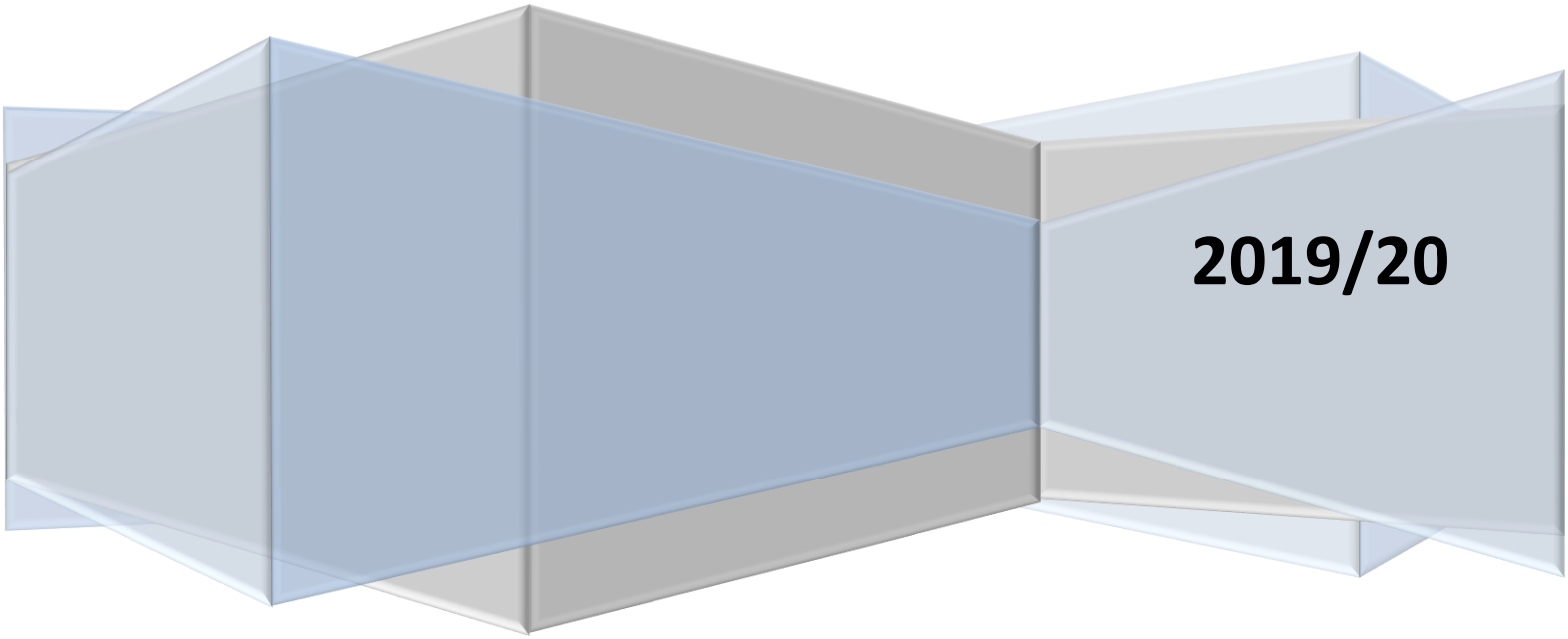
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2019/20

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2019/2020

Presented to Parliament pursuant to Schedule7, paragraph 25(4)(a) of the National Health Service Act 2006

Table of Contents

Performance Report

Statement from the Chair

The year 2019-20 came to a close in extraordinary circumstances with the Trust along with the rest of the NHS and our health and social care partners dealing with the unprecedented challenge of Covid-19. At the time of writing we are still in the midst of managing the incident, and are beginning to consider how we recover, reform and reset.

I have been hugely impressed with the way our response has been led and delivered in a calm, compassionate and well organised manner right across the Trust, and I would like to thank everyone for what they have done at a time when all of us have worries and concerns in our professional and personal lives. Although Covid-19 has dominated the end of the financial year, we should not let it overshadow the continued progress for the Trust in terms of performance, strategy and leadership across the year.

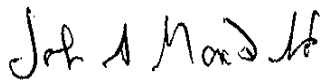
We launched our new strategy; Healthier Communities, Outstanding Care for all at the start of the financial year, and I think we have made significant strides towards the ambitions within the strategy, notably the increased focus on our place in the community, and the wellbeing of our community (including our colleagues). We will continue to closely monitor progress through Board.

In January and February we welcomed the Care Quality Commission to our King's Mill and Newark sites to carry out assessments of a number of services, and we also presented to them on our finance and leadership. It has been our intention throughout to evidence further improvement. This was confirmed by the CQC in rating the Trust as Good overall with Kings Mill Hospital being rated as Outstanding, in the published report in May 2020.

We have seen a number of changes in leadership this year, and I would like to pay tribute to the contributions of Dr Andy Haynes and Suzanne Banks in particular who both left the organisation this year and who both made huge contributions to the improvements we have made in recent years. I believe our current leadership team is in an excellent position to take us into the future.

I would like to recognise the continued support of our stable team of Non-Executive Directors, our Council of Governors who have strengthened their role further this year, and of our wonderful team of 650 volunteers who are essential to the running of our hospitals.

I would like to thank all staff and volunteers across King's Mill, Newark and Mansfield Community Hospitals for contributing to a positive year, and to all of our of partners in the community, and across the health and social care system.



John MacDonald,
Chair

Statement from the Chief Executive

This year has been another 12 months of positive progress at Sherwood Forest Hospitals NHS Foundation Trust but quite rightly our memories of 2019/20 will be dominated by the Covid-19 pandemic. Covid-19 has been an unprecedented global incident and we know we will all feel the impact of this for months to come. Our personal and working lives changed dramatically in March 2020 and I would like to thank Sherwood colleagues, volunteers, patients, the public and partner organisations across health and care for their on-going support as we work together to rebuild our services.

In April 2019, we launched our new strategy "Healthier Communities, Outstanding Care" and this placed a greater emphasis on the mental wellbeing, as well as the physical health, of our colleagues and community. Mental wellbeing and emotional support has been central to our response to Covid. We have effectively embedded our new strategy over the last 12 months and we are more closely working with health and care partners than before. We have taken the lead role in the Mid-Nottinghamshire Integrated Care Partnership and we continue to be committed to the Nottingham and Nottinghamshire Integrated Care System. A number of our Executives and other senior leaders have dual roles across the system.

In terms of our leadership we have seen further change in the last 12 months. In December 2019 we welcomed Julie Hogg, Chief Nurse, Dave Selwyn, Medical Director and Emma Challans into a new role of Director of Culture and Improvement, whilst we also now have Clare Teeney as our joint Director of People with Nottinghamshire Healthcare NHS Trust. These colleagues have made an excellent start to their Sherwood careers and I look forward to working with them over the next year.

In 2019-20, Andy Hayes, who was Medical Director moved to the Nottingham and Nottinghamshire Integrated Care System, Suzanne Banks, Chief Nurse and Julie Bacon, Director of HR retired and Peter Wozencroft, Director of Strategy and Kerry Beadling-Barron, Head of Communication and Engagement, joined the Mid Notts ICP. I would like to thank those five colleagues for their contributions to Sherwood.

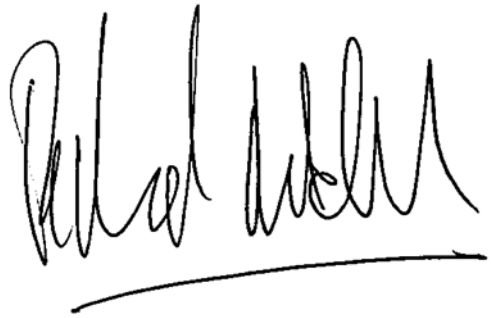
As a provider of care and an employer, we know we can do more to improve but I do think we should take note that the CQC visited us in February and March 2020 and rated Sherwood as Good Overall and Outstanding for Care. All 15 of our services have now been rated Good for Safety. King's Mill Hospital was upgraded to Outstanding Overall and is the first hospital in the East Midlands to be Outstanding and Newark was upgraded to Good Overall. Mansfield Community Hospital was not rated in 2020 so keeps its Good rating. We are proud of our three hospitals and we look forward to working with colleagues and the community to strengthen them over the coming years.

Some of the other achievements we should recognise are:

- Our staff engagement improved again and for the second year in a row we have the best staff engagement across the Midlands. We are now rated ninth in the NHS for staff engagement.
- We have made huge improvements in our speaking up agenda across the last 12 months.

- We are a research friendly Trust and we continue to recruit more patients to trials than some of the teaching hospitals in the East Midlands.
- We are committed to making further improvements but we have made positive steps to improve diversity, equality and inclusion.
- Despite increased pressure we continue to provide timely emergency care and compare well to our surrounding trusts.
- Our quality and safety metrics continue to improve, and we have not had any patients wait 52 weeks for their treatment for the last 12 months.
- We have achieved our financial control total for the fourth year running.

Thank you to everyone who has made such a positive contribution in 2019-20.



Richard Mitchell
Chief Executive

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 acute healthcare services for 420,000 people across Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. We employ in excess of 5000 people across our three hospital sites - King's Mill, Newark and Mansfield Community, and we also run some services from Ashfield Community Village. 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 setting the vision and strategy for the Trust and ensuring their effective implementation. As a Foundation Trust we have a Council of Governors, which represents the interests of both public and staff members, and which holds the Board of Directors to account.

During the past year we have continued to make significant improvements in our journey towards becoming a provider of outstanding care. We are proud the CQC has rated us as 'Good' overall and 'Outstanding' for the care we provide and we are confident we can improve further. Our staff survey results demonstrate that we have the most engaged NHS team in the Midlands, whilst our performance against NHS constitutional standards has been relatively strong.

Our purpose and activities

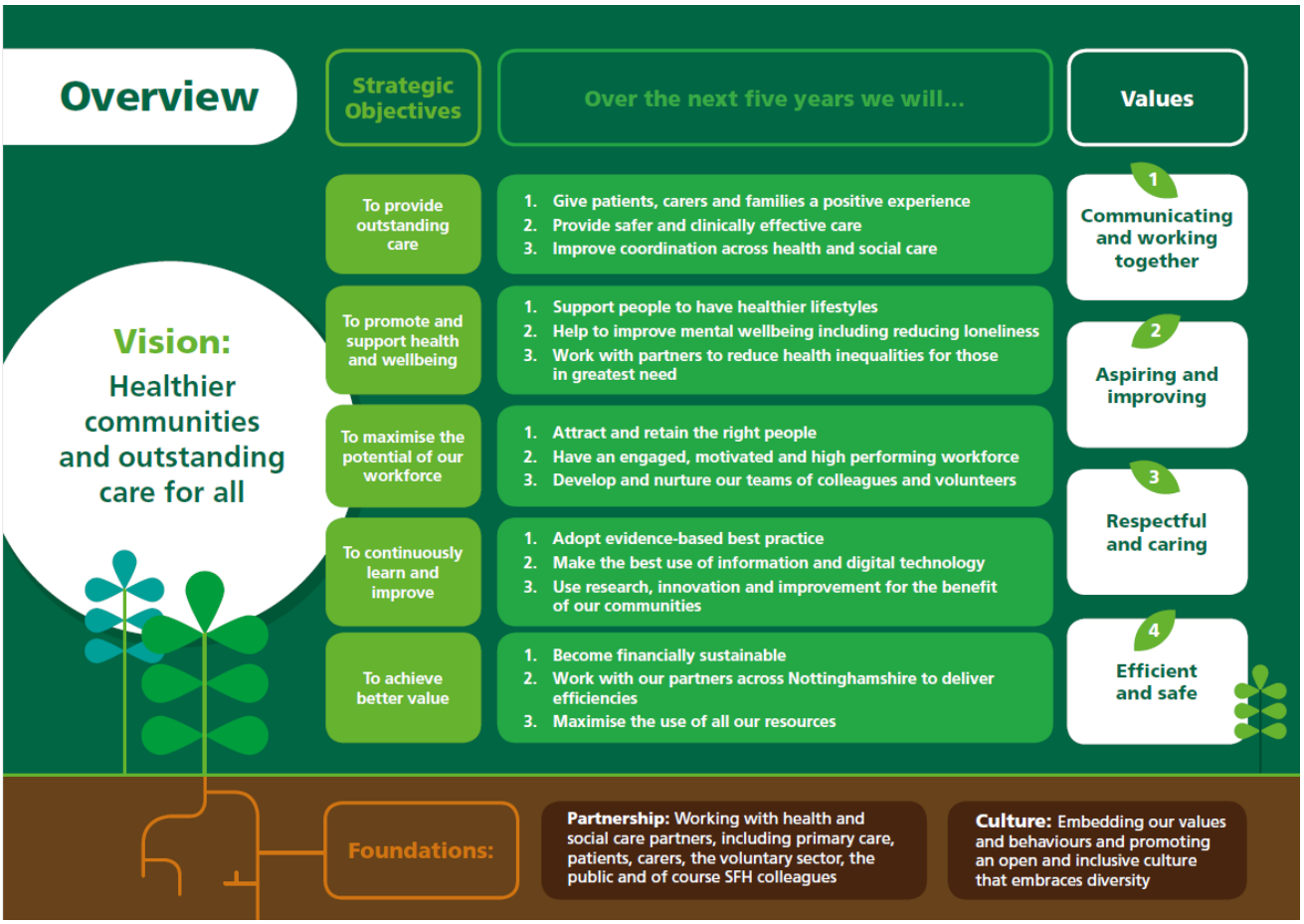
During the past year, we have made good progress in delivering our strategy, 'Healthier Communities, Outstanding Care'. For example, we have:

- Launched our 'Health Heroes' programme, equipping staff to promote health and wellbeing amongst colleagues
- Continued making progress in digitising patient health records, replacing paper-based patient assessments with electronic ones
- Reduced unnecessary patient visits to hospital, through redesigning our outpatient services
- Exceeded our target for the number of apprentices in post
- Continued to provide our street health service
- Offered funded tobacco treatment services to the majority of smokers admitted to our hospitals

In the coming year we will go further in delivering our strategy, improving access to our services through using digital technology more effectively and implementing a healthy behaviours programme. 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. Together with partners we will focus on prevention and ensuring people receive the right support in their home, in the community and in hospital.

Our vision and strategy can be summarised as follows:



Our five year strategy is shaped in the context of the NHS's ten year plan[1]. The challenges and priorities set out in the national plan are relevant to us, and yet the setting that we work in is distinct. Nottinghamshire has been chosen as one of the first areas in the country to develop what is known as an Integrated Care System (ICS). An ICS is a way to bring our local NHS, councils and the voluntary sector together to combine healthcare and other services to look after people within their homes, communities and hospitals. As an ICS we have more freedom to manage local services including deciding how we spend money on health and care.

Within the Nottinghamshire ICS, there are multiple Integrated Care Providers (ICPs), one of which covers mid-Nottinghamshire. ICPs allow providers of care to come together to plan and deliver services for a defined population, based on local needs. Working in this way enables care to be designed and coordinated to meet patients' needs, ensuring that organisational priorities are not in conflict with one another.

The mid-Nottinghamshire ICP (which covers Mansfield, Ashfield, Newark and Sherwood) consists of six Primary Care Networks (PCNs). These networks allow GP practices to come together, working with community providers, mental health services, pharmacies, social care and voluntary services. This enables PCNs to have larger and broader teams of staff, stay open for longer, provide better access to specialist services and proactively care for the population they serve. We will work closely with the six PCNs in our area, to ensure we are collectively meeting the needs of our local communities, sharing information across primary and secondary care and providing the best possible care, in the home, community and hospital.

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

We deliver an extensive range of healthcare services based both in hospital and within the community. These are tailored to meet the needs of our local population and include planned and emergency surgery, 24/7 emergency and urgent care departments, maternity care, and rehabilitation. During the past year we held over 445,792 outpatient appointments, more than 110,182 people attended our Emergency Department at King's Mill Hospital 24,761 patients were seen and treated at the Urgent Care Centre at Newark Hospital, and we delivered around 3,271 babies.

Risks to delivery of objectives

Our vision, values and strategic objectives express our ambition to see healthier communities and outstanding care for all. We are committed to the NHS Constitution and the nationally mandated standards described within. Nevertheless, as with other Trusts across the country, we have continued to experience increasing pressures over the last year and whilst our performance compares favourably with other Trusts, our ability to meet the constitutional standards has been compromised in some areas (see Performance Report for further information). We continue to endeavour to return to meeting the standards in the coming year, but the combination of demand and constrained resources present a risk to this objective.

Working in partnership as part of ICS, ICP and with PCNs is a fundamental mitigation to this risk, as is our continued focus on improving our internal working processes and practices to ensure patients receive high quality care in a timely manner.

In addition, working with our partners across mid-Nottinghamshire, we have a significant opportunity to proactively meet the needs of our local communities, through understanding health inequalities, ensuring patient experience care that is coordinated and through acting as an 'anchor institution' (i.e. an organisation that is rooted in its local community, has significant impact in terms of employment, purchase of goods and services and holds assets). In recognising the assets and impact we have, we have an opportunity to meet a broader range of needs, which cumulatively have a positive impact on people's health and wellbeing.

The Covid-19 outbreak continues to present the organisation with risks in realising its objectives, as we have to flexibly respond to different demands and requirements. Our response has included the need to temporarily change the services provided by the organisation - the potential of future peaks creates a risk to the Trust in this respect. However, the organisation has responded innovatively to changing requirements, in particular through digital technology. We have a huge opportunity to build on this in the coming year. For example, our response to Covid-19 has included the rapid deployment of digital technology to support more mobile working, remote consultations and a greater degree of flexibility in how different colleagues approach their work. There are changes that we want to keep and the accelerated adoption of new technologies is something that we have an opportunity to learn from.

Further detail with regard to 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, and 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 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 the 'Sherwood Six Step' approach to improvement. 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 accounts preparation process, the Trust's ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. In the event that a Foundation Trust is dissolved by NHS England & 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.

The close of the 2019/20 financial year and the early part of 2020/21 has been overshadowed by the Covid-19 outbreak which has had profound effects upon the operations of Health Services throughout the UK. As a consequence NHS finances have been significantly impacted at a National and local level. In relation to the Going Concern assessment, there are implications for Trust.

During this period block contract payments have been received by the Trust and the Department of Health and Social Care (DHSC) has confirmed that:

"It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this".

Recognising the heighted 'Going Concern' uncertainty generated by Covid-19, NHS England and NHS Improvement issued a joint statement on 27 May 2020 which incorporates the following paragraph, reaffirming 'continuity of service' and government funding:

In March 2020 we announced revised arrangements for NHS contracting and payment to apply for part of the 2020/21 year. In May 2020 we issued revised financial management guidance to CCGs for the corresponding period. We are not yet able to definitively announce the contracting arrangements that will be in place for the rest of 2020/21 and beyond. It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this.

Despite the block contract arrangements in place until 31 July 2020, the Trust is operating at a recurrent deficit and faces future uncertainty regarding future contracting and income arrangements.

These conditions indicate that there is a material uncertainty which may cast significant 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.

On this basis the accounts have been prepared on a going concern basis. The Board of Directors has taken steps to ensure this remains the case for the next 12 months.

Performance Analysis

Emergency Department (ED) 4-hour performance

We did not achieve the national standard of 95% of patients being admitted or discharged within 4 hours. As with the rest of the NHS, there was deterioration in performance. Relative to other NHS organisations our performance improved and the Trust was regularly ranked in the top 20 (out of 117 Trusts) within the NHS.

As across the NHS some of the deterioration is linked to increasing demand for Emergency care and the increasing complexity of patients arriving by ambulance.

Accident and emergency attendances

2019/20 saw an increase in A&E attendances overall.

Ambulance arrivals

The number of patients arriving via ambulance has increased on the previous year. 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 the growth in attendances, handover times (when measured as a percentage over 30 minutes) have improved.

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 from ED have increased this year; this has mainly been for admission to medical specialties. A lot of this growth has been managed via 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 that may be 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). Our performance in 19/20 has deteriorated due to a capacity and demand imbalance in specific specialties all of which have improvement plans in place. We have consistently delivered zero patients waiting 52+ weeks at the end of each month and; In the latter half of the year, whilst performance remains below standard we have made progress to reduce the volume of patients waiting for treatment or over-due follow up appointments.
Our plan for 20/21 is to build on our Outpatient Innovation and Theatre Productivity Programmes with commissioner and system partners to ensure that patients are appropriately referred into the right-setting first time and are optimised and receive treatment and any follow up in a timely manner.

Diagnostics – 'DMO1'

Known as 'DM01', 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. We have performed well throughout 2019/20 balancing the demands of routine diagnostic referrals with urgent and cancer activity. It is important to note that performance for the month of March 2020 was significantly impacted by the COVID 19 pandemic which led to a reduction in routine diagnostic capacity.

Cancer standards

Cancer Waiting Times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. There are seven operational standards; We know it is

better for the vast majority of patients to be seen, diagnosed and treated for cancer as soon as possible In 2019/20 we have seen an overall 5% increase in urgent referrals for suspected cancer when compared to the previous year. 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.

Stroke

The Sentinel Stroke National Audit Programme (SSNAP) is a tool used to capture and measure different parts of a patient's journey, from the moment they arrive in the Emergency Department and their admission to the stroke unit, through to rehabilitation and discharge. It consists of 10 domains, such as scanning and thrombolysis, and measures the time taken to undertake a scan and, if applicable, perform thrombolysis from the moment the patient arrives at hospital. It also considers the amount of input provided by a Multi-Disciplinary Team (MDT) which has various therapists, including those from occupational therapy, physiotherapy and speech and language, all of whom are integral to the effective rehabilitation of a stroke survivor as well as the discharge and the service improvement processes. Each domain is closely monitored by our stroke team so that areas of the pathway needing further attention can be addressed, and to maintain areas of good practice. We consistently perform well in this audit programme and are now one of the best in the country and top in the East Midlands for recognising and treating patients who have had a stroke.

Financial Analysis

We are reporting a deficit in the year of £15.93m, which demonstrates delivery of our financial plan. Our regulators, NHS England & NHS Improvement (NHSE&I) issued us with a control total for 2019/20 of a maximum deficit of (£41.52m) excluding Provider Sustainability Fund (PSF) / Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff (MRET) income. After adjusting the deficit for an impairment of £0.52m, which reflects the revaluation of our assets to the current market value, and other items not included in the control total of £0.23m, our deficit on a control total basis excluding PSF / FRF / MRET is (£41.51m), £0.01m better than required.

