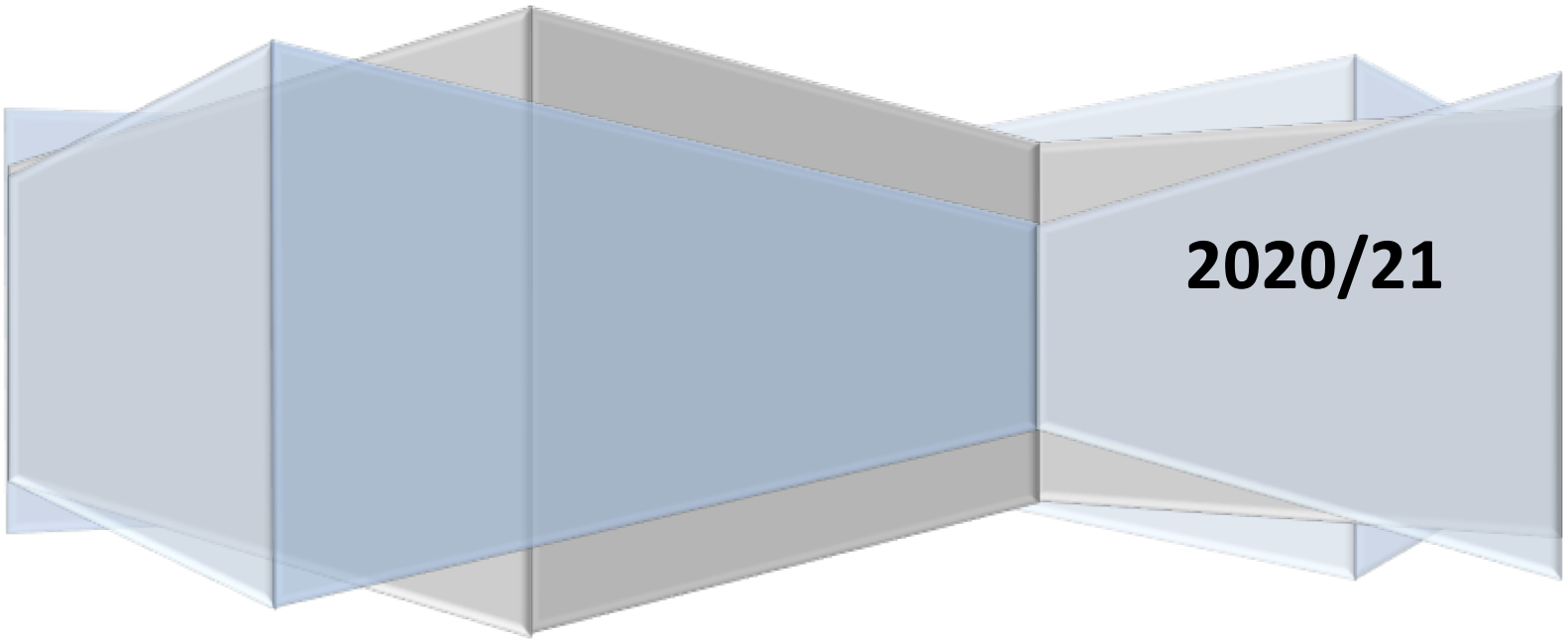
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/2021

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

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Performance Report

Statement from the Chair

The year 2020/21 was extraordinary in many ways with the Trust, along with all parts of the NHS, the health and care system and all of society responding to the huge challenges of the COVID-19 global pandemic, and the impact it has had on all aspects of our professional and personal lives.

We can be proud of the response of Sherwood Forest Hospitals NHS Foundation Trust over the course of the last 12 months, and the way in which we have worked to care for COVID-19 and non-COVID-19-19 patients, protect services and look after the physical and mental wellbeing of our colleagues.

At the time of writing we are on a roadmap to move out of lockdown restrictions and are cautiously optimistic that the impact of restrictions and the COVID-19 vaccine are having the desired impact, and that we can look forward to a more 'normal' way of life in the coming months.

This means we are now working alongside our partners to recover services that have been paused or restricted throughout the COVID-19 pandemic, and pick up with patients that may be waiting for treatment.

The Board will continue to focus on ensuring the welfare of our colleagues is prioritised as we continue this journey, and is committed to embedding lessons that we have learned throughout the course of the last year to further improve the services that we provide to our community. As we look forward, the forthcoming legislation around Integrated Care Systems will also afford Sherwood the opportunity to further develop our partnership working for the benefit of our citizens.

I would also like to take this opportunity to recognise some of the successes that have marked this year. In May 2020 the CQC announced our latest ratings with further improvements recognised in a Good overall rating for the Trust, and King's Mill Hospital being rated as Outstanding.

We have also seen our Staff Engagement rating improve again to be one of the best in the country, and the Trust was named the Health Service Journal 'Acute or Specialist Trust of the Year' for 2020. All of this is just recognition for the immense efforts of all colleagues in recent years and in particular the last 12 months.

Our enormous gratitude must go to the wonderful SFH colleagues who have worked throughout the year in conditions none of us could have envisaged. The resilience, dedication and compassion shown throughout, whatever the role, have been truly humbling to observe.

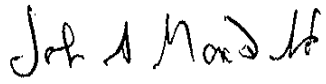
It has been an unusual year for our Trust Governors, volunteers and members, and I would like to thank all involved for their contributions that have been made in so many different ways. While we must also recognise all of our system partners that enable us to work together in the interests of our citizens, and to our community for the support it has given to us throughout the pandemic.

In April 2021 I leave Sherwood to become interim chair at University Hospitals of Leicester, and am being replaced by Claire Ward as Chair.

Sherwood Forest Hospitals has been through an incredible transformation over the past ten years and it has been a privilege to have been part of the journey, culminating in Sherwood being HSJ Trust of the Year. This success is recognition of the excellent care provided by the Trust and each and every colleague has played an important part in receiving this recognition. I know that the Board, under Claire, will continue to move the Trust forward and, in collaboration with partners, will continue to provide high quality integrated care.

Finally I understand the toll that the last year has taken on colleagues and citizens alike, and offer deepest condolences to everyone that has lost a loved one whether through COVID-19 or any other means.

Thank you



John MacDonald,
Chair (April 2020 – March 2021)

Claire Ward
Chair (April 2021 – Present)

Statement from the Chief Executive

It is fitting to start with a tribute to the amazing personal and collective response of Sherwood colleagues over the last 12 months. I am acutely aware how challenging this year has been for all of us. We have had to balance our professional response to COVID-19, along with the impact the pandemic has had on our personal lives. I would like to thank everyone for what they have done, and for the way in which they have done it.

When I look back on the last year for the organisation, my overriding emotion is one of pride, both in how we have collectively cared for patients and delivered vital services, but also in how we have looked after and supported each other. We will not have got everything right, but I am confident the decisions we took were the right decisions based on the information we had available at the time.

We have tried to protect the wellbeing of our colleagues over the last year, including through ensuring safe and adequate levels of equipment, in our approach to mental health, rest and recuperation, and through schemes such as the hardship fund introduced early in 2020/21. We have also had a focus on inclusivity, and I hope Sherwood is now more inclusive than it was 12 months ago. As we continue to restore services, it will be vital that we balance the operational service needs against the physical and mental capacity of our colleagues.

COVID-19 will continue to be with us for some time in our personal and working lives. Our lives changed dramatically in March 2020 and I thank Sherwood colleagues, volunteers, patients, the public and partner organisations across health and care for their on-going support as we work together to restore our services.

Despite the challenges we have faced, this year has been one of continued improvement for Sherwood Forest Hospitals NHS Foundation Trust. There are many ways to judge the success of a hospital trust, but three in particular stand out from the last year:

1. Our latest CQC ratings were announced in May 2020, and we improved again. We have kept our Good rating overall and Outstanding for Care. What is particularly impressive is King's Mill Hospital, where 90% of our services are based, is now rated Outstanding and Newark Hospital improved to Good. KMH is the only outstanding hospital in the Midlands. Mansfield Community Hospital was not rated in 2020 so keeps its Good rating. The ratings for our 15 core services, across our three sites, are amongst the best in the country and are the best in the Midlands.

   The following quote from the CQC summed up the care we aspire to at Sherwood:
   "Patients reported that not only were colleagues kind to them but they observed colleagues being kind to each other and treating each other with respect. This aligns with the Sherwood values."

2. Despite the challenges we have all faced over the last year, engagement has improved at Sherwood for the fifth consecutive year. The 2020 NHS staff survey results saw Sherwood ranked third best acute / acute and community trust in the NHS out of 128. Our Trust has

improved more than any other in the NHS over the last five years for staff engagement and this year we were rated second best overall for morale, third best for quality of care and third best for "recommending my organisation as a place to work". We believe how colleagues are treated significantly influences care provision and organisational performance.

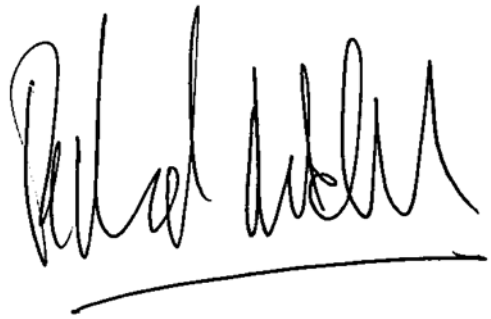
3. We were delighted to be named the Health Service Journal (HSJ) Acute or Specialist Trust of the Year for 2020, which is a huge recognition for our colleagues. Our presentation to the HSJ judges focused on our staff engagement improvement, our response to COVID-19 and the focus we have placed on colleague wellbeing.

This year has also seen the remarkable rollout of the COVID-19 vaccination, and I am proud Sherwood played a key role in this in the region. We opened our vaccination hub on 8 December 2020, and we were chosen as one of the two Trusts to first trial a 24 hour vaccination centre.

As a Trust, we remain committed to working with our partners in the Mid-Nottinghamshire Integrated Care Partnership, the Nottingham and Nottinghamshire Integrated Care System and beyond. Our work with partners across health and social care has been vital to the response to COVID-19 and has helped our communities. I firmly believe Sherwood remains a key part of our communities, and we are hugely grateful for the support we have received from the people served by King's Mill Hospital, Newark Hospital and Mansfield Community Hospital. We have not been able to engage with our community face to face as we would normally like this year, but have strived to listen to and inform through a number of less traditional routes in order to stay connected and transparent.

There is no doubt 2020/21 will be a watermark in the history of the NHS, and we will be feeling the impact for years to come. We have learnt a great deal over the course of the year, and it is vital we embed this to improve our services and to deliver positive change for the communities we serve.

Once again my thanks go to everyone who has contributed this year, including Sherwood colleagues, our volunteers, and those in our partner organisations. It has been difficult for everyone, but I hope you can take pride in what you have personally and collectively achieved.



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 outstanding healthcare across the community to 500,000 people in Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. We work with 5,000 colleagues in our three hospitals – King's Mill, Newark and Mansfield Community and we have well-established relationships with partners in health and social care through the Mid-Nottinghamshire Integrated Care Partnership (ICP).

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

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

As a Foundation Trust we have a Council of Governors, who work with the Board of Directors and represent the interests of our members in the planning of services. The Council of Governors are elected by our public and staff members or appointed to represent community partners, such as the local councils and commissioners.

In May 2020, King's Mill Hospital, where 90% of our services are based, was rated Outstanding by the Care Quality Commission and is the only Outstanding hospital in the East Midlands. Newark Hospital and Mansfield Community Hospital are both rated Good and all 15 of our services are rated Good for Safety with five Outstanding services.

Safe, patient centred care is delivered by well supported people and in 2020 colleagues at Sherwood rated us the third best hospital trust in the NHS through the annual staff survey. For the third consecutive year the Trust was also rated the best in the Midlands.

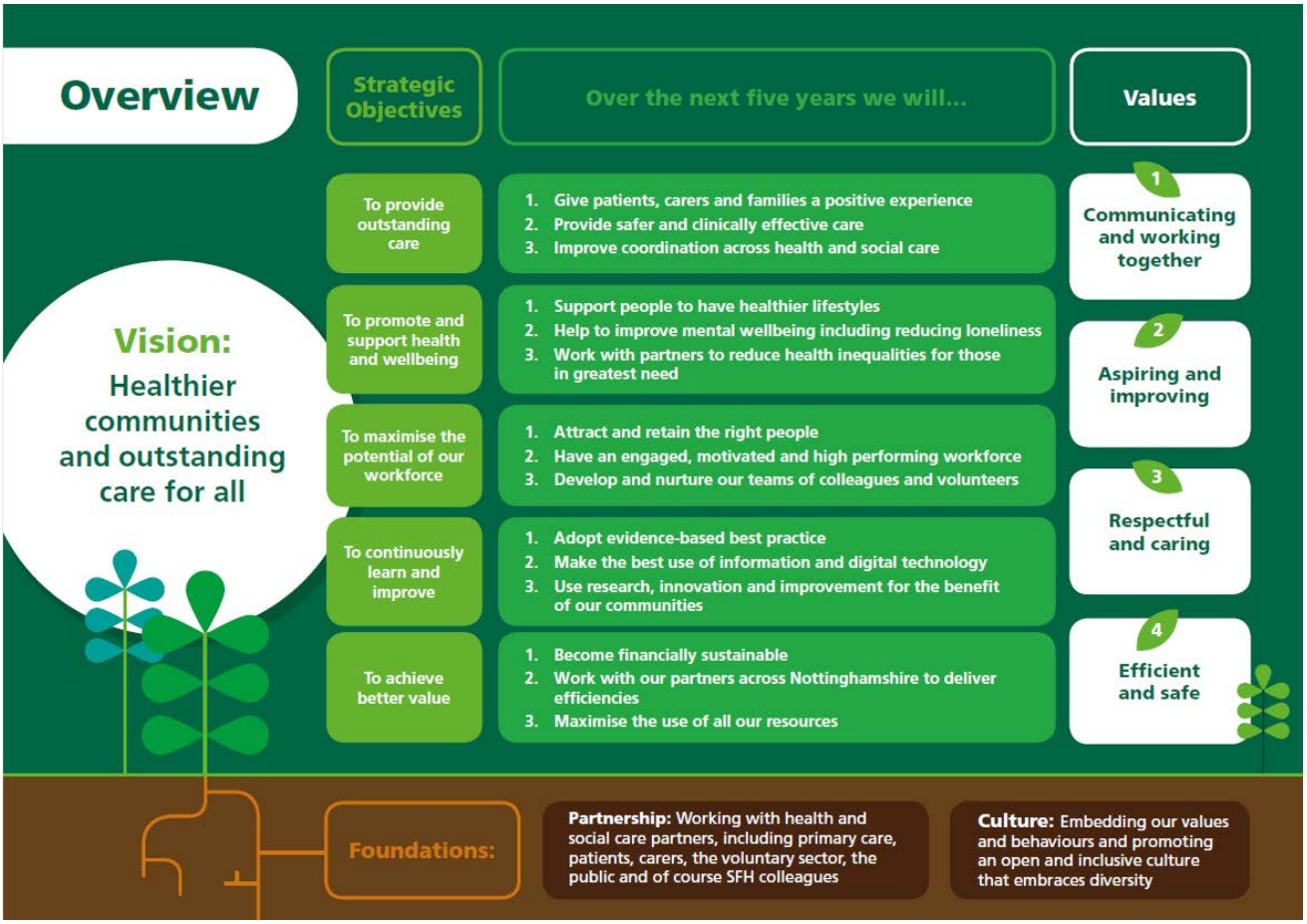
In March 2021 the Trust was recognised as the 'Acute or Specialist Trust of the Year' in the prestigious Health Service Journal Awards. The HSJ awards are the most coveted accolade in UK healthcare and Trust of the Year is the most prestigious category within these awards.

Our purpose and activities

Over the past year the NHS has faced extraordinary challenges and pressures. Our purpose and activities have been more evident than ever before, and the incredible commitment of our

workforce has enabled us to make good progress on delivering our vision of 'Healthier communities and outstanding care for all'.

