous year



There is a significant increase in concerns raised to the FTSU Guardian during the year and contributing to the increase is the appointment of a full time Guardian and active investment in and recruitment of FTSU Champions. The Trust now has more than 20 Champions, and this has increased visibility of and accessibility to our speak up culture. We have had a noticeable increase in our medical workforce raising concerns aided by appointment of a medical FTSU Champion

Top two themes:

1. Incivility, bullying and harassment

2. Leadership styles and behaviours

Organisational learning from the themes is fed through Culture and Improvement workstreams, regular and direct communication with the Executive Team and FTSU Guardian involvement in Training & Development Programmes.

Feedback is requested from all those that raise concerns. No case of detriment for speaking up has been reported in this year. Feedback received on the process is positive and colleagues say they would use it again to raise concerns .

Quality

A review of our performance from 1 April 2021 to 31 March 2022 indicates there are appropriate controls in place. These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse
- Quality governance, quality and performance reports are included in our performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities

We have engaged with a wide range of stakeholders in our activity to improve the quality of care provided. The same assurance processes are used for other aspects of performance.

The global pandemic has disrupted business as usual over the past year; nonetheless the Advancing Quality Programme remains the vehicle to drive the Quality Priorities. The Programme is closely monitored, updated and amended as required throughout the year with regular progress reports through the Advancing Quality Programme Board, the Trust Quality Committee and Board of Directors as part of the routine cycle of business.

We used the following intelligence sources to identify and agree the Quality Priorities for 2021/22.

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient and outpatient surveys
- Feedback from our Board of Directors and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Feedback from senior leadership assurance visits and our ward accreditation programme
- Nursing and midwifery assurance framework and nursing metrics
- Quality and safety reports
- Internal and external reviews
- National policy
- Feedback and observations from Healthwatch through partnership working
- Feedback from stakeholders, partners, regulators, patients and staff in the development of our Advancing Quality Programme

The indicators are shared with each of the Trust's Clinical Divisions and through to the Board of Directors. Specific indicators within the report are monitored and reported through the Trust performance and governance framework namely the:

- Monthly divisional performance review meetings
- Patient Safety Committee

- Nursing, Midwifery and Allied Healthcare Professional Committee
- Maternity Assurance Committee
- Quality Committee.

Ockenden Report

The Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022. This built on Donna Ockenden's interim report published in December 2020. NHSE/I and the Secretary of State for Health have fully accepted the report and offer sincere apologies to families involved.

Within the report, there are 15 areas for national action and 60 local actions for learning for Shrewsbury and Telford Hospital NHS Trust. Four key pillars identified throughout the report are:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families.

The interim report published in 2020 made clear recommendations in the form of Immediate and Essential Actions for all Maternity Services across England. Sherwood Forest Hospitals are fully compliant in six of the seven immediate actions and have processes in place to ensure that as a maternity system we reach full compliance with the final action.

As a Trust, we're proud of what we've achieved and how we are performing but we are not complacent. We have worked hard to ensure our maternity and neonatal services deliver good and safe care. This is reflected in the feedback we receive from families and our safe outcomes as a service. We recently received the results of a CQC Maternity Survey carried out among women that gave birth at Sherwood Forest and we scored very well, particularly in areas such as staff treating new mums with respect and dignity during the birth, being supportive and speaking to them in a way that they understand, as well as involving them in decision making.

Recognising the impact publication and the subsequent headlines may have on maternity teams generally, we have ensured we have a strong visible leadership presence.

The board of directors alongside the externally supported Maternity Assurance Committee will have full oversight of 15 actions released at the end of March 2022.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in the ISA 260 report for the Audit and Assurance Committee and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, and the other Board Committees and plan to address any weaknesses and ensure that continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control was monitored by the Board and its committees. The chairs of these committees play a key role in assuring me of the performance, quality and financial position of the organisation, which in turn supports the management of risks across the organisation.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through their internal audit work. The Head of Internal Audit has provided me with a Significant opinion for 2021/22. See below:

> *I am providing an opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.*
> *In providing my opinion three main areas are considered:*
> *• Board Assurance Framework and strategic risk management*
> *• individual assignments outturn*
> *• follow up of actions.*
> *I am providing significant assurance in relation to the Board Assurance Framework and strategic risk management.*
> *I am providing significant assurance in respect of the outturn of internal audit reviews. Whilst we have a number of limited assurance reports included as part of this opinion (from the 2020/21 plan not reported in the previous annual report and the 2021/22 plan), the Trust has worked in partnership with internal audit and has sought to identify areas for improvement where there are known issues. We have, therefore, considered this in concluding our opinion for this element.*
> *I am providing a moderate assurance opinion for the follow up element of the opinion. In comparison with previous years, the Trust's performance has deteriorated in 2021/22. That said, the Audit and Assurance Committee has maintained good oversight of the position and the Trust has also enhanced the internal processes for monitoring the implementation of actions.*

This reflects the improvements made by the organisation in both embedding risk management and implementing and sustaining a robust Board Assurance Framework assurance process through the Board Risk Committee, which is chaired by me as the Chief Executive.