During the year we received £26.65m of PSF, FRF and MRET funding, which was our allocation of national funds made available to support the delivery of financial plans. This included £1.16m which was dependent on achievement of the system (Nottingham and Nottinghamshire ICS) control total, which was delivered for 2019/20. No further incentive monies were received.

We have successfully delivered a number of transformational initiatives that have improved patient care as well as reducing our costs. These Financial Improvement Plans (FIPs) delivered £12.8m of savings in 2019/20. Among the key improvements realised include: clinical productivity gains, medical and nurse agency cost reductions, and PFI maintenance savings. Plans are in place to continuously improve on our 2019/20 success and deliver further savings. Delivery will be underpinned by the same robust governance process seen in 2019/20.

NHSE&I set the Trust a Financial Improvement Trajectory (control total) for 2020/21 as a maximum deficit of (£29.3m), before Financial Recovery Fund allocations. Subsequent guidance confirmed a suspension of financial planning for 2020/21, with an interim financial framework introduced to manage the impact of Covid-19 until 31 July 2020. It is unclear how the financial framework will change after this date, or whether a revised Financial Improvement Trajectory will be set by NHSE & I. However we remain committed to meeting the financial requirements set out by NHSE & I and will look to build on the improvements that have been made to financial governance and cost control, while working with system partners to ensure alignment with system wide priorities and transformation schemes.

Income and expenditure

NHSE&I, in exercising the statutory functions conferred on Monitor, has directed that our financial statements shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Operating income

Total operating income for the year was £351.95m which represented an increase of 10.47% from the previous year (£318.6m). Income received from patient care activities was £284.20m (compared to £262.44m in 2018/19). Non-clinical income received contributes directly to the provision of healthcare services as well as our operating costs.

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.

Operating expenses

Our total operating expenses (excluding impairments) increased during the year to £349.55m from £328.42m in 2018/19, an increase of 6.43%. Employee costs rose by £16.48m, which includes the costs of the increased employer pension contribution (14.38% to 20.68%), as well as recruitment to vacant posts and national pay awards, offset by a fall in agency spend. Drugs and Clinical Supplies costs remained in line with 2018/19 with a marginal reduction driven by reduced drugs expenditure.

More than half of our operating expenditure was spent on employee costs (£222.32m (63.6%)). A total of £49.26m (14.1%) of our expenditure (excluding impairments) paid for prescription drugs, clinical supplies and services. The majority of the remaining £77.97m (22.3%) was spent on items relating to the PFI and mandatory contributions to the Clinical Negligence Scheme for Trusts.

Fixed assets

During 2019/20 we invested £10.19m in our fixed asset infrastructure, which compares with £10.8m the previous year. This comprised £3.09m invested in buildings and the estate, £2.03m in equipment, and £5.06m in IT infrastructure. Borrowing of £2.77m was required in year to support the delivery of planned expenditure.

Charitable funds

We recognised £0.02m (compared to £0.54m in 2018/19) of charitable income in the statement of comprehensive income to match the value of purchasing equivalent medical equipment from charitable funds.

The Charitable Funds' Trustees were able to make further grants of £0.4m (£0.2m in 2018/19) to enhance the welfare of patients and staff, and support our activities. Included in these figures are the generous donations received from the local community, voluntary services and local charity partners including; Leagues of Friends, for Mansfield and Sutton, and Newark.

PFI

As a result of the adoption of International Financial Reporting Standards (IFRS) in 2009/10, the PFI scheme is included within our Statement of Financial Performance (SOFP). This continues to have a significant adverse impact on the SOFP, because the associated value of the building is low in

comparison to the remaining debt outstanding. Borrowings on the SOFP associated with PFI have reduced to £249.63m (compared to £259.59m in 2018/19). Overall, the scale of the PFI liability, along with the increasing income and expenditure deficit reserve, is the reason that the total taxpayers' equity amounts to a negative £195.0m. Payments of £45.89m were made in year relating to the PFI, of which £34.47m (2018/19 £35.33m) was recognised in the Statement of Comprehensive Income (SOCI).

Cash, liquidity and financial support

Our planned deficit for the year meant we required cash borrowings from the Department of Health to meet our planned expenses. To support the income and expenditure position a number of borrowings, supported by revenue term loans of £24.86m were agreed and drawn, offset by term loan repayments of £4.17m. Interest payments of £3.28m were accounted for on this and previous borrowing. Repayments of £1.71m were made relating to existing capital borrowing, and capital borrowing of £2.77m was required in year.

Principal risks and uncertainties

We continued to strengthen our approach to risk management during the year, with the Board's Risk Committee ensuring that strategic risks have been identified, addressed and managed effectively. These include risks and opportunities within the organisation, such as those associated with treating and caring for patients, employing staff, innovation, reputation, maintenance of premises and managing finances.

Financial risks

The amended financial arrangements for the NHS for the period between 1 April 2020 and 31 July 2020 seek to support NHS organisations in the management of Covid-19. During this period support will be provided to enable all organisations to break-even and some of the financial risks that are traditionally managed by the organisation will be eased. However, it is crucial that the Trust continues to manage expenditure appropriately and that all additional costs relating to the Covid-19 response are recorded and reported appropriately.

At this time it is unclear how the financial framework will be revised beyond this period, or whether the Trust will be issued a revised Financial Improvement Trajectory for the remainder of 2020/21. It is however likely that that the Trust will face the following risks:

- A Financial Improvement Programme (FIP) target, to realise sustainable and recurrent efficiencies and remove unwarranted costs. Although the value of this requirement is unknown, it will likely include a requirement to reduce or remove additional expenditure introduced to manage the initial impact of Covid-19.

- A recovery phase, which will require the re-introduction of services which were scaled back during the initial Covid-19 response and a need to manage an increased backlog of patients.

At this time it is unknown whether this response will be required within existing financial resources.

- A key part of our Strategy is to build on the work during 2019/20 to make sure we are working with partners to make decisions across the Nottinghamshire ICS that are the best for our patients and community rather than what is best for individual organisations. In keeping with strategic objective five 'To achieve better value' we have pledged to maximise the use of resources across the system and work with partners in the development and delivery of system wide transformation plans.

Social, Community, Anti-Bribery and Human Rights

We are fully committed to the principle of equality, inclusivity and diversity for all colleagues, patients and carers. We oppose all forms of unlawful or unfair discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, political affiliation, trade union membership and social and employment status.

We accept that such an environment requires individual differences and cultural diversity to be recognised and valued. Promoting equality, embracing diversity and ensuring full inclusion for people who use our services or work at our sites is central to our vision and values. Our approach is to have an inclusive approach to supporting aspects of social, community, anti-bribery and human rights underpinned by our Equality approach. The effectiveness of policy documents are reviewed regularly ensuring feedback is obtained from users to inform future policy decisions.

Equality of opportunity, tackling discrimination and ensuring equality and diversity at the centre of our organisational culture is integral to delivery of our core values and corporate aims, and to ensuring the delivery of healthcare services which specifically meet the needs of our users. We will continue to develop and harness the skills of our diverse workforce to ensure that we are reflective of the communities we provide services for.

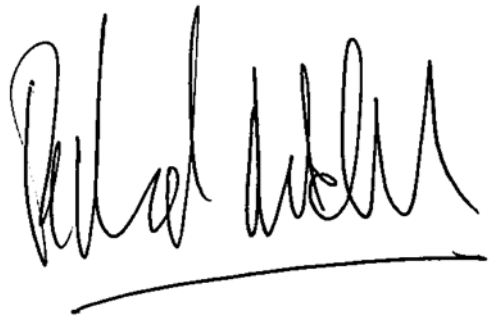
We have an Equality Strategy, which is our public commitment to equalities and human rights and provides a framework and objectives to demonstrate how we will meet the duties placed upon us by The Equality Act 2010 and how we can best ensure that we are meeting the needs of our community and staff at all levels.

We are fully committed to comply with the Bribery Act 2010 and we have a zero tolerance approach to bribery and corruption. We are committed both to providing and maintaining an absolute standard of honesty and integrity in dealing with our assets, and to the elimination of fraud and illegal acts within our organisation. We also ensure due diligence is undertaken with third party organisations whom we work with to ensure that they have high ethical standards and our reputation will not be compromised with our association with them. As recommended by NHS Protect we have policies and procedures in place at our Trust such as the Fraud, Bribery and

Corruption Policy that was ratified in 2018 which allows all staff to report any concern about potential fraud. This is reinforced by awareness training.

We have a Conflicts of Interest Policy which informs colleagues of how to declare interests in order to minimise exposure to any potential perceptions of bribery. All decision making employees are required to make a declaration including a nil declaration if they have nothing to declare. This provides transparency with regard to procurement and tendering processes.

The Human Rights Act 1998 underpins the requirements of the NHS Constitution and speaks directly to the requirements for Freedom, Respect, Equality, Dignity and Autonomy to be provided to all. We have the mandatory e-learning Equality & Diversity training which includes an introduction to Human Rights section.



Richard Mitchell
Chief Executive **22 June 2020**

Accountability Report

Directors' Report

Board of Directors

The Board of Directors is the team responsible for the management and performance of the organisations and also 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 decision on wider stakeholders including staff, suppliers 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 a Director in order to make themselves aware of any relevant audit information and to establish that 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: John MacDonald (Chair) Tim Reddish (Senior Independent Director), Claire Ward (vice Chair), Neal Gossage, Graham Ward, Barbara Brady and Manjeet Gill (all Non-Executive Directors), Richard Mitchell (Chief Executive), Dr Andrew Haynes (deputy Chief Executive to December 2019), Suzanne Banks, Paul Robinson (deputy Chief Executive from December 2019), Julie Bacon, Clare Teeney, Simon Barton, Emma Challens, Shirley Higginbotham (Company Secretary), Robin Smith, Peter Wozencroft and Kerry Bedling-Barron. Full biographies of our current directors and non-executive directors, together with their terms of office, can be found on our website.

The balance, completeness and appropriateness of our Board membership is reviewed periodically and upon any vacancies arising amongst 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 the course of 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 was the Independent Chair of the Better Together Board for Mid-Nottinghamshire until 30th April 2019. The Chair is also the Independent Chair of Joined up Care Derbyshire (STP) from 1st August 2019.

Attendance at Board meetings

	Public		**Private**	
Name	Actual	Possible	Actual	Possible
John MacDonald	11	11	12	12
Richard Mitchell	9	11	10	12
Suzanne Banks	7	8	8	9
Paul Robinson	11	11	12	12
Dr Andrew Haynes	7	8	7	9
Dr David Selwyn	3	3	3	3
Julie Hogg	3	3	3	3
Clare Teeney	6	7	6	7
Simon Barton	9	11	10	12
Shirley A Higginbotham	9	11	10	12
Julie Bacon	2	4	3	5
Emma Challens	2	3	2	3
Robin Smith	10	11	10	12
Tim Reddish	9	11	10	12
Neal Gossage	10	11	11	12
Claire Ward	8	11	8	12
Graham Ward	11	11	12	12
Barbara Brady	9	11	10	12
Manjeet Gill	8	11	9	12

Register of Interests

The Register of Interests for all members our Board is reviewed regularly and published annually on our website. The register is maintained by the Company Secretary, who is based at Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, Kings 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 2020.

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.

The payments of supplier invoices were matched in 20109/20 to the receipt of borrowing and other payments received by the Trust. This extended the average payment terms and reduced the percentage achievement with this metric. Good relationships were maintained with our suppliers throughout and this did not impact the supply of goods or services to the Trust. Compliance has returned to 86.3% and 94.5% as at May 2020.

Our performance against this metric is shown as follows:

	2019/20		2018/19	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	72,810	197,842	76,475	199,558
Total non-NHS trade invoices paid within target	26,294	156,276	64,174	186,363
Percentage of non-NHS trade invoices paid within target	36%	79%	84%	93%
Total NHS trade invoices paid in the year	2,506	24,932	2,621	26,254
Total NHS trade invoices paid within target	915	18,059	2,050	23,799
Percentage of NHS trade invoices paid within target	37%	72%	78%	91%

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 £1k in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2019/20 would be £ 189.6k. (2018/19 £81.5k) 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

In December 2018, we commissioned KPMG to undertake an external Well-Led Review of the organisation. The organisation was assessed against each of the eight questions identified in NHSI Well-led framework.

The Board reviewed the report and developed actions with regard to the recommendations made. A progress report with regard to these actions was presented to Board in July 2019. The report noted the 20 recommendations from the KPMG Well-Led report, 10 rated as Medium priority and 10 rated as Low priority, the report noted 15 of the actions were completed, three were in progress and two would remain on-going as they relate to continuous improvements with regard to Board skills and clinical chairs progression.

The Care Quality Commission inspected us during the year and assessed our overall Trust Well-Led score as Good

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* and *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 agreed our Quality Strategy for 2018/21 as the vehicle for progressing improvement work, monitoring improvement initiatives and providing evidence of achievement to our patients and staff.

Quality Strategy 2018/21 Summary

Improving the quality of care we deliver is about ensuring our care is safe, effective, patient-centred, timely, efficient and equitable. We continue to use the Quality Priorities to monitor service improvement, to demonstrate that high quality care and services are being provided and highlight areas where further improvements are required. Our Quality priorities are 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:

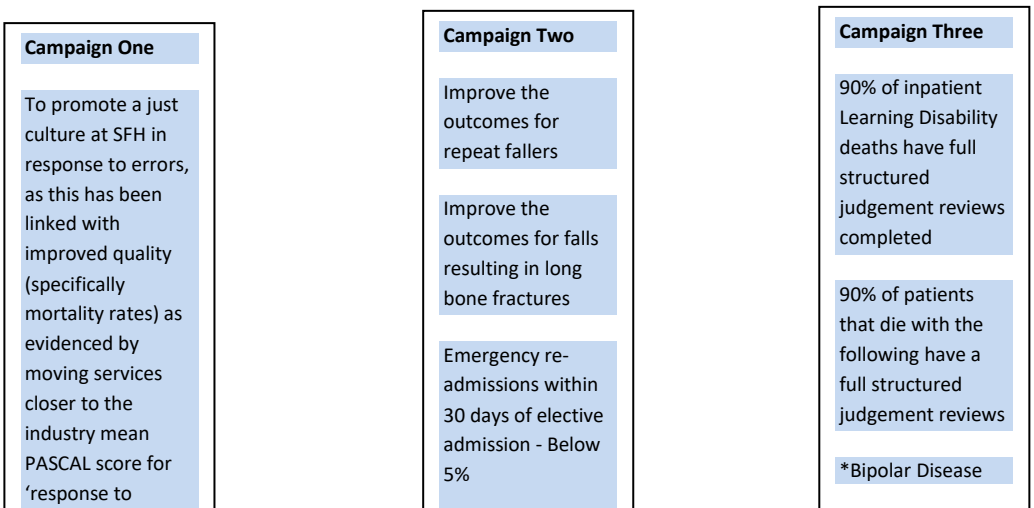
- Ensure patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

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 is monitored and reviewed each month through the Advancing Quality Oversight Group (AQOG) by the Executive Medical Director. Progress is reported to the Quality Committee and Board routinely as part of the routine cycle of business. Each Campaign is comprised of a number of specific improvement work programmes.

The AQP is an evolving dynamic programme that takes account of the changing environment and identification of new areas of improvement. There have been some additions to the programme through year two; examples of these are identified in diagram below:

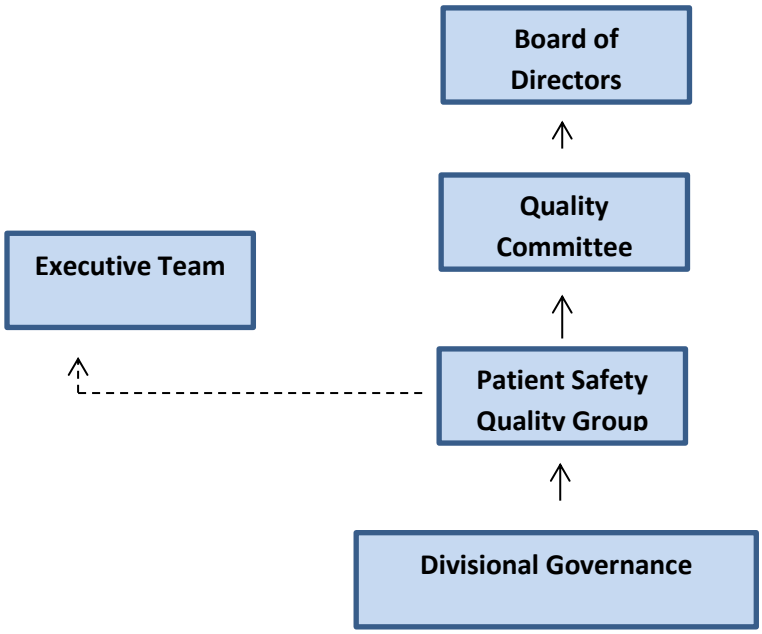


Our improvement journey is now well embedded contributing positively to the overall care we deliver. We are recognised for exemplar practice, benchmarking above the regional or national average in a significant number of indicators.

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

Improvements in Quality Governance

The governance 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 below:



PSQG 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 PSQG Annual Work Plan is aligned to that of the Quality Committee. A number of 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.

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 sub-committee and are also members of our Forum for Patient Involvement. Governors 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. They also provide 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 with the aim of improving knowledge, patient experience and health outcomes.

Members of the Patient Information Forum (PIF) have authorised the use of 'Proud to be a PIF member' badge on our website/emails/presentations etc. This badge demonstrates our commitment to ensuring the health information we deliver is of the highest possible standard. All of our leaflets are up to date, evidence based, accessible and written in plain English.

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 to users.

The patient information leaflet section on our intranet site assists staff in their production of a patient information leaflet. 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 staff.

During the past year we have explored the benefits of providing health information in a video format, with the aim of benefitting a wide range of people who find it challenging to use standard printed material. A video on bowel cancer screening has been produced so far. Future plans include the production of more videos.

Complaint Handling

We are committed to resolving any complaint or concern at the earliest opportunity. Preferably this is achieved through the patient, relative or carer discussing their concerns directly with the relevant clinical team or through the Patient Experience Team (PET). The Patient Experience Team provides confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/ward directly, or where they have done so but their concern remains unresolved.

The Patient Experience Team aim to resolve any concerns raised with them quickly and informally with the full cooperation of the department/ward involved in the care and treatment provided to the patient.

Should the patient or carer feel their concern should be formally investigated they are able to raise the issue through our formal complaint procedure. We operate a centralised complaint service, which supports a patient centred approach to the management of complaints.

All complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt. For complex complaints an alternative timescale can be agreed with the patient, relative or carer.

During 2019/20 we received 368 complaints. A total of 44 Local Resolutions Meetings took place with patients and families to listen and resolve complaints face to face. In the same reporting period we responded to 96% within the recommended 25 days. Some complaints are complex and as such a timeframe to respond will be agreed with the complainant on a case-by-case basis.

A total of 17 applications were received from the Parliamentary and Health Service Ombudsman (PHSO) during 2019/20, 12 proceeded for investigation. Of these 4 were upheld/partly upheld. PHSO currently have 8 on-going investigations at the time of writing this report

Stakeholder relations

We already work well with our partners in, having formed an Integrated Care Partnership (ICP) for our local population, in line with the vision set out in the NHS Long Term Plan and the description provided within the Performance Report. In support of this, during 2019/20 SFH has assigned a number of members of staff to specifically focus on developing the ICP. The ICP has since agreed the following vision: To create happier, healthier communities with the goal of reducing differences in healthy life expectancy by three years. This goal supports the delivery of improved healthcare as people who are happier and healthier will need less support from local services, freeing up resources for those who need extra care. The ICP's strategic objectives have been defined as:

1. To give every child the best start in life
2. To promote and encourage healthy choices, improved resilience and social connection
3. To support our population to age well and reduce the gap in life expectancy
4. To maximise opportunities to develop our built environment into healthy places
5. To tackle physical inactivity by developing our understanding of barriers and motivations

By working with our partners to focus on these areas, we are able to address the wider determinants of health and focus our resources in the areas where they are most needed.
We continue to look to maximise the opportunities afforded to us through working with others. This includes working closely with Nottingham University Hospitals (NUH) in areas that will benefit both patients and staff. This includes continuing to run NUH services on our premises, ensuring that local people have good access to services that may otherwise be unsustainable.

We are committed to improving patient experience through responding to stakeholder feedback. During 2019/20 a group has been set up by ward staff and previous stroke patients to help provide support and give hope to stroke survivors and their families

Consultation with local groups and organisations

During the course of 2019/20, we have continued to have an increased focus on our engagement with our communities and local organisations, using their feedback to help inform services.

This focus encompasses the Engagement and Involvement strategy (2018 – 2021) which aims to build a culture that actively encourages public participation and a two-way dialogue. By doing this, we will improve patient experience and make services more open to patients. We are continuing to build better relationships between us and the communities we serve, which can be demonstrated by the below.

In April 2019 we launched our new strategy; Healthier Communities and Outstanding Care for All following six months of engagement; this involved listening events leading to more than 750 conversations with the public, SFH colleagues and partners and 300+ responses to our survey. Groups engaged with included members of the Trust's Forum for Public Involvement (PFI), Healthwatch and West Notts College. The responses from the engagement phase helped form the five strategic objectives for the Trust with a particular focus on supporting health and wellbeing (specifically on mental health and wellbeing) and how colleagues and SFH contributes to the health and wellbeing of the community we serve. The introduction to our strategy comes not from a member of staff but a research patient, Roger Wyles.

We established a Forum for Public Involvement in November 2017 which has over 40 members and continues to meet monthly. It agrees the agenda and contributes to key Trust documents such as the Annual Review (the summary of the Annual Report) and the Trust strategy, and hears regularly from our Patient Experience team and HR for example. They have also helped co-design our approach on a number of themes including recently how we communicate our outpatient cancelations, and contributing to our outpatients transformation strategy.

PIF members also take part in the annual PLACE audits to ensure the environment for patients is the quality they would expect and individual members have also joined SFH groups to give a patient voice, including our Strategic Digital Group, Smokefree Committee, Medicines Safety Group and Quality Committee. They also review patient information documents to ensure they can be easily understood and have a biannual report that feeds into the Patient Safety Quality Group.

In the last 12-months the footprint of this group has expanded to reflect the entire Mid-Nottinghamshire Integrate Care Partnership (ICP) as the group recognises the importance of system working and members provide a useful link to local GP Practice PPGs. In addition to this, we are in the process of establishing a Youth Forum which will work on a similar agenda, but specifically looking at our services for young people and transitions to adult services.