This vision and strategy can be summarised as follows:



We are proud to say that despite the challenges of managing the pandemic we have been able to take positive actions, to improve our services for patients, colleagues and the wider community. For example, we have:

- Recruited and trained seven citizen Improvement Partners, who have been matched to specific Transformation Programme initiatives. This ensures public involvement and provides a unique insight and expertise in the design and implementation of transformation schemes.

- Begun the adoption of an exemplar ward model of accreditation, which will demonstrate each ward's performance for safety, efficient patient experience, staff experience and improvement.

- Continued to meet as an ICP Executive Team on a monthly basis to progress our ICP objectives and add value to the local community.

- Introduced an additional dedicated clinical psychology support offer for colleagues working in the Emergency Department, Intensive Care Unit and the Respiratory wards, providing extra support for colleagues who have faced unprecedented challenges working in these areas over the past year.

- Commissioned a review into mental health provision for patients and our education programme for staff. An internal audit into the mental health contract has been completed and we are working through the identified actions to ensure this meets the needs of our patients.

- Completed an initial review of patient equality, diversity and inclusion and identified a number of key actions to progress this, such as the patient and carer strategy (currently under consultation) and the carer's passport.

- Improved our ability to attract and retain the right people, through revised and updated recruitment and selection practices for medical appointments, including psychometric and aptitude testing for all positions, through new recruitment branding and art work developed under the focus of "a place to…", and through embedding flexible working opportunities in line with the NHS People Plan.

- Delivered against a number of 'You Said, We Did' actions and designed an evidence-based approach on the 'Continuous Improvement at SFH' initiative, which will support the organisational Recovery Phase and underpin a 'just culture' approach.

- Commenced work on establishing the SFH Proud2bOps operational development network. This is a new offer to strengthen operational management through bespoke development opportunities based on members' needs and requirements.

- Played a key role working in partnership with local social care providers in Nottinghamshire, including being the lead workforce provider for the Nottinghamshire COVID-19 vaccination programme, under which over 125,000 hours of SFH bank resources has been deployed to support the programme across Nottinghamshire. In addition to this there has been the placement of over 750 hours of SFH bank resource that has supported care homes and community services across Nottinghamshire.

- Held a Climate Action Workshop, securing engagement and generating ideas, and appointed Low Carbon Europe to support the development of the Green Plan by March 2021. Hope Orchard event held across Mid-Nottinghamshire ICP partners and local schools, planting fruit trees to help tackle carbon footprint and raise awareness of the link with the environmental and public health.

In the coming year we will go further in delivering our strategy, improving access to our services through using digital technology more effectively and accelerating the implementation of initiatives that have been paused due to the pandemic. 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.

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

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, the Trust has experienced increasing pressures and the same immense challenges faced by the entire NHS over the past year. Whilst our performance compares favourably with other Trusts, our ability to meet all of our objectives has been hampered.

We endeavour to progress these objectives 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 Primary Care Networks 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 and 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 need to recover elective services, whilst balancing the uncertainty of non-elective demands and the wellbeing of our workforce, presents a big challenge for the coming months. Over the past year our ability to respond quickly and innovatively to different demands and requirements has been critical in maintaining safe, effective services. 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 as analysing data that benchmarks the performance of our services against other Trusts'. It is vital that our culture engenders a desire to improve and innovate. That is why we train colleagues in 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.

Significant changes occurred to the funding streams as a result of the pandemic and in-year block contract rather than activity-based payments were received based on the 2019/20 reported position, rather than a formal financial plan submitted by the Trust. In addition for quarters one and two additional top up monies were received and a break even position reported, across the NHS. This was in line with NHS England and NHS Improvement strategy to meet all reasonable costs associated with COVID-19.

For quarters three and four a control total was agreed for both the Trust and the Integrated Care System (ICS) as a whole with NHS England & NHS Improvement.

As part of the change in monitoring of spend there was no requirement to have a formal financial efficiencies plan, however, the trust has continued to review pay, non-pay and income to ensure that outturn is in line with plan, and the Project Management team has been working to identify and risk rate identified schemes for 2021/22.

For the year ending 2020/21 the Trust is reporting a deficit of £15.89m which includes the impact of impairments/gains on the valuation of buildings. Removing this impairment loss/gain, which was £10.42m, we are reporting a deficit of £5.47m. This is in line with our agreed control total for quarter 3-4.

No revenue support was requested in year however, due to PFI liabilities, depreciation does not self-fund the capital expenditure, therefore a Public Dividend Capital (PDC) request for £10.10m was submitted and agreed to support this expenditure.

As disclosed in the 2019/20 accounts, all existing interim revenue and capital loans totalling £233.9m were repaid in year by the receipt of issued PDC from the Department of Health and Social Care (£219.3m revenue and £14.6m capital). The impact of these repayments means that the Trust now

has a positive Statement of Financial Position; however, there is still a significant liability in respect of the PFI which will reduce over the remaining term of the contract.

Outline guidance on the financial framework for 2021/22 has been issued and for at least quarter one the plan will be set nationally for each Trust. The guidance indicated that a formal plan for quarters two to four will be required to be submitted and agreed across the ICS in this period. The guidance continues to be updated; however, the Trust is preparing a financial plan, including cost improvements as it would in any other year, based on the expectation of a return to normal operating practices.

NHS England and NHS Improvement issued an update on 1 April 2021 regarding the 'Going Concern' uncertainty, as follows:

"The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. The publication 'Practice Note 10' was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern. This is the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies", and further highlighted that;

"this assessment should solely be based on the anticipated future provision of services in the public sector. This means that it is highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose".

On this basis of the above assessment including the updated NHSI/E guidance the accounts have been prepared on a going concern basis and the Board of Directors has taken steps to ensure this remains the case for the next 12 months.

Performance Analysis

Equality of Service Delivery

In terms of performance 2020/21 has obviously been a year immensely effected by the COVID-19pandemic and the Trusts response to it, which has been governed by:

- The NHS being on a Level 4 national incident due to COVID-19 and therefore the strict adherence of the Trust to national directives and guidance; a key element of this was the following of the 'Phases' letters particularly Phase 1 in the reduction of elective care to protect NHS staff and patients
- The implementation of the Trusts COVID-19 pandemic plan – some of which meant surges of the capacity of certain areas of the Trust which effected 'normal operating' of other areas of the Trust such as the expansion of Critical Care into Operating Theatres
- In line with bullet one the necessary strict implementation, in line with Government policy, if infection control procedures, some of which impacted on the number of patients that could be seen

Due to the pandemic and lockdowns, the Trust saw varying patient demand at different times of the year and particular falls during the lockdowns of the first and second surges with increasing patient demand in between.

In terms of access for patients to Emergency Care, the Trusts maintained its positive track record of provided timely, safe access to emergency care. The Trust maintained its position as a provider with one of the lowest emergency care waiting times in the Midlands. This was vitally important this year more than any other where emergency department crowding could have led to increasing risk of COVID-19 cross infection within the department. The Trust were also able to ensure EMAS ambulances were not held up waiting to handover at King's Mill ED with turnaround times >30 minutes that were some of the lowest in the EMAS regional area. This is a vital safety indicator that ensures crews are back on the road to respond to 999 calls in a timely manner. None of this would have been possible with the integrated support of partners from East Midlands Ambulance Service, Nottinghamshire Healthcare NHS Trust, Nottinghamshire County Council, Clinical Commissioning Groups and primary care (GPs and other services).

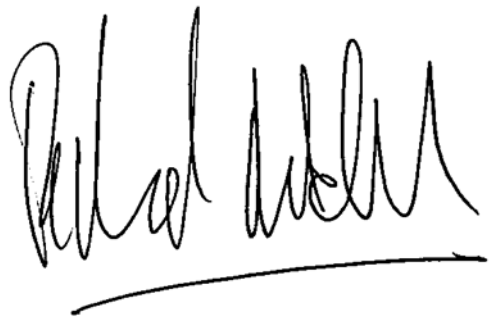
The vast majority of cancer care continued through the pandemic and through the surges, although waiting times did grow in some areas. There was significant work with the cancer tertiary provider, Nottingham University Hospitals NHS Trust, to ensure risk was managed

Surgical care was prioritised by Drs through prioritisation groups where they decided which patients were at highest risk and they were treated within the finite available Theatre capacity. This tried to ensure as equal access as possible to care for patients who needed surgery.

Outpatient activity was constrained most of the year by social distancing, particularly in waiting areas. However, some of this was compensated by the embracing of modern ways of virtual consultations either by phone or video conferencing.

Diagnostic work continued throughout the pandemic for emergency patients and those who are clinically urgent. In some areas waiting times have fallen, notably in imaging, which is very positive. Some of this was helped by the use of additional scanners on site.

2021/22 will be a year with a significant focus on reducing planned care waiting times and ensuring that inequalities within waiting times and waiting lists are well understood and reduced to ensure better access to care for all patients that Sherwood Forest Hospitals NHS FT treat. This will obviously be reliant on COVID-19 inpatient admissions (and community infections) being more controlled and lower for which there is optimism with the rapid roll out vaccine programmes.



Richard Mitchell
Chief Executive **11 June 2021**

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 decisions 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 Directors 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 David Selwyn, Julie Hogg, Paul Robinson (deputy Chief Executive), Clare Teeney, Simon Barton, Emma Challans, Shirley Higginbotham (Company Secretary), Robin Smith, Peter Wozencroft, Kerry Beadling-Barron and Lorna Barton. 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 is also the Independent Chair of Joined up Care Derbyshire (STP). The Chair is undertaking a secondment to the University Hospitals of Leicester from April 2021 for a period of 12 months.

Attendance at Board meetings

	Public		Private	
Name	Actual	Possible	Actual	Possible
John MacDonald	12	12	14	14
Richard Mitchell	12	12	14	14
Paul Robinson	12	12	14	14
Dr David Selwyn	11	11	14	14
Julie Hogg	10*	11*	12*	13*
Clare Teeney	11	11*	12*	13*
Simon Barton	10*	11*	12*	13*
Shirley A Higginbotham	12	12	14	14
Emma Challans	11	11*	11	13*
Robin Smith	7	7	8	8
Lorna Barton	4	4	5	5
Tim Reddish	12	12	14	14
Neal Gossage	12	12	14	14
Claire Ward	12	12	13	14
Graham Ward	12	12	14	14
Barbara Brady	12	12	14	14
Manjeet Gill	12	12	13	14

*Not required to attend due to COVID-19-incident response

April Board members not required to attend this meeting due to the COVID-19 incident

Simon Barton	Chief Operating Officer	SB
Emma Challans	Director of Culture and Improvement	EC
David Selwyn	Medical Director	DS
Julie Hogg	Chief Nurse	JH

Clare Teeney	Director of People	CT
Robin Smith	Acting Head of Communications	RS

Private Board

Simon Barton	Chief Operating Officer	SB
Emma Challans	Director of Culture and Improvement	EC
Julie Hogg	Chief Nurse	JH
Clare Teeney	Director of People	CT
Robin Smith	Acting Head of Communications	RS

Register of Interests

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

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

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

Cost allocation

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

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2021.

Better Payment Practice Code

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

Due to the monthly prepayment of block contract sums in 2020/21 payments were made earlier than in previous years which are reflected in our improved level of compliance with the 95% targets in year.

Our performance against this metric is shown as follows:

	2020/21		2019/20	
	Number	**£000s**	**Number**	**£000s**
Total non-NHS trade invoices paid in the year	70,794	228,825	72,810	197,842
Total non-NHS trade invoices paid within target	64,079	219,807	26,294	156,276
Percentage of non-NHS trade invoices paid within target	91%	96%	36%	79%
Total NHS trade invoices paid in the year	2,640	28,251	2,506	24,932
Total NHS trade invoices paid within target	2,202	27,424	915	18,059
Percentage of NHS trade invoices paid within target	83%	97%	37%	72%

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 £1.7k in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2020/21 would be £ 10.12k (2019/20 £189.6k). 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 of 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 2020 and assessed our overall Trust Well-Led score as Good, and King's Mill Hospital Outstanding.

Patient Care

Our journey to outstanding is the driving force behind our approach to the culture of continuous improvement now well embedded throughout the organisation. This is supported by our values of: *communicating and working together*; *aspiring and improving*; *respectful and caring* 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 continue to work towards our agreed Quality Strategy for 2018/21. This is the vehicle for progressing improvement work, monitoring improvement initiatives and providing evidence of achievement to our patients and staff.

Quality Strategy 2018/21 Summary

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

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

Improving the quality of care we deliver is about making our care safe, effective, patient-centred, timely, efficient and equitable. It is intended that we use quality priorities to monitor service improvement, to demonstrate that high quality care and services are being provided and 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.

Each year we review the quality priorities evaluating the implementation plan to ensure delivery of the Quality Strategy.

The progress made is monitored and reviewed each month by the Medical Director and Chief Nurse. Progress is reported to the Quality Committee and routinely as part of the cycle of business for the Board of Directors. Each Campaign is comprised of a number of specific improvement workstreams, examples of which are illustrated in Diagram 1.

Diagram 1.

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

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

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

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

Improvements in Quality Governance

We continue to build on the robust governance structures implemented in 2015, in particular the successful implementation of the Quality Assurance and Safety Committee (QASC) (initially named Patient Safety Quality Group), co-chaired by the Medical Director and the Chief Nurse. The reporting structure from 'ward to board' provides the required assurances that our patients receive the high quality, safe care they deserve. The reporting structure is illustrated in diagram 2:

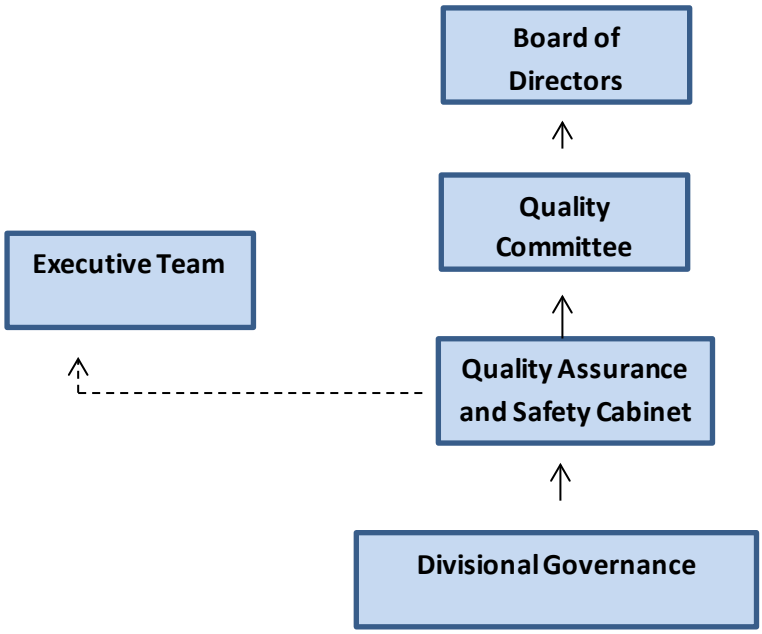


Diagram 2.

QASC is overseen by the Executive Team, and meets monthly, providing a reporting and assurance role to the Trust Board's Quality (Assurance) Committee. QASC 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 QASC 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. Most importantly the sub-groups ensure that lessons are learned and shared across the organisation.

Local governance processes have strengthened with effective and constructive discussion at specialty and divisional level common place. Performance and quality metrics have been aligned to avoid duplication and to provide further assurance that the safety and quality of care is never compromised with the need to meet all necessary activity and financial standards.

Involvement of Governors

Our Council of Governors plays an important role in the delivery of safe, high quality care. Members of the Governing Body act as observers on the Board committees and are also members of our Forum for Patient Involvement. Governors normally take an active role in our formal and informal visits to wards and departments, and provide an invaluable, impartial and observational perspective on how we conduct business. The COVID-19 pandemic has led to the suspension of these in 2020/21; we have a clear plan to reintroduce in 2021/22 that aligns to the Prime Ministers roadmap. They have continued to support our Quality Committee ensuring a vital link between the organisation, our members and local communities, and support our engagement and communication activities.