There have been 20 internal audit assignments during the year, including two advisory reports regarding system wide assurance in respect of the 2021/22 Operational Planning Review and Transformation and Efficiency Planning, eight significant assurance reports, 1 advisory report and six Limited Assurance reports, these are:

Internal Audit Report	High Risk Actions	Medium Risk Actions	Low Risk Actions	Date Actions Due for Completion
Financial Improvement Plan – Programme Management Office	0	2	1	All completed during 2021-22
Consultant Job Planning	0	3	1	1 Low risk outstanding at March 2022, completed April 2022
Patient Consent	0	6	3	April and July 2022
Clinical Effectiveness	0	7	0	April, June and August 2022
Contract Management Review	0	3	0	December 2022
Venous Thromboembolism (VTE) Management	0	5	1	September and December 2022

All the reports, with Limited Assurance have been presented to the Audit and Assurance Committee, by the executive lead, and the actions identified are monitored through the most appropriate committee. All internal audit reports which are rated as Significant Assurance are presented to the most appropriate committee, where the actions are also monitored. Any actions which become overdue are reported back to the Audit and Assurance Committee and the action owners are invited to attend.

The follow up element of the Head of Internal Audit Opinion provided moderate assurance due to the reduction in the number of actions implemented at first follow up falling to 67% with an overall implementation rate of 83%, in comparison with previous years our performance has deteriorated, however the Audit and Assurance Committee has maintained good oversight of the position and challenges throughout the year and we have enhanced our internal processes for monitoring of the implementation of actions to ensure managers are supported in achieving the deadlines agreed in the individual internal audit reports.

Managers and Executive Directors provide me with assurance through regular Board and management reports, all which evidence areas of effective internal control and risk management. The Audit and Assurance Committee and the Risk Committee ensure effective operation of risk management and focus on the establishment and maintenance of controls designed to give assurance that assets are safeguarded, waste and inefficiency are avoided, reliable information is produced and value for money is sought continuously.

My review for 2021/22 is also informed by:

- Regular executive reporting to Board and escalation processes through the Board Committees
- Assessment of financial reports submitted to NHS Improvement
- Patient surveys
- Staff surveys
- Clinical Audit.

Conclusion

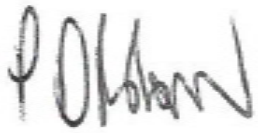
There are no significant control issues in our response to the Covid-19 pandemic. We have continued to take effective decisions and actions ensure the organisation responded effectively to the pandemic's impact on our services and patients. We have led with compassion and with support and we have communicated well.

We maintained our focus, on the transactional aspects of the impact of the pandemic including, Personal Protective Equipment (PPE) planning and fit testing of masks and because of the good work of our procurement team, working with others within the organisation and beyond, we have had sufficient PPE throughout the pandemic crisis and on-going in 2021/22. Our infection control team, working with others, have effectively led on infection prevention and control across our three sites, segregating the hospitals into different sections and we have followed national guidance throughout.

In line with government guidance, during 2021 we continued to support colleagues to work from home and the way we communicate and interact with each other has changed with the use of MS Teams and other platforms. All the feedback I have received from many sources state colleagues have felt the organisation has been well led and we have communicated clearly and inclusively.

The governance processes we implemented in March 2020 and have continued during 2021/22, has strengthened Clinical leadership. The Clinical Chairs are active participants in decision making and the medical managers' forum has evolved.

I am satisfied the organisation has a sound system of internal control supported by a robust governance structure.



Paul Robinson
Chief Executive Officer **17th June 2022**

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Paul Robinson**
Job title **Chief Executive Officer**
Date **17 June 2022**

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	385,658	328,440
Other operating income	4	66,115	94,132
Operating expenses	6, 8	(437,504)	(423,652)
Operating surplus/(deficit) from continuing operations		**14,269**	**(1,080)**
Finance income	11	24	-
Finance expenses	12	(14,876)	(14,772)
PDC dividends payable		(679)	-
Net finance costs		**(15,531)**	**(14,772)**
Other gains / (losses)	13	16	(42)
Surplus / (deficit) for the year		**(1,246)**	**(15,894)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	1,550	(783)
Revaluations	17	-	225
Other reserve movements		-	(4)
Total comprehensive income / (expense) for the period		**304**	**(16,456)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(1,246)	(15,894)
Remove net impairments not scoring to the Departmental expenditure limit		(11,737)	10,417
Remove (gains) / losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		(534)	(366)
Removal of Donated Depreciation		338	304
Remove net impact of inventories received from DHSC group bodies for COVID response		-	-
Adjusted financial performance surplus / (deficit)		**(13,179)**	**(5,235)**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	5,512	6,716
Property, plant and equipment	15	299,258	279,108
Receivables	19	492	1,271
Total non-current assets		**305,262**	**287,095**
Current assets			
Inventories	18	4,965	4,114
Receivables	19	14,656	20,312
Cash and cash equivalents	20	6,324	25,187
Total current assets		**25,945**	**49,613**
Current liabilities			
Trade and other payables	21	(40,238)	(50,214)
Borrowings	23	(10,151)	(9,957)
Provisions	24	(153)	(180)
Other liabilities	22	(5,582)	(1,853)
Total current liabilities		**(56,124)**	**(62,204)**
Total assets less current liabilities		**275,083**	**274,504**
Non-current liabilities			
Trade and other payables	21	-	-
Borrowings	23	(219,776)	(229,927)
Provisions	24	(670)	(1,095)
Total non-current liabilities		**(220,446)**	**(231,022)**
Total assets employed		**54,637**	**43,482**
Financed by			
Public dividend capital		415,445	404,594
Revaluation reserve		16,511	15,183
Income and expenditure reserve		(377,319)	(376,295)
Total taxpayers' equity		**54,637**	**43,482**

The notes on pages 138 -184 form part of these accounts.

