NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts 2019-20

PROUD
TO MAKE A
DIFFERENCE

SHEFFIELD TEACHING HOSPITAL NHS FOUNDATION TRUST

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Contents

Chair's Introduction

Every year in the Annual Report I describe the work of the outstanding team who make up Sheffield Teaching Hospitals NHS Foundation Trust. The professionalism, commitment and dedication of every single person is critical to our ability to deliver, safe, high quality and compassionate care to over two million patients a year in our hospitals and community services. For 2019/20 this has never been more evident than in our response to the COVID-19 pandemic. That same professionalism, commitment and dedication, combined with boundless extra input of time and energy from our team, ensured we were able to remodel our services in a very few weeks to be ready to receive the expected surge in COVID-19 patients. I cannot speak highly enough of what the Sheffield Teaching Hospitals team has achieved.

In addition to describing the impact of COVID-19, my statement gives a summary of some of the other key aspects of the past year and you can read further detail in the following pages of this Annual Report.

I am pleased to report that, during 2019/20, once again our good track record on the majority of clinical outcomes remained strong. Feedback from patients, visitors and our staff continued to be positive with the vast majority of our staff stating they would recommend the Trust as a place to work and to receive care.

Throughout the year we have also continued to consolidate our work on ensuring patients transition through the various stages of care as seamlessly as possible. A number of new ways of working have contributed to significant reductions in patients' length of stay and their effective and timely discharge. And although demand for our services grew once again in 2019/20, we continued to meet the majority of the national waiting time standards.

As well as delivering good quality clinical care, we wanted to ensure our patients are treated in modern and welcoming facilities equipped to a high standard. That is why we invested over £45 million during the year to improve facilities and replace essential equipment. This included the continuation of a £30 million theatre refurbishment project at the Royal Hallamshire Hospital and work to install new public and patient lifts. We built two new wards at the Northern General Hospital as well as completing several ward refurbishments. We opened a new walkway which now links Weston Park Hospital with the Jessop Wing and the Royal Hallamshire Hospital which will make it much easier to transfer patients and be a more pleasant experience for patients and staff travelling between the sites. We also opened a new Brachytherapy Unit and Aseptic Unit at Weston Park to support cancer care and we completed a new Hyper Acute Stroke Unit at the Royal Hallamshire Hospital along with a new musculoskeletal hub to improve the facilities and care pathway for patients with these conditions. On top of these developments we continued to invest in IT systems to enhance clinical safety, efficiency and patient experience.

Looking forward, we have other developments under review to enhance our facilities and notably have begun planning for a multi-million pound development of Weston Park Cancer Centre including a new research facility in partnership with the University of Sheffield.

While our clear focus is to deliver the best we can for patients, it is important to ensure that this is provided in the most cost effective and efficient way. In 2019/20, we continued to meet our financial targets, and further detail about the Trust's financial performance can be found later in the analysis on page 18.

Ensuring those who work across our hospital and community services continue to be supported and valued and given the opportunity to develop is so important if we are to expect all our colleagues to continue to deliver the best possible care to patients. That is why we further strengthened our People Strategy which sets out our vision and plans to ensure Sheffield Teaching Hospitals continues to be a brilliant place to work as well as a brilliant place to receive care. We have reinvigorated our focus on equality and diversity over the last 12 months and to support this we have created a dedicated Programme Board and have a number of hugely enthusiastic staff networks to drive this forward. The People Strategy also continued to focus on how we recruit and retain the workforce we need going forward and how we can best support the health and wellbeing of all of our staff.

Another key area of focus during the year has been our contribution to addressing climate change and sustainability by reviewing both our overall strategy and the way we work, including what we purchase, to ensure we have the least possible impact on our planet. Our catering team has led the way with a reduction in plastic cutlery and cups of up to 77 per cent and changing how they procure products used for patient and staff meals. Almost all ingredients are now being locally sourced.

We continue to be one of the top performing NHS research organisations in the country, and have a proud history of pioneering medical advances that have now become established NHS treatments. Working in partnership with the City's universities, patients, and industry partners, our cutting-edge research helps to advance understanding of how diseases work, leading to the development of new treatments and therapies, improving care for patients both now and in the future. Last year thousands of patients across a wide range of clinical specialities took part in research supported by the National Institute for Health Research at the Trust.

I referred last year to partnership working with our neighbouring NHS and social care organisations which is key to delivering the ambitions set out in the NHS Long Term Plan. We continue to play our full part in this, working with the South Yorkshire and Bassetlaw Integrated Care System (ICS) and Sheffield Accountable Care Partnership (ACP). These collaborative structures bring together health and social care organisations across the region and across Sheffield respectively to jointly plan and deliver services better tailored to the needs of the local population. During the year both of these partnerships were strengthened and a number of clinical and non-clinical work streams are in place aimed at improving patient experience and outcomes. The work on implementing a new stroke care pathway across the region is a great example of the benefits of working collectively to benefit patients and now a pathology transformation programme is underway to maximise the expertise and capacity we have across the partnership organisations.