As a Foundation Trust we have an active and effective Council of Governors some of whom are also members of the Forum for Public Involvement, the governors continue to hold a series of 'Meet Your Governor' events at all three of our sites engaging with service users. The outputs of these sessions are reported in themes on a monthly basis.

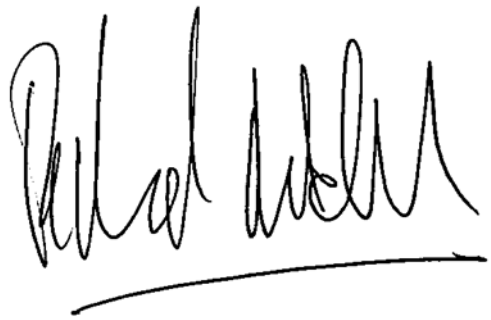
We also have a public Trust Membership of 15,000, which we communicate with through monthly e-newsletter updating members on key news and developments at SFH and invite to take part in key events such as the AGM as well as through social media. Similarly we engage with our Stakeholder Group on a monthly basis, and we ask both groups to contribute to Trust priorities, two examples this year being our new Outpatient Strategy, and our Digital Strategy which is currently being produced.

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 a governance for reporting themes or concerns for oversight and action via our Patient Safety Quality Group. We respond to all comments made via Care Opinion, and regularly share both positive and negative comments on social media, encouraging patients to let us know their feedback to help us improve.

The Trust Chief Executive, Chair and Head of Communications regularly meet with local MPs and Healthwatch representatives.

We also recognise that we are the largest employer in our area by a significant margin and that by engaging effectively with our staff (evidenced by our Staff Engagement performance amongst other measures) we are by extension also communicating effectively with our service users and community. Our increased focus on staff wellbeing is in part based on the same understanding.

For SFH colleagues there is a range of channels that are used to engage with them including both face to face and virtual staff briefings across all sites, executive walk-arounds, blogs, weekly e-newsletter, staff reference group, WhatsApp and closed Facebook group with over 2,700 members. New specific networks for BAME colleagues and LGBTQ+ colleagues have also been established with events around key dates so as Pride Month and Black History Month.



Richard Mitchell
Chief Executive Officer **22 June 2020**

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 ten times during the year and key decisions made included the disestablishment of an Executive Director of Human Resources and Organisational Development and the establishment of a Director of Culture and Service Improvement, the agreement to share a Director of People with Nottinghamshire Healthcare NHS Foundation Trust, an agreement to implement a local resolution to the Pensions and Taxation national issue, the recruitment process for the Chief Nurse and Medical Director and to amend the Terms of Reference to reflect the revised membership of the committee and to appoint a Non-Executive Director as chair of the committee with the Chair of the Trust no longer being a member of the committee.

Senior managers' remuneration policy

We must attract, develop and retain executive directors and senior managers of a high calibre in order to ensure that 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.

However, there are no contractual provisions for performance-related pay for executive directors and senior managers and, as such; no performance related payments were made relating to 2019/20.

Our approach to remuneration is modelled upon the 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 NHS Improvement's (NHSI) published pay ranges and the wider pay policies of the NHS.

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

During 2019/20 the non-executive directors dis-established the position of Executive Director of HR and OD and divided its portfolio between the newly appointed post of Director of Culture and Improvement and the Director of People, the Director of People being a shared role with Nottinghamshire Healthcare NHS Foundation Trust.

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. A lease car allowance or cash equivalent benefit was withdrawn for new appointees in 2016.

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. The newly appointed Chief Nurses relocation expenses were paid during 2019/20 these amounted to £8,000 offered as part of the contractual offer. The Trust policy is currently being amended to reflect this change in maximum payments.

	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 £8,000 are 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 2019/20 this relates to the Chief Finance Officer/Deputy Chief Executive, for his role as Chief Finance Officer of the ICS
How the component supports short 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	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

	to the delivery of the Trust's objectives. Benchmarking takes into consideration other similar medium sized acute district general hospitals to 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	£8,000	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	Individual	N/A	N/A	N/A	N/A	N/A

measures	objectives agreed as part of appraisal process					
Performance Period	Annual Appraisal	N/A	N/A	N/A	N/A	N/A
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 for the CEO and CFO	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.

With effect from 1 April 2019, the committee approved four executive directors to receive a consolidated increase of 1.32% plus a one off non-consolidated cash lump sum of 0.77%. In addition, it also approved a 2.09% non-consolidated cash lump sum for one executive director.

This was in accordance with the NHS Improvement (NHSI) letter to all NHS Trusts and NHS Foundation Trusts on 31st January 2020, in which it recommended to pay a consolidated increase of 1.32% payable from 1st April 2019, plus a one-off non-consolidated cash lump sum of 0.77%. This is commensurate with the percentage increase paid to those at the top pay point of AfC pay band 9 for 2019/20. The award was payable to all Very Senior Managers (VSM) in the Trust who were below the upper quartile pay threshold for their role. Where a VSM is above the upper quartile for their role then NHSI recommended the entire award be paid as a one-off non-consolidated cash lump sum.

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 the NHS Improvement's (NHSI) published pay ranges.

The Remuneration Committee also seeks approval from HM Treasury, NHS Improvement, 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 are able to serve two concurrent terms (no more than six years), dependent on formal assessment and confirmation of satisfactory on-going performance. Non-executive directors are able to apply for a third term if the Council of Governors are in agreement.

Their remuneration framework, as agreed previously by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2019/20 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 2019/20. New guidance with regard to aligning the remuneration of Non-Executive Directors for NHS Foundation Trusts and NHS Trusts was considered and adopted by the Committee during the year. Committee agreed this had no immediate impact on the remuneration of the Non-Executive Directors and will be considered as part of the recruitment process in future.

None of the Non-Executive Directors are employees of SFH; they receive no benefits or entitlements other than fees and expenses incurred whilst 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.

We do 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 both 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 with regard to 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 SFH, 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 2018/19.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

We do not consult with employees when setting our senior manager remuneration policy. However, the pay and conditions of other SFH employees were taken into account. The increase paid to VSM staff was commensurate with the percentage increase paid to those at the top pay point of AfC pay band 9 for 2019/20.

This therefore mirrored the Agenda for Change: National NHS terms pay award that was received by other employees of SFH and the NHS in general with effect from 1 April 2019. All other national NHS terms are mirrored for SFH 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

Service Contracts

Senior managers service contracts do not contain any obligation on the trust

Name	Title	Start Date	Expiry	Notice Period
Richard Mitchell	Chief Executive	01.07.2017		6 months
Dr Andrew Haynes	Executive Medical Director	01.07.2014	08.12.2019	6 months
Suzanne Banks	Chief Nurse	06.02.2017	31.12.2019	3 months
Paul Robinson	Chief Finance Officer	23.03.2015		6 months
Simon Barton	Chief Operating Officer	01.01.2018		3 months
Julie Bacon	Executive Director HR & OD	01.12.2016	31.12.2019	3 months
Peter Wozencroft	Director of Strategy and Improvement	02.12.2013		6 months
Shirley A Higginbotham	Director of Corporate Affairs	04.04.2013		3 months
Kerry Beadling-Barron	Head of Communications	03.07.2017		3 months
Robin Smith	Interim Head of Communications	05.06.2017		3 months
Clare Teeney*	Director of People	02.09.2019		3 months
Emma Challans	Director of Culture & Improvement	09.12.2019		6 months
Julie Hogg	Chief Nurse	09.12.2019		6 months
David Selwyn	Medical Director	09.12.2019		6 months

*Joint appointment with Nottinghamshire Healthcare NHS Foundation Trust, Seconded to Sherwood Forest NHS Foundation Trust

Non-Executive Directors' remuneration

Name	Title	Start Date	Expiry	Notice Period
John MacDonald	Non-Executive Director (Chair)	01.03.2017	31.07.2022	1 month
Claire Ward	Non-Executive Director	01.05.2013	30.04.2020	1 month
Tim Reddish	Non-Executive Director	08.07.2013	31.10.2020	1 month
Neal Gossage	Non-Executive Director	10.05.2015	10.05.2020	1 month
Graham Ward	Non-Executive Director	01.12.2015	30.11.2020	1 month
Barbara Brady	Non-Executive Director	01.10.2018	30.09.2021	1 month
Manjeet Gill	Non-Executive Director	01.11.2018	31.10.2021	1 month

Major decisions on senior managers' remuneration

The remuneration of senior managers was reviewed in 2019/20 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.

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 and 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 Terms of Reference for the committee were reviewed during the year and the membership was revised, to establish four Non-Executive Directors as permanent members of the committee and the Vice Chair of the Trust to Chair of the Committee, the Chair of the Trust is no longer a member of the committee, this is to strengthen the independence of the committee. Two Non-Executive Directors attended meetings after the changes were made to ensure quoracy in the absence of permanent members.

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

Name	**Meetings attended out of possible total**
John MacDonald (Chair)	1/1
Tim Reddish (Senior Independent Director)	3/3 (attended to ensure quoracy)
Graham Ward	2/2 (attended to ensure quoracy)
Neal Gossage	7/10
Claire Ward (Chair of Committee from July 2019)	8/10
Barbara Brady	8/10
Manjeet Gill	9/10

The committee also invited the assistance of our Chief Executive (Richard Mitchell), Executive Director of Human Resources and OD (Julie Bacon), and the Company Secretary (Shirley A Higginbotham), Clare Teeney (Director of People) and Korn Ferry to undertake an Independent

Review of Executive Salaries. 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 and its membership comprises of the Chair, 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 with regard to 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 four times:

Name	**Meetings attended out of possible total**
John MacDonald (Chair)	4/4
Sue Holmes (Lead Governor)	4/4
Martin Stott (Public Governor)	3/4
Roz Norman (Staff Governor)	4/4
Lawerance Abrams (Public Governor)	4/4
Philip Marsh (Public Governor)	4/4
Michael Brown (Appointed Governor)	1/4

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

The committee successfully recommended the re-appointment of the Chair and Non-Executive Directors who had reached the end of their tenure, and also successfully recommend the revised process for the appraisal of the Chair and the guidance from NHSi with regard to new rules with regard to the remuneration of the Chair and the Non-Executive Directors

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 19 (excluding Peter Wozencroft and Kerry Beadling-Barron who have been seconded all year) and the total number of Governors serving on our Council of Governors totalled 38 during the year, due to the election taking place in April 2019 and newly appointed governors due to local government elections. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		**Total paid 2019/20 £'00**	**Total paid 2018/19 £'00**
John MacDonald	Chair	36.96	33.6
Ray Dawson	Non-executive director	N/A	1.2
Claire Ward	Non-executive director	0	1.9

Tim Reddish	Non-executive director	3.22	4.3
Neal Gossage	Non-executive director	14.98	10.7
Graham Ward	Non-executive director	0	1.8
Barbara Brady	Non-executive director	11.1	10.7
Manjeet Gill	Non –Executive director	0	No Claim
Richard Mitchell	Chief Executive	36.87	2.0
Suzanne Banks	Chief Nurse	3.04	3.7
Julie Hogg	Chief Nurse	0	
Julie Bacon	Executive Director of HR & OD	2.88	2.6
Clare Teeney	Director of People	0	N/A
Emma Challens	Director of Culture and Service Improvement	0	N/A
Peter Wozencroft	Director of Strategic Planning and Commercial Development	11.46	15.1
Roz Howie	Chief Operating Officer	NA	7.5
Simon Barton	Chief Operating Officer	5.71	No Claim
Dr Andrew Haynes	Executive Medical Director	0	No Claim
Dr David Selwyn	Executive Medical Director	0	
Paul Robinson	Chief Financial Officer/Deputy CEO	12.39	8.3
Shirley Higginbotham	Director of Corporate Affairs	4.43	2.2
Kerry Beadling-Barron	Head of Communications	0	2.7
Robin Smith	Head of Communications	0	
	TOTAL	**143.04**	**127.5**

Governors	**Constituency**	**Area**	**Total 2019/20 £'00**	**Total 2018/19 £'00**
Amanda Sullivan	Appointed Governor	NHS Newark & Sherwood and Mansfield & Ashfield CCG	No claim	No claim
Angie Emmott	Staff Governor	Newark Hospital	No claim	0.3
Ann Mackie	Public Governor	Newark & Sherwood	6.1	4.1
David Payne	Appointed Governor	Newark & Sherwood District Council	No claim	No claim
Dilip Malkan	Staff Governor	King's Mill & Mansfield	No claim	No claim
Morgan Thanigasalam	Staff Governor	King's Mill & Mansfield	No claim	0.1

Ian Holden	Public Governor	Newark & Sherwood	No claim	No claim
Jackie Hewlett-Davies	Public Governor	Ashfield	No claim	No claim
Jane Stubbings	Public Governor	Ashfield	0.8	1.2
Jayne Leverton	Public Governor	Ashfield	No claim	No claim
Jim Barrie	Public Governor	Newark & Sherwood	No claim	No claim
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	No claim
John Wood	Public Governor	Mansfield	No claim	No claim
Keith Wallace	Public Governor	Mansfield	No claim	No claim
Kevin Stewart	Public Governor	Ashfield	3.5	N/A
Louise Knott	Appointed Governor	Vision West Notts	No claim	No claim
Martin Stott	Public Governor	Newark & Sherwood	1.8	2.3
Nick Walkland	Public Governor	Rest of East Midlands	No claim	1.6
Ron Tansley	Volunteer Governor	King's Mill & Mansfield	No claim	No claim
Roz Norman	Staff Governor	King's Mill & Mansfield	No claim	No claim
Susan Holmes	Public Governor	Ashfield	0.1	0.7
Valerie Bacon	Public Governor	Derbyshire	3.3	1.4
Belinda Salt	Public Governor	Mansfield	No Claim	N/A
Ben Clarke	Staff Governor	King's Mill & Mansfield	No Claim	N/A
Brian Bacon	Public Governor	Derbyshire	2.8	N/A
Craig Whitby	Appointed Governor	Mansfield District Council	No Claim	N/A
David Walters	Appointed Governor	Ashfield District Council	No Claim	N/A
Dean Whelan	Public Governor	Mansfield	No Claim	N/A
Gerald Smith	Public Governor	Mansfield	1.4	N/A
Jacqueline Lee	Staff Governor	Newark	No Claim	N/A
Jayne Revill	Staff Governor	King's Mill & Mansfield	No Claim	N/A
Lawrence Abrams	Public Governor	Rest of East Midlands	9.8	N/A
Michael Brown	Appointed Governor	Newark & Sherwood District Council	No Claim	N/A
Nikki Slack	Appointed Governor	West Notts College	1.4	N/A
Philip Marsh	Public Governor	Ashfield	No Claim	N/A
Richard Boot	Staff Governor	Newark	No Claim	N/A
Richard Shillito	Public Governor	Newark & Sherwood	4.1	N/A

Steve Vickers	Appointed Governor	Nottinghamshire County Council	No Claim	N/A
TOTAL			**3.55**	**11.7**

Annual Report on Remuneration (subject to audit)

Senior Managers Disclosure

	2019/20						2018/19					
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	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)	190 - 195	3,700	0	0	42.5 - 45	240 - 245	170 - 175	2,100	0	0	42.5 - 45	215 - 220
Mr P Robinson (Chief Financial Officer) (2)	135 - 140	1,200	0	0	0	135 - 140	150 - 155	800	0	0	0	150 - 155
Ms S Banks (Chief Nurse) (3)	95 - 100	300	0	0	0	95 - 100	125 - 130	400	0	0	0	125 - 130
Ms J Hogg (Chief Nurse) (4)	45 - 50	0	0	0	7.5 - 10	55 - 60	N/A	N/A	N/A	N/A	N/A	N/A
Dr A Haynes (Executive Medical Director) (5)	105 - 110	0	0	0	0	105 - 110	180 - 185	0	0	0	0	180 - 185
Dr D Selwyn (Executive Medical Director) (6)	60 - 65	0	0	0	37.5 - 40	100 - 105	N/A	N/A	N/A	N/A	N/A	N/A
Ms J Bacon (Executive Director of Human Resources and Organisational Development) (7)	140 - 145	300	0	0	0	140 - 145	110 - 115	300	0	0	0	110 - 115
Mr S Barton (Chief Operating Officer)	125 - 130	600	0	0	32.5 - 35	160 - 165	120 - 125	0	0	0	87.5 - 90	210 - 215
Non voting members												
Ms S Higginbotham (Director of Corporate Affairs)	110 - 115	400	0	0	32.5 - 35	145 - 150	100 - 105	200	0	0	40 - 42.5	145 - 150
Mr P Wozencroft (Director of Strategic Planning and Commercial Development) (8)	5 - 10	1,100	0	0	2.5 - 5	10 - 15	110 - 115	1,500	0	0	15 - 17.5	130 - 135
Ms C Teeney (Director of People (HR) (9)	15 - 20	0	0	0	17.5 - 20	35 - 40	N/A	N/A	N/A	N/A	N/A	N/A
Ms E Challans (Director of Culture and Improvement) (10)	35 - 40	0	0	0	0	35 - 40	N/A	N/A	N/A	N/A	N/A	N/A
Mr R Smith Acting Head of Communications) (11)	65 - 70	0	0	0	17.5 - 20	85 - 90	N/A	N/A	N/A	N/A	N/A	N/A
Ms Kerry Beadling-Barron (12)	5 - 10	0	0	0	0 - 2.5	5 - 10	70 - 75	300	0	0	20 - 22.5	90 - 95
Mr P Moore (13)	N/A	N/A	N/A	N/A	N/A	N/A	25 - 30	0	0	0	62.5 - 65	90 - 95
Ms B Brady (14)	N/A	N/A	N/A	N/A	N/A	N/A	5 - 10	400	0	0	0	5 - 10
Non-Executive Directors												
Mr J MacDonald (Chair)	50 - 55	3,700	0	0	0	50 - 55	50 - 55	3,400	0	0	0	50 - 55
Mr T Reddish	10 - 15	300	0	0	0	15 - 20	15 - 20	400	0	0	0	15 - 20
Ms C Ward	10 - 15	0	0	0	0	10 - 15	10 - 15	200	0	0	0	10 - 15
Mr G Ward	15 - 20	0	0	0	0	15 - 20	10 - 15	200	0	0	0	10 - 15
Mr N Gossage	15 - 20	1,500	0	0	0	15 - 20	15 - 20	1,100	0	0	0	15 - 20
Ms B Brady	10 - 15	1,100	0	0	0	10 - 15	5 - 10	700	0	0	0	5 - 10
Ms M Gill	10 - 15	100	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10

Notes (2019/20)

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 S Banks Retired 31st Dec 2019.
4 - Ms J Hogg appointed Chief Nurse 9th Dec 2019 (incl. Relocation Allowance).
5 - Dr A Haynes seconded to Nottinghamshire ICS from 24th Jun to 1st Oct (2.5-3 Days) & Full time from 1st Oct to 8th Dec when Appointed to Nottinghamshire ICS (Executive Medical Director) .
6 - Dr D Selwyn Appointed Medical Director 9th December 2019.
7 - Mr P Wozencroft assigned to work for Nottinghamshire ICS from 1st May 2019.
8 - Ms J Bacon Retired 31st Dec 2019 (incl. Arrears & Lieu of notice).
9 - 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
10 - Ms E Challans appointed Director of Culture and Improvement 9th Dec 2019.
11 - Mr R Smith, Non Voting Director, Acting Head of Communications 1st May 2019.
12 - Ms K Beadling-Baron assigned to work for Nottinghamshire ICS from 1st May 2019.
13 - Mr P Moore (Director of Governance) left 8th Jul 2018.
14 - Ms M Brady became non-executive Director on 13th Sep 2018.

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. In 2018/19 Pensions-related benefit was disclosed for the full year for all senior managers, regardless of their period of time in post.

Notes (2018/19)

1 - Pension increase is due to the effect of part year appointment in 2017/18 - it is a notional calculation of the pension entitlement to retirement age as defined in the NHS Business Services Authority disclosure instructions.
2 - Ms B Brady Became non-Executive Director on 13 September 2018.
3 - Ms R Howie (Chief Operating Officer).
Appointed 1 October 2016 - left post 3 September 2017 - Seconded to Nottingham City CCG, terminated with SFH 2 September 2018
All staff costs noted above exclude non-recoverable VAT where charged.
Expenses relate to travel/subsistence claims which may be taxable dependent on value/type.
Pensions-related benefit is disclosed for the full year for all senior managers, regardless of their period of time in post.

It should be noted that for the pay table above and the pension table below'

- that benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud judgment.
- that CETV values at 31 March 2019 and 31 March 2020 may have been calculated using different methodologies (due to the introduction of GMP indexation also known as GMP equalisation), and to highlight that this change may have impacted the real increase in CETV figure.
-

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 2019-20 was £205,000 - £210,000 (2018-19, £180,000 - £185,000). This was 8.51 times

(2018-19, 7.43 times) the median remuneration of the workforce, which was £24,214 (2018-19, £24,214). In 2019-20, no employees (2018-19, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £7,626 to £206,000 (2018-19, £7,234 to £180,000).

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.

During 2019/20 there were some changes in personnel amongst the Board of Directors. The recruitment of replacement directors has led to a change in the highest paid director, which has caused an increase in the ratio to the median remuneration of the organisations workforce

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.

There were no agency Board members as at 31 March 2020.