Name **Paul Robinson**
Position **Chief Executive Officer**
Date **17 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	**404,594**	**15,183**	**(376,295)**	**43,482**
Surplus/(deficit) for the year	-	-	(1,246)	**(1,246)**
Other transfers between reserves	-	(18)	18	**-**
Impairments	-	1,550	-	**1,550**
Revaluations	-	-	-	**-**
Public dividend capital received	10,851	-	-	**10,851**
Public dividend capital repaid	-	-	-	**-**
Other reserve movements	-	(204)	204	**-**
Taxpayers' and others' equity at 31 March 2022	**415,445**	**16,511**	**(377,319)**	**54,637**

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	**149,615**	**15,977**	**(360,633)**	**(195,041)**
Surplus/(deficit) for the year	-	-	(15,894)	**(15,894)**
Other transfers between reserves	-	(23)	23	**-**
Impairments	-	(783)	-	**(783)**
Revaluations	-	225	-	**225**
Public dividend capital received	254,979	-	-	**254,979**
Other reserve movements	-	(213)	209	**(4)**
Taxpayers' and others' equity at 31 March 2021	**404,594**	**15,183**	**(376,295)**	**43,482**

Information on reserves

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

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

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		14,269	(1,080)
Non-cash income and expense:			
Depreciation and amortisation	6.1	13,494	12,135
Net impairments	7	(11,737)	10,417
Income recognised in respect of capital donations	4	(534)	(366)
(Increase) / decrease in receivables and other assets		6,444	8,107
(Increase) / decrease in inventories		(851)	352
Increase / (decrease) in payables and other liabilities		1,690	14,285
Increase / (decrease) in provisions		(451)	110
Other movements in operating cash flows		1	(4)
Net cash flows from / (used in) operating activities		**22,325**	**43,956**
Cash flows from investing activities			
Interest received		11	3
Purchase of intangible assets		(639)	(4,990)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(26,049)	(11,998)
Sales of PPE and investment property		111	65
Net cash flows from / (used in) investing activities		**(26,566)**	**(16,920)**
Cash flows from financing activities			
Public dividend capital received		10,851	254,979
Public dividend capital repaid		-	-
Movement on loans from DHSC		-	(233,958)
Capital element of PFI, LIFT and other service concession payments		(9,957)	(9,744)
Interest on loans		-	(746)
Other interest		(10)	(2)
Interest paid on PFI, LIFT and other service concession obligations		(14,867)	(14,761)
PDC dividend (paid) / refunded		(639)	-
Net cash flows from / (used in) financing activities		**(14,622)**	**(4,232)**
Increase / (decrease) in cash and cash equivalents		**(18,863)**	**22,804**
Cash and cash equivalents at 1 April - brought forward		**25,187**	**2,383**
Cash and cash equivalents at 31 March	20.1	**6,324**	**25,187**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. 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 GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidated as the balances are not deemed material, however, the revenue and capital grants are reflected in the accounts. Non consolidated balances as at 31 March 2022 were £1.1m.This decision is ratified by the Board on an annual basis.

Note 1.4 Revenue from contracts with customers

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Standard credit terms apply to invoiced revenue with all NHS debt due for payment within 14 days and all non NHS receivables due within 30 days of the invoice date. Invoices are not raised where revenue is recognised on performance of a contractual obligation until this has been met.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2020/21 and 2021/22 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a [Integrated Care System/Sustainability and Transformation Partnership] level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from various sources including items such as pharmacy sales and on site creche services.

Note 1.6 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 recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.The Trust following advice form the District Valuer does not separately recognise any components within the PFI property as it is the responsibility of the PFI provider to maintain all assets at condition B until the date of transfer to the Trust in 2043.

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

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, and to the extent that, 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.

De-recognition

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Lifecycle replacement costs are reviewed and charged to revenue or capital when they meet the capital definition and are then accounted for as part of the annual valuation assessment." In 2021/22 all lifecycle replacement costs were capitalised in line with the PFI model.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	57
Dwellings	1	57
Plant & machinery	5	15
Transport equipment	-	-
Information technology	5	8
Furniture & fittings	5	10

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.

Note 1.10 Intangible assets

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 to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life	**Max life**
	Years	**Years**
Software licences	5	10

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.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Cash and cash equivalents

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

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

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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.

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.

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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 component is separated from the building component and the classification for each is assessed separately.

The trust as a 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.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount;

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles 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 at note 2.4.2 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 particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	5,124
Additional lease obligations recognised for existing operating leases	(5,124)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,006)
Additional finance costs on lease liabilities	(49)
Lease rentals no longer charged to operating expenditure	1,001
Other impact on income / expenditure [If this line is material, further disclosure should be added and/or this line disaggregated]	-
Estimated impact on surplus / deficit in 2022/23	**(54)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,910**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

Financial year for which the change first applies	Standard
Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.	IFRS 14 Regulatory Deferral Accounts
Standard, as interpreted and adapted by the FReM, is to be effective from 1 April 2021.	IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.	IFRS 17 Insurance Contracts

Note 1.28 Critical judgements in applying accounting policies

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.
Assumptions have been made regarding the treatment of Lifecycle costs which have all been capitalised in year, £1.90m based on the PFI model.