We are keen to reflect the work described above in a refreshed corporate strategy, however, we have decided to pause work on this as a result of the immediate need to focus on the pressures of the COVID-19 outbreak. We will look to resume work on

the new corporate strategy when it is appropriate to do so.

I have already mentioned our outstanding team but many of the achievements outlined in this document would not be possible without the additional support of our volunteers, our very hard-working Governors, our excellent charities and all our other partners. Their commitment has been invaluable and on behalf of the Board of Directors, I thank them all for their dedication and support during this unprecedented year for the NHS and for our own organisation.

Tony Pedder OBE

Chair

Performance Report

Overview of Performance

This section provides an overview of the Trust, its purpose, key risks to the achievement of its objectives and how it has performed during the year.

Annual Performance Statement from the Chief Executive

2019/20 has been an unprecedented year for the NHS and for our own organisation as a result of the COVID-19 outbreak. The response from our colleagues across acute and community services was remarkable but would not have been made possible without the incredible support of non-clinical colleagues across the organisation. At the time of writing this situation is still developing and ongoing, but I have every confidence in the ingenuity and adaptability of the organisation, its people and its services.

The COVID-19 outbreak will remain with us as we move into 2020/21 and whilst we will have a significant task ahead to reset services and address the care needs of patients whose care was postponed, we have also learned many lessons and tested new ways of delivering care which we could adopt on a permanent basis. For example telephone and video consultations have been popular with many patients and have also had a very positive impact on the number of vehicles needing to come on site. We will also need to continue to be vigilant and ready to escalate plans for further outbreaks of COVID-19.

Whilst the last month of the year was consumed by COVID-19 I would like to mention other developments, investments and performance achieved in 2019/20.

Growing demand resulted in even more patients being treated during the year for emergency and planned care compared to 2018/19. We treated around two per cent more inpatients and day cases as well as almost three per cent more outpatients. The number of attendances to our Accident and Emergency Department also increased by almost five per cent.

Delivering safe, high quality care in a timely way continued to be our main priority and we continued to look for opportunities to innovate and improve where possible to build on the strong foundations reviewed by the Care Quality Commission in 2018 which resulted in a rating of 'Good' overall with many 'Outstanding' features.

Across the five domains that the Care Quality Commission uses, we were rated as follows:

Fig: 2018 CQC Rating

Safe	GOOD
Effective	GOOD
Caring	GOOD
Responsive	OUTSTANDING
Well-led	GOOD
Overall rating	GOOD

These ratings are a testament to all our staff who work hard to do the right thing for our over two million patient contacts every year in our hospitals and community services.

Our performance during the year

In addition to the opinion of the Care Quality Commission, there are a number of indicators and national standards which provide important information about our performance during the year.

- We have continued to work hard so that the majority of our patients are seen within 18 weeks from the date their GP refers them for a hospital consultation and have consistently delivered the 92 per cent 'incomplete standard'. Our average waiting time from GP referral to treatment is approximately eight weeks.
- The percentage of patients waiting less than six weeks for a diagnostic test increased to over 99 per cent within the year.
- Whilst we did not consistently achieve the national standard of 95 per cent four hour waiting time standard in Accident and Emergency, on average we did treat and then discharge or admit almost nine out of 10 patients (87.3 per cent) who came to Accident and Emergency Department within the required four hour timeframe.
- We continued to focus on good infection control and prevention to ensure our patients are as safe as possible. We once again achieved positive ratings for our facilities cleanliness and invested in modernising wards and departments as part of an ongoing programme. During 2019/20, we had a very low level of MRSA bacteraemia cases (three cases) and the number of cases of Clostridioides difficile remained relatively low too.
- We met or exceeded the national standard for urgent cancer referrals being seen within two weeks. However, we underachieved for some of the subsequent treatment standards and we have been working hard throughout the year to address this despite significant growth in the demand for our cancer services.
- The Trust exceeded its control total in terms of financial performance, despite the year being as challenging as ever.
- Patient surveys and Friends and Family Test feedback were consistently positive. We use this information to seek assurance about where we are getting things right, but more importantly to gain insight into where we may not be meeting patients' expectations and need to learn or change.

Further information about our performance is included later in this report.

Key achievements 2019/20

Our continuous drive for improvement has resulted in some important enhancements to safety, clinical care, patient experience and our facilities. A small selection is outlined here.