Patient Care: Improvements in patient/carer information

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

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

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

In October 2020 the Trust signed up to the Patient Information Forum (PIF) health and digital literacy commitment charter. By signing the charter, organisations are recognising the importance of health and digital literacy and committing to becoming 'health literacy friendly'.

There is a strong link between low health and digital literacy, and health inequality. Many working age adults in the UK lack skills to understand and use information on health and wellbeing.

The call to sign the charter came following the publication of PIF's Health and Digital Literacy Survey results on Monday 5 October 2020.

One of the key recommendations of the report is that organisations producing health information should aspire to become 'health and digital literacy friendly' to help tackle health inequalities.

Work is now in progress to provide accredited health and digital literacy training sessions for Trust colleagues.

Complaint Handling

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

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

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

Complaint management was paused during the first wave of COVID-19 following guidance from NHS England/NHS Improvement to pause for to three months. This was to allow staff to concentrate on front-line duties and responsiveness to COVID-19. During this time all complaints were acknowledged and reviewed for any patient safety concerns, safeguarding issues, etc. Where concerns were identified, action was taken in accordance with the complaints policy. Complaints management resumed three weeks later.

During 2020/21 we received 256 complaints, showing a 30% decrease from 2019/20. During April, May and June the number of new complaints reduced by 50%; this is likely due to the reduction in Outpatient activity during the COVID-19 pandemic. In the same reporting period, we responded to 92% within the recommended 25 days; in some cases due to COVID-19 pressures and complexities of the complaint investigations, a revised timescale of 40 working days was agreed with the complainant.

To help the NHS focus resource on tackling the COVID-19 pandemic, the Parliamentary and Health Service Ombudsman (PHSO) paused work on existing NHS complaints and acceptance of new health complaints in March 2020, resuming on 1 July 2020. A total of 19 applications were received from the Parliamentary and Health Service Ombudsman (PHSO) during 20/21; 6 cases were not accepted by the PHSO; 4 were upheld/partly upheld and action plans and learning has been completed. PHSO currently have 13 on-going investigations at the time of writing this report.

Stakeholder relations

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

Prevention - More action on, and improvements in, the upstream prevention of avoidable illness and its exacerbations.

Proactive care, self-management and personalisation - Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation.

Urgent and Emergency Care - Re-design the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting.

Mental Health - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population.

Value, resilience and sustainability - Deliver increased value, resilience and sustainability across the system, including estates.

The ICS has strengthened governance arrangements over the past year, which has supported closer system working and encouraged a greater level of transparency and consistency between organisations. In support of this the Trust has a number of senior managers and executives working in the ICS to further improve collaboration. This includes the Trust's Chief Financial Officer, who also held the role of ICS Director of Finance for the year 2020/21.

More locally the Nottingham and Nottinghamshire ICS is supported by three Integrated Care Partnerships (ICPs) and we are a partner in the Mid-Nottinghamshire ICP, which brings together health and social care services across Mansfield, Ashfield, Newark and Sherwood for everyone who lives or works within these areas.

We continue to look to maximise the opportunities afforded to us through working with others. This includes working closely with other NHS provider organisations, including Nottingham University Hospitals (NUH) and Nottinghamshire Healthcare NHS Foundation Trust (NHFT), 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.

Local collaboration with Nottinghamshire Healthcare NHS Foundation Trust is aided by the joint roles of two of our senior leaders. Clare Teeney is our joint Director of People and Shirley Higginbotham is our joint Director of Corporate Affairs.

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

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

Consultation with local groups and organisations

It has been more important than ever to engage with our communities and stakeholders in 2020/21, to keep them informed and engaged whilst the Trust has been managing our response to the COVID-19 pandemic.

The pandemic has meant that that many traditional forms of face-to-face engagement haven't been available to us. We have had to be flexible and innovative, relying more on digital channels to stay in contact with groups that we have been actively encouraging to stay away from hospital sites. Staying in contact with these groups has been vital though, to help them understand what life has been like at our hospitals, to inform services and to communicate essential public health messages.

We continue to work towards the Trust's five year strategy, Healthier Communities, Outstanding Care for All, and this year supported the development of a new Digital Strategy for the organisation in which we engaged with partners, stakeholders and patient representatives.

We have continued to engage our citizens and partners through a number of channels this year, including running eight live-streamed, interactive broadcast updates, updating our community on the status of COVID-19 and winter in our hospitals. These sessions were hosted by our Chief Executive and other senior colleagues, and supported by the independent voice of Healthwatch Nottingham and Nottinghamshire, which further represents the patient voice.

We have also published a number of open letters shared through our communications channels and local media, and have initiated a regular Community Update from our Chief Executive shared through the same channels. These aim to ensure that our citizens are as informed as possible on how we have been managing through COVID-19 and of any changes in services or access. We have also strengthened our links with Primary Care with regular attendance in each other's key meetings opening up channels between GPs and the Trust.

Our now well established Forum for Public Involvement has continued to meet virtually each month. The group has more than 40 members and sits across the Mid-Nottinghamshire Integrated Care Partnership footprint. It develops and agrees its own agenda and as a result hears regularly from teams across the Trust, for example Patient Experience and HR. The group also contributes to key Trust documents such as the Annual Review (the summary of the Annual Report) and the Digital Strategy.

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. Our Governors have been less able than normal to meet face-to-face with members of their constituencies over the course of the financial year, but we have maintained communication through a series of virtual events. We plan to return to our regular 'Meet Your Governor' sessions across all three sites later in 2021.

We also have a public Trust Membership of 15,000, which we communicate with monthly, through an e-newsletter which features key news and developments at SFH. We also invite members to take part in key events such as the AGM and share news through social media. Similarly, we engage with

our Stakeholder Group of partner organisations, elected members and community representatives on a monthly basis, and we ask both groups to contribute to Trust priorities.

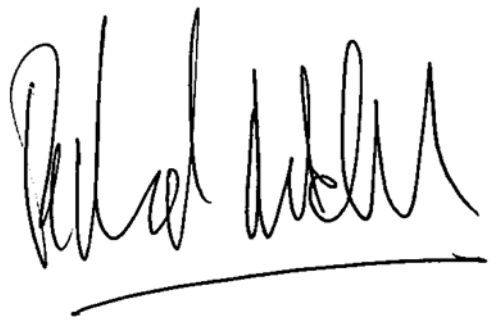
Within the last year we have been working to better understand the diversity of the membership group, aiming to ensure that our membership reflects the diversity of our local community, As a result of this work we have started to focus on recruiting more young members to the membership, establishing links with our local further education college.

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

The Trust Chief Executive, Chair and communications lead regularly meet with local MPs and Healthwatch representatives.

We are the largest employer in our area by a significant margin and we know that by engaging effectively with our staff (evidenced by our Staff Engagement performance amongst other measures) we are, by extension, also communicating effectively with our service users and community. Our continued 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 and communicate, including both face to face and virtual staff briefings across all sites, blogs, a weekly e-newsletter, WhatsApp and a closed Facebook group with over 2,700 members. Specific networks for BAME, disabled and LGBTQ+ colleagues have also all been strengthened during this period.



Richard Mitchell
Chief Executive Officer **11 June 2021**

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 six times during the year and key decisions made included the agreement to share a Director of Corporate Affairs with Nottinghamshire Healthcare NHS Foundation Trust, approve the 1.03% salary increase for Very Senior Managers (VSM) staff as recommended by NHSE/I, approve parity of notice period for all executive directors and approve the change in job title for the Head of Communications to Director of Communications, noting the role remained unchanged.

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 2020/21.

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.

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

Senior manager remuneration

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

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

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	All senior managers receive a basic pay element to their remuneration, which is pro-rata for part time staff	The Trust pays employer contributions for all senior managers who are enrolled in the NHS pension scheme. This is a % of pay set by NHS Pensions Authority	Reimbursement of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Up to £8,000 is available to newly appointed senior managers in accordance with the terms of the Trust's general relocation scheme	Payment is only applicable to the Medical Director and is in accordance with the local and national scheme	The Trust pays remuneration to senior managers who have additional system / duties above the expressed duties in the contract of employment. For 2020/21 this relates to the Chief Financial Officer / Deputy Chief Executive, for his role as Finance Director 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

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	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	Trust appraisal	N/A	N/A	N/A	N/A	N/A

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

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

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

In accordance with the NHS England and Improvement (NHSEI) letter to Chairs of all NHS Trusts and NHS Foundation Trusts dated 23 December 2020, the letter recommended an annual recommended pay increase for Very Senior Managers (VSMs) relating to 2020/2021 pay. This was a consolidated increase of 1.03% and payable from 1 April 2020. The letter outlined if the organisation elects to apply more than the recommendation set out in the letter, then ministerial comment (for NHS Foundation Trusts or CCGs) or approval (for NHS Trusts) would be required in cases where the £150,000 threshold was exceeded, or further exceeded. Sherwood Forest Hospitals NHS Foundation Trust recommended the 1.03% consolidated pay increase in line with the NHSEI letter.

In addition to consolidated pay increase of 1.03% payable from 1 April 2020, the Committee approved 3 executive directors to receive a non-consolidated cash lump sum of 10%. One was approved from 1 August 2020, one from 1 October 2020 and the final one was implemented from 1 January 2021. None of these increased exceeded or further exceeded the £150,000 threshold.

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 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.

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

The balance of the Board complies with the Code of Governance, which requires 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 2020/21.

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 2020/21.

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 2020. 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
Paul Robinson	Chief Financial Officer	23.03.2015		6 months
Simon Barton	Chief Operating Officer	01.01.2018		6 months
Peter Wozencroft	Director of Strategy and Improvement	02.12.2013	30.06.2020	6 months
Shirley A Higginbotham*	Director of Corporate Affairs	04.04.2013		6 months
Kerry Beadling-Barron	Head of Communications	03.07.2017	20.07.2020	3 months
Lorna Branton	Director of Communications	16.11.2020		3 months
Robin Smith	Interim Head of Communications	05.06.2017	15.11.2020	3 months
Clare Teeney*	Director of People	02.09.2019		6 months
Emma Challans	Director of Culture & Improvement	09.12.2019		6 months
Julie Hogg	Chief Nurse	09.12.2019		6 months
David Selwyn	Medical Director	09.12.2019		6 months

*Joint appointment with Nottinghamshire Healthcare 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	30.04.2022	1 month
Tim Reddish	Non-Executive Director	08.07.2013	31.10.2021	1 month
Neal Gossage	Non-Executive Director	10.05.2015	30.04.2022	1 month
Graham Ward	Non-Executive Director	01.12.2015	30.11.2021	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 2020/21 as there were a number of changes in senior manager appointments and the roles of senior managers.

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

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

Payments for loss of office

No payments for loss of office were made during 2020/21.

Payments to past senior managers

No payments to past senior managers were made during 2020/21, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Remuneration and Nominations Committees

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

Our Board appoints the Remuneration and Nominations Committee 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.

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

Name	Meetings attended out of possible total
Graham Ward	6/6
Claire Ward (Chair of Committee)	6/6
Barbara Brady	6/6
Manjeet Gill	5/6

The committee also invited the assistance of our Chief Executive (Richard Mitchell), the Company Secretary (Shirley A Higginbotham) and Director of People (Clare Teeney). 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 and public, staff and appointed governors. The Committee

meets to determine, on behalf of the Council of Governors, the remuneration for the Chair and Non-Executive Directors, the composition of the Board 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)	3/4 (conflict of interest)
Sue Holmes (Lead Governor)	4/4
Martin Stott (Public Governor)	3/4
Roz Norman (Staff Governor)	4/4 (Virtual for 1)
Lawrence Abrams (Public Governor)	2/4
Philip Marsh (Public Governor)	4/4
Michael Brown (Appointed Governor)	0/4

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 appraisal of the Chair and objectives for approval by the Council of Governors. The Committee also agreed the secondment of the Vice Chair to Interim Chair of the Trust whilst the substantive Chair, John MacDonald was seconded to the Chair of the University Hospitals Leicester for a period of 12 months. The Committee successfully recommended the secondment to the Council of Governors in March 2021.

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 17 and the number of Governors serving on our Council of Governors totalled 25 during the year. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		**Total paid 2020/2021 £'00**	**Total paid 2019/20 £'00**
John MacDonald	Chair	9.8	36.96
Claire Ward	Non-executive director	0	0
Tim Reddish	Non-executive director	0	3.22
Neal Gossage	Non-executive director	0.3	14.98
Graham Ward	Non-executive director	0	0
Barbara Brady	Non-executive director	1.0	11.1

Directors		Total paid 2020/2021 £'00	Total paid 2019/20 £'00
Manjeet Gill	Non–executive director	0	0
Richard Mitchell	Chief Executive	66.51*	36.87
Suzanne Banks	Chief Nurse	0	3.04
Julie Hogg	Chief Nurse	0	0
Julie Bacon	Executive Director of HR & OD	0	2.88
Clare Teeney	Director of People	0	0
Emma Challans	Director of Culture and Service Improvement	4.74	0
Peter Wozencroft	Director of Strategic Planning and Commercial Development	0	11.46
Simon Barton	Chief Operating Officer	0	5.71
Dr Andrew Haynes	Medical Director	0	0
Dr David Selwyn	Medical Director	0	0
Paul Robinson	Chief Financial Officer / Deputy CEO	0.9	12.39
Shirley Higginbotham	Director of Corporate Affairs	0	4.43
Kerry Beadling-Barron	Head of Communications	0	0
Robin Smith	Head of Communications	0	0
Lorna Branton	Director of Communications	**0**	
	TOTAL	**83.2**	**143.04**

*includes items for staff health and wellbeing

Governors	Constituency	Area	Total 2020/21 £'00	Total 2019/20 £'00
Amanda Sullivan	Appointed Governor	NHS Newark & Sherwood and Mansfield & Ashfield CCG	N/A	No claim
Angie Emmott	Staff Governor	Newark Hospital	N/A	No claim
Ann Mackie	Public Governor	Newark & Sherwood	No claim	6.1
David Payne	Appointed Governor	Newark & Sherwood District Council	N/A	No claim
Dilip Malkan	Staff Governor	King's Mill & Mansfield	N/A	No claim
Morgan Thanigasalam	Staff Governor	King's Mill & Mansfield	N/A	No claim
Ian Holden	Public Governor	Newark & Sherwood	No claim	No claim

Governors	Constituency	Area	Total 2020/21 £'00	Total 2019/20 £'00
Jackie Hewlett-Davies	Public Governor	Ashfield	N/A	No claim
Jane Stubbings	Public Governor	Ashfield	No claim	0.8
Jayne Leverton	Public Governor	Ashfield	N/A	No claim
Jim Barrie	Public Governor	Newark & Sherwood	N/A	No claim
John Doddy	Appointed Governor	Nottinghamshire County Council	N/A	No claim
John Wood	Public Governor	Mansfield	No claim	No claim
Keith Wallace	Public Governor	Mansfield	N/A	No claim
Kevin Stewart	Public Governor	Ashfield	No claim	3.5
Louise Knott	Appointed Governor	Vision West Notts	N/A	No claim
Martin Stott	Public Governor	Newark & Sherwood	No claim	1.8
Nick Walkland	Public Governor	Rest of East Midlands	N/A	No claim
Ron Tansley	Volunteer Governor	King's Mill & Mansfield	N/A	No claim
Roz Norman	Staff Governor	King's Mill & Mansfield	No claim	No claim
Susan Holmes	Public Governor	Ashfield	0.08	0.1
Valerie Bacon	Public Governor	Derbyshire	No claim	3.3
Belinda Salt	Public Governor	Mansfield	No claim	No Claim
Ben Clarke	Staff Governor	King's Mill & Mansfield	No claim	No Claim
Brian Bacon	Public Governor	Derbyshire	No claim	2.8
Craig Whitby	Appointed Governor	Mansfield District Council	No claim	No Claim
David Walters	Appointed Governor	Ashfield District Council	No claim	No Claim
Dean Whelan	Public Governor	Mansfield	No claim	No Claim
Gerald Smith	Public Governor	Mansfield	0.2	1.4
Jacqueline Lee	Staff Governor	Newark	No claim	No Claim
Jayne Revill	Staff Governor	King's Mill & Mansfield	No claim	No Claim
Lawrence Abrams	Public Governor	Rest of East Midlands	No claim	9.8
Michael Brown	Appointed Governor	Newark & Sherwood District Council	No claim	No Claim
Nikki Slack	Appointed Governor	West Notts College	No claim	1.4
Philip Marsh	Public Governor	Ashfield	No claim	No Claim