External Valuation where reliance has been placed on the valuation report as at 31 March 2022, as this represents the best available evidence of current value. Further details are included in note 1.9, note 7 and note 17.

Note 1.29 Sources of estimation uncertainty
The External valuation report has bene used has been used as the basis of property valuation which is based on estimated values. There are no other assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2 Operating Segments

"No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Diagnostics & Outpatients. In addition there is a supporting corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

A detailed analysis of all income is disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income	333,841	287,267
High cost drugs income from commissioners (excluding pass-through costs)	15,475	14,588
Other NHS clinical income	-	712
Ambulance services		
A & E income	-	-
Patient transport services income	-	-
Other income	-	-
Community services		
Block contract / system envelope income	17,697	13,584
Income from other sources (e.g. local authorities)	2,834	2,457
All services		
Private patient income	96	95
Elective recovery fund	4,682	-
Additional pension contribution central funding*	10,342	9,089
Other clinical income	691	648
Total income from activities	**385,658**	**328,440**

*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
Income from patient care activities received from:	**£000**	**£000**
NHS England	26,322	26,379
Clinical commissioning groups	354,914	297,764
Department of Health and Social Care	-	-
Other NHS providers	738	712
NHS other	63	81
Local authorities	2,834	2,761
Non-NHS: private patients	96	95
Non-NHS: overseas patients (chargeable to patient)	64	39
Injury cost recovery scheme	627	609
Non NHS: other	-	-
Total income from activities	**385,658**	**328,440**
Of which:		
Related to continuing operations	385,658	328,440
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 23.76% to reflect expected rates of collection. (22.43% 2020/21)

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22	2020/21
	£000	£000
Income recognised this year	64	39
Cash payments received in-year	13	9
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	35	13

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	799	-	**799**	771	-	**771**
Education and training	12,423	501	**12,924**	11,612	380	**11,992**
Non-patient care services to other bodies	29,694		**29,694**	26,795		**26,795**
Reimbursement and top up funding	16,650		**16,650**	43,413		**43,413**
Income in respect of employee benefits accounted on a gross basis	228		**228**	229		**229**
Receipt of capital grants and donations		534	**534**		366	**366**
Charitable and other contributions to expenditure		1,904	**1,904**		7,396	**7,396**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**
Rental revenue from operating leases		690	**690**		700	**700**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income	2,692	-	**2,692**	2,470	-	**2,470**
Total other operating income	**62,486**	**3,629**	**66,115**	**85,290**	**8,842**	**94,132**
Of which:						
Related to continuing operations			66,115			94,132
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end		574
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods		-

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	2020/21
	£000	£000
Income from services designated as commissioner requested services	384,871	327,697
Income from services not designated as commissioner requested services	787	743
Total	**385,658**	**328,440**

Note 5.4 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,083	887
Purchase of healthcare from non-NHS and non-DHSC bodies	2,992	1,389
Purchase of social care	-	-
Staff and executive directors costs	293,695	263,228
Remuneration of non-executive directors	152	143
Supplies and services - clinical (excluding drugs costs)	34,672	36,007
Supplies and services - general	3,425	3,384
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	27,079	23,026
Inventories written down	-	-
Consultancy costs	187	125
Establishment	4,202	4,559
Premises	20,052	21,394
Transport (including patient travel)	456	362
Depreciation on property, plant and equipment	11,651	10,559
Amortisation on intangible assets	1,843	1,576
Net impairments	(11,737)	10,417
Movement in credit loss allowance: contract receivables / contract assets	280	675
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	(55)	86
Change in provisions discount rate(s)	-	-
Fees payable to the external auditor		
audit services- statutory audit	118	105
other auditor remuneration (external auditor only)	-	-
Internal audit costs	129	100
Clinical negligence	15,499	12,931
Legal fees	50	102
Insurance	-	-
Research and development	-	-
Education and training	1,562	1,395
Rentals under operating leases	353	403
Early retirements	104	184
Redundancy	80	68
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	22,045	22,129
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	143	60
Car parking & security	-	-
Hospitality	130	119
Losses, ex gratia & special payments	177	255
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	7,137	7,984
Total	**437,504**	**423,652**
Of which:		
Related to continuing operations	437,504	423,652
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2021/22 £000	2020/21 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	-
Total	**-**	**-**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(11,737)	10,417
Other	-	-
Total net impairments charged to operating surplus / deficit	**(11,737)**	**10,417**
Impairments charged to the revaluation reserve	(1,550)	783
Total net impairments	**(13,287)**	**11,200**

Material impairments / (reversals) charged to the SOCI resulting from changes in market price

	2021/22 £000	2020/21 £000
Reversals of impairments charged to the SOCI in previous years		
Tower 1,2,3 Kings Mill Site	(7,177)	-
Newark Site	(1,116)	-
Trust Admin Building		-
Kings Treatment Centre	(3,374)	-
FM building		-
Block 40		-
Elipse	(702)	-
Renal		-
Other	(3,808)	(19)
Impairments charged to SOCI in year		
PFI lifecycle	1867	1806
FM building	183	55
Histopathology / Mortuary	125	834
PFI Tower 1,2,3 / E.D		3571
Other	2,265	4170
	(11,737)	**10,417**

The District valuer has undertaken an on site review of the Trust estate as at 31 March 2022. This takes account of numerous factors contributing to an overall assessment of each building asset on a modern equivalent basis: these include functional and external obsolescence, investment into the property since the previous valuation and any changes of use.