A new toolkit supporting safeguarding of children and young people who miss healthcare appointments, often for reasons beyond their control, was launched by the British Dental Association after being piloted by our community and special care dentistry experts. The 'was not brought' toolkit aims to encourage healthcare professionals to consider the child's perspective when they are not brought for healthcare appointments, including dental appointments.

A new pathway was introduced by our emergency care and palliative care teams in partnership with GPs to enable patients nearing the end of their life and who arrived at our Accident and Emergency Department to be supported to return to their preferred place of death, which is often their home rather than be admitted to hospital. The pathway includes a 'comfort box' that contains items such as syringe drivers, incontinence pads and mouth care equipment which are crucial to patients' levels of comfort at the end of their lives.

The rise in knife crime across the UK's cities is well documented and so we spent time with NHS colleagues in Glasgow to learn how they had played a part in achieving a reduction in the number of young people whose involvement with crime resulted in injury or

death. As a result of this we worked together with the local Violence Reduction Unit and Sheffield Hospitals Charity to become the first NHS trust in England to appoint Emergency Department (ED) Navigators. The aim of their role is to work with people affected by violence that come into Accident and Emergency and guide them to the support they need to make positive changes and lifestyle choices.

We opened an ambulatory care room providing specialist care for patients with respiratory conditions at the Northern General Hospital. The room provides a range of diagnostic procedures and dedicated recovery area, for respiratory and hepatology patients who may previously have had to stay in hospital for treatment. Being treated in the ambulatory facility means they are able to return home more quickly and enjoy a better quality of life, while reducing unnecessary hospital admissions.

Many more examples of improvements made throughout the year are featured on our website www.sth.nhs.uk.

Investing in our facilities and infrastructure

As well as making changes to how we deliver care, we have also continued to ensure our facilities meet the personal and clinical needs of patients.

This included the continuation of a £30 million theatre refurbishment project at the Royal Hallamshire Hospital and work to install new public and patient lifts. We built two new wards at the Northern General Hospital as well as completing several ward refurbishments. We were very excited to begin planning for a multi-million pound development of Weston Park Cancer Centre including a new research facility supported by our partner the University of Sheffield. We completed a new walkway which now links Weston Park with Jessop Wing and the Royal Hallamshire Hospital which will make it much easier to transfer patients and be a more pleasant experience for staff travelling between the sites. We also opened a new Brachytherapy Unit and Aseptic Unit to support cancer care.

We completed a new Hyper Acute Stroke Unit at the Royal Hallamshire Hospital along with a new musculoskeletal hub to improve the facilities and pathway for patients with these conditions. We also opened a new video telemetry unit helping to diagnose patients with suspected epilepsy and sleep and movement disorders.

In total we have invested over £45 million in our facilities and equipment throughout the year.

We continued to invest in IT systems to enhance clinical safety, efficiency and patient experience. During 2019/20 we began to plan for the procurement of a fully comprehensive Electronic Patient Record which we see as an essential requirement for the Trust to achieve its goal of being paperless. However this had to be paused due to the COVID-19 outbreak and will resume during 2020/21.

Employing caring and cared for staff

Ensuring the people who work across our hospital and community services are supported, valued and given the opportunity to develop is so important if we are to expect them to deliver the best possible care to patients. That is why we continued to implement our People Strategy which sets out our vision and plans to ensure Sheffield Teaching Hospitals is a ‘brilliant place to work’ as well as a brilliant place to receive care.

We particularly focused on equality and diversity over the last 12 months and created a dedicated Equality, Diversity and Inclusion Board with a number of hugely enthusiastic staff networks to support this work.

The People Strategy also continued to focus on how we recruit and retain the workforce we need going forward and how we can best support staff health and wellbeing. We are particularly proud to have developed a professional development programme for our administrative colleagues whose work underpins many of our clinical services.

We were also planning to begin a period of engagement with staff and patients on the behaviours which underpin the PROUD values

we developed in 2012. As with a number of our large scale engagement activities we decided to pause this work to enable our staff to focus on the response required for COVID-19. We will pick this work back up during 2020/21.

Delivering sustainable services

We are very aware that our size means we have a significant impact on our environment and the prosperity of the City and wider region. We take these responsibilities very seriously and during the year we began to look at how we could accelerate the work already undertaken on sustainability, job creation, widening education opportunities and improving population health.

With respect to sustainability, over two million patient contacts a year means it is important we consider how we deliver care and where possible reduce reliance on transport or multiple visits. We have started work on a piece of work to look at how we work now and how we can adapt.

Our response to the COVID-19 outbreak will further inform this, particularly for outpatient appointments which have switched rapidly to video and telephone consultations due to the rules around physical distancing. We also want to continue to change the way we work, purchase and plan to ensure we have the least possible impact on our planet. Our catering team has led the charge with a reduction in plastics and a buy local policy for ingredients. We have dramatically reduced our energy consumption too. But our new strategy for sustainability will widen our approach on this agenda during 2020/21.