Governors	Constituency	Area	Total 2020/21 £'00	Total 2019/20 £'00
Richard Boot	Staff Governor	Newark	No claim	No Claim
Richard Shillito	Public Governor	Newark & Sherwood	N/A	4.1
Steve Vickers	Appointed Governor	Nottinghamshire County Council	N/A	No Claim
TOTAL			0.28	**3.55**

Annual Report on Remuneration (subject to audit)

Senior Managers Disclosure

	2020/21						2019/20					
Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total
	£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors												
Mr R Mitchell (Chief Executive Officer) (1)	180 - 185	6,700	0	0	47.5 - 50	235 - 240	190 - 195	3,700	0	0	42.5 - 45	240 - 245
Mr P Robinson (Chief Financial Officer) (2)	100 - 105	100	0	0	0	100 - 105	135 - 140	1,200	0	0	0	135 - 140
Ms J Hogg (Chief Nurse) (3)	130 - 135	0	0	0	0	130 - 135	45 - 50	0	0	0	7.5 - 10	55 - 60
Mr S Barton (Chief Operating Officer)	135 - 140	0	0	0	22.5 - 25	155 - 160	125 - 130	600	0	0	32.5 - 35	160 - 165
Dr D Selwyn (Executive Medical Director) (4)	160 - 165	0	0	0	0	160 - 165	60 - 65	0	0	0	37.5 - 40	100 - 105
Non voting members												
Ms S Higginbotham (Director of Corporate Affairs) (5)	110 - 115	0	0	0	20 - 22.5	130 - 135	110 - 115	400	0	0	32.5 - 35	145 - 150
Ms C Teeney (Director of People (HR) (6)	15 - 20	0	0	0	35 - 37.5	50 - 55	15 - 20	0	0	0	17.5 - 20	35 - 40
Ms E Challans (Director of Culture and Improvement)	110 - 115	500	0	0	0	110 - 115	35 - 40	0	0	0	0	35 - 40
Ms L Branton Head of Communications) (7)	30 - 35	0	0	0	20 - 22.5	50 - 55	N/A	N/A	N/A	N/A	N/A	N/A
Mr R Smith Acting Head of Communications) (8)	40 - 45	0	0	0	25 - 27.5	65 - 70	65 - 70	0	0	0	17.5 - 20	85 - 90
Mr P Wozencroft (Director of Strategic Planning and Commercial Development) (9)	75 - 80	0	0	0	0	75 - 80	5 - 10	1,100	0	0	2.5 - 5	10 - 15
Ms Kerry Beadling-Barron (10)	25 - 30	0	0	0	5 - 7.5	30 - 35	5 - 10	0	0	0	0 - 2.5	5 - 10
Ms S Banks (Chief Nurse) (11)	N/A	N/A	N/A	N/A	N/A	N/A	95 - 100	300	0	0	0	95 - 100
Dr A Haynes (Executive Medical Director) (12)	N/A	N/A	N/A	N/A	N/A	N/A	105 - 110	0	0	0	0	105 - 110
Ms J Bacon (Executive Director of Human Resources and Organisational Development) (13)	N/A	N/A	N/A	N/A	N/A	N/A	140 - 145	300	0	0	0	140 - 145
Non-Executive Directors												
Mr J MacDonald (Chair) (14)	50 - 55	1,000	0	0	0	50 - 55	50 - 55	3,700	0	0	0	50 - 55
Mr T Reddish	15 - 20	0	0	0	0	15 - 20	10 - 15	300	0	0	0	15 - 20
Ms C Ward	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mr G Ward	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr N Gossage	15 - 20	0	0	0	0	15 - 20	15 - 20	1,500	0	0	0	15 - 20
Ms B Brady	10 - 15	100	0	0	0	10 - 15	10 - 15	1,100	0	0	0	10 - 15
Ms M Gill	10 - 15	0	0	0	0	10 - 15	10 - 15	100	0	0	0	10 - 15

Notes (2020/21)

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

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

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

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
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.

Pension disclosure

2020/21

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
Executive Directors	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mr R Mitchell *	2.5 - 5	-2.5 - 0	40 - 45	70 - 75	516	25	567	0
Ms J Hogg **	0	0	0	0	0	0	0	0
Mr S Barton *	0 - 2.5	-2.5 - 0	30 - 35	60 - 65	514	16	556	0
Dr D Selwyn	-2.5 - 0	-2.5 - 0	65 - 70	200 - 205	1602	11	1658	0
Ms S Higginbotham (nee Clarke) *	0 - 2.5	0	20 - 25	0	318	16	362	0
Ms C Teeney *	0 - 2.5	0	60 - 65	0	711	35	812	0
Ms L Branton *	0 - 2.5	0	10 - 15	0	61	12	106	0
Mr R Smith	0 - 2.5	0	0 - 5	0	26	3	40	0
Mr P Wozencroft *	-5 - -2.5	-15 - -12.5	30 - 35	65 - 70	824	-4	648	0
Ms K Beadling-Barron *	0 - 2.5	0 - 2.5	15 - 20	25 - 30	169	20	219	0

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	82.5 - 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

Notes

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

** Ms J Hogg terminated involvement in the NHS pension scheme from Feb 20

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 Trust in the financial year 2020-21 was £205,000 - £210,000 (2019-20, £205,000 - £210,000). This was 7.64 times (2019-20, 8.51 times) the median remuneration of the workforce, which was £26,970 (2019-20, £24,214). In

2020-21, no employees (2019-20, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £8,320 to £206,000 (2018-19, £7,626 to £206,000).

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

The median remuneration is based on annualised, full-time equivalent remuneration of all employees as at the reporting date. This has been calculated excluding any enhancements or overtime payments.

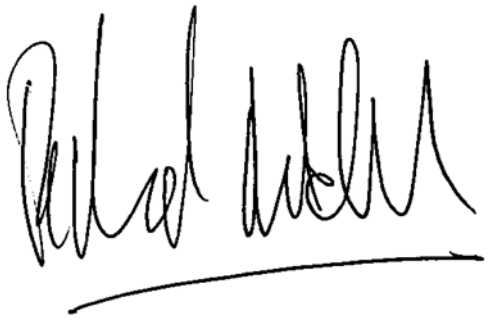
There were no agency Board members as at 31 March 2021.

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

11 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 2020 to 31 March 2021 are:

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

		2020/21		2019/20
	Total	**Permanent**	**Other**	**Total**
Medical and dental	**673**	588	85	**604**
Ambulance	**4**	4	0	**3**
Administration and estates	**1,086**	1,086	0	**1,064**
Healthcare assistants and other support staff	**1,035**	1,035	0	**975**
Nursing, midwifery and health visiting staff	**1,336**	1,237	99	**1,263**
Nursing, midwifery and health visiting learners	**0**	0	0	**0**
Scientific, therapeutic and technical staff	**394**	377	17	**378**
Healthcare science staff	**132**	129	3	**119**
Other	**10**	10	0	**8**
Total average numbers	**4,670**	**4,466**	**204**	**4,414**
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 2020/21 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 2021)

	Male	Female	Total
Director	9	6	15
Other Senior Manager	930	4049	4979
Employee	80	148	228
Grand Total	1019	4203	5222

Staff Costs- Subject to audit

Staff Costs				
	Total	Permanent	Other	Total
	31-Mar-21	31-Mar-21	31-Mar-21	31 Mar 2020
	2020/21	2020/21	2020/21	2019/20
Salaries and wages	197,025	197,025	0	164,902
Social security costs	20,409	20,409	0	16,978
Apprenticeship levy	972	972	0	850
Pension cost - employer contributions to NHS pension scheme	21,133	21,133	0	19,256
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	9,089	9,089	0	8,337
Pension cost - other*	0	0	0	0
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	34
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	15,160	0	15,160	12,842
TOTAL GROSS STAFF COSTS	**263,788**	**248,628**	**15,160**	**223,199**
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	**263,788**	**248,628**	**15,160**	**223,199**
Included within:				
Costs capitalised as part of assets	308	308	0	427

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 2020/21

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 and Control Committee to ensure that the full range health and safety related risks are properly identified and suitable and sufficient controls are put in place.

In 2020 the Trust successfully achieved its first ROSP Gold Achievement Award for the Trust's health and safety performance during 2019. There are 4 grades of award from Merit up to Gold and The Trust was awarded the top level of recognition in our first year of entry.

In line with other services 2020/21 has been an unprecedented year with the spotlight on keeping colleagues as safe as reasonably practicable from the SARS-Cov2 Virus. The Health and Safety Team has been working closely with colleagues and the staff side on issues such as respirator fit testing, PPE specification, risk assessments, signage and cleaning practices. The Trust passed an HSE COVID-19 spot inspection in December 2020 without incurring any enforcement action from the HSE.

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 2020/21 The Trust reported 17 staff injuries and zero patient injuries under the reporting requirements of RIDDOR. Some 5,308 people were employed by the Trust during the year (excluding bank and agency staff) and the rate of RIDDOR reportable non-fatal injuries per 100,000 employees was 320 against a reported latest national average rate for the human health activities sector of 350 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, 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 health.

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

Table 1: Relevant union officials

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

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

Table 2: Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	**23**

1-50%	**15**
51%-99%	**0**
100%	**3**

Table 3: Percentage of pay bill spent on facility time

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

First Column	Figures
Provide the total cost of facility time	97,007.93
Provide the total pay bill	254,890,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.38%

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	6.0%

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. The Trust spent £0.123m on consultancy during the year (2019/20 £0.41m).

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 2021, for more than *£245* per day and that last for longer than six months

Number of existing engagements as of 31 March 2021	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 2020 and 31 March 2021, 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 2020 and 31 March 2021	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 2020 and 31 March 2021

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)

	2020/21			2019/20		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Number of exit Packages by Cost Band
<£10,000	0	0	0	0	9	3
£10,001 - £25,0000	0	5	5	1	3	0
£25,001 - £50,000	0	3	3	2	0	0
£50,001 - £100,000	0	1	1	1	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	1	1	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	0	10	10	4	12	3
Total resource used	0	408	408	155	83	238

	2020/21		2019/20	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	0	0	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	8	368	11	73
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval	2	40	1	10
Total	10	408	12	83
Of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Staff Survey

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.

2020 was the final year of this strategy and a new People, Culture and Improvement Strategy based upon the NHS People Plan and NHS People Promise will be developed and launched in April 2021 which will build on the success of the previous strategy.

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, Improvement and OD initiatives have contributed to improving our culture.

During the COVID-19 pandemic the Trust significantly increased its engagement with colleagues through daily communication updates which were valued by staff. We also strengthened our wellbeing offers with the creation of an SFH Den, psychological support services and wellbeing road shows. We also undertook Learning from COVID-19 exercise which helps to make further improvements in our organisational engagement, wellbeing, leadership development and colleague experience offers.

This year has seen the introduction of several organisational engagement initiatives such as leading remote and virtual teams toolbox talks, using MS Teams to deliver training online, significant expansions of E-Learning programmes and 14 bespoke organisational development team interventions.

SFH Today – our culture and improvements 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 9% over the last 3 years in our staff survey.
- Colleagues want to stay at this Trust because of the way we support and develop them.
- We have improved our on-boarding experience for new starters to ensure that it is a personal experience that is slick, informative and effective.
- Improved Communication & Engagement through the COVID-19 pandemic.
- Responded to PPE requests, Fitmask training and improved access to COVID-19 tests.
- Invested in buying IT equipment to support working from home (500 laptops).
- Recruited over 300 more bank staff to help maintain safe staffing and provide outstanding patient care.
- Launched a wide range of health and wellbeing offers and resources.
- Opened the Well Being DENs at KMH and Newark.
- Supported colleagues to get to work easier by public transport.
- Ran Schwartz rounds to discuss emotional and social aspects of work.
- Worked with Costa to be open 24/7 and Morrisons to have dedicated NHS hours.
- Offered free meals during the COVID-19 pandemic.
- Created a hardship fund.
- Created online engagement sessions with local schools and colleges and themed career sessions to support succession planning.
- Supported over 150 staff to undertake apprenticeships.

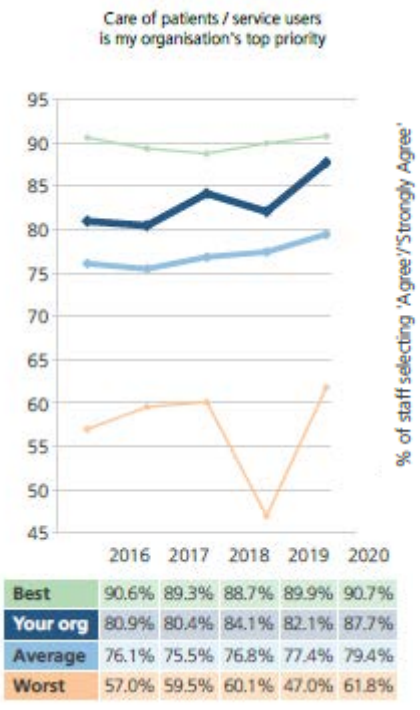
The NHS Staff Survey

In 2020 the Trust engaged staff in its annual staff survey through a mix mode approach of electronic and paper surveys.

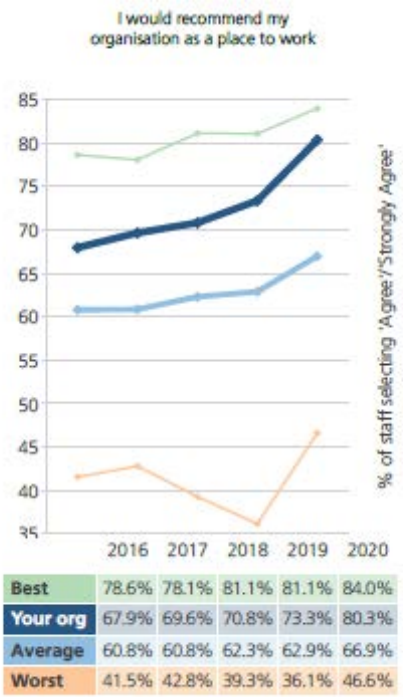
For the third year running the Trust scored the highest engagement score as the best acute trust to work at in the Midlands and was the joint third best acute trust in England which is a fantastic achievement.

Our EDI analysis also shows that SFH is trending higher than the national average for acute trusts nationally which is extremely positive.

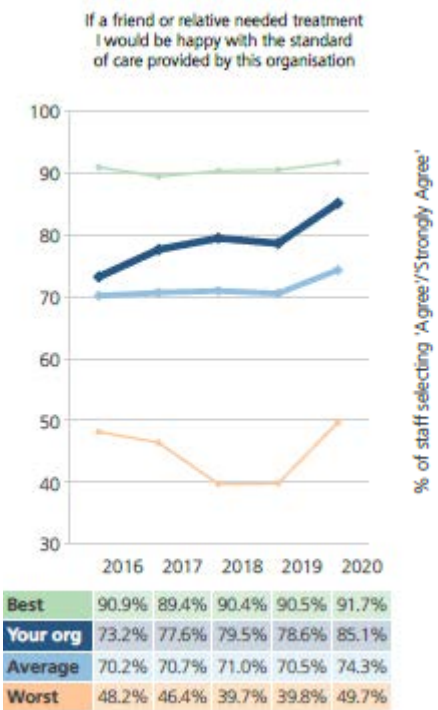
The tables below summarises the Trusts 2020 staff survey results both internally and externally.