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	218,926	197,025
Social security costs	23,021	20,409
Apprenticeship levy	1,102	972
Employer's contributions to NHS pensions	33,997	30,222
Pension cost - other	179	-
Temporary staff (including agency)	16,885	15,160
Total gross staff costs	**294,110**	**263,788**
Recoveries in respect of seconded staff	-	-
Total staff costs	**294,110**	**263,788**
Of which		
Costs capitalised as part of assets	231	308

Note 8.1 Retirements due to ill-health

During 2021/22 there were 2 early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £123k (0k in 2020/21).

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

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 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 2021, is based on valuation data as at 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2022 there were 7,801 members of the NHS Pension Scheme, 788 are enrolled within NEST and 4,263 are not currently contributing through a workplace pension scheme.

Note 10 Operating leases

Note 10.1 Sherwood Forest Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Sherwood Forest Hospitals NHS Foundation Trust is the lessor.

Contingent Rent described in Operating Lease revenue is a technical disclosure resulting from the IFRS disclosure requirements in respect of the PFI asset.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	690	700
Total	**690**	**700**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	500	399
- later than one year and not later than five years;	1,783	35
- later than five years.	-	7
Total	**2,283**	**441**

Note 10.2 Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sherwood Forest Hospitals NHS Foundation Trust is the lessee.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	353	403
Total	**353**	**403**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	224	309
- later than one year and not later than five years;	836	1,059
- later than five years.	46	46
Total	**1,106**	**1,414**

Future minimum sublease payments to be received

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	24	-
Total finance income	**24**	**-**

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	10	2
Main finance costs on PFI and LIFT schemes obligations	5,485	5,707
Contingent finance costs on PFI and LIFT scheme obligations	9,382	9,054
Total interest expense	**14,877**	**14,763**
Unwinding of discount on provisions	(1)	9
Total finance costs	**14,876**	**14,772**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22	2020/21
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	10	2
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	111	65
Losses on disposal of assets	(95)	(107)
Total gains / (losses) on disposal of assets	**16**	**(42)**

- -

Note 14.1 Intangible assets - 2021/22	2021/22	2020/21
	Software licences	**Software licences**
	£000	**£000**
Valuation / gross cost at 1 April 2021 - brought forward	**9,593**	**17,845**
Additions	639	3,009
Reclassifications	-	22
Disposals / derecognition	-	(11,283)
Valuation / gross cost at 31 March 2022	**10,232**	**9,593**
Amortisation at 1 April 2021 - brought forward	**2,877**	**12,574**
Provided during the year	1,843	1,576
Reclassifications	-	-
Disposals / derecognition	-	(11,273)
Amortisation at 31 March 2022	**4,720**	**2,877**
Net book value at 31 March 2022	**5,512**	
Net book value at 1 April 2021		**6,716**

Asset Lives	**Minimum life Years**	**Maximum life years**
Software Licenses	5	10

Note 15.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**17,681**	**230,701**	**2,373**	**230**	**41,763**	**20,769**	**612**	**314,129**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	4,709	194	701	7,577	5,429	-	**18,610**
Impairments	-	(4,250)	-	-	-	-	-	**(4,250)**
Reversals of impairments credited to operating expenses	975	15,012	-	-	-	-	-	**15,987**
Reversals of impairments credited to revaluation reserve	-	1,550	-	-	-	-	-	**1,550**
Revaluations	-	(5,742)	-	-	-	-	-	**(5,742)**
Reclassifications	-	230	-	(230)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,322)	(179)	-	**(1,501)**
Valuation/gross cost at 31 March 2022	**18,656**	**242,210**	**2,567**	**701**	**48,018**	**26,019**	**612**	**338,783**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**22,549**	**12,058**	**414**	**35,021**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,742	-	-	3,384	2,457	68	**11,651**
Revaluations	-	(5,742)	-	-	-	-	-	**(5,742)**
Disposals / derecognition	-	-	-	-	(1,249)	(156)	-	**(1,405)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**24,684**	**14,359**	**482**	**39,525**
Net book value at 31 March 2022	**18,656**	**242,210**	**2,567**	**701**	**23,334**	**11,660**	**130**	**299,258**
Net book value at 1 April 2021	**17,681**	**230,701**	**2,373**	**230**	**19,214**	**8,711**	**198**	**279,108**

Note 15.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**17,456**	**250,526**	**2,186**	**387**	**35,431**	**16,292**	**506**	**322,784**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2020 - restated	**17,456**	**250,526**	**2,186**	**387**	**35,431**	**16,292**	**506**	**322,784**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	8,762	187	-	7,302	4,477	106	**20,834**
Impairments	-	(11,219)	-	-	-	-	-	**(11,219)**
Reversals of impairments	-	19	-	-	-	-	-	**19**
Revaluations	225	-	-	-	-	-	-	**225**
Reclassifications	-	(17,387)	-	(157)	(22)	-	-	**(17,566)**
Disposals / derecognition	-	-	-	-	(948)	-	-	**(948)**
Valuation/gross cost at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**41,763**	**20,769**	**612**	**314,129**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**11,662**	**-**	**-**	**20,419**	**10,412**	**364**	**42,857**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2020 - restated	**-**	**11,662**	**-**	**-**	**20,419**	**10,412**	**364**	**42,857**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,882	-	-	2,981	1,646	50	**10,559**
Reclassifications	-	(17,544)	-	-	-	-	-	**(17,544)**
Disposals / derecognition	-	-	-	-	(851)	-	-	**(851)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**22,549**	**12,058**	**414**	**35,021**
Net book value at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**19,214**	**8,711**	**198**	**279,108**
Net book value at 1 April 2020	**17,456**	**238,864**	**2,186**	**387**	**15,012**	**5,880**	**142**	**279,927**