Our strategic partnership working

In terms of improving access for our communities to education, employment and health we cannot do this alone, which is why our partnerships are so important to us.

We continue to play our full part in this, working with the South Yorkshire and Bassetlaw Integrated Care System (ICS) and Sheffield Accountable Care Partnership (ACP). These collaborative structures bring together health and social care organisations across the region and across Sheffield respectively to plan and deliver services better tailored to the needs of the local population jointly. During the year both of these partnerships strengthened and a number of work streams are in place aimed at improving health outcomes and population health.

Delivering excellent research

Our partnerships with the City's universities and industry enabled us to remain one of the top performing NHS research organisations. Research helps to advance understanding of how diseases work, leading to the development of new treatments and therapies, improving care for patients both now and in the future. We also know that patients who participate in research studies tend to make better progress in their care and recovery than those who do not, so research is a core part of what we do in striving to provide excellent healthcare.

Our Clinical Research and Innovation Office is one of only 10 sites across the country to have tested and adopted new national standards to improve the way members of the public can get involved in developing research projects.

Throughout 2019/20 we were involved in many research studies which seek to transform healthcare and treatment. We are at the helm of a new £2.5 million STAMINA study which aims to improve the lives of those living with prostate cancer by analysing if a longer term exercise programme can counter problems caused by androgen deprivation therapy and is one of 20 UK sites involved in a landmark trial assessing whether a drug commonly used to prevent nausea and sickness after surgery, radiotherapy or chemotherapy could help treat patients suffering with the symptoms of irritable bowel syndrome.

We are also one of 11 major trauma centres across the country to recruit patients to a national trial researching the best way to stop bleeding in patients with severe injuries. The UK-REBOA trial is looking at whether inserting a balloon into the aorta (the main artery that carries blood away from the heart) of a patient with life threatening bleeding from their abdomen or pelvis can improve their outcome.

Conclusion

In summary, we have had a successful year which once again demonstrated that our ability to innovate, adapt and respond to opportunities and challenges has placed us in a good position to deliver safe, high quality care to our patients.

We have continued to ensure we create a positive and personal place to work for our staff and remain at the heart of shaping health and social care with our NHS and other partners. Our continued focus on education and research underpins our curiosity to continually improve.

I would like to say once again how very proud I am of all our staff and volunteers for their tremendous achievements, which are the basis for this organisation's success and for the quality of care provided to patients. We are also very grateful for the support of our local community through our Membership and Council of Governors. Given the financial climate we continue to be grateful for the generosity of those who support us and the tireless work of our charities.

Kirsten Major
Chief Executive
12 June 2020

History, purpose and principal activities of the Trust

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS foundation trusts. Above all, patients lie at the heart of everything we do and we have a history of delivering high quality care, clinical excellence and innovation in medical research.

Formed in 2001, we are a high performing organisation providing personalised, acute, elective, community and specialist healthcare services of a high standard for over two million patients each year. We achieved Foundation Trust status on 1 July 2004.

We are one of the largest integrated NHS trusts in England. During the past year we have seen and treated over 1.1 million outpatients, over 190 thousand nurse contacts with community patients, over 119 thousand inpatients, almost 128 thousand day case patients and almost 158 thousand attendances to our Accident and Emergency Department.

Our staff provide a full range of local hospital and community services for adults in Sheffield, as well as specialist care for patients from further afield including cancer, spinal cord injuries, renal and cardiothoracic services. In addition to community health services, the Trust comprises five of Yorkshire's best known teaching hospitals.

The Northern General Hospital is the home of the City's Accident and Emergency Department which is also one of the three Major Trauma Centres for the Yorkshire and Humber region. A number of specialist medical and surgical services are also located at the Northern General Hospital including cardiac, orthopaedics, burns, plastic surgery, spinal injuries and renal, to name a few. A state-of-the-art laboratories complex provides leading edge diagnostic services, which have been at the forefront of our response to COVID-19.

The Royal Hallamshire Hospital has a dedicated Neurosciences Department including an Intensive Care Unit for patients with head injuries, neurological conditions such as stroke and for patients who have undergone neurosurgery. It also has a large Tropical Medicine and Infectious Disease Unit and a specialist Haematology Centre and other medical and surgical services.

Sheffield Teaching Hospitals is home to the largest dental school in the region, a women's hospital with a specialist Neonatal Intensive Care Unit and a Fertility Unit. The Weston Park Cancer Centre is also part of our Trust.

The Trust also provides community health services to deliver care closer to home for patients and prevent admissions to hospital wherever possible.