	2016	2017	2018	2019	2020
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	80.9%	80.4%	84.1%	82.1%	87.7%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%



	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	67.9%	69.6%	70.8%	73.3%	80.3%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%



	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	73.2%	77.6%	79.5%	78.6%	85.1%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

The table below gives an overview of the key staff survey themes at a midlands and national level as to how SFH ranked. With the exception of Violence, the Trust scored in the top 3 trusts in the midlands regions for all domains and in the top quartile nationally.

Staff Survey Results - Themes	Midlands rank (Out of 21)	National rank (Out of 129)
Participation rate	*1*	*5*
Overall Theme score	1	3
Equality & Diversity	3	17
Safety Culture	1	5
HWB	1	8
Immediate Managers	2	9
Quality of care	1	3
Morale	1	2
Engagement	1	6
Bullying & Harassment	3	23
Violence	20	119
Teamworking	1	4

Below are the 10 key indicator themes from the 2020 SFH Staff Survey:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.3	6.4	7.2	6.7	7.9	8.3	9.3	7.2	7.4	6.9
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,004	3,016	3,020	2,985	2,662	2,927	2,991	3,002	3,030	2,994

Areas for development for 2021/22

- Build on what has been achieved and to support the post COVID-19 recovery.
- Reduce variation of colleague experience.
- Better understanding of colleagues' experience that identify as disabled and our younger and mature workforces to improve their SFH experience.
- Focus on further improvements in how we treat each other.
- Civility, Respect, Bullying and Harassment, Inclusion.
- 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.
- Reduce variability of management capability through targeted leadership training and development.
- Visibility and support for our Diversity Staff Networks.
- Further develop our talent management approach and offer to support succession planning.
- 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.
- Focus our people and improvement coaches to better support colleagues in an inclusive and compassionate manner.

- Improve colleagues' well-being and resilience offer as part of our Well Being Strategy.

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 People, Culture and Improvement Strategy 2021/22 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 Trust's requirements under the Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS).

Staff Survey Action Plan 2021/2022

Action	Executive Lead	Date
To build on what has been achieved	**Director of Culture and Improvement**	
To engage with the divisions on a quarterly basis to celebrate successes and focus		Quarterly

OD support.		
To develop a Trust engagement calendar with seasonal values based campaigns on recovery, civility, wellbeing and violence and aggression.		Quarterly
Address the Violence experienced from patients, carers and visitors	**Chief Nurse**	Sept 21
To establish a Violence and Aggression task and finish group		Mar 21
To develop a SFH Strategy for Violence and Prevention and Reduction		Sept 21
To identify the top 10 areas reporting violence and aggression		April 21
To launch new breakaway and clinical holding skills training course to better protect staff		April 2021
Reduce variation of experience (where you work)	**Director of Culture and Improvement**	
Creation of Bullying and Harassment task and finish group		April 21
Creation of Civility Task and finish group		May 21
Launch of updated civility saves lives toolbox talk		April 21
Creation of Trust and ICS Civility conference		Sept 21
To support career development and talent recognition across all services and SFH workforce.		Dec 21
Tackle issues of EDI (age and disability)	**Director of People**	
To create EDI focus groups to explore colleague experience		July 21
To engage with EDI Staff Networks to feedback Staff Survey Results		April 21
To update the Trusts EDI Strategy with actions to improve findings from focus group engagement sessions.		Aug 21
Rebuilding after COVID-19	**Director of Culture and Improvement**	
Development and launch of		May 21

'Building Better Together' Managers pack		
Admin and Clerical Transformation group to be created		Mar 21
Development of admin and clerical transformation work plan to identify opportunities to work differently		Apr 21

Equality Reporting

Over the past 12 months the Trust has invested in the Equality agenda and introduced a dedicated Equality Diversity and Inclusion lead along with a revised Inclusion Strategy that is aligned to the objectives of the Trust and the NHS People Plan and People Promise.

In the last year, much of our activity centred on our response to COVID-19 and the following were undertaken to support our most vulnerable colleagues;

- Personalised support for BAME colleagues.
- Individual risk assessments for those most at risk from COVID-19 (risk assessments also offered to all staff).
- Access to on-site COVID-19 testing for all staff and their household members.
- Occupational Health clinician support for those most vulnerable to COVID-19 infection for recommendations on workplace support and adjustments.
- Supported staff to work from home where possible.
- Q&A session for disabled staff / those with long term health conditions.
- New return to work policy and manager toolkit for supporting those returning to work from shielding.

Engaging our staff networks:
We are focussing on the development of our staff networks to increase membership, engagement of colleagues and the inclusion and collaboration of staff networks in decision making within the Trust to support equality of service delivery and transformation for the benefit of all colleagues and our patients. We are also supporting our staff networks to participate in activity across the system.

In the last year, despite COVID-19, our staff networks have contributed to key activities across the Trust and System

- BAME
  - Sherwood supported the Nottingham and Nottinghamshire ICS Black History month event in October
  - Staff from Sherwood shared powerful personal stories through poetry
  - We shared extracts from the HSJ BAME Powerlist to celebrate the success of BAME in our health and care system

- LGBT+
  - First ever Sherwood Pride march in July (socially distanced and video footage shared on social media platforms)
  - Executive Leaders videos for Pride
  - Sherwood co-hosted the very first Nottingham & Nottinghamshire ICS partnership Pride event in July (on-line)
  - Pride branding designed and proudly displayed on a banner outside King's Mill Hospital
  - Rainbow Flag flying at King's Mill Hospital
  - New Rainbow Crossing at King's Mill Hospital (the first of its kind in Nottinghamshire)
  - LGBT+ Allies scheme launched with Rainbow lanyards
  - LGBT+ History month celebrated in February with staff stories

- International Day of persons with Disabilities
  - Video shared of staff experiences
  - Presentation to Public Board including lived experience poem
  - Staff stories shared via Sherwood Voices

Gender Pay Gap

Sherwood Forest Hospitals Foundation Trust has complied with the expectations associated with the gender pay regulations; our response for 2020/21 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. In the past year we have updated our Equality Diversity and Inclusion 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. We continue to be a signatory 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 Trust's 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 2020/21 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.

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 Social Care and will actively refer any cases we identify through the delivery of our services that may indicate any of our service users have been victim to modern day slavery, whilst in the community. We report quarterly and annually via our safeguarding reporting mechanisms data relating to any safeguarding issues, along with trends and themes.

Valuing our Members

Membership information for annual report ending 31 March 2021

Public breakdown by constituency

Mansfield	4,571
Ashfield	4,428
Newark & Sherwood	3,448
Derbyshire	1,511
Rest of East Midlands	784
Rest of England	126

Public membership breakdown

	Number of members	Membership profile	Population profile
Age (years)			
0-16	6	0.04%	19.6%
17-21	31	0.2%	5.9%
22+	13, 745	92.4%	7.3%
Not stated	1,106	7.4%	0%
Ethnicity			
White	13,269	89.2%	89.1%
Mixed	29	0.19%	1.6%
Asian	83	0.5%	6.2%
Black	30	0.2%	1.7%
Other	8	0.05%	0.3%
Not stated	1,469	9.8%	0%
Gender			
Male	5,352	35.9%	49.4%
Female	9,334	62.7%	50.5%

	Number of members	Membership profile	Population profile
Not stated	202	1.3%	0%

Membership activity, events and communication

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

Annual General Meeting / Annual Members' Meeting

This year's AGM was held virtually via Microsoft Teams on Monday 28 September 2020. The link to the event was shared with all public and staff members, stakeholder and members of the general public to allow them to view the event.

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

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

Valuing our Governors

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

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

In addition, the Council of Governors, 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 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. However due to the pandemic these haven't taken place this year. Governors have continued to feedback where possible comments, from patients and the public on an ad hoc basis.

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

We held governor elections in October 2020, to fill vacancies across the Ashfield, Newark and Sherwood and Rest of East Midlands constituencies, three governors were elected, unfortunately there were no nominations for the Rest of East Midlands constituency, the Council of Governors have agreed to leave the vacancy open until the next election period, in line with section 7.14.2.3 of our Constitution. 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.

Attendance at Council of Governor meetings

There have been four general Council meetings during the year. The Council of Governors scheduled for May 2020 was cancelled due to the pandemic; however an additional meeting was scheduled in September to ensure the Council of Governors adhered to the Constitutional requirements of the Trust. The following table details the Governors, the constituency they represent, their attendance and the date elected/appointed.

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	TERM ENDS
			11/08/2020	28/09/2020	10/11/2020	09/02/2021			
Ann Mackie	Newark & Sherwood	Public	P	X	P	P	3	01/05/19	30/04/22
Belinda Salt	Mansfield	Public	P	X	P	X	3	01/05/19	30/04/22
Ben Clarke	King's Mill Hospital	Staff	P	X	X	P	3	01/09/19	31/08/22
Councillor Craig Whitby	Mansfield District Council	Appointed	P	A	A	A	4	21/05/19	31/05/23
Councillor David Walters	Ashfield District Council	Appointed	P	P	P	P	1	23/04/20	31/05/21
Councillor Kevin Rostance	Nottinghamshire County Council	Appointed			P	X		15/10/20	31/05/21
Councillor Michael Brown	Newark & Sherwood District Council	Appointed	X	A	X	X	1	18/05/20	31/05/21
David Ainsworth	Mansfield & Ashfield CCG	Appointed	P	P	P	P	N/A	20/02/20	N/A
Dean Whelan	Mansfield	Public	A	A	X	X	3	01/09/22	31/08/22
Gerald Smith	Mansfield	Public	X	X	A	P	3	01/05/19	30/04/22
Ian Holden	Newark & Sherwood	Public	P	P	P	P	3	01/05/19	30/04/22
Jacqueline Lee	Newark Hospital	Staff	P	P	X	P	3	01/05/19	30/04/22
Jane Stubbings	Ashfield	Public	P	A			3	01/11/17	31/10/20
Jayne Revill	King's Mill Hospital	Staff	X	X	A	X	3	01/05/19	30/04/22

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	TERM ENDS
			11/08/2020	28/09/2020	10/11/2020	09/02/2021			
John Wood	Mansfield	Public	P	P	P	P	3	01/05/19	30/04/22
Kevin Stewart	Ashfield	Public	P	P	P	P	3	01/05/19	30/04/22
Lawrence Abrams	Rest of East Midlands	Public	P	P	A	P	3	01/05/19	30/04/22
Martin Stott	Newark & Sherwood	Public	P	P	P	P	3	01/05/19	30/04/22
Maxine Huskinson	Ashfield	Public			P	P	3	01/11/20	31/10/23
Nikki Slack	Vision West Notts	Appointed	X	P	P	P	N/A	17/07/19	N/A
Paul Baggaley	Newark & Sherwood	Public			P	A	3	01/11/20	31/10/23
Philip Marsh	Ashfield	Public	P	P	P	P	3	01/05/19	30/04/22
Richard Boot	Newark Hospital	Public	P	X	P	X	3	01/05/19	30/04/22
Roz Norman	King's Mill Hospital	Staff	P	P	A	P	3	01/05/19	30/04/22
Sue Holmes	Ashfield	Public	P	P	P	P	3	01/11/20	31/10/23

Key:

P= Present

A= Apologies

X= Did not attend

Not in post

Non-Executive Director Attendance at Council of Governors

NAME	FULL COG MEETING DATES			
	11/08/2020	28/09/2020	10/11/2020	09/02/2021
John MacDonald	P	P	P	P
Tim Reddish	P	P	P	P
Neal Gossage	P	P	P	P
Graham Ward	P	P	P	P
Claire Ward	A	P	P	P
Barbara Brady	P	P	A	A
Manjeet Gill	P	A	P	P

Lead Governor Annual Report 2021

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

We have changed our Constitution regarding Governors and now there are the following publicly elected Governors

- For Ashfield Philip Marsh, Kevin Stewart Sue Holmes and Michelle Hutchinson
- For Mansfield Dean Whelan, Gerald Smith and John Wood (1 vacancy)
- For Newark and Sherwood Ann Mackie, Ian Holden, Martin Stott (1 vacancy)
- For the rest of the East Midlands Lawrence Abrams (1 vacancy) Derbyshire is now included with the rest of the East Midlands

Staff Governors

- For King's 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

Because of COVID-19 restrictions, the Governors have been unable to engage with public and patients in both the 'Meet your Governor' sessions and the 15 steps programme. Any feedback received by governors from our constituents is passed on.

We have been able to continue to hold our Non-Executive Directors to account by having Governor Observers on all of the Board Committees which are all now held virtually.

The Trust Awards Evening was held – virtually - and was a 'glittering' event. Congratulations to the Communications Team for making it as good as it could possibly be. This year there were also an extra set of 'COVID-19' awards and as a member of the judging panel I would have given the awards to all the nominees. Never has it been so difficult to choose winners as it was this year.

We are again finalists for the HSJ 'Best Acute Hospital' award. This again will be held on-line and at the time of writing the results have not been announced but if anyone deserves this award – our staff do – from porters and cleaners, admin staff, medical staff, back office staff – each and every one of them has contributed their very best.

Our project linking with the students at Vision West Notts is starting to get off the ground. Our 'Grow your own'' scheme was a finalist in the Governwell Showcase submissions. It was chosen for a workshop in February which was 'virtually' attended by 100 governors. I did the presentation and I am pleased to say that it was well received and there was a great deal of interest from other trusts. We will continue to expand this scheme in the coming year.

The Gamma Scanner that our amazing volunteers raised £485,000 for is now being installed. Not content with that, the volunteers now have a target of £20,000 for end-of-life care.

Our volunteers provide such amazing support for all our hospitals and we are truly grateful to them, this year they have provided a service of receiving items from friends and family and delivering them to the relevant wards. I have seen for myself just how necessary and successful this has been in times when there is a no visiting restriction.

Last year when I wrote my report, I expressed the hope that by the time the AGM came around 'COVID-19' would all be over. Since then, there have been midnight dashes by the Procurement team to pick up PPE; ICU overwhelmed, medical staff working long hours and facing more deaths than they had ever thought possible; admin staff working from home, and finally everyone learning what to do when '*you're on mute'!*

Not only have COVID-19 patients been cared for, a very successful vaccination centre has been set up at King's Mill making a huge contribution to the future safety of both staff and community.
I do hope, that this year, I can say with some confidence that we will all be back to a new normal by the time of the AGM.

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.	65-66 81
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.	18 -19 40 - 41 78
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.	67 - 68

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.	67 - 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.	18
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Sherwood Forest Hospitals (sfh-tr.nhs.uk)
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	39
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.	40 - 41
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.	40 - 41
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.	19
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.	65 - 66

Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012).	N/A
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	41 76 83
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.	22
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.	85 - 86
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 96 - 97

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 – 80 92
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 the director will retain such earnings.	N/A
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors,	65 - 66

		develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	
Board / Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	64 - 65
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.	65
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' 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.	21

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), six executive Directors (voting), including the Chief Executive, and three 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 the Directors and Governors receive accurate, timely and clear information. Directors are encouraged to update their skills, knowledge and familiarity with the organisation's business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with Governors.

There is an understanding that any Non-Executive Director, wishing to do so in the furtherance of their duties, may take independent professional advice through the 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 meetings.

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

The Board committees report annually on their effectiveness and review their Terms of References and work plans to ensure alignment with 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 several bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. In November 2020 we took part in Fraud Awareness Month and several alerts were issued to employees, 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 increased by £1.92m in 2020/21 (£10.83m to £12.75m). This represents a 17.7% increase. Note the premiums are the net charge including the rebate received in respect of the maternity incentive scheme.