Note 15.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	18,656	11,445	-	701	21,889	-	11,657	126	**64,474**
On-SoFP PFI contracts and other service concession arrangements	-	229,639	-	-	-	-	-	-	**229,639**
Off-SoFP PFI residual interests	-	-	2,567	-	-	-	-	-	**2,567**
Owned - donated/granted	-	1,126	-	-	1,445	-	3	4	**2,578**
NBV total at 31 March 2022	**18,656**	**242,210**	**2,567**	**701**	**23,334**	**-**	**11,660**	**130**	**299,258**

Note 15.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	17,681	12,567	-	230	17,670	-	8,707	190	**57,045**
On-SoFP PFI contracts and other service concession arrangements	-	216,973	-	-	-	-	-	-	**216,973**
Off-SoFP PFI residual interests	-	-	2,373	-	-	-	-	-	**2,373**
Owned - donated/granted	-	1,161	-	-	1,544	-	4	8	**2,717**
NBV total at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**19,214**	**-**	**8,711**	**198**	**279,108**

Note 16 Donations of property, plant and equipment

The Trust received donations during the year of £873k. (2020/21 £485k). No restrictions were placed on these donations of which £535k funded the purchase of tangible capital assets.

Note 17 Revaluations of property, plant and equipment

An independent desktop revaluation was undertaken of the Trust's buildings by the District Valuer with an effective date of 31st March 2022. The review was performed by Rob Mapletoft, (MRICS), RICS registered valuer.

This walk round on site revaluation has been undertaken on the following basis:

Assets in existing use:

For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use.

Within this methodology, consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly based on the remaining useful life advised by the District Valuer. This had minimal effect on remaining lives. Modern Equivalent Asset (MEA) concept is applied: the “replacement cost” being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued.

The Trust has no assets identified as no longer in operational use and therefore ' surplus' or any assets held for sale.

The carrying value of land building and dwellings valued on an open market valuation basis at 31 March 2022 is detailed in note 15.1.

The useful economic asset lives for intangibles and plant and equipment are initially assessed when an asset is first recognised. Periodically the Trust does review these lives to identify and adjust for any assets impaired or where the useful economic life requires adjustment. This exercise was undertaken in 2019/20 for I.T assets.

The asset lives for individual buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

Note 18 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	1,888	1,442
Work In progress	-	-
Consumables	2,879	2,488
Energy	198	184
Other	-	-
Total inventories	**4,965**	**4,114**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,245k (2020/21: £32,246k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,509k of items purchased by DHSC (2020/21: £7,168k).

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

Note 19.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	10,810	16,790
Allowance for impaired contract receivables / assets	(448)	(402)
Prepayments (non-PFI)	2,350	1,684
Interest receivable	13	-
VAT receivable	1,434	1,757
Other receivables	497	483
Total current receivables	**14,656**	**20,312**
Non-current		
Contract receivables	1,164	1,324
Allowance for impaired contract receivables / assets	(1,117)	(883)
PFI lifecycle prepayments	45	49
Other receivables	400	781
Total non-current receivables	**492**	**1,271**
Of which receivable from NHS and DHSC group bodies:		
Current	7,461	12,751
Non-current	400	781

Note 19.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,285**	**-**	**966**	**-**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**1,285**	**-**	**966**	**-**
Transfers by absorption	-	-	-	-
New allowances arising	280	-	675	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	-	-	(356)	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2022	**1,565**	**-**	**1,285**	**-**

The majority of carrying debt relates to NHS organisations, therefore no significant credit risk is assumed in non impaired receivables.

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**25,187**	**2,383**
Transfers by absorption	-	-
Net change in year	(18,863)	22,804
At 31 March	**6,324**	**25,187**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	6,318	25,181
Total cash and cash equivalents as in SoFP	**6,324**	**25,187**
Total cash and cash equivalents as in SoCF	**6,324**	**25,187**

Note 20.2 Third party assets held by the trust

Sherwood Forest Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Bank balances	-	-
Monies on deposit	5	1
Total third party assets	**5**	**1**

Note 21.1 Trade and other payables

	31 March 2022	31 March 2021
	£000	£000
Current		
Trade payables	5,514	4,680
Capital payables	3,891	11,868
Accruals	17,364	19,758
Receipts in advance and payments on account	922	437
Social security costs	3,216	2,954
Other taxes payable	3,048	2,808
PDC dividend payable	40	-
Other payables	6,243	7,709
Total current trade and other payables	**40,238**	**50,214**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	4,280	2,171
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

The payables note above includes no amounts in relation to early retirements.