We aim to reflect the diversity of local communities and have developed strong partnerships with local people, patients, and neighbouring NHS organisations, the local authorities, charitable bodies and GPs. We are one of the region's largest employers and we take our responsibility to be a good corporate citizen very seriously.

We have a proud history of pioneering medical advances that have now become established NHS treatments, and undertaking high quality research that provides the NHS with the evidence it needs to introduce new treatments and care. Together with our partners at The University of Sheffield and Sheffield Hallam University we are leading the way on the development of world class clinical research in a wide range of disease areas, including cancer, progressive diseases such as dementia, stroke and multiple sclerosis, as well as heart disease and many other lesser known conditions.

Overview of the Trust's Strategy

Our 'Making a Difference' corporate strategy was originally developed in 2012 and has enabled the Trust to be successful in providing high quality clinical care to our patients, being financially sound and remaining at the forefront of research and innovation.

Our Vision

Our vision is to be recognised as the best provider of healthcare, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

Our Mission

We are here to improve health and wellbeing, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. We aim to work at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most to people.

Our Aims

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation

Our Values

- Patient first - Ensure that the people we serve are at the heart of all we do
- Respectful - Be kind, respectful to everyone and value diversity
- Ownership - Celebrate our successes, learn continuously and ensure we improve
- Unity - Work in partnership and value the roles of others
- Deliver - Be efficient, effective and accountable for our actions

The rising challenges associated with maintaining the highest standards of healthcare delivery, responding to new government policy and change initiatives within the organisation prompted us to revisit the strategy in 2017. After a period of consultation with staff, patients, our Members and partners we refreshed the strategy, albeit it was felt that the Mission, Vision and Aims were still strong and applicable.

The current 'Making a Difference' strategy runs until 2020 and so we began the process of developing a new corporate strategy in the later part of the financial year. However, due to COVID-19 we paused the process to enable us to consider how the pandemic will impact on our services and objectives in the future. It was also not feasible to conduct meaningful staff, patient, public or partner engagement to inform the strategy during the outbreak period.

Trends and factors likely to affect the Trust's future development, performance and position

In the context of delivering the Trust's strategy, a number of key issues and risks facing the Trust have been identified.

The Trust's Risk Register details a number of risks which may, should they be realised, impact on the delivery of high quality services and our strategic aims and objectives.

Principal risks to maintaining and improving quality of care are included in the Integrated Risk and Assurance Report. These risks and mitigating action plans are presented and discussed regularly at meetings of the Board of Directors and its committees and span a number of themes. Looking ahead, the impact and response to COVID-19 will add uncertainty across all areas of major risk.

Maintaining quality of care

Maintaining the quality of our care in the face of increased financial challenge, pressures on our workforce and a changing strategic environment will require focus on balancing risks to ensure that the quality of our patient care remains uncompromised. Clearly a significant additional factor will be the ongoing impact of the presence of COVID-19.

While there are many uncertainties at this stage, we do know that the provision of care and our interactions with our patients in the future is likely to be profoundly different from how it was before the emergence of this new virus. A key focus for 2020/21 will be to carefully manage our response to these challenges.

Well embedded quality governance and leadership arrangements support the Trust in ensuring that the quality of our care is being routinely monitored across all services.

Delivery of key operational standards

Some areas of performance continue to be a challenge. Increasing demand and constraints in clinical capacity for a number of specialties are impacting on the delivery of key targets.

Through our 'Making it Better' transformation programmes for improvement and sustained change we shall continue to streamline processes and work towards improving and sustaining performance against necessary thresholds.

Workforce shortages including nurse staffing

As is the case across the NHS, a key challenge is recruiting sufficient numbers of appropriately qualified clinical staff in some professions and roles.

Nursing is one example of this. We continue to safely mitigate nurse vacancy levels through proactive review of staffing to ensure that each ward area is staffed according to real-time need and in line with best practice staffing models. The Trust has embarked on new models of working to address other staffing challenges including the Integrated Wards initiative which enables Therapists and Nurses to deliver collaborative care by sharing core competencies and skills. We are also undertaking continual recruitment for Registered Nurses and Midwives and trialling alternative methods to attract new employees; this includes an increased use of rotational roles, the trialling of one-stop-shop recruitment events, and improved clarity in how we promote the Trust as an employer of choice.

As part of the Trust's annual business planning cycle, the planning of our workforce identifies staffing pressures, proposed service changes and other factors affecting our workforce provision. A key element of our People Strategy is our Workforce Redesign, Innovation and Planning (WRIP) workstream.

External environment

Our external strategic landscape continues to be driven by government policy, focused on the importance of managing systems rather than organisations, recognising the need to integrate services around the needs of the patient and the importance of out-of-hospital care.