Pension disclosure

2019/20

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 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
Executive Directors	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mr R Mitchell *	2.5 - 5	-2.5 - 0	35 - 40	70 - 75	464	17	516	0
Ms S Banks	-7.5 - -5	83 - 85	40 - 45	260 - 265	1071	0	0	0
Ms J Hogg *	0 - 2.5	-2.5 - 0	5 - 10	5 - 10	55	5	76	0
Dr A Haynes	0 - 2.5	0 - 2.5	80 - 85	245 - 250	1959	0	0	0
Mr S Barton *	2.5 - 5	0 - 2.5	30 - 35	60 - 65	462	23	514	0
Dr D Selwyn	0 - 2.5	5 - 7.5	65 - 70	195 - 200	1378	52	1602	0
Ms S Higginbotham (nee Clarke) *	0 - 2.5	0	20 - 25	0	269	27	318	0
Mr P Wozencroft *	0 - 2.5	0 - 2.5	40 - 45	95 - 100	757	3	824	0
Ms C Teeney *	0 - 2.5	0	50 - 55	0	608	9	711	0
Mr R Smith	0 - 2.5	0	0 - 5	0	13	5	26	0
Ms K Beadling-Barron *	0 - 2.5	0 - 2.5	10 - 15	20 - 25	169	1	194	0

2018/19

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
Executive Directors	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mr R Mitchell *	2.5 - 5	0 - 2.5	35 - 40	65 - 70	354	99	464	0
Ms S Banks	0 - 2.5	0 - 2.5	45 - 50	145 - 150	934	90	1071	0
Ms J Hogg *	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr A Haynes	-2.5 - 0	-2.5 - 0	75 - 80	235 - 240	1750	131	1959	0
Mr S Barton *	2.5 - 5	7.5 - 10	25 - 30	60 - 65	327	107	462	0
Dr D Selwyn	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mr P Wozencroft *	0 - 2.5	-2.5 - 0	35 - 40	90 - 95	642	80	757	0
Ms S Higginbotham (nee Clarke) *	2.5 - 5	0	15 - 20	0	196	53	269	0
Ms C Teeney *	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mr R Smith	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ms K Beadling-Barron *	0 - 2.5	0 - 2.5	10 - 15	20 - 25	126	31	169	0
Mr P Moore *	0 - 2.5	0 - 2.5	35 - 40	95 - 100	547	29	686	0

Notes

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

Payments for loss of office

No payments for loss of office were made during 2019/20.

Payments to past senior managers

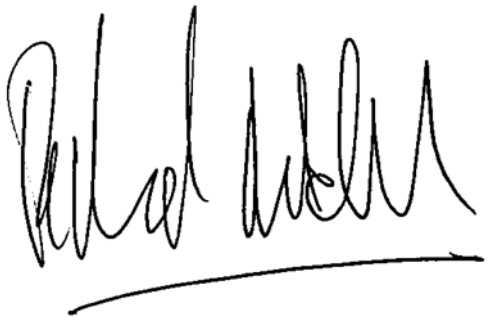
No payments to past senior managers were made during 2019/20, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

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 Director's fees.



Richard Mitchell
Chief Executive

22 June 2020

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 2019 to 31 March 2020 are:

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

Average monthly number of persons employed				
		2019/20		2018/19
	Total	Permanent	Other	Total
Medical and dental	**603**	525	78	**548**
Ambulance	**3**	3	0	**0**
Administration and estates	**1,064**	1,063	1	**1,022**
Healthcare assistants and other support staff	**975**	975	0	**938**
Nursing, midwifery and health visiting staff	**1,262**	1,176	86	**1,236**
Nursing, midwifery and health visiting learners	**0**	0	0	**0**
Scientific, therapeutic and technical staff	**378**	366	12	**388**
Healthcare science staff	**119**	119	0	**113**
Other	**8**	8	0	**8**
Total average numbers	**4,412**	**4,235**	**177**	**4,253**
Of which:				
Number of employees (WTE) engaged on capital projects	**1**	1		**1**

While only 1 full time member of staff is employed to permanently manage capital, other staff costs have been incurred and capitalised relating to specific 2019/20 capital projects.

The permanent WTE's numbers disclosed are based on the average number of montly 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 as at 31 March 2020)

	Male	Female	Total
Director	9	6	15
Other Senior Manager	75	133	208
Employee	867	3984	4851
Grand Total	951	4123	5074

Staff Costs- Subject to audit

Staff Costs				
	Total	Permanent	Other	Total
	31 Mar 2020	31 Mar 2020	31 Mar 2019	31 Mar 2019
	2019/20	2019/20	2018/19	2018/19
Salaries and wages	164,902	164,902	0	156,410
Social security costs	16,978	16,978	0	16,497
Apprenticeship levy	850	850	0	809
Pension cost - employer contributions to NHS pension scheme	19,256	19,256	0	18,133
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	8,337	8,337	0	0
Pension cost - other*	0	0	0	0
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	34	34	0	99
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	12,842	0	12,842	14,272
TOTAL GROSS STAFF COSTS	**223,199**	**210,357**	**12,842**	**206,220**
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	**223,199**	**210,357**	**12,842**	**206,220**
Included within:				
Costs capitalised as part of assets	427	427	0	317

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 2019/20

The Trust recognises the importance of ensuring the health, safety and well-being of all Trust employees as enshrined within 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 a wide range of 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. An additional two days per week have been allocated to appoint a staff side officer for health and safety to complete joint workplace safety audits with managers to ensure the working environment remains in a safe condition.

The Health and Safety Committee 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 Committee also works closely with the Health and Wellbeing group, the Estates Governance Group and the Infection Prevention Committee to ensure that the full range health and safety related risks are properly identified and suitable and sufficient controls are put in place.

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 2019/20 The Trust reported 15 staff injuries and zero patient injuries under the reporting requirements of RIDDOR. Some 4,836 people were employed by the Trust during the year and the rate of RIDDOR reportable non-fatal injury per 100,000 employees was 310 against a reported latest national average rate for the human health activities sector of 369 non-fatal injuries per 100,000 employees.

In line with both local and national health and safety priorities the work plan for the coming year will focus on the prevention of ill health, with a focus on work related musculoskeletal disorders, work-related stress 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 staff member 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 the '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,
- Asking employees with a disability at least once a year what can be done to make sure they can develop and use their abilities at work, usually asked as part of the appraisal process

- 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 Mindful Employer. This Charter 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 h

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
40	**33.48**

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%	**22**
1-50%	**15**
51%-99%	**2**
100%	**1**

Table 3: Percentage of pay bill spent on facility time

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

First Column	Figures
Provide the total cost of facility time	86,479.18
Provide the total pay bill	222,323,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.039%

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	4.3%

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. No consultancy has been used for Executive level appointments. We spent £0.41m on consultancy during the year, (2018/19 £0.43m).

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 2020, for more than *£245* per day and that last for longer than six months

Number of existing engagements as of 31 March 2020	0
Of which...	
No. that have existed for less than one year at time of reporting	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 2019 and 31 March 2020, 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 2019 and 31 March 2020	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 2019 and 31 March 2020

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.

These appointments 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 on the basis of 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)

Exit Packages

	2019/20			2018/19		
	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	9	9	0	1	1
£10,001 - £25,0000	1	3	4	1	2	3
£25,001 - £50,000	2	0	2	0	1	1
£50,001 - £100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	4	12	16	1	4	5
Total resource used	155	83	238	24	79	103

	2019/20		2018/19	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	0	0	0	0
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	11	73	3	38
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval	1	10	2	65
Total	12	83	5	103
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

2019 National NHS Staff Survey

Approach to staff engagement

In 2017 the Trust launched its Maximising our Potential (MoP) workforce strategy which brought previous HR, training and education, well-being, engagement and organisational development strategies under one integrated strategy. This strategy was designed to develop and improve our organisational culture and enabling our people to deliver outstanding healthcare through empowering them with the knowledge, skills and tools to improve our culture and make a difference. It supports the Trust strategic objective of Maximising the Potential of our Workforce.

A key to the success of this strategy is the alignment to our Trust strategic objectives and the strong interactions and relationships between HR and Training, OD, Freedom to Speak Up mechanisms, and our well-being services

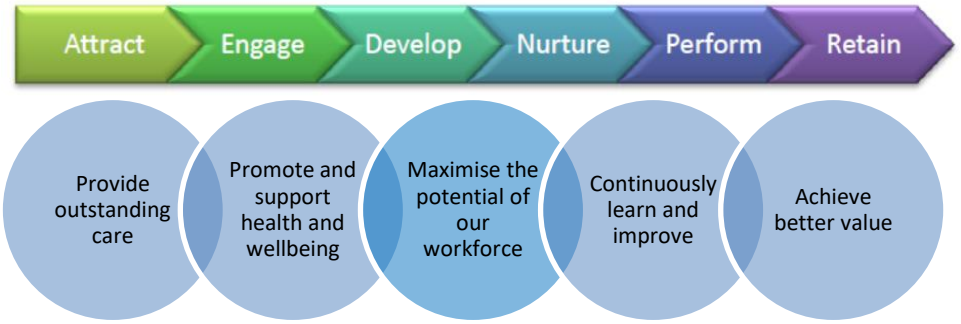


Fig 1. Maximising our Potential approach

Each year the MoP action plan is refreshed and has specifically focused on improving themes from our annual staff survey and Friends and Family (FFT) tests. Evidence from our staff surveys, Staff Friends and Family Test, Freedom to Speak Up Guardian and HR workforce data indicates that many of our HR and OD initiatives have contributed to improving our culture

The CEO leads a monthly Team Brief at each of the hospital sites for all staff to attend and then the presentation is then made available on the Trust Intranet for all staff to access. The CEOs weekly blog is well received by staff as a means of receiving regular updates along with a weekly organisational update through the Trust bulletin.

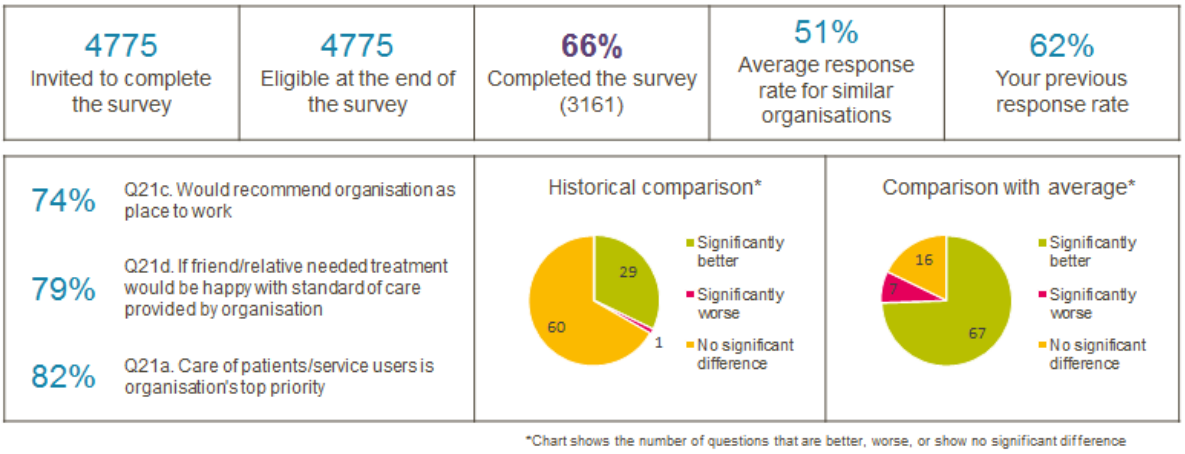
This year has seen the introduction of several organisational engagement initiatives such as Kindness Trolleys, engagement walls, Civility Saves Lives master classes, high performing and inclusive teams toolbox talks, #Bekind and 18 bespoke organisational development team interventions.

SFH Today – our culture and improvements supported by our MoP Strategy include:

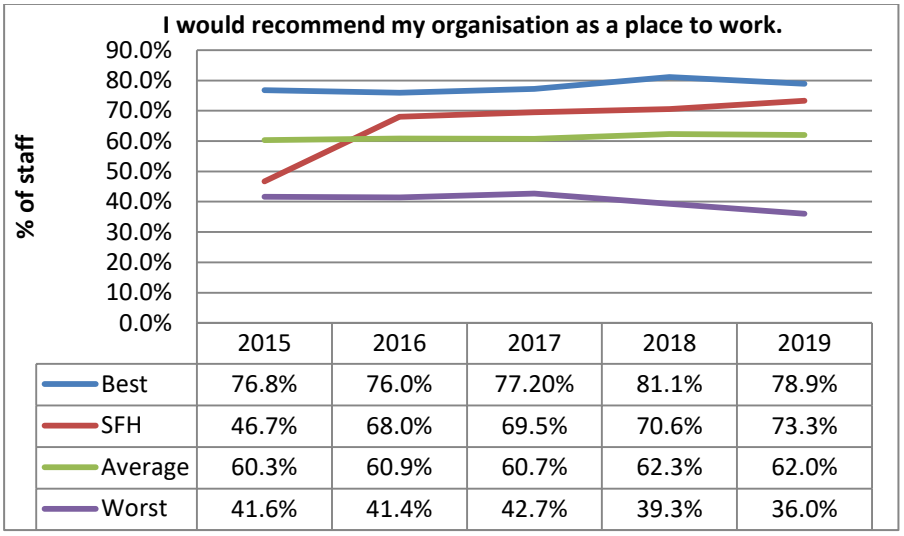
- Colleagues would strongly recommend SFH as a great place to work as they feel valued and want to stay at the Trust. This has improved 6% over the last 3 years in our staff survey.
- In 2018 we were the top scoring Trust in the Midlands and East Region as a place to work and receive care.
- Colleagues want to stay at this Trust because of the way we support and develop them.
- We enjoy a high retention rate, 0.89% turnover rates and the reputation of the Trust as a great place to work is attracting more talent to the organisation.
- We have improved our on-boarding experience for new starters to ensure that it is a personal experience that is slick, informative and effective.
- The Trust has made significant improvements to support colleagues with disabilities to do a good job through combined Occupational Health and Moving and Handling services.
- Supporting colleagues in a fair and just manner where they have been involved in incidents has improved through the implementation of Schwartz Rounds, restorative approaches, better feedback mechanisms and supportive Occupational Health service.
- Significant investment in leadership development to ensure managers and leaders are visible and inclusive, although there is still work to do in addressing pockets of inconsistency.
- Improvement in the quality of colleagues experience of appraisal and leaving them feeling valued has been achieved through a refreshed appraisal training programme.
- Successful local, national and international recruitment campaigns have resulted in increased appointments and have contributed to ensuring that colleagues feel supported to deliver safe patient care which comes out as a strength in our 2019 Staff Survey.
- Improvements in colleagues not experiencing bullying and harassment through CARE values visits, leadership development, civility saves lives and #bekind initiatives.
- Supportive line managers and senior managers who value their colleagues have increased through leadership tool box talks such as leading high performing and inclusive teams.
- Support for colleagues health and wellbeing through 24/7 phone counselling services introduction of CBT resources, health heroes initiatives and pop up well-being clinics

The NHS Staff Survey

In 2019 the Trust engaged staff in its annual staff survey through a mix mode approach of electronic and paper surveys. The table below summarises the Trusts 2019 staff survey results.



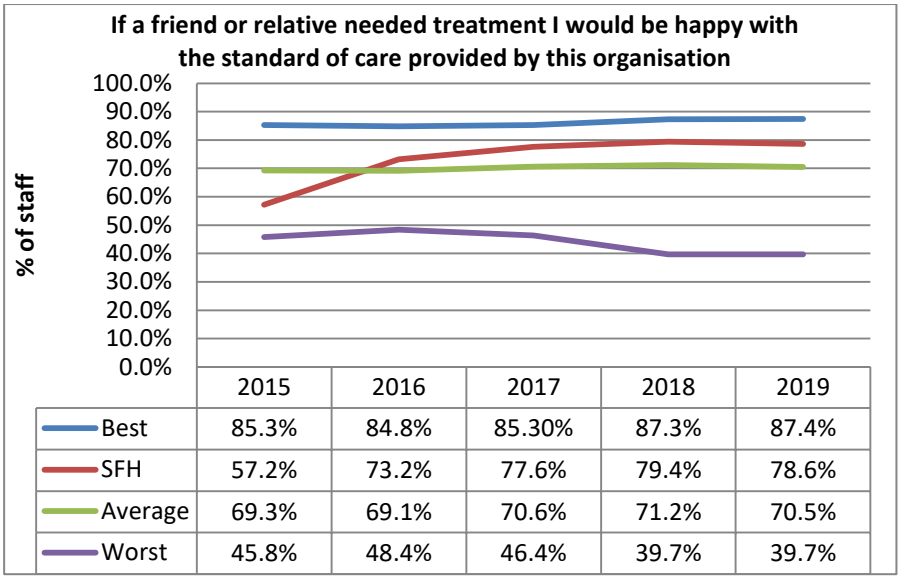
The table below presents the results from the national Staff Survey on recommending the Trust as a place to work from 2015 to 2019.



	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.20%	81.1%	78.9%
SFH	46.7%	68.0%	69.5%	70.6%	73.3%
Average	60.3%	60.9%	60.7%	62.3%	62.0%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

These results indicated a very positive step change for the Trust in 2016 and since then there has been incremental improvement each subsequent year. Since 2016 the Trust's score has continued to be well above average for an acute Trust in England. The Trusts Maximising our Potential Workforce Strategy has been a key driver in increasing this success and has resulted in many positive impacts for our recruitment and retention activities.

The table below presents the results from the annual Staff Survey on recommending the Trust as a place to receive care from 2015 to 2019.



These results indicated a very positive step change for the Trust in 2016 with incremental improvements in the 2017 and 2018 Staff Surveys. In 2019 the national average dipped by 0.7%, with the Trust's score following this trend being 0.8% below the score for 2018. However, the Trust's score is well above average for an acute Trust in England and is very significantly above the worst scoring acute trust.

Below are the first five of the 11 key indicator themes from the 2019 SFH Staff Survey:

(Score 1 - 10)	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
Best (Acute Trusts in England)	9.4	6.7	7.4	6.7	6.6
Trust (SFH)	9.3	6.1	7.1	6.5	5.8
Average (Acute Trusts in England)	9.0	5.9	6.8	6.1	5.6
Worst (Acute Trusts in England)	8.3	5.3	6.0	5.5	4.8

Table 1 – Best, average and worst acute trusts in England in the 2019 NHS Staff Survey by the first 5 key domains.

(Score 1 - 10) Trust comparison	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
2017 score	9.3	5.9	6.9	NA	5.4
2018 score	9.2	5.9	7.0	6.4	5.6
2019 score	9.3	6.1	7.1	6.5	5.8
Trust comparison statistically significant change from 2018 to 2019	Not significant	Not significant	↑	Not significant	↑

Table 2- SFH 2019 NHS Staff Survey results by first 5 key domains.

All five areas were above the national average for acute Trusts in England in 2019 as outlined in table 2 above and two have significantly improved from 2018.

The table below lists the remaining six of the eleven key indicator themes:

(Score 1 - 10)	Quality of Care	Safe Environment – Bullying & Harassment	Safe Environment – Violence	Safety Culture	Staff Engagement	Team Working
Best (Acute Trusts in England)	8.1	8.5	9.6	7.2	7.5	7.2
Trust (SFH)	7.7	8.1	9.3	6.9	7.2	6.9
Average (Acute Trusts in England)	7.5	7.9	9.4	6.7	7.0	6.6
Worst (Acute Trusts in England)	6.7	7.3	9.2	5.7	6.1	5.9

Table 3 – Best, average and worst acute trusts in England in the 2019 NHS Staff Survey by the remaining 6 key indicators.

(Score 1 - 10) Trust comparison	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement	Team Working
2017 score	7.8	8.0	9.3	6.7	7.2	NA
2018 score	7.8	7.9	9.3	6.8	7.3	NA
2019 score	7.7	8.1	9.3	6.9	7.2	6.9
Trust comparison statistically significant change from 2018 to 2019	Not significant		Not significant		Not significant	

Table 4- SFH 2019 NHS Staff Survey results by the remaining 6 key indicators

Five of the six scores are above the national average for acute Trusts in England as outlined in table 4 and one (safe environment violence) is below the national average. This score has not changed since 2017 and will be a key focus for improvement of the Maximising our Potential Workforce Plan for 2019.

Areas for development for 2020/21

- Perceptions that the organisations top priority of delivering patient care and recommending the Trust as a place to receive care has declined.
- Colleagues feeling frustrated about having inadequate time to deliver the patient care that they wish to.
- Engagement sessions will be planned to better understand how we can help colleagues to understand the changing NHS landscape and to celebrate the high standard of care that they give to patients.

- Perceptions of colleagues being exposed to bullying and harassment have improved but the reporting of bullying and harassment continues to be a concern which we need to understand in more detail.
- Colleagues experiencing and reporting physical violence from patients/service users and families needs to be better understood through targeted staff engagement.
- Colleagues working additional paid hours in order to deliver a service.
- The number of colleagues reporting MSK related issues from work has increased since 2016.
- Reduce variability of management capability through targeted training and development
- Improve the visibility and support for our Diversity Staff Networks.
- Better inform the Trust about cultural improvements made at a Trust and local level through the development of a new Staff Engagement Framework and our You Said, Together We Did campaign.
- Improve our coaching and mentoring approaches for leaders to better support colleagues in an inclusive and compassionate manner.
- Improve colleague's well-being and resilience offer as part of our Well Being Strategy.
- To engage with colleagues to better understand their feelings at being pressured to attend work when they are not feeling well enough by themselves and their managers.

Actions and Monitoring

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

The reports are analysed including scrutiny of the individual (anonymous) comments that were captured in the free text as these provide further important context. Analysis is also undertaken by staff group, Division and Department and site. Our People, Culture and Improvement Committee will consider the themes and comments in detail.

Our Divisions are sent a copy of the SFH report, their Divisional results and the free text comments. They explore the themes further with their teams and develop action plans 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 would like to improve the culture within their divisions.

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce KPIs and Speaking Up concerns. This enables more targeted actions and interventions to be identified, supported by our OD Team and HR Business Partners

There will be Trust wide initiatives for incorporation into the Workforce Strategy 2020/21 Implementation Plans, particularly in relation to our culture, improvement and leadership work. These include a strong focus on employee health, safety and well-being and diversity and inclusivity aimed at addressing recurrent themes.

The Diversity and Inclusivity results will be scrutinised by our Diversity and Inclusivity Group 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 Trusts requirements under the Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS)

Equality Reporting

We are committed to providing an environment where all SFH colleagues, service users and carers enjoy equality of opportunity. We understand the importance of being compliant with equality legislation, and acknowledge the benefits and contributions that managing equality and diversity make to the achievement of our business objectives in the areas of employment, service planning and service delivery.

We have an Equality, Diversity and Inclusivity Group to support activities within the Trust to ensure the statutory board responsibilities and obligations under law relating to equality and diversity are met, plus raise awareness and promote diversity and inclusivity across the Trust. The Equality, Diversity and Inclusivity Group has continued to take forward the equality and diversity agenda by ensuring equality legislation is embedded across the organisation whilst also working at operational levels within divisions and corporate areas. Our objectives reflect an inclusive approach to the protected characteristics of the Equality Act 2010.

We have a number of Time to Change Mental Health employee champions in addition to our BAME (Black, Asian and Minority Ethnic), LGBT (Lesbian, Gay, Bisexual and Transgender) and Disability support networks. They provide an appropriate opportunity for colleagues and patients either to raise their concerns safely and confidentially, or to offer suggestions on how to improve the working environment and patient care in relation to mental health, BAME, Disability and LGBT groups.