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2020/21 these committees included:

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

Audit and Assurance Committee

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

- Graham Ward 7/7
- Barbara Brady 7/7
- Manjeet Gill 7/7

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, PWC and KPMG, and the internal auditors, 360 Assurance, on the work they had undertaken in reviewing and auditing the control environment.
The Committee works with the 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 2020/2021, the plan was significantly reduced to take account of the pressures across the Trust of the 15 audit assignments included within the Plan, to date, nine reports have been issued with Significant Assurance, and were submitted to the relevant committee for

discussion and monitoring, and four reports were issued with Limited Assurance; the lead executive for each report presented the report to the Audit & Assurance Committee and discussed the actions, providing assurance with regard to timelines and agreement to deliver the changes required. Two reviews from the 2020/21 Plan have still to be concluded.

- Three reviews from the 2019/20 plan were carried forward to be completed in 2020/21, two of these were subsequently cancelled due to the impact Plan were also concluded in year, both providing significant assurance
- Progress and achievement of actions against all internal audit reports are reported to the 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 111 standards being met.
- The Committee received annual reports about risk, procurement and counter fraud.
- The Register of Interests is reported to each Committee meeting; significant improvement has been made this year with further initiatives to improve compliance being implemented. The Committee also received a report with regard to breaches as advised by Counter Fraud; these were followed up with the individuals.
- The Speaking Up arrangements and process were reviewed by the Committee to ensure no issues of internal control were identified.
- The Scheme of Delegation and Standing Financial Instructions were reviewed.
- A report regarding the effectiveness of the Committee was developed and submitted to Board.
- The members of the Committee undertook a maturity assessment review against the plan previously developed.
- Members of the Committee formed part of the working group with members from the Council of Governors to appoint the new external auditor. KPMG were appointed by the Council of Governors.
- 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, to assure themselves of the effective financial propriety of the Trust, the Committee reviews and considers:
    - 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

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 2020/2021 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. As a result of the impact of the pandemic, during the year the plan was decreased by 25%. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or under way. All audits with Limited Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate Board committee. However, our Audit and Assurance Committee receives a report stating which reports have been reported to other committees. Outstanding recommendations from internal audit are reported to our Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the organisation. Where owners of recommendations have not completed the actions by the implementation date they are invited to Audit and Assurance Committee to report on progress.

External audit service

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

We incurred £105,000 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12 month period to 31 March 2021 (£99,646 net of VAT for the period to 31 March 2020). Non-audit services amounted to £Nil net of VAT (£Nil net of VAT for the period to 31 March 2020) in respect of the Quality Report.

KMPG has not provided any non-audit services to the Trust during the year and this is the first year of their appointment, with services last year provided by PWC.

Remuneration and Nomination Committee

As at 31 March 2021 and on-going, membership of the Remuneration and Nomination Committee comprises Claire Ward as Chair and Barbara Brady, Manjeet Gill and Graham Ward, 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 Claire Ward as Chair and representatives from the public, staff and appointed governor classes. The role of this Committee is to ensure that appropriate procedures are in place for the nomination, selection, training and evaluation of Non-Executive Directors and for succession plans. The Committee is also responsible for setting the remuneration of Non-Executive Directors, including the Chair. It considers Board structure, size and composition, thereby keeping under review the balance of membership and the required blend of skills, knowledge and experience of the Board.

Compliance with the Code of Governance

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

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2021, the Board considers that it was fully compliant with the NHS Foundation Trust Code of Governance with the following exceptions, where we have alternative arrangements in place.

In March 2020, NHSE/I issued guidance regarding 'Reducing burden and releasing capacity at NHS providers to manage the COVID-19 pandemic'. The Board reviewed its own processes to provide assurance to the Board that Corporate and Financial Governance continued to comply with guidance, our own assurance processes and the scheme of delegation.
As the organisation has recovered, restored and reset we have identified transformational and workforce changes both internally and externally across the system to ensure all our governance processes are fit for purpose and provide assurance the Trust is achieving its strategic objectives, regulatory requirements and performance standards.

As a Trust we took the decision early to cancel Board meetings and Board committees. The April Board meeting was held in abbreviated form with NEDs in attendance via MS Teams and the Chair, CEO, CFO and Director of Corporate Affairs in attendance at King's Mill Hospital. A Standard Operating Procedure for Business Continuity for Governance Forums was approved by Board in April 2020. All Board meetings have been undertaken, however the annual work plans were reviewed and all non-essential items were deferred.

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

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

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

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

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

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

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

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

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

The directors of the Board are appraised by the Chief Executive who, in turn, is appraised by the Chair. The Council of Governors does not routinely consult external professional 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 (Single Oversight Framework) SOF categorisation segment 3 to segment 2 in January 2019 and the Trust remains in segment 2 as at 31 March 2021.

This segmentation information is the Trust's position as at 31 March 2021. The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

This element of the segmentation has been suspended by NHSI for 2020/21; the table below reflects the most recent data from previous years.

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 Licence.

Statement of the Chief Executive's responsibilities as the accounting officer of Sherwood Forest Hospitals NHS Foundation Trust

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

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

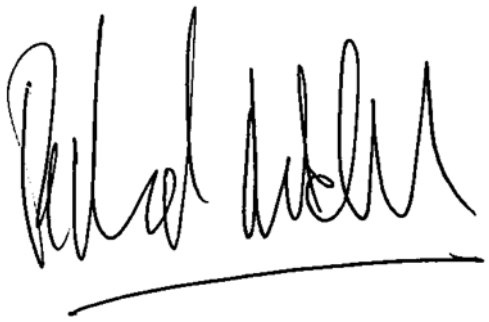
In preparing the accounts and overseeing the use of public funds the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

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

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

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



Signed…….
Richard Mitchell **11 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 foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Regulation

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

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

An extract from the Final CQC report states:

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

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

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

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

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

Capacity to handle risk

Our Board of Directors provide leadership on the overall governance agenda. On the Board's behalf our Risk Committee has maintained and kept under review a policy for the management of risk. Our Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Audit and Assurance Committee, Finance Committee, Quality Committee and People, Culture and Improvement Committee. Our Risk Committee is an executive committee focussing on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. Our Risk Committee is chaired by our Chief Executive (CEO) and comprises 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 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 and 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 and continually reviewed Board Assurance Framework.

6. **Risk Review**

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

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

The most significant strategic risks facing us continue to be: (i) the maintenance of sufficient numbers of skilled employees to deliver our full range of clinical services; (ii) financial sustainability 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, working closely with local health and care partners and the potential for major disruptive incidents. Capacity and demand for care, and workforce capacity are expected to remain for the foreseeable future, and strategic partnerships will further develop over the coming months and years.

A breakdown of the risks addressed 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
Significant deterioration in standards of safety and care.	*This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality within the governance of Sherwood Forest Hospitals.*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	Progress and outcomes are monitored through the Quality Committee, supported by the Quality Assurance and Safety Committee and other sub-groups. This includes safety and quality indicators, incident investigations and key performance indicators.
Demand that overwhelms capacity.	*This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease.*	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward.	Progress and outcomes are monitored through the Quality Committee, supported by the Quality Assurance and Safety Committee. This includes safety and quality indicators, incident investigations and key performance indicators.
A critical shortage of workforce capacity and capability.	*Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges to be significant.*	The *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.
Failure to achieve the Trust's financial strategy.	*The delivery of high quality care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk may arise if the trust is not able secure sufficient funds to*	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	Frequent assessment of performance and forecast trajectories is monitored through the Finance Committee.

	meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals.	the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Medical Director and Chief Nurse.	
Inability to initiate and implement evidence-based improvement and innovation.	*This risk may arise if there is a lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care.*	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's improvement agenda; striving for excellence and challenging unsatisfactory performance regarding organisational development; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	In addition to the Trust's Improvement Strategy, frequent correspondence and discussions with our partners and commissioners to ensure focus is maintained on quality and systems improvement, whilst maintaining compliance with regulatory requirements.
Working more closely with local health and care partners does not fully deliver the required benefits.	*This risk, which is currently being mitigated, may arise where strategic partners are unable to balance competing demands and/or work collaboratively across the whole health and social care system.*	Active participation and engagement with all ICS and ICP stakeholders to ensure effective planning, implementation and governance at a system level. 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 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 and Assurance Committee utilises the reports of management and internal audit to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

Clinical Audit - National Audits

The trust identified 64 projects over the year 2020-2021 that it was mandated to participate in, as detailed within the NHSE/I Quality Account list.

Due to the COVID-19 pandemic, many of the bodies regulating national audits - Health Quality Improvement Partnership (HQIP) and the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) advised that, in order not to distract frontline clinical colleagues, the National Clinical Audit program was deemed non-essential; organisations were asked to submit data only if this was possible in light of local pressures. The Trust stepped down all clinical audit activity from March 2020 to June 2020, and then again from December 2020 to March 2021.

This means that the Trust, along with many acute organisations nationally, will not have submitted a full set of data to several national audits during this calendar year.

However national audit regulators have continued to publish reports relating to data captured during 2019/20. These outcomes are summarised here:

- The National Hip Fracture Database (NHFD) reported that Sherwood Forest achieved all 6 of the criteria for treating patients who had suffered a hip fracture, as well as scoring above the national average.
- The Parkinson's National Audit shows that we are consistently performing ahead of the National average in the standards being measured. An example of this is that 96.4% of patients surveyed within our service had been reviewed within the last six months compared to 62.7% nationally, as well as 100% of our clinic patients are seen within a specific Parkinson's / Movement Disorder clinic compared to 50% nationally.
- The National Emergency Laparotomy Audit shows that there is a consultant anaesthetist and consultant surgeon present in 99% of cases where the risk of death is calculated at being equal to or greater than 5%. This is 10% higher than the national average. The organisation's average post-operative stay is recorded at 13 days which is 3 days lower than national level, and 2 days lower than the local Academic Health Science Network region.
- The Chronic Obstructive Pulmonary Disease (COPD) Audit results show that 35% of Patients requiring acute treatment with NIV received it within 2 hours of arrival. This is 11% above the national target and an increase of 6% on the previous year. We also saw an increase in the % of discharge bundles completed on the previous year rising from 80% to 85%.
- We are targeted to provide systemic steroids to an adult patient experiencing an asthma attack within 1 hour of arrival at hospital. The Adult Asthma audit shows that we achieve this in 50% of cases against a national target of 27%. We also achieve the standard of a respiratory specialist carrying out a review within 24 hours of arrival at hospital.
- The Sentinel Stroke National Audit Programme for 2019 shows that SFH met 5 out of 10 criteria including minimum establishment of band 6 and band 7 nurses per 10 beds, the out–of-hours presence of stroke specialist nurses, at least two types of therapy available 7 days a week, formal surveys undertaken seeking patient/carer views on stroke services and lastly, first line of brain imaging for TIA patients in MRI.
-

Workforce

Our workforce plan is linked to the national, interim "NHS People Plan". This strategy was nationally introduced in July 2020 and is underpinned by an annual implementation plan, with progress regularly reported to our Board and associated Committees. A key part of the

implementation plan has been to respond the challenges faced during the global pandemic of COVID-19.

Our workforce strategy and plan reflect our numerical and skill mix requirements and is aligned with the Integrated Care System People and Culture Strategy, alongside being focused on supporting the workforce during the global pandemic of COVID-19. It is consistent with our financial, quality and activity plans and supports the Developing Workforce Safeguards recommendations as it is the result of a structured cross-trust approach. However, it is noted that due to the pandemic our workforce strategy for 2021/22 is focused on the recovery and restoration of services.

During 2020/21 the planning arrangements were paused, and as a result our plans have been carried over into the 2021/22 period. However, the work we have undertaken on restoration and recovery has moved forward our workforce plans. Our divisional teams are supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver on the projected activity levels, in the short, medium and longer term. This bottom-up approach to ensuring we have safe and adequate staffing levels is supported by our executive-led Workforce Group.

Regular, 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.

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

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

Key risks concerning workforce capacity and capability are contained in the Board Assurance Framework and were regularly reviewed by the People, OD and Culture Committee during 2020/21. New roles are being developed to support our medium- and longer-term workforce requirements.

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

The Trust has implemented a Just and Restorative Culture for people practices which focus on why issues have arisen and what has contributed to errors or concerns rather than apportioning blame. This approach has resulted in a significant decline in the number of employee relation incidents.

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

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

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 anticipated 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 regarding 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 Trust's People, OD and Culture Committee assurance is provided in regard to the Trust's 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 July 2020. 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:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively.
   a. For timely and effective scrutiny and oversight by the Board of the Licensee's operations.
   b. 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.
   c. 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).
   d. To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making.
   e. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.
   f. 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
   g. To ensure compliance with all applicable legal requirements.

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

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

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

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

Our governance committee structure has provided our Board of Directors with assurance during the year 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. In response to the rollout of the COVID-19 vaccination programme the Trust applied under set regulations the extension of its registration to the following vaccination sites – The Mansfield Vaccination Centre, Newark Showground, King's Meadow Campus, Richard Herrod Centre, Gamston Community Hall and Forest Recreation Ground. The Trust also provides vaccination centres at King's Mill Hospital and Ashfield Health Village; this falls under the Treatment of Disease, Disorder, and Injury condition of our current registration.

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

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

We have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (band 7 and above) within the past 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.

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

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

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

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

Transformation Cabinet: The Transformation Cabinet leads on the delivery of longer-term strategic change on behalf of the Trust Board. The Cabinet meets monthly to review progress on the nine programmes of work, supporting programme leads to deliver transformational change that will improve services for the local population.

Incident Control Team (ICT): Since the onset of the pandemic the Trust has had in place an Incident Control Team, chaired by the Trust's Accountable Emergency Officer (the Chief Operating Officer). This group meets daily as required and has decision making powers delegated to it from the Executive team (financial approval, policy etc.). Financial decisions made by ICT are then further ratified by the Executive Team.

People and Inclusion Cabinet: The People and Inclusion Cabinet's principal purpose is to provide scrutiny and assurance of the development, delivery and impact of the Trust's People and Inclusion strategy and plan. This includes the review of associated BAF risks, to provide assurance that those risks are being effectively mitigated or managed in a controlled way, and

to provide assurance that suitable structures, systems and processes are in place and functioning to support colleagues in the provision and delivery of high quality patient care.

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

In response to the COVID-19 pandemic an interim financial framework was introduced across the NHS for the financial year 2020/21. Under this framework the Trust has largely been funded through fixed allocations. During the first half of the financial year these fixed allocations were supplemented with additional retrospective funding to match costs. These retrospective adjustments ceased at the end of September 2020 and the framework allowed surplus or deficit positions against allocations for the period October 2020 to March 2021.

The Trust has reviewed governance processes early in the pandemic and a governance update paper was provided to the Board in May 2020. Income and expenditure are reviewed on an 'actuals' basis and changes to run rate are reviewed and explained as part of the monthly reporting process. The Trust has also worked closely with our Counter Fraud Specialist and Internal Auditors throughout the pandemic.

We have ended the year with a deficit of £15.89m. Adjusting for asset impairments and other non-control total items gives a control total basis deficit of £5.47m. This value is aligned with the forecast outturn agreed between the Nottinghamshire ICS and NHS England & NHS Improvement for the financial year 2020/21. Details relating to this position are included elsewhere in this report. Although the financial outturn is consistent with the agreed position we remain in a financially challenged position with a significant underlying deficit.

The Trust's Standing Financial Instructions (SFIs) have remained in place throughout the pandemic. COVID-19 related expenditure is only incurred following approval (except for some pay costs for covering COVID-19 related absences, which are reviewed through month-end processes). All non-COVID-19 costs are reviewed monthly against the financial plan and forecast, with a variance analysis completed on any significant movements. In addition, the Trust continues to report an underlying financial position the Finance Committee at each meeting.