As a Trust, we are actively engaged in regional partnership work. We will need to keep under review the financial risks and opportunities that arise from new collaborative working arrangements; in particular the implementation of shared governance and financial structures and the Board of Directors' focus continues to be placed on this.

National commissioning changes also present significant risk to the Trust and we will continue to review and manage the impact of financial pressures arising from our responses to these changes.

A further uncertainty across our external environment is how leaving the European Union will impact on the Trust's strategy, partnerships, investments and commercial activities.

Delivery of transformation

Significant productivity and efficiency savings were again achieved in 2019/20 to underpin our financial and operational performance. 2020/21 will be a very different year in terms of transformation as we seek to redesign services to cope with the COVID-19 implications and support directorates to identify and deliver savings opportunities where this is still possible.

We continue to drive transformation through our 'Making it Better' improvement programme and also look to deliver benefits by working with other organisations within the South Yorkshire and Bassetlaw area.

With workstreams across elective surgery (Seamless Surgery), emergency care (Excellent Emergency Care) and outpatients (Outstanding Outpatients), our 'Making it Better' programme aims to drive the quality of care forward through spreading best practice and innovation across the organisation.

Each programme comprises multiple projects, each with specific improvement aims and metrics to demonstrate impact. Many of the workstreams are supported by our nationally recognised Microsystems Coaching Academy which has trained 158 Trust staff in service improvement and team coaching skills. Additionally, we have 37 Trust coaches trained through the Flow Coaching Academy to deliver improvements at the pathway level.

Overview of Going Concern

After making enquiries Directors have a reasonable expectation that Sheffield Teaching Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Analysis of Operational Performance

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS foundation trusts. Above all, patients lie at the heart of everything we do.

Last year continued to be a challenging one for the NHS with all trusts expected to provide the highest standards of care whilst achieving demanding efficiency savings and responding to the COVID-19 pandemic.

Despite the enormous challenge of COVID-19, we treated around two per cent more inpatients and day cases as well as almost three per cent more outpatients. The number of attendances to our Accident and Emergency Department also increased by almost five per cent.

There are several national standards for waiting times, which we endeavour to achieve alongside this growth in activity whilst still ensuring the best possible patient care. We consider rigorous infection prevention and control and clean facilities to be fundamental to our care standards and we continue to work hard to minimise the chances of patients acquiring hospital acquired infections.

Further details of activity trends and the Trust's performance across key performance indicators are set out in the following tables:

Fig: Trust activity by activity type

Activity type	2015/16	2016/17	2017/18	2018/19	2019/20
Day cases	113,339	119,450	121,758	126,017	127,895
Elective Inpatient spells	29,297	31,787	30,088	29,266	28,909
Non-Elective spells	83,558	84,753	87,269	88,199	89,010
New Outpatient attendances	307,304	311,320	302,854	307,650	312,017
Follow up Outpatient attendances	727,790	765,669	778,005	802,329	802,402
Accident and Emergency attendances	152,539	147,643	149,531	156,968	158,561

Fig: 2019/20 Operational performance against key performance indictors

		2019/20 Performance			2019/20 Quarterly Trend			
		Target	Annual		Q1	Q2	Q3	Q4
Accident and Emergency (A&E)	95% of A&E patients wait less than four hours	95%	**83.99%**	●	**84.12%**	**84.50%**	**82.46%**	**85.03%**
Referral To Treatment	Patients waiting less than 18 weeks for treatment	92%	**92.36%**	●	**93.01%**	**92.95%**	**92.46%**	**91.02%**
Diagnostics	Patients waiting less than six weeks for diagnostic test	99%	**99.17%**	●	**97.92%**	**99.80%**	**99.92%**	**99.14%**
Cancelled Operations	Non Urgent operations cancelled on the day	N/A	**0.71%**		**0.68%**	**0.74%**	**0.81%**	**0.74%**
Cancer access initial appointments	Urgent GP referrals seen within two weeks	93%	**94.8%**	●	**94.0%**	**94.9%**	**95.1%**	**95.0%**
	Breast symptomatic referrals seen within two weeks	93%	**92.6%**	●	**89.2%**	**96.6%**	**94.2%**	**91.1%**
Cancer access initial treatments	First treatment within 31 days	96%	**94.9%**	●	**92.8%**	**95.3%**	**95.5%**	**95.9%**