The Equality, Diversity and Inclusivity Group regularly review reports on equality data, including workforce information, recruitment data, the workforce race equality standard (WRES), the equality delivery system (EDS2), the gender pay gap and the staff survey. An equality dashboard is reviewed by the group on a six monthly basis, investigating equality patterns to improve the experience of staff and patients.

Gender Pay Gap

Sherwood Forest Hospitals Foundation Trust has complied with the expectations associated with the gender pay regulations; our response for 2019/20 can be viewed at the following link - https://gender-pay-gap.service.gov.uk/employer/nnAqxOHJ

We publish relevant, proportionate information on our internet and intranet site, demonstrating our compliance with the Equality Duty. We have a three year Equality Strategy,

which is available to the public, which includes specific measurable equality objectives we will be working towards.

We continue to operate fair recruitment practices to ensure equal access to employment opportunities for all. We have been awarded the 'Disability Confident Employer' status for a further two years and have also signed up to the Time to Change, Dying to Work and Safe Places charters in 2017/2018. We continue to be a signatory for an eighth year to the Mindful Employer Charter for Employers who are positive about Mental Health. This Charter helps us to support colleagues who experience mental ill health, along with the Time to Change charter.

Modern Slavery

This section outlines the Trusts responsibilities and responses to the Modern Slavery Act 2015 and sets out the steps that Sherwood Forest Hospitals NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Sherwood Forest Hospitals 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 or nationally where our patients may have been subject to modern slavery.

All members of staff within the organisation 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 2019/20 procurement and the safeguarding team have worked actively to ensure all staff within the procurement team are aware of the risk of modern slavery and the responses required where this is suspected.

This is in addition to the Think Family level 3 safeguarding training which all clinical facing staff attends, this sessions also refer to modern slavery, its identification and responses.

Our Policies on Slavery and Human Trafficking

Sherwood Forest Hospitals is aware of its responsibilities towards patients, carers, employees and the local community and expects all suppliers to Sherwood Forest Hospitals 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 Sherwood Forest Hospitals policies.

We operate a number of 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 wide 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, access to 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 in how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Raising Concerns Policy: We operate a Raising Concerns policy to support all employees to be able know that they can raise a concern 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 & 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 which will allow the Trust to gain assurance that slavery and human trafficking have no place in our business. Sherwood Forest Hospitals 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 prior to 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.

Our Performance Indicators

We will know the effectiveness of the steps we are taking to ensure that 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 Multi-agency Safeguarding Hub 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 rends and themes.

Valuing our Members

Membership information for annual report ending March 31 2020

Public breakdown by constituency

Mansfield	4673
Ashfield	4589
Newark and Sherwood	3635
Derbyshire	1555
Rest of East Midlands	798
Rest of England	126

Public membership breakdown

	Number of members	Membership profile	Population profile
Age (years)			
0-16	4	0.03%	19.74%
17-21	32	0.21%	6.03%
22+	14,215	92.34%	74.22%
Not stated	1,144	7.43%	0%
Ethnicity			
White	13,737	89.23%	89.29%
Mixed	32	0.21%	1.90%
Asian	83	0.54%	6.46%
Black	31	0.20%	1.79%
Other	8	0.05%	0%
Not stated	1,504	9.77%	0%
Gender			
Male	5,590	36.31%	49.48%
Female	9,604	62.38%	50.52%
Not stated	201	1.31%	0%

Membership activity, events and communication

As with the previous years, the Governors' Membership and Engagement Committee has continued to focus on how best to engage with members. We have continued to host digital events via the monthly e-newsletter, Trust Matters. We have also continued to hold our monthly Meet Your Governor events across all three of our hospital sites, and have introduced these sessions out in the community at local leisure centres and colleges. These events enable governors to engage with members and the general public and to gain feedback on the services provided by the Trust.

Annual General Meeting/Annual Members' Meeting

Held on 23rd September 2019 at King's Mill Hospital, this event was attended by members who visited the interactive display stands as well as attending the health check event and the Annual General Meeting itself.

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, HG17 4JL or 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, amongst 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 wide ranging debate across a number of areas of interest.

One of the key roles of the governors is engagement with their constituencies in order to gain feedback and report to the Council and subsequently the Board of Directors. Our governors

achieve this aim by holding regular 'Meet your Governor' events across all three hospital sites and out in the community. At these events new members are recruited and patients, visitors and staff are given the opportunity to discuss their views of the services provided. A regular report is provided to the Governor Membership and Engagement Committee on the outcomes of these events.

The governors continue to observe board committees in order 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, one of which is held in Newark to ensure wider opportunities for the public and members to attend.

We held governor elections in April 2019, where seventeen public governors and five staff governors where elected. We have also appointed new governors from our partner organisations, Newark and Sherwood District Council, Ashfield District Council, Mansfield District Council, Nottinghamshire County Council and West Notts College. This refreshed Council of Governors is incredibly proactive in undertaking all their statutory and non-statutory duties. 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.

There will be governor elections in the autumn of 2020 as two governors in the Ashfield constituency will come to the end of their tenure and there is a vacancy in the Newark constituency as a governor recently resigned. The Council of Governors agreed to leave this vacancy open until the autumn elections in line with section 7.14.2.3 of our Constitution.

Attendance at Council of Governor meetings

There have been four general Council meetings during the year. The following table details the Governors, the constituency they represent, their attendance and the date of their appointment.

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	NUMBER OF MEETINGS ATTENDED
			14/05/2019	13/08/2019	12/11/2019	11/02/2020			
Amanda Sullivan	M&A and N&S CCG	Appointed	X					01/06/17	0/1
Ann Mackie	Newark & Sherwood	Public	P	P	P	P	3	01/05/19	4/4
Belinda Salt	Mansfield	Public	P	X	P	A	3	01/05/19	2/4
Ben Clarke	King's Mill Hospital	Staff			P	P	3	01/09/19	2/2
Brian Bacon	Derbyshire	Public	P	P	P	P	3	01/05/19	4/4
Councillor Craig Whitby	Mansfield District Council	Appointed		A	A	P	4	21/05/19	1/3
Councillor David Walters	Ashfield District Council	Appointed		P	P	P	1	16/05/19	3/3
Councillor Helen Hollis	Ashfield District Council	Appointed	X				1	14/05/18	0/1
Councillor John Doddy	Nottinghamshire County Council	Appointed	X	X			4	27/07/17	0/2
Councillor Michael Brown	Newark & Sherwood District Council	Appointed		A	X	A	1	21/05/19	0/3
Councillor Steve Vickers	Nottinghamshire County Council	Appointed			P	A	2	04/06/19	1/2
Dean Whelan	Mansfield	Public			P	P	3	01/09/22	2/2
Gerald Smith	Mansfield	Public	P	P	A	P	3	01/05/19	3/4
Ian Holden	Newark & Sherwood	Public	P	P	P	P	3	01/05/19	4/4
Jacqueline Lee	Newark Hospital	Staff	P	P	P	P	3	01/05/19	4/4
Jane Stubbings	Ashfield	Public	P	P	A	P	3	01/11/17	3/4
Jayne Revill	King's Mill Hospital	Staff	P	X	A	A	3	01/05/19	1/4
John Wood	Mansfield	Public	P	P	P	A	3	01/05/19	3/4
Kevin Stewart	Ashfield	Public	P	P	P	P	3	01/05/19	4/4
Lawrence Abrams	Rest of East Midlands	Public	A	P	P	P	3	01/05/19	3/4
Louise Knott	Vision West Notts	Appointed	P				N/A	01/03/15	1/1
Martin Stott	Newark & Sherwood	Public	P	P	A	P	3	01/05/19	3/4
Morgan Thanigasalam	King's Mill Hospital	Staff	P				3	01/10/17	1/1
Nikki Slack	Vision West Notts	Appointed		P	P	A	N/A	17/07/19	2/3
Philip Marsh	Ashfield	Public	P	P	P	P	3	01/05/19	4/4
Richard Boot	Newark Hospital	Public	A	P	A	A	3	01/05/19	1/4

Richard Shillito	Newark & Sherwood	Public	P	P	P		3	01/05/19	3/3
Roz Norman	King's Mill Hospital	Staff	P	P	P	P	3	01/05/19	4/4
Sue Holmes	Ashfield	Public	P	P	P	P	3	01/11/17	4/4
Tony Egginton	Mansfield	Public	A				3	01/05/19	0/1
Valerie Bacon	Derbyshire	Public	P	P	P	P	3	01/08/19	4/4

Key:
P= Present
A= Apologies
X= Did not attend
Not in post

Lead Governor Annual Report 2020

This has been the strangest year to be Lead Governor or indeed any Governor for our Trust.

At the beginning of the year we welcomed our new Governors

Publicly elected Governors

- For Ashfield Philip Marsh and Kevin Stewart
- For Mansfield Dean Whelan, Gerald Smith and Belinda Salt
- For Newark and Sherwood Richard Shillitoe (since resigned)
- For Derbyshire Brian Bacon
- For the rest of the East Midlands Lawrence Abrams

Staff Governors

- For Kings Mill and Mansfield Community Ben Clarke and Jane Revill
- For Newark Richard Boot and Jacqueline Lee

Appointed Governors

- For Ashfield District Council Cllr. David Walters
- For Mansfield District Council Cllr. Craig Whitby
- For Newark District Council Cllr. Michael Brown
- For Vision West Notts Nilkki Slack
- For CCG David Ainsworth

The Governors have continued to engage with patients and the public in our Meet the Governor Sessions which are held monthly on all sites and there has been some valuable feedback to pass on to the Board of Directors. The 15 steps programme has also continued with many Governors taking part. This has provided a valuable insight for us into all parts of our hospitals and we are able to engage with patients.

We continue to hold our Non-Executive Directors to account by having Governor Observers on all of the Board Committees.

There have been many new initiatives to celebrate and which have won awards – notably the Street Health project and we must congratulate all of those who are involved.

The Trust Awards Evening was again a very glittering event – deservedly so for all of the staff taking part. So many staff had been nominated by their colleagues for outstandingly upholding the Trust's CARE values.

I was privileged to be one of the cohorts attending the HSJ awards last year. This was a splendid event in London and although we did not win the fact that we were finalists in the 'Best Hospital' category was amazing showing such progress over the last few years. Again all the credit going to our wonderful staff

We have an exciting new project – forming a link with the student's at Vision West Notts. When we enrol them as members we will be able to inform them in a monthly newsletter about the work of the Trust – beyond 'Doctors and nurses' and of the opportunities that are available. Hopefully when this link is established, we will be able to roll it out to other young people at other establishments throughout our area.

Our local communities and our charity raised a tremendous £485,000 for the Gamma Scanner Appeal.

Our volunteers provide such amazing support for all of our hospitals and we are truly grateful to them

In the first quarter of this year we were visited by the CQC and for a while the outcome of this inspection was eagerly awaited. Events then put everything into perspective with the Trusts preparations for the treatment of patients with Covid-19. How can we thank our staff enough from cleaners and porters, health care assistants, nurses, doctors and admin staff, for all their hard work in caring for all our patients at this most unprecedented times

I hope that by the time the AGM arrives it will all be over and all of our staff safe and well.

Sue Holmes
Public Governor for Ashfield and 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.	20 66-67 82-38
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.	20-21 39-40
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.	68-69
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.	68

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.	20
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.	(refer to website for profiles)
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	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.	39-43
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.	39-40
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.	21
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.	66-67
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.	N/A

		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)	
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.	30-34
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.	23
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.	20 22-25 104
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.	87 94-95 97-99 101 104

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.	78
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.	78-80
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	N/A

		the director will retain such earnings.	
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, 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.	66-67
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.	65-64
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.	72
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.	65-70
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'	20

		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.	

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 wide 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), five executive Directors (voting), including the Chief Executive, and four corporate Directors (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 are able to 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 Company Secretary ensures that the Directors and Governors receive accurate, timely and clear information. Directors are encouraged to update their skills, knowledge and familiarity with the organisations 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 Company Secretary 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.

A number of 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 organisations 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 Protect. All investigations are reported to the Audit and Assurance Committee.

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 on joining the organisation and a number of bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. In November 2019 we took part in Fraud Awareness Month and a number of alerts were issued to employee' e.g. 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 decreased by £1.63m in 2019/20 (£12.84m to £11.21m). This represents a 12.7% decrease. This excludes a rebate received in year of £0.36m relating to meeting the requirements of the maternity incentive scheme.

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2019/20 these committees included:

- The Audit and Assurance Committee's 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, Organisational Development and Culture Committee's principal purpose is to provide scrutiny and assurance of the development, delivery and impact of the Trusts 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's 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 5/7

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, PWC, and the internal auditors, 360 Assurance, on the work they had undertaken in reviewing and auditing the control environment.
The committee works with Counter Fraud Service and SFH 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 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.

Key agenda items of the committee during the year were:

- Operation of the Board Assurance Framework document,
- Report with regard to delivery and performance against the internal audit plan for 2019/20, of the 16 audit assignments included within the Plan, to date, seven reports have been issued with Significant Assurance, and were submitted to the relevant committee for discussion and monitoring, and one report was issued with Limited Assurance; the lead executive presented this report to the Audit & Assurance Committee and discussed the actions, providing assurance with regard to timelines and agreement to deliver the changes required. Two reports have been issued relating to advisory reviews and, therefore, did not have an opinion. Five reviews from the 2019/20 Plan have still to be concluded.
- Two reviews from the 2018/19 Plan were also concluded in year, both providing significant assurance
- Progress and achievement of actions against all internal audit reports are reported to committee.
- Counter Fraud progress reports are discussed at the committee and we were involved in the National Fraud Initiative.
- Information Governance is discussed at each meeting and the committee were updated with progress against the IG Toolkit requirements and noted the achievement of all 116 standards being met.
- The committee received annual reports with regard to risk, procurement and counter fraud
- The Data Quality Group reported the planning requirements and progress during the year.
- The Register of Interests is reported to each committee, significant improvement has been made this year with further initiatives to improve compliance being implemented.
- The Speaking up arrangements and process were reviewed by the committee to ensure no issues of internal control were identified.
- The Scheme of Delegation was reviewed
- The Audit Committee self-assessed against the maturity matrix and a development session with 360 Assurance was undertaken and an action plan developed.
- A report regarding the effectiveness of the committee was developed and submitted to Board.
- The committee reviewed the letter of representation to External Audit.
- As part of the year-end process and approval of the accounts to the Board for ratification, in order to assure themselves of the effective financial propriety of the Trust, the committee reviews and takes into account:
    - The head of internal audit opinion on both financial and non-financial matters
    - The external audit opinion on the accounts, including the external value for money opinion
    - Going concern/principal risks and uncertainties

- Review of accounts and ISA260 (report for the Audit and Assurance Committee) prepared by External Audit

2018/19

- Financial statements - Unmodified opinion on the financial statements but that a material uncertainty exists relating to going concern.
- Value for Money (VFM) conclusion – modified VFM conclusion in respect of financial position and section 111 license condition which was in place for a significant part of the financial year.
- Quality Report – A clean limited assurance opinion on the content and consistency of the Quality Report.
- A qualified assurance opinion on one out of the two mandated performance indicators. A disclaimer conclusion was issued for 'Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge'.
- One internal control deficiency.

2019/20

- External audit plan including significant financial statements risks and significant risks relating to VFM.
- Update on the impact of coronavirus on our risk assessment and audit approach (April 2020).

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 2019/20 was developed in line with the mandatory requirements of the NHS 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 underway. 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 & Assurance Committee to report on progress.

External audit service

The External Audit contract was retendered during 2017/18 and the Council of Governors, supported by the Chair of the Audit and Assurance committee, subsequently appointed PwC as our external auditors, for a period of three years, commencing with the 2017/18 Annual Accounts and Report.

We incurred £99,646 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12 month period to 31 March 2020 (£78,084 net of VAT for the period to 31 March 2019). A £3,500 (net of VAT) scope variation was also raised after the audit for the period to 31 March 2019. Non-audit services amounted to £Nil net of VAT (£8,636 net of VAT for the period to 31 March 2019) in respect of the Quality Report.
PwC has provided non-audit services to the Trust during the year, this related to assurance on the quality report, this was also included in the plan for 2019/20 however this is no longer required due to revised guidance as a result of COVID-19, all of which was approved by the appropriate partner and is permissible under the applicable ethical standards

Remuneration and Nomination Committee

As at 31 March 2020 and on-going, membership of the Remuneration and Nomination Committee comprises Claire Ward as Chair and Barbara Brady, Manjeet Gill and Neal Gossage all Non-Executive Directors as members. 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 John MacDonald 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 2020, 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.

The governance structure, which has evolved over the year to keep pace with an ever changing environment, will stand us in good stead and allow the Board to continue to learn and develop from the fresh skills and experiences of its members. During the year, board development sessions for the full Board of Directors have been included in the meeting schedules on a bi-monthly basis. This helps to ensure that we continue to look to current and evolving best practice as a guide in meeting the governance expectations of patients, members and the wider stakeholder community.

In common with the health service and public sector as a whole, we are operating in a fast changing and demanding external environment. We recognise the need to deliver significant increases in efficiency whilst 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.

We made sure that due regard was taken to our legal obligations by developing and implementing Governor Development sessions. This accorded with and ensured a detailed understanding of the requirements of the Health and Social Care Act to include equipping Governors with the requisite knowledge and skills to deliver their responsibilities effectively. Governors were also supported in attending development session with external providers.

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 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 Board 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. Governors and Non-Executive Directors take part in internal assurance visits to clinical areas across our sites and are involved in patient and staff engagement events.

Our Executive Team consulted with the Council of Governors during the year on matters such as the annual plan, Trust Strategy, quality account and quality indicator and other relevant strategies and reports.

In a 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 advisors 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

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

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

NHS Improvement approved us moving from SOF categorisation segment 3 to segment 2 in January 2019 and the Trust remains in segment 2 as at 31 March 2020.

This segmentation information is the Trust's position as at 31 March 2020. The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 Scores				2018/19 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	3
Financial efficiency	I & E margin	4	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	2	2
Overall Scoring		3	3	3	3	3	3	3	3

Foundation Trust License

There are no additional conditions on our Foundation Trust License.

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.

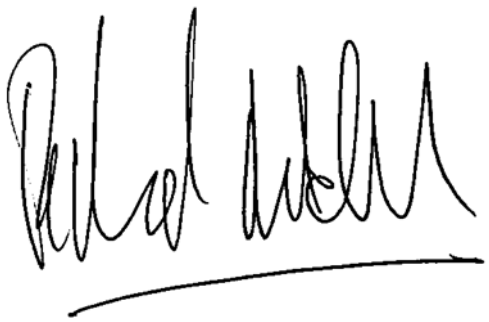
In preparing the accounts and overseeing the use of public funds the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- 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.



Signed…….
Richard Mitchell **22 June 2020**

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest 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 NHS Foundation Trust for the year ended 31 March 2020 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,. We improved our maintained our overall rating of Good and Kings 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 & Assurance Committee, Finance Committee, Quality Committee and People, OD & Culture 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 of the Executive Team and selected members of the Senior Leadership Team. Senior managers and specialist advisors routinely attend each meeting. We have kept under review and updated risk management policies during the course of 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 in order 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 and patient feedback 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 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 in order 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 & Assurance Committee and Board of Directors have led 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 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 as funding levels reduce in real terms year on year, whilst 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). 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, maintaining stakeholder confidence 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 within 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
Catastrophic failures in standards of safety and	*This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety and Quality

care.	*patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality within the governance of Sherwood Forest Hospitals.*	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.	Group and other sub-groups. This includes safety and quality indicators, incident investigations and key performance indicators.
Demand for care overwhelms our capacity to deliver care safely and effectively.	*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 outcomes are monitored through the Quality Committee, supported by the Patient Safety and Quality Group. 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 *Maximising our Potential* 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 Workforce Planning Group. This includes vacancy levels, training and development progress.
A failure to maintain financial sustainability.	*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 arise if the trust is not able 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.*	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-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	Frequent assessment of performance and forecast trajectories is monitored through the Finance Committee.

		Executive Medical Director and Chief Nurse.	
A fundamental loss of stakeholder confidence.	*This risk may arise should: (i) the controls fail to mitigate the risks outlined above; (ii) there are periods of prolonged adverse publicity; (iii) the Trust fails to make sufficient progress on agreed quality improvement; and/or fails to comply with statutory/regulatory obligations.*	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. The Board oversees compliance obligations.	In addition to the Trust's established control framework, frequent correspondence and discussions with our regulators and commissioners to ensure focus is maintained on quality controls and improvement, and compliance with regulatory requirements.
A breakdown of strategic partnerships.	*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. Continue to play a leading role in the Integrated Care System.	Frequent review of progress through ICS and ICP 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, Brexit 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.

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 & Assurance Committee utilises the reports of management and internal audit in order to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

We assure the quality and accuracy of our elective waiting time data through the following measures:

- Weekly PTL meetings for RTT and Cancer including;

  - A review of current position at reporting specialty level and action plans to address failing services
  - Patient level review of long waits
  - Monitoring of operational reports that impact on elective care data e.g. outpatient referral and waiting list management reports
  - Access to live self-service RTT PTL
- Elective Care Training programme for administrative staff involved in the management and validation of elective care pathways.
- RTT and Data Quality educator with remit to improve data accuracy of reported information through various mediums.
- Clear lines of responsibility for the management of patient pathways including the Central Booking Team, Operational Managers, waiting list staff, Cancer Tracking Team, Operational Outpatient Teams, Patient Pathway Coordinators, and Data Quality Validation Staff.
- Chief Operating Officer nominated and responsible for the sign-off of RTT and cancer returns.

We acknowledge that there are risks to the quality and accuracy of this data and have the following mitigating actions in place:

- Trust wide Data Quality Strategy which sets out the organisational expectations for all colleagues relating to internally and externally reported data. The Strategy defines both ours strengths and known weaknesses and plans for improvement.
- Data Quality Oversight Group provides updates to the Board regarding known data quality issues to ensure both visibility of issues and assurance.
- Data quality dashboard with KPIs that reflect known risks to the accuracy of our data for example unreconciled outpatient attendances, mismatched RTT information in our PAS (e.g. incompatible codes) etc.
- Internal audit programmes designed to highlight and assure the quality of our elective care data with feedback mechanisms to address themes and inform training requirements.
- External audit review and testing of reported data.
- Validation Team who validate and correct data on a daily basis to ensure accuracy of reported data.

We have developed a robust governance and performance framework that is now well established throughout the organisation. This ensures that risks to the safety and quality of patient care, in addition to financial stability are identified and well managed resulting in the maintenance of clinical sustainability and financial viability.