During 2020/21 the Trust has been supported with advanced cash payments to cover expected costs. Therefore, the Trust has not accessed additional interim revenue support in the financial year. However, capital support of £10.1m has been agreed with NHS England and NHS Improvement and drawn down in the form of Public Dividend Capital. In addition, all outstanding revenue and capital loans were cleared, with a revenue repayment of £219.3m and a capital loan repayment of £14.6m. This has significantly improved the Statement of Financial Position of the Trust, which has returned to a positive position.

The pandemic has also led to significant changes in working practices and presented challenges in relation to recruitment and retention of employees. We have continued to actively recruit to our employee establishment and have been successful in reducing our number of vacant posts, although recruitment difficulties continue in the nursing and medical workforce. Changing demands and unprecedented levels of staffing absence rates, including those directly related to COVID-19, have necessitated the requirement for additional temporary staffing during the year.

This has influenced an increase in agency expenditure to £15.2m in 2020/21, compared to £12.8m in the prior year. Although the formal agency expenditure ceiling has been relaxed for 2020/21 the Trust has maintained controls to manage agency usage and costs, with the total expenditure for the year lower than the previous ceiling of £15.3m set by NHS England and NHS Improvement.

The utilisation of bank employees has been particularly important in the past year and the Trust has continued to grow this resource, with over 2,500 staff now on the Trust's bank. In addition, the Trust has taken on responsibility for the roster management of the COVID-19 Vaccination Programme in Nottinghamshire. This has significantly increased pay costs; however, these costs are matched by funding from NHS England and NHS Improvement.

The Trust's Programme Management Office (PMO) is responsible for the overall Financial Improvement Programme (FIP). Identification of FIP schemes is led by the PMO and supported by divisional teams and finance. The Trust uses benchmarking information from the Model Hospital and PLICS to help to identify opportunities. For 2020/21 the Trust has not been required to deliver FIP savings under the interim financial framework; however, development of the FIP plan for 2021/22 has started.

The Department of Health and Social Care (DHSC) has confirmed that the revised financial framework will remain in place for Quarter 1 of 2021/22.

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

The Nottinghamshire ICS has strengthened governance arrangements over the past year, which has supported closer system working and encouraged a greater level of transparency and consistency between organisations. The introduction of an ICS Transformation Cabinet and an ICS Finance Committee will facilitate the sustainable recovery and transformation of services.

These conditions indicate that there is uncertainty which may cast doubt about the Trust's ability to continue as a Going Concern. However, the assurance provided by the immediate continuing provision of healthcare services and improved access to funding through changes in the NHS financing regime significantly mitigates this.

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

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

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs, who is also our 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 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 2020/21, 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 reviews Data Impact Assessments, as part of the wider stakeholder engagement. This is to assess the level of risk and consider both the likelihood and the severity of any impact on individuals' rights and freedoms. The group also reviews national guidance to inform both strategy and policy development together with implementation plans and processes.

The IG Committee monitors the completion of the Data Protection Security Toolkit (DSPT) submission, data flow mapping, and information asset registers. We have implemented the DSPT requirements achieving 121/121 standards met.

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2020/2021 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 2020/21 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 two incidents that required reporting to the Information Commissioners Office (ICO). We have had no further action from the regulators after investigation. The incidents ranged from information being disclosed on social media and security around the storage of paper records.

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 2020/21 to date the Trust processed a total of 497 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
497	146	0

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

Of the requests, 484 are currently completed, 9 on hold waiting further information and 4 still in progress. Of the requests completed 304 have been completed within 20 days which show a compliance rate of 62.8%.

Subject Access Requests

The Trust has received 2,506 requests for access to patient records. Most cases are processed in line with national guidance which is exemplary given some of these cases represent hundreds of pages of information and require methodical attention to detail to ensure information is released appropriately.

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

The Trust has seen a decrease in the number of requests from April 20 to March 2021 against previous years due to the coronavirus pandemic, however over the past couple of months we are starting to see a gradual rise in line with the lockdown restrictions lifting.

April 20 to March 21 Total	Completed < 21 days	Completed 21-30 days	Completed > 30 days
King's Mill – 2130 Newark – 358 IG – 18	King's Mill – 1909 Newark – 348 IG - 10	King's Mill – 218 Newark – 10 IG – 6	King's Mill – 3 Newark – 0 IG - 2

Horizon Scanning

Information governance, data protection and security, privacy, accountability, cyber security and artificial intelligence (AI) are just some of the trends that are becoming increasingly difficult to keep up to date with.

We have already seen a rapid growth in telemedicine in 2020 due to the pandemic and this is set to expand in 2021; with this more NHS staff are working from home which means that policies need to be robust and fit the user being onsite and working from home.

Artificial intelligence is now looking at pandemic detection, vaccine development, thermal screening, facial recognition and analysing CT scans.

We are also seeing an increase in mobile apps and devices which are playing a critical role in tracking the public to prevent illness, so we are now seeing the internet of medical things. As we use more technology we share more data electronically and therefore we increase the risk landscape and the increased risk of data loss.

Data Quality and Governance

SOP – Quality Assurance and sign off process

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

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

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

pre submission by the Divisional General Manager before signing off by the relevant Executive Director.

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

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

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

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

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

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

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

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

Quality

A review of our performance over the period covered from April 2020 to 31 March 2021 indicates there are appropriate controls in place. These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse
- Quality governance, quality and performance reports are included in our performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills
- 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 global pandemic has disrupted business as usual over the last year; nonetheless 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 2020/21.

- 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 review meetings
- Quality Assurance and Patient Safety Cabinet
- Nursing, Midwifery & AHP Committee
- 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 2020/21. 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. All the reports have been presented to the Audit and Assurance Committee, by the executive lead, and the actions identified will be monitored through the most appropriate committee. Any actions which become overdue will be reported back to the Audit and Assurance Committee and the action owners will be invited to attend.

The structure of the Board of Directors meetings was reviewed and reduced during the year to take account of the pressures on the organisation due to the pandemic, in order to ensure sufficient time to guarantee 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 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 2020/21 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

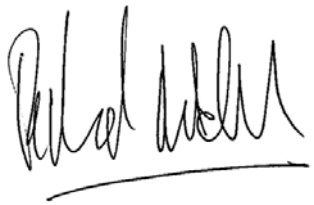
There are no significant control issues in our response to the COVID-19 pandemic. I believe we have taken a number of effective decisions and actions to prepare the organisation and our colleagues for the surge in patients with COVID-19 our preparation began early; we have led with compassion and with support and we have communicated well.

Our initial focus, at the beginning of 2020/21, was on some of the transactional aspects of preparation and delivery. Personal protective equipment (PPE) planning and fit testing of masks and because of the good work of our procurement team, working with others within the organisation and beyond, we have had sufficient PPE throughout the pandemic crisis and on-going in 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.

In line with government guidance, during 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 **11 June 2021**

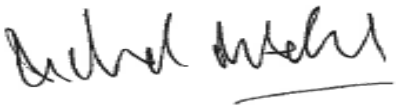
Sherwood Forest Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, 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 **11 June 2021**

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	328,440	284,196
Other operating income	4	94,132	67,758
Operating expenses	6, 8	(423,652)	(350,068)
Operating (deficit) / surplus from continuing operations		**(1,080)**	**1,886**
Finance income	11	-	89
Finance expenses	12	(14,772)	(17,819)
Net finance costs		**(14,772)**	**(17,730)**
Other (losses) / gains	13	(42)	(88)
(Deficit) / Surplus for the year		**(15,894)**	**(15,932)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(783)	-
Revaluations	17	225	(202)
Other reserve movements		(4)	-
Total comprehensive(expense) / income for the period		**(16,456)**	**(16,134)**

(Deficit) / Surplus for the year as stated above		**(15,894)**	**(15,932)**
Reversal of impairment	7	(19)	(1,627)
Impairment	7	10,436	2,148
(Deficit) from continuing operations excluding the impact of impairments.		**(5,477)**	**(15,411)**

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

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	6,716	5,271
Property, plant and equipment	15	279,108	279,927
Receivables	19	1,271	1,284
Total non-current assets		**287,095**	**286,482**
Current assets			
Inventories	18	4,114	4,466
Receivables	19	20,312	28,412
Cash and cash equivalents	20	25,187	2,383
Total current assets		**49,613**	**35,261**
Current liabilities			
Trade and other payables	21	(50,214)	(29,893)
Borrowings	23	(9,957)	(244,448)
Provisions	24	(180)	(167)
Other liabilities	22	(1,853)	(1,208)
Total current liabilities		**(62,204)**	**(275,716)**
Total assets less current liabilities		**274,504**	**46,027**
Non-current liabilities			
Trade and other payables	21	-	(195)
Borrowings	23	(229,927)	(239,884)
Provisions	24	(1,095)	(989)
Total non-current liabilities		**(231,022)**	**(241,068)**
Total assets employed		**43,482**	**(195,041)**
Financed by			
Public dividend capital		404,594	149,615
Revaluation reserve		15,183	15,977
Income and expenditure reserve		(376,295)	(360,633)
Total taxpayers' equity		**43,482**	**(195,041)**

The notes on pages 120 to 164 form part of these accounts.

Name **Richard Mitchell**
Position **Chief Executive Officer**
Date 11 June 2021

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**149,615**	**15,977**	**(360,633)**	**(195,041)**
Surplus/(deficit) for the year	-	-	(15,894)	**(15,894)**
Other transfers between reserves	-	(23)	23	**-**
Impairments	-	(783)	-	**(783)**
Revaluations	-	225	-	**225**
Public dividend capital received	254,979	-	-	**254,979**
Other reserve movements	-	(213)	209	**(4)**
Taxpayers' and others' equity at 31 March 2021	**404,594**	**15,183**	**(376,295)**	**43,482**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£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)**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(1,080)	1,886
Non-cash income and expense:			
Depreciation and amortisation	6.1	12,135	11,502
Net impairments	7	10,417	521
Income recognised in respect of capital donations	4	(366)	(23)
Decrease / (Increase) in receivables and other assets		8,107	(573)
Decrease / (Increase) in inventories		352	(1,044)
Increase / (decrease) in payables and other liabilities		14,285	(1,125)
Increase / (decrease) in provisions		110	285
Other movements in operating cash flows		(4)	-
Net cash flows from / (used in) operating activities		**43,956**	**11,429**
Cash flows from investing activities			
Interest received		3	94
Purchase of intangible assets		(4,990)	(2,413)
Purchase of PPE and investment property		(11,998)	(7,086)
Sales of PPE and investment property		65	11
Receipt of cash donations to purchase assets		-	-
Net cash flows (used in) / from investing activities		**(16,920)**	**(9,394)**
Cash flows from financing activities			
Public dividend capital received		254,979	2,055
Public dividend capital repaid		-	-
Movement on loans from DHSC		(233,958)	21,755
Capital element of PFI, LIFT and other service concession payments		(9,744)	(9,962)
Interest on loans		(746)	(3,230)
Other interest		(2)	(1)
Interest paid on PFI, LIFT and other service concession obligations		(14,761)	(14,524)
PDC dividend (paid) / refunded		-	-
Net cash flows (used in) / from financing activities		**(4,232)**	**(3,907)**
Increase / (decrease) in cash and cash equivalents		**22,804**	**(1,872)**
Cash and cash equivalents at 1 April - brought forward		**2,383**	**4,255**
Cash and cash equivalents at 31 March	20.1	**25,187**	**2,383**

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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

Note 1.2 Going concern

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

Significant changes occurred to the funding streams as a result of the pandemic and in year block contract rather than activity based payments were received based on the 2019/20 reported position, rather than a formal financial plan submitted by the Trust. In addition for quarter's one and two additional Top up monies were received and a break even position reported, across the NHS. This was in line with NHS England and NHS Improvement strategy to meet all reasonable costs associated with Covid-19.

For quarters three and four a control total was agreed for both the Trust and the Integrated Care System (ICS) as a whole with NHS England & NHS Improvement.

As part of the change in monitoring of spend there was no requirement to have a formal financial efficiencies plan, however, the trust has continued to review pay, non-pay and income to ensure that outturn is in line with plan, and the Project Management team has been working to identify and risk rate identified schemes for 2021/22.

For the year ending 2020/21 the Trust is reporting a deficit of (£10.93m) which includes the impact of impairments/gains on the valuation of buildings. Removing this impairment loss/gain, which was £5.46m, we are reporting a deficit of (£5.48m). This is in line with our agreed control total for quarter 3-4. In year the trust received £xx.xxm in respect of top up monies which are included in the reported outturn position.

No revenue support was requested in year however, due to PFI liabilities, depreciation does not self-fund the capital expenditure, therefore a Public Dividend Capital (PDC) request for £10.10m was submitted and agreed to support this expenditure.

Outline guidance on the financial framework for 2021/22 has been issued and for at least quarter one the plan will be set nationally for each Trust. The guidance indicated that a formal plan for quarter's two to four will be required to be submitted and agreed across the ICS in this period. The guidance continues to be updated, however, the Trust is preparing a financial plan, including cost improvements as it would in any other year, based on the expectation of a return to normal operating practices.

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.

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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a [Integrated Care System/Sustainability and Transformation Partnership] level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Other income

Income from various sources including items such as 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.

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

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

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

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 the criteria in IFRS 5 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

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

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

The annual contract payments are apportioned between the 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	**Max life**
	Years	**Years**
Land	-	-
Buildings, excluding dwellings	1	57
Dwellings	1	57
Plant & machinery	5	15
Transport equipment	-	-
Information technology	5	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

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

Software

Software which is integral to the operation of hardware, 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 licences	5	10

Note 1.11 Inventories

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

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

Note 1.12 Cash and cash equivalents

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

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

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; 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 2021:

		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 0.95% 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, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.18 Value added tax

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

Note 1.19 Climate change levy

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

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

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

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

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

Note 1.21 Third party assets

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

Note 1.22 Losses and special payments

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

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

Note 1.23 Gifts

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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

amendments and

	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 16 Leases	Standard, as interpreted and adapted by the FReM, is to be effective from 1 April 2021.
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 1.27 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, £1.86m based on the PFI model.
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.
External Valuation where reliance has been placed on the valuation report as at 31 March 2021, as this represents the best available evidence of current value. Further details are incuded in note 1.28.

Note 1.28 Sources of estimation uncertainty
The External valuation report has bene used has been used as the basis of property valuation which is based on estimated values. There are no other assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2 Operating Segments

"No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The ""Chief Operating Decision Maker"" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Diagnostics & Outpatients. In addition there is a supporting corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment.""