Note 22 Other liabilities

	31 March 2022	31 March 2021
	£000	£000
Current		
Deferred income: contract liabilities	5,582	1,853
Total other current liabilities	**5,582**	**1,853**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2022	31 March 2021
	£000	£000
Current		
Obligations under PFI, LIFT or other service concession contracts	10,151	9,957
Total current borrowings	**10,151**	**9,957**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	219,776	229,927
Total non-current borrowings	**219,776**	**229,927**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**-**	**-**	**-**	**239,884**	**239,884**
Cash movements:					
Financing cash flows - payments and receipts of principal	-	-	-	(9,957)	**(9,957)**
Financing cash flows - payments of interest	-	-	-	(5,485)	**(5,485)**
Non-cash movements:					
Application of effective interest rate	-	-	-	5,485	**5,485**
Carrying value at 31 March 2022	**-**	**-**	**-**	**229,927**	**229,927**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**234,704**	**-**	**-**	**249,628**	**484,332**
Prior period adjustment	-	-	-	-	**-**
Carrying value at 1 April 2020 - restated	**234,704**	**-**	**-**	**249,628**	**484,332**
Cash movements:					
Financing cash flows - payments and receipts of principal	(233,958)	-	-	(9,744)	**(243,702)**
Financing cash flows - payments of interest	(746)	-	-	(5,707)	**(6,453)**
Non-cash movements:					
Application of effective interest rate	-	-	-	5,707	**5,707**
Carrying value at 31 March 2021	**-**	**-**	**-**	**239,884**	**239,884**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Equal Pay (including Agenda for Change)	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**303**	**63**	**128**	**-**	**781**	**1,275**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	**-**
Arising during the year	30	-	54	-	-	**84**
Utilised during the year	(48)	(5)	(29)	-	-	**(82)**
Reversed unused	(24)	-	(48)	-	(381)	**(453)**
Unwinding of discount	(1)	-	-	-	-	**(1)**
At 31 March 2022	**260**	**58**	**105**	**-**	**400**	**823**
Expected timing of cash flows:						
- not later than one year;	44	4	105	-	-	**153**
- later than one year and not later than five years;	176	20	-	-	-	**196**
- later than five years.	40	34	-	-	400	**474**
Total	**260**	**58**	**105**	**-**	**400**	**823**

Pensions relate to liabilities for employees who retired pre 1994 for whom the Trust retains responsibility for the payments being made.

Equal Pay relates to untaken annual leave as at 31 March, which is due to employees and is being carried forward into the next financial year.

Other relates to pension tax liability where there is an offsetting accounts receivable balance held with the DoHSC.

Note 24.2 Clinical negligence liabilities

At 31 March 2022, £272,599k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2021: £143,504k).

Note 25 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(63)	(83)
Gross value of contingent liabilities	**(63)**	**(83)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(63)**	**(83)**
Net value of contingent assets	**-**	**-**

The contingent liability relates to the element of insurance excess (on Public and Employee claims) not provided for based on the current estimate of future payment.

Note 26 Contractual capital commitments

	31 March 2022	31 March 2021
Property, plant and equipment	2,700	3,494
Intangible Assets	400	800
Total	**3,100**	**4,294**

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

The Trust is currently committed to two on-statement of financial position PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the assets as if it were assets of the Trust.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA)*, to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a capital value of £1.3m. Throughout the term of the agreement there is a requirement to keep the premises clean, tidy and in good order and to keep in good and substantial repair and condition in accordance with the Operating Agreement.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional consideration.

The annual charge relating to the MAS scheme is subject to an annual inflation uplift based on RPI. The LHA schemes are a fixed charge over the life of the contract. All liquidity and associated market and financing risks for both schemes rests with Central Nottinghamshire plc and Leicester Housing Association respectively.

* Leicester Housing Association is now known as Paragon Asra Housing (PA Housing).

Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

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

	31 March 2022	31 March 2021
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**655,881**	**660,686**
Of which liabilities are due		
- not later than one year;	26,113	25,125
- later than one year and not later than five years;	104,068	100,465
- later than five years.	525,700	535,096
Finance charges allocated to future periods	(425,954)	(420,802)
Net PFI, LIFT or other service concession arrangement obligation	**229,927**	**239,884**
- not later than one year;	10,151	9,957
- later than one year and not later than five years;	37,781	38,262
- later than five years.	181,995	191,665

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2022	31 March 2021
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,513,037**	**1,481,164**
Of which payments are due:		

- not later than one year;	54,314	50,871
- later than one year and not later than five years;	235,659	217,028
- later than five years.	1,223,064	1,213,265

Note 27.3 Analysis of amounts payable to service concession operator

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

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**48,752**	**48,449**
Consisting of:		
- Interest charge	5,485	5,707
- Repayment of balance sheet obligation	9,957	9,744
- Service element and other charges to operating expenditure	22,034	22,116
- Capital lifecycle maintenance	1,894	1,828
- Revenue lifecycle maintenance	-	-
- Contingent rent	9,382	9,054
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	11	13
Total amount paid to service concession operator	**48,763**	**48,462**

Note 28 Off-SoFP PFI, LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT arrangements:

The Trust is currently committed to one 'off statement of financial position' PFI scheme relating to residential accommodation for the King's Mill site. The transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual, but the Trust does not have control. Accordingly the Trust does not recognise the scheme as an asset of the Trust.

The arrangement is with PA Association, and includes the construction of new residential accommodation and the upgrade of existing accommodation combined with a 35 year contract to manage and operate the accommodation. The Trust has guaranteed to utilise a minimum level of the overall accommodation but the majority of risks associated with operating and letting the properties have been transferred to PA Housing Association. The capital value of the scheme was £6.7m.