KPMG undertook an external well-led review of the organisation, as required by NHSI, these should be undertaken every 3 years, the final report including recommendations was presented to Board in December 2018.

The progress against the twenty recommendations: 10 rated as Medium priority and 10 rated as Low priority was reported to Board in July 2019 15 are now completed, 3 are in progress and 2 are an on-going

The full report is available on our website, see link below

https://www.sfh-tr.nhs.uk/media/5207/sherwood-forest-hospitals-nhs-ft-final-report-141218.pdf

Clinical Audit - National Audits

We actively participated in 100% of the National Clinical Audit Programme (57 out of 57) projects over the year. This provides assurance to the Board of Directors on our quality outcomes and informs regulatory oversight. In 2019/20 the outcomes from national clinical audits can be summarised as follows:

- The National Audit of Breast Cancer in Older People demonstrates that 100% of patients received the 'Triple Assessment' which is seen as the gold standard approach to diagnosis. This is in comparison to the national figure of 67%.
- The Chronic Obstructive Pulmonary Disease (COPD) Audit results show that the trust has seen a huge increase in the number of current smokers accepting Nicotine Replacement Therapy, rising from 48% in March 2018 to 85% in March 2019.
- The National Heart Failure Audit shows that the proportion of patients who have input from a Heart Failure specialist has increased to >80% with more patients having Heart Failure specialist nurse input.
- The British Thoracic Society National Audit of Smoking Cessation sees the trust continuing to achieve excellent results with 96% of patients being screened for their smoking status, compared to the national average of 76.8%.
- The Sentinel Stroke National Audit shows that 97.5% of patients had their swallowing screened within 72 hours of being admitted, which is higher than the national average of 88.6%.
- The National Hip Fracture Database (NHFD) indicated that patients undergoing a Delirium assessment at pre-operative stage have increased, for a second year, with 93.8% patients being reviewed.
- The Royal College of Emergency Medicines audit relating to Vital Signs In Adults shows that we are above the National Average of 50% for measuring and recording the 'six vital signs' of respiratory rate, oxygen saturation, pulse, blood pressure, Glasgow Coma Score or AVPU (patient consciousness) score and temperature within 15 minutes of arrival or triage, with 75% patients undergoing these checks.
- The National Emergency Laparotomy Audit shows that there is a consultant anaesthetist and consultant surgeon present in 100% of cases where the risk of death is calculated at being equal to or greater than 5%. This is 16% higher than the national average. The organisation's average post-operative stay is recorded at 11 days which is 5 days lower

than national level, and 4 days lower than the local Academic Health Science Network region.

- The National Audit of Adult Asthma shows that 85% of patients requiring systemic steroids have these administered within 4 hours of arrival at the hospital. This is higher than the national average of 65%.
- The National Paediatric Diabetes Audit results show that the percentage of children with a Hba1c measurement below 58mmol (which is a measure of blood glucose control) is 43.3%. This is 14% above the national average, and has improved year on year.

The Clinical Audit service at SFH integrated with the Service Improvement function in July 2019, in order to strengthen the alignment between improvement, audit and positive patient outcomes.

Workforce

Our workforce plan is linked to our workforce strategy, "Maximising our Potential", which seeks to attract, engage, develop, nurture and retain staff whilst supporting optimum performance. This strategy was approved by our Board in 2017 and contains annual implementation plans, with progress regularly reported to our Board and associated Committees.

Our workforce strategy and plan reflects our numerical and skill mix requirements and is aligned with the Integrated Care System People & Culture Strategy. It is consistent with our financial, quality and activity plans and also supports the Developing Workforce Safeguards recommendations as it is the result of a structured cross-trust approach.

In developing our workforce plans, divisional teams are supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver anticipated 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 Workforce planning group. In addition, we have a Medical Taskforce led by the Executive Medical Director and a Nursing Taskforce led by the Chief Nurse.

Regular, nurse staffing establishment reviews are also undertaken 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.

Historically we have been disproportionately reliant on a temporary workforce due to recruitment challenges which arose for a number of reasons, including our geographic location, market factors affecting the domestic supply of available qualified employees and challenges with international recruitment. However, in the past 18 months we have made significant progress in increasing our substantive workforce, extending our pool of available bank workers and strengthening our temporary staffing governance processes. This has significantly reduced our dependency on higher cost agency staff and for since 2017/18, we have delivered our NHSI agency control total.

Part of our approach to workforce planning is to ensure that we optimally utilise the workforce that we already have. Electronic rostering and electronic 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 OD and Culture Committee during 2019/20. New roles are being developed in order to support our medium and longer term workforce requirements.

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 NHS Elect during 2019/20 in order to develop the existing workforce.

The combined impact of internal efficiency improvements and the ICS led transformation work resulted in some re-shaping of our services in 2019/20 and will continue over the medium and longer term. We will see growth in some areas through the introduction of new roles to meet planned activity changes, but a reduction in others due to meeting our financial control total and responding to ICS changes. We are also taking a lead role in the establishment of a Talent Academy for the system and we coordinate all work experience placements for Nottinghamshire.

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 Programmes.

A point of success across the year has been the work achieved around Health and Wellbeing agenda. The introduction of a new counselling provision, weekly health and wellbeing clinics, investment within the Trusts Occupational Health Service have all been contributing factors.

International recruitment of both doctors and nurses is a key part of our workforce strategy. We have also assessed the risk associated with EU nationals in our workforce. We anticipate the impact of Brexit on our workforce supply to be minimal, due to our limited reliance on EU staff. However, we have taken steps to make funding available to cover the cost of our EU colleagues applying to the settlement scheme as a precautionary measure.

As an NHS employer the Trust ensures, staff entitled to membership with the NHS Pension Scheme are offered the scheme and measures are in place to ensure Scheme regulations are complied with in regards to relevant deductions, 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 Trusts People OD and Culture Committee assurance is provided in regards to the Trusts obligations to ensure equality, diversity and human rights legislation are complied with.

We have adopted the NHS Improvement *Workforce Safeguards* to ensure our staffing governance processes are informed, safe and sustainable, this 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, however 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 2019. 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; and
   (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:

   (d) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
   (e) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(f) 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;
(g) 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);
(h) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(i) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(j) 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; and
(k) To ensure compliance with all applicable legal requirements.

"

5. 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.

Our governance committee structure has provided our Board of Directors with assurance during the year with regard to quality, including compliance with the CQC standards and finance, particularly with regard to 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 via 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. 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 recent CQC Inspection resulting in a more streamlined visit.

We have undertaken numerous public stakeholder engagement events during the year providing a great deal of focus on the development of our new strategy, together with the development of our public engagement strategy. More detail is provided earlier in this report within the consultation of local groups and organisations section

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 twelve 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.

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). 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.

We continue to actively recruit to our employee establishment and have been successful in reducing our number of vacant posts, but recruitment difficulties continue in the nursing and medical workforce. Although the challenges in our nursing and medical workforce remain we have reduced our spending on agency and locum colleagues and continue to be within the ceiling set by NHS Improvement. Agency spending reduced in year to £12.8m against a target of £16.7m.

The Board receives a substantial amount of assurance concerning agency usage:

- **Executive-led Taskforces:** We have a Medical Taskforce and a Nursing Taskforce, both of which are core work streams within our Cost Improvement Programme (CIP). The Medical Taskforce is led by our Medical Director, and the nursing equivalent by our Chief Nurse. Fortnightly work stream meetings are chaired by the executive lead.
- **Cost Improvement Programme (CIP) Board:** Every month the CIP Board, chaired by the Chief Financial Officer, and featuring wider executive membership together with representatives from the programme management office and divisional management teams, seeks assurance of progress against the agreed savings trajectory for all workstreams including the executive led Taskforces.
- **Finance Committee:** The CIP Board presents an exception report to the Finance Committee detailing progress against savings trajectories, as well as core risks of non-delivery with respective mitigating solutions. The Finance Committee also receives detailed financial operating and outturn information, including pay spend and assurance about financial control.
- **Risk Committee:** This Committee receives assurance regarding the risks on the Board Assurance Framework, a number of which relate to workforce recruitment and retention, organisational sustainability and financial performance.
- **Trust Board**: The Board receives assurance from its committees mentioned above. In particular, the Finance Committee provides assurance to the Board about performance of the Trust's CIP programme and overall financial position, including an update on agency expenditure.

We have ended the year with a deficit of £15.9m. Adjusting for asset impairments and other non-control total items gives a control total basis deficit before PSF, FRF and MRET of £41.5m, which meets the adjusted financial control total agreed with NHS England & NHS Improvement. Details relating to this position are included elsewhere in this report. Despite meeting our agreed financial control totals, we remain in a financially challenged position with a significant underlying deficit.

We work closely with our commissioners and NHS England & NHS Improvement to manage contractual risks and our liquidity position. We are working with partners to identify and implement health economy improvements to deliver financial savings across the regional footprint, whilst also delivering improvements in service provision and patient experience. Our partnership work in the Nottinghamshire-wide Integrated Care system is pivotal to achieving this.

Liquidity support has been agreed with NHS Improvement/the Department of Health and Social Care in the form of loans. A total of £24.86m of additional revenue support term loans and £2.77m of capital loans have been drawn down during 2019/20, offset by term loan repayments of £4.17m and capital loan repayment of £1.71 made in year.

Due to the impact of Covid 19 changes have been made to the financing arrangements of the NHS, and for an initial period April to July 2020, block funding is in place matched to underlying costs.

In addition the Department of Health and Social Care (DHSC) has confirmed that:

"It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this".

Despite the block contract arrangements in place until 31 July 2020, the Trust is operating at a recurrent deficit and faces future uncertainty regarding future contracting and income arrangements.

These conditions indicate that there is a material uncertainty which may cast significant 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.

On this basis the accounts have been prepared on a going concern basis. The Board of Directors has taken steps to ensure 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.

Our programme management office supported us in achieving cost improvement programme savings of £12.8m in 2019/20. The improvements realised include clinical productivity gains, medical and nurse agency cost reductions, procurement and other corporate service cost reductions and outpatient transformation savings. We continue to seek opportunities to build on our 2018/19 success and deliver further savings in 2020/21. Delivery will be underpinned by the same robust governance process seen in 2019/20.

We continue to utilise the Model Hospital framework to benchmark activities, identifying opportunities for efficiencies and the monitoring of progress in achievement.

As a result of challenges with regard to recruitment of colleagues, we have a reliance on agency staff, however the shift to improving and utilising bank staff has continued in year. This together with successful negotiation with regard to rates paid to agencies means we have reduced agency expenditure by £1.4 million from 2018/19, ensuring an underspend against the agency ceiling set by NHS England & NHS Improvement.

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs who is also our Caldicott Guardian and the Chief Finance Officer, who is our Senior Information Risk Owner (SIRO). 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 Caldicott Guardian and the SIRO 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 of 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 2019/20, 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 across a variety of mediums to ensure that incidents and lessons learned are raised 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 identifies learning from incidents and develops the actions required to address these, ensuring prevention of any future recurrence. 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 (DSPT) submission, data flow mapping, and information asset registers. We have implemented the DSPT requirements achieving 116/116 standards met..

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2019/2020 in order to ensure refresh of 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, national opt out relevant 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 2019/20 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 have been five, level 2, incidents reported to the Information Commissioners Office (ICO). We have had no further action from the regulators after investigation. The incidents ranged from information being disclosed inappropriately, inappropriate access to medical records, an email being sent to an intended recipient that did not have adequate security. Of the incidents reported none remain open.

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 2019/20 to date the Trust processed a total of 475 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
475	79	1

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 will ensure where possible full compliance.

Of the 475 requests, 396 are currently completed, 5 on hold waiting further information and 26 still in progress. Of the 475 requests completed 396 have been completed within 20 days which show a compliance rate of 83%.

The request escalated to the ICO has concluded with no action for the Trust.

Subject Access Requests

The Trust has received 2988 requests for access to patient records. The majority of 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.

The trust has seen a 18.33 % increase in requests from January 2017 to January 2020, and are currently monitoring whether this is due to the changes in the DPA 2018 or attributable to other care providers as we work to a more integrated service.

April 2018 to March X 2019 Total	Completed < 21 days	Completed 21-30 days	Completed > 30 days
2988	KM -2097 NWK -456 IG-18	KM-361 NWK –43 IG - 6	KM –0 NWK -6 IG -1

Horizon Scanning 2020/21

The information governance landscape is changing at an alarming rate, with ever changing privacy regulations and information security challenges to protect the Trust data.

The lines between information governance and data/ IT governance continue to overlap and we need to develop a strong information/ data governance model to adapt to new emerging technologies, environmental and social governance. We are seeing social governance changes in the form of integrated care services (ICS) which will enable us to achieve better outcomes for patients and their carers. With this there is the need to share more information at greater speed and the Trust needs to develop a governance model to support this.

Data breaches will remain a cyber-security concern, as data remains valuable to criminals. We will continue to strengthen its data privacy and security controls.

We are already seeing advances in Artificial Intelligence (AI) with the EMRAD consortium which we are a member of. AI is currently being trailed by hospitals in Lincolnshire and Nottinghamshire to identify breast cancer in patients. It is hoped the project will help to offset staff shortages as the increase in imaging increases and also improve the quality and efficiency in the service.

Cloud computing is another trend we can predict we will be using more often in healthcare, it has the potential to improve telemedicine and has better storage capacity at a lower cost. There are however disadvantages of cloud computing which must be taken into consideration, including other organisation being responsible for our information, leading to limited control, along with the increased potential of insider threats and security.

Data Quality and Governance

A review of our performance over the period covered from April 2019 to 31 March 2020 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 and 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
- 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 utilised for other aspects of performance.

The Advancing Quality Programme will remain the vehicle to drive the Quality Priorities. The Programme will be 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 2019/20.

- 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 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 joint 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 five Clinical Divisions and through to the Board of Directors. Specific indicators within the report are monitored and reported via the Trust performance and governance framework namely the:

- Monthly divisional performance management meetings
- Patient Safety and Quality Group
- Quality Committee

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 2019/20. 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. Internal Audit has issued one Limited Assurance report Mental Capacity Act and Deprivation of Liberty Standards) the actions identified are monitored via the Audit and Assurance Committee, to ensure timely completion.

The structure of the Board of Directors meetings during the year allowed sufficient time to ensure that matters regarding performance, quality and finance could be managed effectively by the Board.

Managers and executive Directors provide me with assurance through regular board and management reports, all of 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 that value for money is sought continuously.

My review for 2019/20 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, although the impact of the pandemic affected only the end of the financial year. I believe we have taken a number of effective decisions and actions to prepare the organisation and our colleagues for the surge in patients with Covid-19 our preparation began early, we have led with compassion and with support and we have communicated well.

Our initial focus, towards the end of 2019/20, was on some of the transactional aspects of preparation and delivery. Personal protective equipment (PPE) planning and fit testing of masks began in January 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 initial pandemic crisis and on-going in 2020/21. 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.

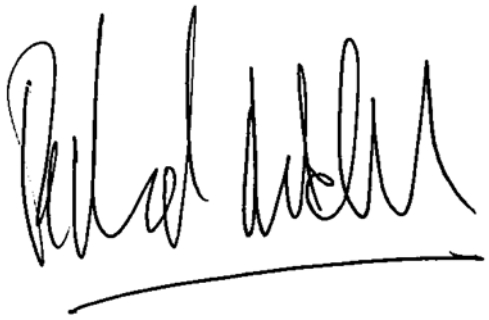
More, particularly in 2020/21 all colleagues or members of their house who meet the criteria for testing have been offered a test.

We took decisions, in 2019/20, earlier than national guidance suggested, to pause elective care but continued to provide emergency and cancer care to patients, and early action for 2020/21 will be to work with colleagues and partners to reinstate paused services..

In line with government guidance, during March 2020 we supported high numbers of 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 ensured Clinical leadership was strengthened. 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.



Richard Mitchell
Chief Executive

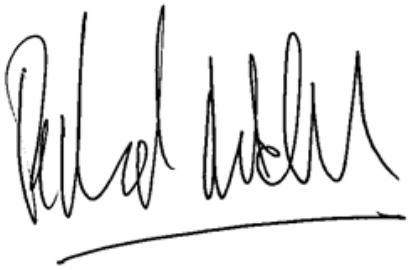
22 June 2020

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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	**Richard Mitchell**
Job title	**Chief Executive Officer**
Date	**22 June 2020**

Statement of Comprehensive Income
For the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	284,196	262,441
Other operating income	4	67,758	56,184
Operating expenses	6, 8	(350,068)	(314,265)
Operating surplus/(deficit) from continuing operations		**1,886**	**4,360**
Finance income	11	89	82
Finance expenses	12	(17,819)	(17,049)
PDC dividends payable		-	-
Other (losses)	13	(88)	(64)
Corporation tax expense		-	-
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
(Deficit) for the year		**(15,932)**	**(12,671)**
Other comprehensive (expense) / income			
Will not be reclassified to income and expenditure:			
Revaluations	17	(202)	1,999
Share of comprehensive income from associates and joint ventures		-	-
Total comprehensive income / (expense) for the period		**(16,134)**	**(10,672)**

(Deficit) / Surplus for the year as stated above		**(15,932)**	**(12,671)**
Reversal of impairment	7	(1,627)	(15,582)
Impairment	7	2,148	1,426
Deficit from continuing operations excluding the impact of impairments.		**(15,411)**	**(26,827)**

The Trust's financial performance is reported to NHS Improvement using the surplus / (deficit) per the statement of Comprehensive Income adjusted for technical accounting items. Donations in respect of assets, depreciation on donated assets and net impairments are excluded in the Trust's reported financial performance. Further details are provided in note 2 to the accounts.

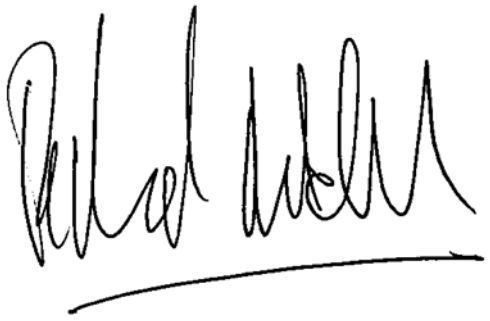
Statement of Financial Position

As at 31 March 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	5,271	3,356
Property, plant and equipment	15	279,927	283,981
Receivables	19	1,284	602
Total non-current assets		**286,482**	**287,939**
Current assets			
Inventories	18	4,466	3,422
Receivables	19	28,412	28,530
Cash and cash equivalents	20	2,383	4,255
Total current assets		**35,261**	**36,207**
Current liabilities			
Trade and other payables	21	(28,927)	(28,482)
Borrowings	23	(244,448)	(79,254)
Provisions	24	(1,133)	(1,502)
Other liabilities	22	(1,208)	(1,814)
Total current liabilities		**(275,716)**	**(111,052)**
Total assets less current liabilities		**46,027**	**213,094**
Non-current liabilities			
Trade and other payables	21	(195)	(500)
Borrowings	23	(239,884)	(393,238)
Provisions	24	(989)	(318)
		(241,068)	**(394,056)**
Total assets employed		**(195,041)**	**(180,962)**
Financed by			
Public dividend capital		149,615	147,560
Revaluation reserve		15,977	16,314
Income and expenditure reserve		(360,633)	(344,836)
Total taxpayers' equity		**(195,041)**	**(180,962)**

The notes on pages 119-166 form part of these accounts and were approved by the Board and signed on

Signed



Name **Richard Mitchell**
Job Description **Chief Executive Officer**
Date **22 June 2020**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**147,560**	**16,314**	**(344,836)**	**(180,962)**
Surplus/(deficit) for the year	-	-	(15,932)	**(15,932)**
Other transfers between reserves	-	(135)	135	**-**
Revaluations	-	(202)	-	**(202)**
Public dividend capital received	2,055	-	-	**2,055**
Taxpayers' and others' equity at 31 March 2020	**149,615**	**15,977**	**(360,633)**	**(195,041)**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**146,415**	**14,517**	**(332,367)**	**(171,435)**
Surplus/(deficit) for the year	-	-	(12,671)	**(12,671)**
Other transfers between reserves	-	(201)	201	**-**
Revaluations	-	1,999	-	**1,999**
Transfer to retained earnings on disposal of assets	-	(1)	1	**-**
Public dividend capital received	1,145	-	-	**1,145**
Taxpayers' and others' equity at 31 March 2019	**147,560**	**16,314**	**(344,836)**	**(180,962)**

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. No charges have been payable by the trust, to the Department of Health.

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 for the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,886	4,360
Non-cash income and expense:			
Depreciation and amortisation	6.1	11,502	9,055
Net impairments	7	521	(14,156)
Income recognised in respect of capital donations	4	(23)	(542)
(Increase) in receivables and other assets		(573)	(2,600)
(Increase) in inventories		(1,044)	(303)
(Decrease) / increase in payables and other liabilities		(1,125)	1,745
Increase / (decrease) in provisions		285	(105)
Other movements in operating cash flows		-	(1)
Net cash flows from / (used in) operating activities		**11,429**	**(2,547)**
Cash flows from investing activities			
Interest received		94	80
Purchase of intangible assets		(2,413)	(2,745)
Purchase of PPE and investment property		(7,086)	(8,776)
Sales of PPE and investment property		11	113
Net cash flows (used in) investing activities		**(9,394)**	**(11,328)**
Cash flows from financing activities			
Public dividend capital received		2,055	1,145
Movement on loans from DHSC		21,755	34,573
Capital element of PFI, LIFT and other service concession payments		(9,962)	(9,581)
Interest on loans		(3,230)	(2,722)
Other interest		(1)	(1)
Interest paid on PFI, LIFT and other service concession obligations		(14,524)	(14,189)
Net cash flows (used in) / from financing activities		**(3,907)**	**9,225**
(Decrease) in cash and cash equivalents		**(1,872)**	**(4,650)**
Cash and cash equivalents at 1 April - brought forward		**4,255**	**8,905**
Cash and cash equivalents at 31 March	20.1	**2,383**	**4,255**

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 2019/20 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.

Note1.1.1 Accounting Convention

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

Note 1.2 Going concern
These accounts have been prepared on a going concern basis.

The going concern concept is further covered in IAS 1 – 'Presentation of Financial Statements'. IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. In the event that a Foundation Trust is dissolved by Monitor any property or liabilities of the Trust may be transferred to another Foundation Trust, an NHS Trust or the Secretary of State.