A detailed analysis of all income is disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£0
Acute services		
Block contract / system envelope income*	287,267	240,856
High cost drugs income from commissioners (excluding pass-through costs)	14,588	16,605
Other NHS clinical income	712	781
Community services		
Block contract / system envelope income*	13,584	12,632
Income from other sources (e.g. local authorities)	2,457	2,352
All services		
Private patient income	95	141
Additional pension contribution central funding**	9,089	8,337
Other clinical income	648	2,492
Total income from activities	**328,440**	**284,196**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

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

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	26,379	20,930
Clinical commissioning groups	297,764	256,901
Department of Health and Social Care	-	-
Other NHS providers	712	863
NHS other	81	43
Local authorities	2,761	2,826
Non-NHS: private patients	95	141
Non-NHS: overseas patients (chargeable to patient)	39	47
Injury cost recovery scheme	609	2,213
Non NHS: other	-	232
Total income from activities	**328,440**	**284,196**
Of which:		
Related to continuing operations	328,440	284,196
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 22.43% to reflect expected rates of collection. (21.79% 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)

	2020/21	2019/20
	£000	£000
Income recognised this year	39	47
Cash payments received in-year	9	14
Amounts written off in-year	13	43

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	771	-	**771**	726	-	**726**
Education and training	11,612	380	**11,992**	11,173	-	**11,173**
Non-patient care services to other bodies	26,795		**26,795**	25,254		**25,254**
Provider sustainability fund (2019/20 only)			**-**	7,028		**7,028**
Financial recovery fund (2019/20 only)			**-**	14,807		**14,807**
Marginal rate emergency tariff funding (2019/20 only)			**-**	5,385		**5,385**
Reimbursement and top up funding	43,413		**43,413**			**-**
Income in respect of employee benefits accounted on a gross basis	229		**229**	486		**486**
Receipt of capital grants and donations		366	**366**		23	**23**
Charitable and other contributions to expenditure		7,396	**7,396**		384	**384**
Rental revenue from operating leases		700	**700**		698	**698**
Other income	2,470	-	**2,470**	1,794	-	**1,794**
Total other operating income	**85,290**	**8,842**	**94,132**	**66,653**	**1,105**	**67,758**
Of which:						
Related to continuing operations			94,132			67,758
Related to discontinued operations			-			-

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	574	605
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods		-

Note 5.2 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:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	327,697	281,563
Income from services not designated as commissioner requested services	743	2,633
Total	**328,440**	**284,196**

Note 5.3 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

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	887	815
Purchase of healthcare from non-NHS and non-DHSC bodies	1,389	3,237
Staff and executive directors costs	263,228	222,516
Remuneration of non-executive directors	143	143
Supplies and services - clinical (excluding drugs costs)	36,007	26,646
Supplies and services - general	3,384	3,615
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,026	22,610
Consultancy costs	125	411
Establishment	4,559	3,087
Premises	21,394	18,462
Transport (including patient travel)	362	666
Depreciation on property, plant and equipment	10,559	10,452
Amortisation on intangible assets	1,576	1,050
Net impairments	10,417	521
Movement in credit loss allowance: contract receivables / contract assets	675	137
Increase/(decrease) in other provisions	86	(324)
Audit fees payable to the external auditor		
audit services- statutory audit	105	100
Internal audit costs	100	118
Clinical negligence	12,931	10,983
Legal fees	102	111
Education and training	1,395	598
Rentals under operating leases	403	404
Early retirements	184	136
Redundancy	68	120
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	22,129	19,961
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	60	113
Car parking & security	-	110
Hospitality	119	230
Losses, ex gratia & special payments	255	-
Other	7,984	3,040
Total	**423,652**	**350,068**
Of which:		
Related to continuing operations	423,652	350,068
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	-	-
Total	**-**	**-**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	10,417	521
Other	-	-
Total net impairments charged to operating surplus / deficit	**10,417**	**521**
Impairments charged to the revaluation reserve	783	-
Total net impairments	**11,200**	**521**

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

	2020/21	2019/20
	£000	£000
Reversals of impairments charged to the SOCI in previous years		
Tower 1,2,3 Kings Mill Site	-	(672)
Newark Site	-	(215)
Trust Admin Building	-	(117)
Kings Treatment Centre	-	(184)
FM building	-	-
Block 40	-	-
Elipse	-	(64)
Renal	-	-
Other	(19)	(375)
Impairments charged to SOCI in year		
PFI lifecycle	1806	1434
FM building	55	345
Histopathology / Mortuary	834	
PFI Tower 1,2,3 / E.D	3571	
Other	4,170	369
	10,417	**521**

The District valuer has undertaken a desktop review of the Trust estate as at 31 March 2021, full review 2018/19. This takes account of numerous factors contributing to an overall asesment 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

	2020/21	2019/20
	£000	£000
Change in market price	225	(202)
Total impairement for **PPE** charged to reserves	225	(202)

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	197,025	164,902
Social security costs	20,409	16,978
Apprenticeship levy	972	850
Employer's contributions to NHS pensions	30,222	27,593
Termination benefits	-	34
Temporary staff (including agency)	15,160	12,842
Total gross staff costs	**263,788**	**223,199**
Recoveries in respect of seconded staff	-	-
Total staff costs	**263,788**	**223,199**
Of which		
Costs capitalised as part of assets	308	427

Note 8.1 Retirements due to ill-health

During 2020/21 there were no early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is 0k (£137k in 2019/20).

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 for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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 2021 there were 7,527 are members of the NHS Pension Scheme, 692 are enrolled within NEST and 3,771 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.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	700	698
Total	**700**	**698**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	399	528
- later than one year and not later than five years;	35	374
- later than five years.	7	16
Total	**441**	**918**

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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	403	404
Total	**403**	**404**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	309	330
- later than one year and not later than five years;	1,059	1,074
- later than five years.	46	145
Total	**1,414**	**1,549**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	89
Total finance income	**-**	**89**

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	3,277
Interest on late payment of commercial debt	2	1
Main finance costs on PFI and LIFT schemes obligations	5,707	5,932
Contingent finance costs on PFI and LIFT scheme obligations	9,054	8,592
Total interest expense	**14,763**	**17,802**
Unwinding of discount on provisions	9	17
Total finance costs	**14,772**	**17,819**

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

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	2	1

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	65	11
Losses on disposal of assets	(107)	(99)
Total (losses) / gains on disposal of assets	**(42)**	**(88)**

Note 14.1 Intangible assets - 2020/21	2020/21	2019/20
	Software licences £000	**Software licences**
Valuation / gross cost at 1 April 2020 - brought forward	**17,845**	14,880
Additions	**3,009**	2,965
Reclassifications	**22**	-
Disposals / derecognition	**(11,283)**	-
Valuation / gross cost at 31 March 2021	**9,593**	**17,845**
Amortisation at 1 April 2020 - brought forward	**12,574**	11,524
Provided during the year	**1,576**	1,050
Disposals / derecognition	**(11,273)**	**-**
Amortisation at 31 March 2021	**2,877**	**12,574**
Net book value at 31 March 2021	**6,716**	**6,716**
Net book value at 1 April 2020	**5,271**	**5,271**

Asset Lives	**Minimum life Years**	**Maximum life years**
Software Licenses	5	10

Note 15.145 Property, plant and equipment -

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**17,456**	**250,526**	**2,186**	**387**	**35,431**	**16,292**	**506**	**322,784**
Additions	-	8,762	187	-	7,302	4,477	106	**20,834**
Impairments	-	(11,219)	-	-	-	-	-	**(11,219)**
Reversals of impairments	-	19	-	-	-	-	-	**19**
Revaluations	225	-	-	-	-	-	-	**225**
Reclassifications	-	(17,387)	-	(157)	(22)	-	-	**(17,566)**
Disposals / derecognition	-	-	-	-	(948)	-	-	**(948)**
Valuation/gross cost at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**41,763**	**20,769**	**612**	**314,129**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**11,662**	**-**	**-**	**20,419**	**10,412**	**364**	**42,857**
Provided during the year	-	5,882	-	-	2,981	1,646	50	**10,559**
Reclassifications	-	(17,544)	-	-	-	-	-	**(17,544)**
Disposals / derecognition	-	-	-	-	(851)	-	-	**(851)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**22,549**	**12,058**	**414**	**35,021**
Net book value at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**19,214**	**8,711**	**198**	**279,108**
Net book value at 1 April 2020	**17,456**	**238,864**	**2,186**	**387**	**15,012**	**5,880**	**142**	**279,927**

Asset Lives	**life Years**	**life years**
Buildings Excluding Dwellings	1	57
Dwellings	1	57
Pland and Machinery	5	15
Information Technology	5	8
Furniture and Fittings	5	10

Note 15.146 Property, plant and equipment -

	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 - as previously stated	**17,396**	**248,789**	**2,000**	**-**	**33,775**	**14,198**	**506**	**316,664**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2019 - restated	**17,396**	**248,789**	**2,000**	**-**	**33,775**	**14,198**	**506**	**316,664**
Transfers by absorption	-	-	-	-	-	-	-	**-**
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 - as previously stated	**-**	**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**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	17,681	12,567	-	230	17,670	-	8,707	190	**57,045**
On-SoFP PFI contracts and other service concession arrangements	-	216,973	-	-	-	-	-	-	**216,973**
Off-SoFP PFI residual interests	-	-	2,373	-	-	-	-	-	**2,373**
Owned - donated/granted	-	1,161	-	-	1,544	-	4	8	**2,717**
NBV total at 31 March 2021	**17,681**	**230,701**	**2,373**	**230**	**19,214**	**-**	**8,711**	**198**	**279,108**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 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/granted	-	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 16 Donations of property, plant and equipment

The Trust received donations during the year of £485k. (2019/20 £406k). No restrictions were placed on these donations of which £366k 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 2021. The review was performed by Rob Mapletoft, (MRICS), RICS registered valuer.

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 2021 is detailed in noite 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 lifes to identify and adjust for any assets impaired or where the useful economic life requires adjustment. This excercise 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 2021	31 March 2020
	£000	£000
Drugs	1,442	1,565
Consumables	2,488	2,827
Energy	184	74
Total inventories	**4,114**	**4,466**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,246k (2019/20: £27,221k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,168k of items purchased by DHSC.

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

Note 19.1 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	16,790	25,769
Allowance for impaired contract receivables / assets	(402)	(304)
Prepayments (non-PFI)	1,684	1,336
Interest receivable	-	3
VAT receivable	1,757	1,366
Other receivables	483	242
Total current receivables	**20,312**	**28,412**
Non-current		
Contract receivables	1,324	1,229
Allowance for impaired contract receivables / assets	(883)	(662)
PFI lifecycle prepayments	49	52
Other receivables	781	665
Total non-current receivables	**1,271**	**1,284**
Of which receivable from NHS and DHSC group bodies:		
Current	12,751	22,043
Non-current	781	665

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	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	**966**	**-**	**829**	**-**
New allowances arising	675	-	-	-
Changes in existing allowances	-	-	211	-
Reversals of allowances	-	-	(74)	-
Utilisation of allowances (write offs)	(356)	-	-	-
Allowances as at 31 Mar 2021	**1,285**	**-**	**966**	**-**

Note 19.3 Exposure to credit risk	31-Mar-21 receivables	31-Mar-20 receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	21	41
30-60 Days	45	43
60-90 days	62	34
Over 90 days	1158	848
	1,286	966

Ageing of non-impaired financial assets past their due date	**£000**	**£000**
0 - 30 days	7,684	21,500
30-60 Days	316	1,213
60-90 days	120	1,020
Over 90 days	1,834	5,591
	9,954	29,324

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

	2020/21	2019/20
	£000	£000
At 1 April	**2,383**	**4,255**
Prior period adjustments		-
At 1 April (restated)	**2,383**	**4,255**
Transfers by absorption	-	-
Net change in year	22,804	(1,872)
At 31 March	**25,187**	**2,383**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	25,181	2,377
Total cash and cash equivalents as in SoFP	**25,187**	**2,383**

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 2021	31 March 2020
	£000	£000
Monies on deposit	1	1
Total third party assets	**1**	**1**

Note 21.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	4,680	5,070
Capital payables	11,868	5,382
Accruals	19,758	11,243
Receipts in advance and payments on account	437	-
Social security costs	2,954	2,456
Other taxes payable	2,808	1,938
Other payables	7,709	3,804
Total current trade and other payables	**50,214**	**29,893**
Non-current		
Other payables	-	195
Total non-current trade and other payables	**-**	**195**
Of which payables to NHS and DHSC group bodies:		
Current	2,171	4,601
Non-current	-	195

Note 21.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2021 £000	31 March 2021 Number	31 March 2020 £000	31 March 2020 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 22 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,853	1,208
Total other current liabilities	**1,853**	**1,208**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	-	234,704
Obligations under PFI, LIFT or other service concession contracts	9,957	9,744
Total current borrowings	**9,957**	**244,448**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	229,927	239,884
Total non-current borrowings	**229,927**	**239,884**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2020	**234,704**	**249,628**	**484,332**
Cash movements:			
Financing cash flows - payments and receipts of principal	(233,958)	(9,744)	**(243,702)**
Financing cash flows - payments of interest	(746)	(5,707)	**(6,453)**
Non-cash movements:			
Application of effective interest rate	-	5,707	**5,707**
Carrying value at 31 March 2021	**-**	**239,884**	**239,884**

Note 23.3 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**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2018 - restated	**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 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**315**	**63**	**113**	**665**	**1,156**
Arising during the year	48	5	114	116	**283**
Utilised during the year	(48)	(5)	(85)	-	**(138)**
Reversed unused	(21)	-	(14)	-	**(35)**
Unwinding of discount	9	-	-	-	**9**
At 31 March 2021	**303**	**63**	**128**	**781**	**1,275**
Expected timing of cash flows:					
- not later than one year;	47	5	128	**-**	**180**
- later than one year and not later than five years;	190	21	-	**-**	**211**
- later than five years.	66	37	-	**781**	**884**
Total	**303**	**63**	**128**	**781**	**1,275**

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 2021, £143,504k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2020: £137,939k).

Note 25 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(83)	(74)
Gross value of contingent liabilities	**(83)**	**(74)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(83)**	**(74)**
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 2021 £000	31 March 2020 £000
Property, plant and equipment	3,494	3,661
Intangible assets	800	864
Total	**4,294**	**4,525**

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 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**660,686**	**685,192**
Of which liabilities are due		
- not later than one year;	25,125	24,506
- later than one year and not later than five years;	100,465	100,099
- later than five years.	535,096	560,587
Finance charges allocated to future periods	(420,802)	(435,564)
Net PFI, LIFT or other service concession arrangement obligation	**239,884**	**249,628**
- not later than one year;	9,957	9,744
- later than one year and not later than five years;	38,262	38,756
- later than five years.	191,665	201,128

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

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,481,164**	**1,530,747**
Of which payments are due:		
- not later than one year;	50,871	49,583
- later than one year and not later than five years;	217,028	211,292
- later than five years.	1,213,265	1,269,872

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:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**48,449**	**45,888**
Consisting of:		
- Interest charge	5,707	5,932
- Repayment of balance sheet obligation	9,744	9,962
- Service element and other charges to operating expenditure	22,116	19,951
- Capital lifecycle maintenance	1,828	1,451
- Revenue lifecycle maintenance	-	-
- Contingent rent	9,054	8,592
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	13	10
Total amount paid to service concession operator	**48,462**	**45,898**

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 2021	31 March 2020
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**60**	**113**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	328	324
- later than one year and not later than five years;	1,394	1,381
- later than five years.	3,707	4,157
Total	**5,429**	**5,862**

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 wil 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 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	18,093	-	-	**18,093**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	25,187	-	-	**25,187**
Total at 31 March 2021	**43,280**	**-**	**-**	**43,280**

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**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	2,383	-	-	**2,383**
Total at 31 March 2020	**29,325**	**-**	**-**	**29,325**

Note 29.8 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	239,884	-	**239,884**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	44,011	-	**44,011**
Other financial liabilities	-	-	**-**
Provisions under contract	1,275	-	**1,275**
Total at 31 March 2021	**285,170**	**-**	**285,170**

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 finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	249,628	-	**249,628**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	24,728	-	**24,728**
Other financial liabilities	-	-	**-**
Provisions under contract	2,122	-	**2,122**
Total at 31 March 2020	**511,182**	**-**	**511,182**

Note 29.9 Maturity of financial liabilities

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

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	70,411	284,876
In more than one year but not more than five years	100,676	100,510
In more than five years	535,979	561,360
Total	**707,066**	**946,746**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	11	18	15
Bad debts and claims abandoned	202	19	302	50
Stores losses and damage to property	3	1	5	1
Total losses	**208**	**31**	**325**	**66**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	-	-
Ex-gratia payments	31	381	48	239
Special severance payments	2	40	1	10
Total special payments	**34**	**422**	**49**	**249**
Total losses and special payments	**242**	**453**	**374**	**315**
Compensation payments received		-		-

Note 31 Related parties

The Trust undertakes a large number of related party transactions with other Government

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 Prior period adjustments

Where prior period figures have been adjusted this is clearly stated in the associated note to these accounts.

Note 33 Events after the reporting date

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

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

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

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

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These include unexpected cash postings, journals by people who do not typically post journals and journals made in the post-closing period.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating a sample of accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 86, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

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

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

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

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Sarah Brown
for and on behalf of KPMG LLP
Chartered Accountants
Birmingham

22 June 2021