The annual charge is fixed over the life of the contract and the only liability to the Trust is a minimum room usage guarantee. All liquidity and associated market and financing risks rests with PA Housing Association.

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2022	31 March 2021
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**143**	**60**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	352	328
- later than one year and not later than five years;	1,517	1,394
- later than five years.	3,528	3,707
Total	**5,397**	**5,429**

Note 29 Financial instruments

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

Note 29.1 Financial risk management

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Note 29.2 Currency Risk

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

Note 29.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

Note 29.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The Trust mitigates its exposure to credit risk relating to receivables from customers through regular review of debtor balances and by calculating an expected allowance for credit losses at the end of the year. Changes have been made to funding flows at least for the period April to July 2020 as part of the COVID 19 response. These changes are not seen as an increase to credit risk as the operational expenditure and related financing is provided by the DoHSC.

Note 29.5 Liquidity Risk

The Trust’s net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust’s compliance with the ‘Use of Resources Risk Rating’ system created by NHSI, the Independent Regulator.

The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

The fair values recognised in these accounts do not differ materially from the carrying amounts.

Note 29.7 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	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	11,319	-	-	**11,319**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	6,324	-	-	**6,324**
Total at 31 March 2022	**17,643**	**-**	**-**	**17,643**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	18,093	-	-	**18,093**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	25,187	-	-	**25,187**
Total at 31 March 2021	**43,280**	**-**	**-**	**43,280**

Note 29.8 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	229,927	-	**229,927**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	33,012	-	**33,012**
Other financial liabilities	-	-	**-**
Provisions under contract	823	-	**823**
Total at 31 March 2022	**263,762**	**-**	**263,762**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	239,884	-	**239,884**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	44,011	-	**44,011**
Other financial liabilities	-	-	**-**
Provisions under contract	1,275	-	**1,275**
Total at 31 March 2021	**285,170**	**-**	**285,170**

Note 29.9 Maturity of financial liabilities

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

	31 March 2022 £000	31 March 2021 £000
In one year or less	59,278	70,411
In more than one year but not more than five years	104,264	100,676
In more than five years	526,174	535,979
Total	**689,716**	**707,066**

Note 30 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				
Cash losses	13	4	3	11
Bad debts and claims abandoned	182	40	202	19
Stores losses and damage to property	3	4	3	1
Total losses	**198**	**48**	**208**	**31**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	1
Ex-gratia payments	27	188	33	1,118
Special severance payments	-	-	2	40
Total special payments	**27**	**188**	**36**	**1,159**
Total losses and special payments	**225**	**236**	**244**	**1,190**
Compensation payments received		-		-

Note 31 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. Related parties include but are not limited to

Department of Health and Social Care ministers
The Department of Health and Social Care
Board members of the Trust
Nottingham University Hospitals NHS Trust
University Hospitals of Leicester NHS Trust
Chesterfield Royal Hospital NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Northampton General Hospital NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust
NHS Bassetlaw CCG
NHS Lincolnshire West CCG
NHS Derby and Derbyshire CCG
NHS Nottinghamshire CCG
NHS South West Lincolnshire CCG
NHS England
Health Education England
NHS Resolution
NHS Property Services
Department of Health and Social Care
HM Revenue & Customs
NHS Pension Scheme
NHS Blood and Transplant
Criminal Injuries Compensation Authority
Nottinghamshire County Council
NHS charitable funds (where not consolidated)

As of 1 July 2022 the CCG detailed above will cease and will become part of Integrated Care Boards (systems) in line with current DHSC / Government legislation.

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund. Charitable Income of £874k (2020/21 £406k) has been recognised in these accounts all of which relates to Sherwood Forest Hospitals General Charitable Fund. In addition a recharge of £56k (2020/21 £56k) has been made to Sherwood Forest Hospitals General Charitable Fund in relation to management / staff costs.

The accounts are not consolidated on the basis of materiality as approved by the Trustees subject to annual review and approval.

The Trust made no payments to related parties for whom the Chair, Non Executive or Executive Directors are named Directors.

Note 32 Prior period adjustments

Where prior period figures have been adjusted this is clearly stated in the associated note to these accounts.

Note 33 Events after the reporting date

There are no adjusting or non-adjusting events after the reporting period which affect the financial information and disclosures made in these accounts.

It should be noted as above that the main commissioners of services (CCGs) will be replaced by Integrated Care Boards as of 1 July 2022. These have been in place in shadow form for a number of years, and it is not expected to impact on operational or funding flows under current DHSC guidance.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOPSITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

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

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit and Assurance 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 and Assurance Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that income outside of the Trust's block contract funding is accounted for in the incorrect financial period and the risk that Trust management may be in a position to make inappropriate accounting entries.

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

We did not identify any additional fraud risks.

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 unusual account combinations, material post close journals and other high risk criteria.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices after year end, where applicable.
- Performing cut-off testing of income and expenditure in the period from 1 March 2022 to 30 April 2022 to determine whether amounts have been recorded in the correct period.

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

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards) and discussed with the directors 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 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 that 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 99, 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.

We have nothing to report in this respect.

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

Richard Walton
for and on behalf of KPMG LLP
Chartered Accountants
St Nicholas House
Park Row
Nottingham NG1 6FQ
United Kingdom

21 June 2022