For the public sector the context of IAS 1 going concern is modified to show that "For entities that are not trading funds, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

The close of the 2019/20 financial year and the early part of 2020/21 has been overshadowed by the Covid-19 outbreak which has had profound effects upon the operations of Health Services throughout the UK. As a consequence NHS finances have been significantly impacted at a National and local level. In relation to the Going Concern assessment, there are implications for Trust.

For the year ending 2019/20 the Trust is reporting a deficit of (£15.93m) which includes the impact of impairments on the valuation of buildings. Removing this impairment loss, which was £0.52m, we are reporting a deficit of
(£15.41m). On a control total basis this is favourable to the plan by £0.01m.

In year the Trust received £26.65m of Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Tariff (MRET), which was exactly to plan due to the Integrated Care System meeting the overall control total.

To support this financial position the Trust has received £24.86m of revenue support term loans and repaid £4.17m of previous revenue borrowing. In addition capital borrowing of £2.77m was incurred, however in year repayments of
£1.71m were made against existing capital loans.

The increased costs incurred in the final quarter (£1.07m), associated with preparation for and the treatment of patients suffering from Covid-19 have been recognised in full. NHS England and NHS Improvement in line with Government releases have agreed to meet all reasonable costs associated with Covid-19 and have funded 2019/20 costs accordingly.

NHSE&I set the Trust a Financial Improvement Trajectory (control total) for 2020/21 as a maximum deficit of (£29.34m), before Financial Recovery Fund allocations. Subsequent guidance confirmed a suspension of financial planning for 2020/21, with an interim financial framework introduced to manage the impact of Covid-19 until 31 July
2020.

Financial plans for 2020/21 have been deferred with Trusts and CCGs operating in accordance with guidance issued by NHSI in March.

This guidance states that for an initial period covering 1 April – 31 July 2020:

• NHS providers will receive block contract payments from commissioners, and income from non-NHS sources.
• Where this is not sufficient to cover a provider's underlying cost base, additional central top up payments will be made. Further top up payments will be made to cover reasonable costs of responding to the crisis, net of any cost reductions e.g. for consumables not required.

During this period block contract payments have been received by the Trust and the Department of Health and Social Care (DHSC) has confirmed that:

"It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore
continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this".

In a further change on 2 April 2020, the DHSC and NHS England and NHS Improvement announced reforms to the NHS cash regime moving forward.
Effective from 1 April 2020.
• Interim revenue loans at 31 March 2020 are to be extinguished during 2020/21. Providers will be issued Public Dividend Capital (PDC) to effect the repayment of outstanding balances at 31 March 2020.
• Within the statement of financial position all loans affected by this change have been recorded as current liabilities. Net current liabilities at 31 March 2020 are recorded as £195.04m, excluding those loans to be converted during 2020/21 this reverts to net current assets of £39.66m.
• For 2020/21, the Financial Recovery Fund (FRF) will be the sole source of financial support for NHS providers and CCGs that are otherwise unable to live within their means.
• Organisations' entitlement to FRF will continue to depend on full-year financial performance and, where financial trajectories are not achieved, any FRF that has been paid but not earnt will be converted to DHSC financing (PDC).
• Future revenue support will be available for exceptional short-term cash flow requirements and longer-term revenue support for providers in financial distress. This support will be provided as PDC (rather than loans) and does not require principal repayment but carries a dividend payable at the current PDC rate (3.5%).

In addition to these changes, and building upon the guidance to NHS bodies outlining measures in relation to Covid-19 contract arrangements covering 1 April – 31 July 2020, block contract payments will be made monthly in advance.

Recognising the heighted 'Going Concern' uncertainty generated by Covid-19, NHS England and NHS Improvement issued a joint statement on 27 May 2020 which incorporates the following paragraph, reaffirming 'continuity of service' and government funding:

In March 2020 we announced revised arrangements for NHS contracting and payment to apply for part of the 2020/21 year. In May 2020 we issued revised financial management guidance to CCGs for the corresponding period. We are not yet able to definitively announce the contracting arrangements that will be in place for the rest of 2020/21 and beyond. It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this.

Despite the block contract arrangements in place until 31 July 2020, the Trust is operating at a recurrent deficit and faces future uncertainty regarding future contracting and income arrangements.

These conditions indicate that there is a material uncertainty which may cast significant 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 has led the Board of Directors to conclude that it remains appropriate to prepare the financial statements on a going concern basis.

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 2010 were £1.5m.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 main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

(1) As per paragraph 121 of the Standard, the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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 car parking, 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. Significant annual leave was carried over whewre this relates to Covid 19 staff have until 31 March 2022 to reduce leave balances to normal carry forward levels.

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. There have been no discountinued operations in year, however there have been minor some changes to service provision where contracts have transferred to other NHS providers.

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.

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 (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that 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.

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
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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.

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 IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease 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 service charge (charged to operating expenses), lifecycle replacement cost and the finance lease liability. The finance lease liability is further split into the principal repaid, the loan interest expense and the contingent rent in accordance with IAS 17, and reflects the fact that the lease rental may increase due to uncertain factors.

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 2019/20 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	Indefinite	Indefinite
Buildings, excluding dwellings	1	57
Dwellings	1	57
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	5	10

An external review was commissioned and completed in year which has increased the maximum useful life of Information assets from 5 to 8 years.

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.

In year an exercise was undertaken with external advice to assess the remaining life of I.T. This has amended the remaining life of a large number of assets which has been reflected in the Trust's capital asset register.

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 and is £5k or more.

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, eg 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, eg 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 Years	**Max life Years**
Software licenses	5	10

An external review was commissioned and completed in year which has increased the maximum useful life of some assets from 5 to 10 years.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is valued on the basis of a first in first out basis.
IAS 2 states that "Where DHSC and PHE hold inventories considered to be “strategic” in the context of stockpiling for national emergencies, they must be treated as non-current assets". No such stocks were held.

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.

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; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

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.

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, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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 Corporation tax

No liability for corporation tax has been recognised or incurred when applying the current legislation.

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 (note 20.2) 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 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.25 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 2021. 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 re-measurement 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 2021, the trust will apply the standard retrospectively 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. Currently this rate is 1.27% but this may change between now and adoption of the standard. 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 2021 for existing finance leases.

For leases commencing in 2021/22, 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.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

	Financial year for which the change first applies
IFRS 14 Regulatory Deferral Accounts	Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 17 Insurance Contracts	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.

Note 1.26 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, £1.45m based on the PFI model.

External Valuation where no reliance has been placed on the valuation report as at 31 March 2020, as this represents the best available evidence of current value. Further details are included in note 1.27.
Inventory - A full year end stock take was not possible and only 50% of stock was counted. Overall stock levels are not material and therefore this is not considered a risk to the reported I&E or Inventory reported figures.

Note 1.27 Sources of estimation uncertainty

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

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)	**2019/20**	**2018/19**
	£000	**£000**
Acute services		
Elective income	37,846	35,562
Non elective income	99,718	96,741
First outpatient income	18,967	22,527
Follow up outpatient income	26,941	21,556
A & E income	20,462	17,232
High cost drugs income from commissioners (excluding pass-through costs)	16,605	16,784
Other NHS clinical income	37,703	47,568
Community services		
Community services income from CCGs and NHS England *	12,632	-
Income from other sources (e.g. local authorities) *	2,352	-
All services		
Private patient income	141	94
Agenda for Change pay award central funding**	-	3,586
Additional pension contribution central funding***	8,337	-
Other clinical income	2,492	791
Total income from activities	**284,196**	**262,441**

* More detailed analysis is available than previous years to enhance disclosure. Prior year comparators are not available and previously this was included in other NHS clinical income.

**Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers 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)**

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	20,930	12,953
Clinical commissioning groups	256,901	241,504
Department of Health and Social Care	-	3,586
Other NHS providers	863	605
NHS other	43	138
Local authorities	2,826	2,770
Non-NHS: private patients	141	94
Non-NHS: overseas patients (chargeable to patient)	47	42
Injury cost recovery scheme	2,213	749
Non NHS: other	232	-
Total income from activities	**284,196**	**262,441**
Related to continuing operations	284,196	262,441
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 21.79% to reflect expected rates of collection. (21.89% 2018/19)

The movement in income from NHS England relates to the centrally paid increase in NHS Pension contributions of £8.34m for 2019/20.

Other income relates to additional pay award funding for 2019/20.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20 £000	2018/19 £000
Income recognised this year	47	42
Cash payments received in-year	14	12
Amounts written off in-year	43	22

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	726	-	**726**	737	-	**737**
Education and training	11,173	-	**11,173**	11,268	-	**11,268**
Non-patient care services to other bodies	25,254	-	**25,254**	7,187	-	**7,187**
Provider sustainability fund (PSF)	7,028	-	**7,028**	18,908	-	**18,908**
Financial recovery fund (FRF)	14,807	-	**14,807**	-	-	**-**
Marginal rate emergency tariff funding (MRET)	5,385	-	**5,385**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	486	-	**486**	311	-	**311**
Receipt of capital grants and donations	-	23	**23**	-	542	**542**
Charitable and other contributions to expenditure	-	384	**384**	-	248	**248**
Rental revenue from operating leases	-	698	**698**	-	690	**690**
Other income	1,794	-	**1,794**	16,290	3	**16,293**
Total other operating income	**66,653**	**1,105**	**67,758**	**54,701**	**1,483**	**56,184**
Of which:						
Related to continuing operations			**67,758**			**56,184**
Related to discontinued operations			**-**			**-**

Provider Sustainability / Financial Recovery Fund relates to income received for meeting agreed operational and financial targets.

Note 4.1 Fees and Charges

HM Treasury requires the disclosure of fees and charges income where income from that service exceeeds £1m. No services exceeded this figure in 2019/20.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	606	605
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2020	31 March 2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	587	632
after one year, not later than five years	621	1,182
after five years	-	-
Total revenue allocated to remaining performance obligations	**1,208**	**1,814**

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

Note 5.3 Income from activities arising from commissioner requested services

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

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	281,563	261,556
Income from services not designated as commissioner requested services	2,633	885
Net income from services not designated as commissioner requested s	**284,196**	**262,441**

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

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	815	473
Purchase of healthcare from non-NHS and non-DHSC bodies	3,237	1,203
Staff and executive directors costs	222,516	205,847
Remuneration of non-executive directors	143	136
Supplies and services - clinical (excluding drugs costs)	26,646	26,534
Supplies and services - general	3,615	3,168
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,610	24,355
Inventories written down	-	(75)
Consultancy costs	411	430
Establishment	3,087	3,220
Premises	18,462	17,342
Transport (including patient travel)	666	668
Depreciation on property, plant and equipment	10,452	7,357
Amortisation on intangible assets	1,050	1,698
Net impairments	521	(14,156)
Movement in credit loss allowance: contract receivables / contract assets	137	(110)
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	(324)	(253)
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	100	78
other auditor remuneration (external auditor only)	-	9
Internal audit costs	118	124
Clinical negligence	10,983	13,031
Legal fees	111	75
Education and training	598	575
Rentals under operating leases	404	332
Early retirements	136	52
Redundancy	120	4
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	19,961	21,156
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	113	156
Car parking & security	110	-
Hospitality	230	183
Other	3,040	653
Total	**350,068**	**314,265**
Of which:		
Related to continuing operations	350,068	314,265
Related to discontinued operations	-	-

£8.34m of the increase in pay costs is driven by the centrally paid increase in NHS Pension contributions for 2019/20.

Note 6.2 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	9
Total	**-**	**9**

There are no otheer fees in 2019/20 as there is no audit required for the quality accounts in 2019/20.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Reversal of impairment	(1,627)	-
Impairment due to changes in market price	2,148	(14,156)
Total net impairments charged to operating surplus / deficit	**521**	**(14,156)**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**521**	**(14,156)**

Material impiarments / (reversals) charged to the SOCI in 2019/20 resulting from changes in market price

	2019/20 £000	2018/19 £000
Reversals of impairments charged to the SOCI in previous years		
Tower 1,2,3 Kings Mill Site	(672)	(4,903)
Newark Site	(215)	(1,773)
Trust Admin Building	(117)	
Kings Treatment Centre	(184)	(3,596)
FM building	-	(444)
Block 40	-	(3,162)
Elipse	(64)	(528)
Renal	-	(420)
Other	(375)	(756)
Impairments charged to SOCI in year		
PFI lifecycle	1434	1304
FM building	345	0
Other	369	122
	521	**(14,156)**

The District valuer has undertaken a desktop review of the Trust estate as at 31 March 2020, full review 2018/19. 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.

Property Plant and Equipment impairments and reversals charged to the revaluation reserve

	2019/20 £000	2018/19 £000
Change in market price	(202)	1,999
Total impairment for PPE charged to reserves	**(202)**	**1,999**

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	164,902	156,410
Social security costs	16,978	16,497
Apprenticeship levy	850	809
Employer's contributions to NHS pensions	19,256	18,133
Pension cost - other	8,337	-
Termination benefits	34	99
Temporary staff (including agency)	12,842	14,272
Total gross staff costs	**223,199**	**206,220**
Recoveries in respect of seconded staff	-	-
Total staff costs	**223,199**	**206,220**
Of which		
Costs capitalised as part of assets	427	317

Note 8.1 Retirements due to ill-health

During 2019/20 there were 2 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liability of these ill-health retirements is £137k (£382k in 2018/19).

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. Based on 2019/20 it is anticipated that the Trust will contribute at least £27.6m in
2020/21.

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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2020 there were 5,102 are members of the NHS Pension Scheme, 375 are enrolled within NEST and 633 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.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	698	690
Total	**698**	**690**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	528	487
- later than one year and not later than five years;	374	373
- later than five years.	16	24
Total	**918**	**884**

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.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	404	332
	404	**332**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	330	396
- later than one year and not later than five years;	1,074	155
- later than five years.	145	2
Total	**1,549**	**553**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	89	82
Total finance income	**89**	**82**

Note 12.1 Finance expenses

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,277	2,866
Interest on late payment of commercial debt	1	1
Main finance costs on PFI and LIFT schemes obligations	5,932	6,153
Contingent finance costs on PFI and LIFT scheme obligations	8,592	8,036
Total interest expense	**17,802**	**17,056**
Unwinding of discount on provisions	17	(7)
Other finance costs	-	-
Total finance costs	**17,819**	**17,049**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£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	1	1

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	11	113
Losses on disposal of assets	(99)	(177)
Total gains / (losses) on disposal of assets	**(88)**	**(64)**

Note 14.1 Intangible assets - 2019/20	2019/20	2018/19
	Software licences	**Software licences**
	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**14,880**	14,105
Additions	2,965	2,276
Reclassifications	-	(1,501)
Valuation / gross cost at 31 March 2020	**17,845**	**14,880**
Amortisation at 1 April 2019 - brought forward	**11,524**	9,826
Provided during the year	1,050	1,698
Amortisation at 31 March 2020	**12,574**	**11,524**
Net book value at 31 March 2020	**5,271**	-
Net book value at 1 April 2019	**3,356**	-
Net book value at 1 April 2018	-	**4,279**

Note 15.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**17,396**	**248,789**	**2,000**	**-**	**33,775**	**14,198**	**506**	**316,664**
Additions	-	2,520	186	387	2,031	2,096	-	**7,220**
Impairments	-	(2,148)	-	-	-	-	-	**(2,148)**
Reversals of impairments	-	1,627	-	-	-	-	-	**1,627**
Revaluations	60	(262)	-	-	-	-	-	**(202)**
Disposals / derecognition	-	-	-	-	(375)	(2)	-	**(377)**
Valuation/gross cost at 31 March 2020	**17,456**	**250,526**	**2,186**	**387**	**35,431**	**16,292**	**506**	**322,784**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**5,492**	**-**	**-**	**17,760**	**9,119**	**312**	**32,683**
Provided during the year	-	6,170	-	-	2,935	1,295	52	**10,452**
Disposals / derecognition	-	-	-	-	(276)	(2)	-	**(278)**
Accumulated depreciation at 31 March 2020	**-**	**11,662**	**-**	**-**	**20,419**	**10,412**	**364**	**42,857**
Net book value at 31 March 2020	**17,456**	**238,864**	**2,186**	**387**	**15,012**	**5,880**	**142**	**279,927**
Net book value at 1 April 2019	**17,396**	**243,297**	**2,000**	**-**	**16,015**	**5,079**	**194**	**283,981**

A revalution was undertaken as at 31 March 2020. Had this not been performed the carrying value of buidlings would have been £0.5m higher than that disclosed above.

Note 15.2 Property, plant and equipment - 2018/19

	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 2018 - as previously stated	**17,361**	**228,605**	**1,826**	**-**	**32,411**	**11,454**	**427**	**292,084**
Additions	-	4,064	174	-	2,928	1,252	79	**8,497**
Reversals of impairments	-	14,156	-	-	-	-	-	**14,156**
Revaluations	35	1,964	-	-	-	-	-	**1,999**
Reclassifications	-	-	-	-	-	1,501	-	**1,501**
Disposals / derecognition	-	-	-	-	(1,564)	(9)	-	**(1,573)**
Valuation/gross cost at 31 March 2019	**17,396**	**248,789**	**2,000**	**-**	**33,775**	**14,198**	**506**	**316,664**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**-**	**-**	**-**	**19,213**	**7,246**	**263**	**26,722**
Provided during the year	-	5,492	-	-	(66)	1,882	49	**7,357**
Disposals / derecognition	-	-	-	-	(1,387)	(9)	-	**(1,396)**
Accumulated depreciation at 31 March 2019	**-**	**5,492**	**-**	**-**	**17,760**	**9,119**	**312**	**32,683**
Net book value at 31 March 2019	**17,396**	**243,297**	**2,000**	**-**	**16,015**	**5,079**	**194**	**283,981**
Net book value at 1 April 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**

Note 15.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	17,456	11,698	-	387	14,208	5,875	90	**49,714**
On-SoFP PFI contracts and other service concession arrangements	-	225,971	-	-	-	-	-	**225,971**
Off-SoFP PFI residual interests	-	-	2,186	-	-	-	-	**2,186**
Owned - donated	-	1,195	-	-	804	5	52	**2,056**
NBV total at 31 March 2020	**17,456**	**238,864**	**2,186**	**387**	**15,012**	**5,880**	**142**	**279,927**

Note 15.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	17,396	11,226	-	-	14,645	5,072	173	**48,512**
On-SoFP PFI contracts and other service concession arrangements	-	230,841	-	-	-	-	-	**230,841**
Off-SoFP PFI residual interests	-	-	2,000	-	-	-	-	**2,000**
Owned - donated	-	1,230	-	-	1,370	7	21	**2,628**
NBV total at 31 March 2019	**17,396**	**243,297**	**2,000**	**-**	**16,015**	**5,079**	**194**	**283,981**

Note 16 Donations of property, plant and equipment
The Trust received donations during the year of £406k. (2018/19 £790k). No restrictions were placed on these donations of which £22k 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 2020.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

This desktop 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 lonoger 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 2020 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 2020 £000	**31 March 2019 £000**
Drugs	1565	1315
Consumables	2827	2033
Energy	74	74
Total inventories	**4,466**	**3,422**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £27,221k (2018/19: £29,319k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Note 19.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	25,769	25,755
Allowance for impaired contract receivables / assets	(304)	(278)
Prepayments (non-PFI)	1,336	1,597
Interest receivable	3	8
VAT receivable	1,366	1,318
Other receivables	242	130
Total current receivables	**28,412**	**28,530**
Non-current		
Contract assets	1,229	1,097
Allowance for other impaired receivables	(662)	(551)
PFI prepayments - capital contributions	52	56
	665	-
Total non-current receivables	**1,284**	**602**
Of which receivable from NHS and DHSC group bodies:		
Current	22,043	20,876
Non-current	665	-

Comparable contract receivables prior to the adoption of IFRS 15 for 2017/18 were £22,702.

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	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	**829**	**-**	**-**	**1,048**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	1,048	(1,048)
New allowances arising	-	-	79	-
Changes in existing allowances	211	-	(189)	-
Reversals of allowances	(74)	-	-	-
Utilisation of allowances (write offs)	-	-	(109)	-
Allowances as at 31 March 2020	**966**	**-**	**829**	**-**

Note 19.3 Exposure to credit risk	31-Mar-20 Contract receivables and contract assets	31-Mar-19 Contract receivables and contract assets
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	41	24
30-60 Days	43	26
60-90 days	34	32
Over 90 days	848	747
	966	829
Ageing of non-impaired financial assets past their due date	**£000**	**£000**
0 - 30 days	21,500	25,023
30-60 Days	1,213	1,823
60-90 days	1,020	531
Over 90 days	5,591	1,755
	29,324	29,132

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.

	2019/20 £000	2018/19 £000
At 1 April	**4,255**	**8,905**
Net change in year	(1,872)	(4,650)
At 31 March	**2,383**	**4,255**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	2,377	4,249
Total cash and cash equivalents as in SoFP	**2,383**	**4,255**

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 2020 £000	31 March 2019 £000
Monies on deposit	1	1
Total third party assets	**1**	**1**

Note 21.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	5,070	4,292
Capital payables	5,382	4,723
Accruals	10,277	10,933
Receipts in advance and payments on account	-	20
Social security costs	2,456	2,211
Other taxes payable	1,938	1,867
Other payables	3,804	4,436
Total current trade and other payables	**28,927**	**28,482**
Non-current		
Other payables	195	500
Total non-current trade and other payables	**195**	**500**
Of which payables from NHS and DHSC group bodies:		
Current	4,601	4,582
Non-current	195	500

Note 21.2 Early retirements in NHS payables above

There were no amounts included in trade and other payables in relation to early retirements.

Note 22 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,208	1,814
Total other current liabilities	**1,208**	**1,814**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Comparable contract liabilities prior to the adoption of IFRS 15 for 2017/18 were £2,419.