		2019/20 Performance			2019/20 Quarterly Trend			
		Target	Annual		Q1	Q2	Q3	Q4
Cancer access subsequent treatments	Subsequent treatment (surgery) within 31 days	94%	92.0%	●	90.8%	89.8%	96.4%	91.5%
	Subsequent treatment (chemotherapy) within 31 days	98%	99.6%	●	99.6%	99.6%	99.7%	99.3%
	Subsequent treatment (radiotherapy) within 31 days	94%	91.9%	●	95.2%	93.3%	87.7%	91.4%
	Treatment within 62 days of an urgent GP referral	85%	73.2%	●	74.1%	73.4%	72.6%	72.6%
	Treatment within 62 days of referral from screening	90%	87.4%	●	91.9%	90.2%	83.5%	84.4%
Infections	MRSA	0	3	●	0	0	1	2
	MSSA	N/A	71		13	13	27	18
	Clostridioides difficile (Community Onset)	N/A	39		9	11	8	11
	Clostridioides difficile (Hospital Onset)	N/A	115		18	33	22	42

Fig: Community performance 2019/20

Service measure	Target	Q1	Q2	Q3	Q4	2019/20
Intermediate Care Community Beds – number of admissions *(Includes SPARC - Excludes the Community Off Site 'Route 2' Beds)*	N/A	287	295	328	350	1,260
Intermediate Care Community Beds – Average Stroke Length of Stay	35 days	53.5	32.4	24.7	33.9	36.1
Intermediate Care Community Beds – Average Orthomedical Length of Stay	35 days	32.9	31.5	34.4	33.5	33.1
Intermediate Care at Home – Patients assessed within required timescales *(Data only available for Active Recovery Assessment and Community Stroke Service - Not ICT Active Recovery)*	98%	96.6%	94.0%	93.0%	92.7%	94.1%
Intermediate Care Number of packages delivered at home *(Active Recovery Assessment and Community Stroke Service and ICT Active Recovery)*	N/A	2,247	2,288	1,744	919	7,198
Community Nursing Referrals *(Includes additional information and resumptions)*	N/A	10,301	10,292	10,368	8,546	39,246
Community Nursing Contacts	N/A	217,273	206,498	190,325	190,389	804,485

Analysis of Financial Performance

After another challenging year, the Trust's financial results for 2019/20 are very satisfactory. The position can be summarised as follows:

Fig: 2019/20 Financial outturn against Plan

	2019/20 Plan £m	2019/20 actual £m	variance £m
Total income	1,128.5	1,197.1	68.6
Expenses excluding depreciation	-1,092.4	-1,157.6	-65.2
Depreciation and impairments	-25.6	-46.4	-20.8
Operating surplus	**10.5**	**-6.9**	**-17.4**
Public Dividend Capital Dividend	-9.7	-8.0	1.7
Other Financing Costs (net)	-2.1	-1.7	0.4
Deficit for the year	**-1.3**	**-16.6**	**-15.3**

The Trust had a deficit from continuing operations of £16.6 million (1.4 per cent of turnover). However, within this position there are abnormal items, principally relating to £23.1 million of impairment charges arising from the Estate Revaluation undertaken during the year. Without this and other technical items there would have been a £4.5 million surplus (0.4 per cent of turnover) which is an improvement on the Plan.

The Trust had another challenging financial year due to the ongoing national financial environment, a range of service, workforce and financial pressures, and the need to deliver a stretching national Control Total. Significant one-off in-year benefits were critical to achieving the outturn position, along with generally good performance at directorate level.

The Trust's income position for 2019/20 was as below:

Fig: 2019/20 Income position

	£m	% change over 2018/19
Income from patient services	1,019.2	9.1
Other operating income	177.9	-11.7
Total income	**1,197.1**	**5.4**

Income growth was significant. Growth in income from patient services was from a combination of increases in activity volumes, a richer case-mix, increased High Cost Drugs and Devices reimbursements, some specific additional allocations, and £28.5 million of national funding for the increase to the Employer's Superannuation contribution rate. Activity levels were impacted by the COVID-19 outbreak in March 2020 but the Trust's commissioners funded the Trust on the basis of normal activity / income levels. COVID-19 costs of around £2 million were also covered nationally.

The decrease in other operating income was largely due to the reduced level of Provider Sustainability Funding (PSF) which was £15.4 million compared to £40.1 million last year. This reflects the transfer of some PSF into tariffs in 2019/20 and the incentive / bonus funding in 2018/19 which was not repeated this year.

Pay costs rose by 9.6 per cent over 2018/19 levels or 5.3 per cent if the increased pension costs referred to above are excluded. This reflects pay awards, increased staff numbers and lower levels of vacancies. Bank and Agency costs were higher than in 2018/19 but the Trust kept agency costs within the national ceiling. Drugs costs increased by 8.2 per cent and clinical supplies / services by 2.2 per cent. Premises costs, including IT, increased by 8.9 per cent and the Clinical Negligence Premium increased by 31.7 per cent. The combined depreciation, loan interest and Public Dividend Capital Dividend charges reduced by 4.6 per

cent. There was a net impairment charge of £23.1 million in 2019/20. The latter two items were driven by the Estate Revaluation.