Note 23.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	234,704	69,508
Obligations under PFI, LIFT or other service concession contracts	9,744	9,746
Total current borrowings	**244,448**	**79,254**
Non-current		
Loans from DHSC	-	143,394
Obligations under PFI, LIFT or other service concession contracts	239,884	249,844
Total non-current borrowings	**239,884**	**393,238**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2019	**212,902**	**259,590**	**472,492**
Cash movements:			
Financing cash flows - payments and receipts of principal	21,755	(9,962)	**11,793**
Financing cash flows - payments of interest	(3,230)	(5,932)	**(9,162)**
Non-cash movements:			
Application of effective interest rate	3,277	5,932	**9,209**
Carrying value at 31 March 2020	**234,704**	**249,628**	**484,332**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2018	**177,630**	**269,172**	**446,802**
Cash movements:			
Financing cash flows - payments and receipts of principal	34,573	(9,581)	**24,992**
Financing cash flows - payments of interest	(2,722)	(6,154)	**(8,876)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	555	-	**555**
Application of effective interest rate	2,866	6,153	**9,019**
Carrying value at 31 March 2019	**212,902**	**259,590**	**472,492**

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 2019	**313**	**57**	**70**	**1,159**	**221**	**1,820**
Arising during the year	**40**	**7**	**114**	**-**	**665**	**826**
Utilised during the year	(49)	(5)	(55)	-	-	**(109)** Reversed
unused	(2)	-	(16)	(193)	(221)	**(432)** Unwinding of discount
13 4 - - - **17**						
At 31 March 2020	**315**	**63**	**113**	**966**	**665**	**2,122**
Expected timing of cash flows:						
- not later than one year;	49	5	113	966	**-**	**1,133**
- later than one year and not later than five years;	195	21	-	-	**-**	**216**
- later than five years.	71	37	-	-	**665**	**773**
Total	**315**	**63**	**113**	**966**	**665**	**2,122**

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 2020, £137.94m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2019: £110.36m).

Note 25 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
Other	(74)	(50)
Gross value of contingent liabilities	**(74)**	**(50)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(74)**	**(50)**
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 2020 £000	31 March 2019 £000
Property, plant and equipment	3,661	2,905
Intangible assets	864	-
Total	**4,525**	**2,905**

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 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**685,192**	**717,676**
Of which liabilities are due		
- not later than one year;	24,506	24,307
- later than one year and not later than five years;	100,099	101,430
- later than five years.	560,587	591,939
Finance charges allocated to future periods	(435,564)	(458,086)
Net PFI, LIFT or other service concession arrangement obligation	**249,628**	**259,590**
- not later than one year;	9,744	9,746
- later than one year and not later than five years;	38,756	39,489
- later than five years.	201,128	210,355

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,530,747**	**1,597,022**
Of which payments are due:		
- not later than one year;	49,583	48,433
- later than one year and not later than five years;	211,292	208,155
- later than five years.	1,269,872	1,340,434

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:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**45,888**	**46,237**
Consisting of:		
	5,932	6,153
- Repayment of balance sheet obligation	9,962	9,583
- Service element and other charges to operating expenditure	19,951	21,146
- Capital lifecycle maintenance	1,451	1,319
- Contingent rent	8,592	8,036
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	10	10
Total amount paid to service concession operator	**45,898**	**46,247**

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 2020 £000	31 March 2019 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**113**	**156**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	324	317
- later than one year and not later than five years;	1,381	1,363
- later than five years.	4,157	4,582
Total	**5,862**	**6,262**

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.

The key risks that the Trust has identified are as follows:

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 Trust initially identified a cash shortfall in its 2020/21 operational plan, which required borrowing support from the Department of Health and Social Care. Due to the change in funding flows resulting from Covid 19 no such support is currently required. Should funding flows be amended from August 2020, monthly applications for cash support will be made if required. 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 2020	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	26,942	-	-	**26,942**
Cash and cash equivalents	2,383	-	-	**2,383**
Total at 31 March 2020	**29,325**	**-**	**-**	**29,325**

Carrying values of financial assets as at 31 March 2019	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	25,909	-	-	**25,909**
Cash and cash equivalents	4,255	-	-	**4,255**
Total at 31 March 2019	**30,164**	**-**	**-**	**30,164**

Note 29.8 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	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	234,704	-	**234,704**
Obligations under PFI, LIFT and other service concession contracts	249,628	-	**249,628**
Trade and other payables excluding non financial liabilities	24,728	-	**24,728**
Provisions under contract	2,122	-	**2,122**
Total at 31 March 2020	**511,182**	**-**	**511,182**

Carrying values of financial liabilities as at 31 March 2019	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	212,902	-	**212,902**
Obligations under PFI, LIFT and other service concession contracts	259,590	-	**259,590**
Trade and other payables excluding non financial liabilities	24,511	-	**24,511**
Provisions under contract	1,820	-	**1,820**
Total at 31 March 2019	**498,823**	**-**	**498,823**

Note 29.9 Maturity of financial liabilities

	2020	2019
	£000	£000
In one year or less	270,291	104,813
In more than one year but not more than two years	12,972	103,486
In more than two years but not more than five years	26,018	75,151
	201,901	215,373
Total	**511,182**	**498,823**

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	18	15	20	3
Bad debts and claims abandoned	302	50	400	26
Stores losses and damage to property	5	1	8	-
Total losses	**325**	**66**	**428**	**29**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	38
Ex-gratia payments	48	239	37	7
Special severance payments	1	10	2	65
Total special payments	**49**	**249**	**42**	**110**
Total losses and special payments	**374**	**315**	**470**	

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 Mansfield and Ashfield CCG NHS Newark and Sherwood CCG NHS Derby and Derbyshire CCG
NHS Nottingham City CCG
NHS Nottingham North and East CCG NHS Nottingham West CCG
NHS Rushcliffe 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)

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund. Charitable Income of £406k (2018/19 £790k) has been recognised in these accounts all of which relates to Sherwood Forest Hospitals General Charitable Fund. In addition a recharge of £56k (2018/19 £60k) has been made to Sherwood Forest Hospitals General Charitable Fund in relation to management / staff costs.

The Trust made no payments to related parties for whom the Chair, Non-Executive or Executive Directors are named Directors.

Note 32 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £77.87m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

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.

There are no other non-adjusting events after the reporting period which affects the financial information and disclosures made in these accounts.

Independent Auditors' Report to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Sherwood Forest Hospitals NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Comprehensive Income for the year ended 31 March 2020, the Statement of Financial Position as at 31 March 2020; the Statement of Changes in Equity for the year ended 31 March 2020; the Statement of Cash Flows for the year ended 31 March 2020; and the Notes to the Accounts, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.2 to the financial statements concerning the Trust's ability to continue as a going concern.

Sherwood Forest Hospitals NHS Foundation Trust recorded a deficit from continuing operations, excluding the impact of impairments, of £15.41 million. The Trust is also forecasting a deficit for the year ending 31 March 2021. The forecast is based on a number of assumptions but there is significant uncertainty in the financial plan for the year ending 31 March 2021 as a result of the COVID-19 pandemic and its impact on the Trust. These factors have created uncertainty regarding future contracting and income arrangements for the Trust.

These conditions, along with the other matters explained in note 1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant 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 has led the Board of Directors to conclude that it remains appropriate to prepare the financial statements on a going concern basis. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Explanation of material uncertainty

The Department of Health and Social Care Group Accounting Manual 2019/20 requires that the financial statements of the Trust should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

The Trust recorded a deficit in the year ended 31 March 2020 of £15.41 million (deficit from continuing operations, excluding the impact of impairments). The Trust submitted a draft financial plan for the year ending 31 March 2021 to NHS Improvement which, if achieved, would not meet the agreed financial improvement trajectory of a £29.34 million deficit. The deficit in the draft financial plan was £37.22 million. The Trust intended to reduce the gap on the deficit by the time a final plan was submitted. As a result of the COVID-19 pandemic in March 2020, this was not progressed.

The Trust has produced a cash flow forecast until 30 June 2021. This forecasts that the Trust will not be reliant on external cash support from the Department of Health and Social Care. However, due to the COVID-19 pandemic and resulting changes to funding arrangements in the NHS, there is uncertainty regarding future contracting and income arrangements for the Trust.

What audit work we performed

In considering the financial performance of the Trust and the appropriateness of the going concern assumption in the preparation of the financial statements, we:

- obtained the financial trajectory target set by NHS England and NHS Improvement for the year ending 31 March 2021 and reviewed how this compared to the draft financial plan the Trust had developed in March 2020 prior to the COVID-19 pandemic;
- compared the Trust's Financial Improvement Plan (FIP) performance outturn for the year ended 31 March 2020 against the targeted savings and considered the degree to which the FIP programme for the year ending 31 March 2021 has been developed; and
- reviewed the Trust's cash flow forecast until 30 June 2021 to understand the forecast cash position of the Trust and the assumptions that the Trust has applied in preparing it.

As a result of this work, we concluded that the forecasts used by Sherwood Forest Hospitals NHS Foundation Trust in its determination of the appropriateness of the going concern basis of accounting were consistent with the evidence available. We also concluded that there is a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern for the reasons above.

Our audit approach

Context

Sherwood Forest Hospitals NHS Foundation Trust provides acute healthcare services across Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. It is funded predominantly by local Clinical Commissioning Groups ("CCGs") and NHS England.

NHS Improvement has placed Sherwood Forest Hospitals NHS Foundation Trust in segment 2 of its Single Oversight Framework as at 31 March 2020. NHS Improvement's Single Oversight Framework is the framework for overseeing providers and identifying potential support needs. Segment 2 is described by NHS Improvement as 'Providers offered targeted support'.

Our audit for the year ended 31 March 2020 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. The Trust's financial stability remained a key area of focus. The Trust's operations were also affected as a result of the COVID-19 pandemic. In light of this, our approach to the audit, in terms of scoping and key audit matters, was largely unchanged apart from the COVID-19 key audit matter that was new this year.

Our audit also involved forming a conclusion on the arrangements for securing economy, efficiency and effectiveness in the use of resources (the "3 Es"), in accordance with the Code of Audit Practice.

Overview

- Overall materiality: £6,539,740 (2019: £5,876,000) which represents 2% of total revenue (operating income from patient care activities and other operating income) in the annual plan.

- All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statements.
- During our audit we visited the King's Mill Hospital and performed the majority of our audit of the financial information remotely as the COVID-19 pandemic affected working arrangements for staff.

Our key audit matters were:

- Going concern (explained under "Material uncertainty relating to going concern" above).
- Management override of control and fraud in revenue and expenditure recognition.
- Valuation of Property, Plant and Equipment.
- COVID-19 (Trust and 3 Es).

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and the conclusion on the arrangements for securing economy, efficiency, and effectiveness in the use of resources, and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to going concern, described in the 'Material uncertainty relating to going concern' section above, and the matters described in the 'Arrangements for securing economy, efficiency and effectiveness in the use of resources' section below, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the key audit matter*
Management override of control and fraud in revenue and expenditure recognition *See note 1 to the financial statements for the Trust's disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3 – 6 for further information.* Under ISAs (UK) 240 there is a (rebuttable) presumption that there are risks of fraud in revenue recognition. We extend this presumption to the recognition of expenditure in the NHS in general. The main source of revenue for the Trust is from contracts with commissioning bodies in respect to healthcare services, under which revenue is recognised when, and to the extent that, healthcare services are provided to patients. We focussed on this area because there is a heightened risk due to: • the risks surrounding the financial sustainability of Sherwood Forest Hospitals NHS Foundation Trust, as described in the section 'Material uncertainty relating to going concern'; and • due to the wider financial challenge in the NHS, the pressure Sherwood Forest Hospitals NHS Foundation Trust is under to achieve its forecast deficit for the year ended 31 March 2020 set out in its plan submitted to NHS Improvement and gain access to the available Provider Sustainability Funding ('PSF'); and therefore the incentive to recognise income for services which have not been delivered during the financial year, and to omit to recognise expenditure in the year ended 31 March 2020, to improve the reported financial position. We considered revenue recognition to be a risk, in particular revenue streams from the Clinical Commissioning Groups ("CCGs") and NHS England, which together comprise £278 million of the Trust's £352 million of income. The service level agreements with the CCGs consist of standard monthly instalments. A monthly adjustment is then negotiated with the CCGs to reflect actual levels of activity. The value of the adjustment is subject to management judgement. The Trust can also earn Commissioning for Quality and Innovation (CQUIN) revenue as a percentage of the contract value for demonstrating improvements in quality and innovation in specified areas of patient care.	*Revenue and expenditure* We evaluated and tested the accounting policies for revenue and expenditure recognition to ensure that they were consistent with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20 and IfRS 15. We noted no issues in this respect. For a sample of transactions recognised during the year and around the year-end (both before and after), we checked that income and expenditure had been recognised in line with the Trust's accounting policies and in the correct accounting period by agreeing transactions to the supporting invoice and cash receipts/payments where appropriate. We also performed testing to identify whether there were any unrecorded liabilities. We: • tested a sample of payments made and invoices received after 31 March 2020 to supporting documentation, to check that, where they related to the year ended 31 March 2020, an accrual was recognised appropriately; and • performed a sample test of accrued expenses recognised at 31 March 2020 to confirm that they had been recorded at an appropriate value. As a result of the above tests, we identified expenditure transactions with an approximate value of £1.26 million which related to the year ended 31 March 2020 but had not been recorded in the accounts. These transactions were not material to the financial statements but would have impacted on the Trust's achievement of its financial control total for the year ended 31 March 2020, if adjusted. We therefore requested the Trust obtain confirmation from NHS Improvement, that these misstatements would not affect the Trust's entitlement to PSF income for the year ended 31 March 2020. NHS Improvement confirmed that PSF entitlement for the year ended 31 March 2020 would not be affected. For a sample of CCG income, we obtained the signed contract and agreed its value to the income recognised during the year. For this sample, we also agreed income to invoice and cash receipts. For a sample of income from over and under performance against the contract, we agreed the income to supporting evidence. This included inspecting information from the year-end intra-NHS balance agreement process to identify any significant differences between the income and accounts receivable reported with NHS organisations. No material issues were identified from the work performed.

We also considered expenditure recognition to be a risk. Given the incentive described above, we focussed on the completeness of expenditure in the Statement of Comprehensive Income and of liabilities recorded in the Statement of Financial Position.

We focused our work on the elements of income and expenditure that are most susceptible to manipulation:

- non-standard journal transactions;
- expenditure accruals;
- expenditure incurred close to year end; and
- unrecorded liabilities.

We also inspected the information from the year-end intra-NHS balance agreement process to identify any significant differences between the expenditure and accounts payable reported with NHS organisations. No material issues were identified from the work performed.

We obtained an understanding of the movement for each category of expenditure provision recorded in the Trust's accounts. No unusual material movements were identified as part of this review.

No material issues were identified from the work performed on revenue and expenditure transactions and we did not identify any transactions that were indicative of fraud in the recognition of revenue or expenditure.

Journals

Our journals work was carried out using a risk-based approach across the general ledger used by the Trust. We used data analysis techniques to identify the journals that had higher risk characteristics.

We tested a sample of journal transactions that had been recognised in both income and expenditure throughout the year but also tested related journals at each quarter end, focussing in particular on those that arose from unexpected account combinations and confirming there were no journals posted by senior management. We agreed the journal entries to supporting documentation, such as invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income and expenditure was recognised in the appropriate accounting period, for the correct value.

Valuation of Property, Plant and Equipment

See note 1 to the financial statements for the Trust's disclosure of accounting policies relating to the valuation of the Trust's land and buildings and note 15 and note 17 for further information.

Property, Plant and Equipment represents one of the largest balances in the Statement of Financial Position. The valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions. Therefore, our work has focused on whether the methodology, assumptions and underlying data used to determine the value of Property, Plant and Equipment were appropriate and correctly applied.

Property, Plant and Equipment as at 31 March 2020 has a Net Book Value of £280 million of which £17.5 million is land, £238.9 million is buildings and £23.6 million relates to other assets.

All Property, Plant and Equipment assets are measured initially at cost, with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by a professionally qualified District Valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date.

A valuation of Sherwood Forest Hospitals NHS Foundation Trust's portfolio of land and buildings was undertaken as at 31 March 2020 by Sherwood Forest Hospitals NHS Foundation Trust's valuation expert who noted that the COVID-19 pandemic has not impacted on property valuations but has advised that a revaluation be performed as soon as some level of normality returns.

The specific areas of risk are:

- accuracy and completeness of detailed information on assets provided to the valuation expert;
- the methodology, assumptions and underlying data used by the valuation expert; and

We obtained the valuation reports directly from Sherwood Forest Hospitals NHS Foundation Trust's valuation expert and read the relevant sections of the reports. We confirmed that the valuer had relevant experience and was a member of a relevant professional body.

We used our valuation expert to evaluate the assumptions and methodology applied in the valuation exercise. We concluded that the methodology and approach applied by the Trust's independent expert are reasonable.

We looked at the assumptions and inputs used in the valuation. This included testing the floor area for a sample of assets upon which the valuer conducted their valuation, confirming the right location was used. No matters were identified.

We also undertook a sample test to confirm whether buildings had been correctly identified as specialist or non-specialist. We found no material issues from these procedures.

We tested whether the valuation was correctly accounted for and appropriately disclosed in the financial statements and found that it was.

Due to the uncertainty created by the COVID-19 pandemic regarding the valuation of the Trust's land and buildings, we asked for additional disclosures to be added to the financial statements to reflect the impact of COVID-19 on the valuation process as at 31 March 2020. The Trust has disclosed this material valuation uncertainty as part of note 17 in the financial statements.

We reviewed how the Trust has accounted for lifecycle costs in the year ended 31 March 2020. The Trust has accounted for all costs as capital due to a lack of information on the split of costs between capital and revenue expenditure. The total value of costs in the year ended 31 March 2020 was £1.45 million. This is not material and the financial statements were not changed.

We performed a review to understand where the Trust had updated the useful lives of assets in the year ended 31 March 2020. Changes had predominantly occurred for IT equipment. The Trust had accounted for these changes correctly in the financial statements for the year ended 31 March 2020.

- the accounting transactions resulting from this valuation.

The valuation of the Trust's Property, Plant and Equipment is also impacted by other factors that we determined to be of a heightened risk. These being:

- how the Trust accounts for lifecycle costs in the financial statements for buildings included under Private Finance Initiative (PFI) arrangements; and
- changes made to the useful lives of Property, Plant and Equipment assets and how these are accounted for in the financial statements.

COVID-19 (Trust and 3 Es)

During the course of the audit, both management and the engagement team considered the impact that the ongoing COVID-19 pandemic has had on the activities, suppliers and wider economy of the Trust and its financial statements.

Management's assessment is that there was not a significant impact on the outturn financial position, because the Trust's operations only significantly changed in scope during March 2020 and the Trust was able to reclaim COVID-19 related costs.

Due to the significance of the pandemic, the financial statements have recognised the impact as a non-adjusting post balance sheet event in the financial statements. The actions the Trust took in response have been disclosed as part of its Annual Governance Statement in the Annual Report.

As a result of this, we determined that the impact of COVID-19 should be a key audit matter.

We performed the following procedures to address the impact that COVID-19 has on the financial statements:

- Evaluated and challenged management's assessment of the pandemic and its impact on valuations and going concern. This included using our own valuations experts to consider the assumptions underpinning the Trust's valuation. Our work on evaluating management's going concern assessment is described in the "Material uncertainty relating to going concern" section above.
- Sample tested items recognised as COVID-19 related costs to ensure the classification as being reimbursable was appropriate. We did not identify any errors.
- Performed extended sample testing of non-pay expenditure transactions posted after 31 March 2020 to address the heightened risk that transactions may have been posted to the wrong period. Our conclusions from our sample testing of non-pay expenditure have been set out in the key audit matter on fraud in expenditure recognition, above.
- Assessed the disclosures made by management and ensured that the impact of the pandemic was reflected in the Annual Report, and in the accounting policies and as a non-adjusting post balance sheet event in the financial statements.
- Held regular discussions with the Trust's finance team to understand the impact of the COVID-19 pandemic on the Trust.
- Read the Board paper prepared by the Trust setting out how financial governance has been maintained during the COVID-19 pandemic.

We concluded that the Trust's assessment of the impact of the COVID-19 pandemic on arrangements for securing economy, efficiency and effectiveness in its use of resources was reasonable, as it has disclosed in the Annual Governance Statement in the Annual Report.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

Due to the impact of the COVID-19 pandemic, the audit was primarily conducted remotely by working with Trust finance staff and other Trust employees who are based at Sherwood Forest Hospitals NHS Foundation Trust's largest site in Mansfield (King's Mill Hospital).

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£6,539,740 (2019: £5,876,000)
How we determined it	2% of revenue* in the annual plan (2019: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

*Revenue includes operating income from patient care activities and other operating income.

We agreed with the Audit and Assurance Committee that we would report to them misstatements identified during our audit above £300,000 (2019: £293,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2019/20 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2020 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20, and for being satisfied that they give a true and fair view. The directors 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.

In preparing the financial statements, the directors are responsible for 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 the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

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

Auditors' responsibilities for the audit of the financial statements

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

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

We are required under Schedule 10 (1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice, we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020. Key audit matters relating to this reporting requirement are set out in the Key audit matters table above and identified as relating to the 3 Es conclusion, and in the Basis for qualified opinion paragraph below.

Qualified opinion

Except for the matters set out in the basis for qualified opinion paragraph below and key audit matter included in the table above, we have nothing to report as a result of this requirement.

Basis for qualified opinion and key audit matters

The Trust's outturn position for the year ended 31 March 2020 is a deficit from continuing operations, excluding the impact of impairments, of £15.41 million. Included as part of this deficit, is £26.65m of Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Tariff ('MRET') income. A further £0.57m of 2018/19 PSF reallocation was also received in the year ended 31 March 2020.

The Trust has been reliant on external cash support from the Department of Health and Social Care on a rolling monthly basis throughout the year ended 31 March 2020. In the year, £24.86m of revenue loans was provided to the Trust. Additionally, a capital loan of £2.77m was also provided.

The Trust is forecasting a deficit for the year ending 31 March 2021. The forecast deficit is based on a number of assumptions and there is significant uncertainty in the financial plan for the year ending 31 March 2021 as a result of the COVID-19 pandemic and its impact on the Trust.

These issues, along with the other matters explained in the material uncertainty relating to going concern section, are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable deployment of resources to deliver the Trust's strategic priorities. In this respect, we have concluded that Sherwood Forest Hospitals NHS Foundation Trust has not put in place all necessary arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2020.

In arriving at this conclusion, the work that we performed included:

- comparing the Trust's Financial Improvement Plan (FIP) performance outturn for the year ended 31 March 2020 against the targeted savings and considered the degree to which the FIP programme for the year ending 31 March 2021 has been developed;
- reviewing the outturn position for the year ended 31 March 2020 compared to the planned financial performance for the year ended 31 March 2020; and

- obtaining the financial trajectory target set by NHS England and NHS Improvement for the year ending 31 March 2021 and reviewing how this compared to the draft financial plan the Trust had developed in March 2020 prior to the COVID-19 pandemic.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors in the Accountability Report, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report 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 is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- The section of the Annual report in the Accountability Report, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court
Pegasus Business Park
Castle Donington

Date: 24 June 2020