Efficiency savings

The Trust again faced a major challenge to deliver the national efficiency requirement and to deliver savings to offset income losses and cost pressures. For 2019/20 the efficiency requirement was again around £20 million. The major challenge is the cumulative effect of such savings year-on-year for the last 15 years or so. There was an over-achievement against the Plan, although there were some non-recurrent items. The Trust continued to seek efficiency savings in clinical and support functions through its 'Making it Better' Programme, by developing improvement capability and capacity within staff, by supporting directorates to identify and deliver savings opportunities and by working with other organisations within the South Yorkshire and Bassetlaw area. This continues to be a critical area with the challenge of delivering efficiency savings from areas already under significant service pressure.

Capital investment

Total capital expenditure for the year was £45.8 million and has been analysed in the following table. The focus in 2019/20 was again on investing in the Trust's medical equipment and supporting physical infrastructure whilst promoting new service developments and modernising theatres in order to improve the service to patients across the Trust.

Fig: Capital investment 2019/20

	£,000	£,000
Medical Equipment	**6,922**	
Equipment Replacement Programmes (e.g., Scopes, Ultrasounds, Dialysis Machines)		2,588
Northern General Hospital Plain Film Room Equipment		907
Royal Hallamshire Hospital MRI Replacement		906
Royal Hallamshire Hospital Symptomatic and Assessment Mammography Equipment		588
Royal Hallamshire Hospital Fluoroscopy Replacement Rooms (x2)		529
Other		1,404
Information Technology	**3,617**	
IT Infrastructure (including N3 Transition to HSCN)		1,274
Wired Network Core		1,137
Accident and Emergency Virtual Desktop Infrastructure (VDI)		400
Picture Archiving Communication System (PACS)		328
Other		478
Service Development	**14,686**	
Weston Park Hospital to Jessop Park Wing Link Bridge		3,132
Musculoskeletal Hub		2,773
Hyper Acute Stroke Unit		2,433
Weston Park Hospital Pharmacy Aseptic Unit		2,132
5 Beech Hill Road Refurbishment		966
Office Accommodation		852
Northern General Hospital Radiology D Floor Refurbishment		795
Other smaller schemes / adjustments		1,603
Infrastructure	**20,532**	
Northern General Hospital Modular Wards		7,751
Royal Hallamshire Hospital A Floor Theatres		6,956
Northern General Hospital Firth Wing Theatres		1,509
Royal Hallamshire Hospital Main Lifts		1,491
Other		2,825
TOTAL EXPENDITURE	**45,757**	

Overall there was a high level of capital expenditure in 2019/20 which was very close to Plan. Internally generated resources were supplemented by £2.1 million of National Public Dividend Capital allocations and £1.4 million of donations for capital expenditure.

Cash Flow and Balance Sheet

The Trust's net assets employed at 31 March 2020 were £398.1 million compared with £414.7 million at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2019 was £396.9 million. The reduction in 2019/20 reflects the Estate Revaluation referred to above. Outstanding 'borrowings' relating to Foundation Trust Financing Facility loans, a Private Finance Initiative (PFI) contract and finance leases totalled £37.5 million at the year-end.

Cash balances decreased to £90.8 million at 31 March 2019 (£94.0 million at 31 March 2019) and net current assets at 31 March 2020 decreased to £34.4 million (from £50.8 million at 31 March 2019). This reflects the high level of capital expenditure in 2019/20 as surpluses and additional PSF earned in previous years were invested. A significant amount of the remaining balances are committed to capital schemes and research projects in future years. The Trust has also aspired, as a Foundation Trust, to have a sound working capital position in order to provide a degree of financial security and ensure the continuity of patient services.

Use of Resources Risk Rating

NHS England / NHS Improvement assess Trust financial performance through its Use of Resources Risk Rating. This operates on a scale of one to four, where one (1) represents low risk and four (4) represents very high risk. Based on the outturn results, the Trust's risk rating for 2019/20 was one (1).

Conclusion

Generally, 2019/20 was another challenging financial year for NHS acute providers given the constrained funding position over many years, the national focus on improving the deficit position and a range of pressures. System working has added a fair degree of complication with little obvious benefit at organisational level. The COVID-19 outbreak also had a significant impact in March 2020 and this will clearly carry on for much of 2020/21.

In this context, the Trust's 2019/20 financial results are good with stability maintained, a small (real) surplus and a high level of capital investment. However, the underlying position remains challenging and the apparent national focus on removing deficits in the most challenged trusts may add to the challenge for providers such as Sheffield Teaching Hospitals, where the position is relatively favourable.

The Trust's ability to continue to deliver and enhance high quality services will, as always, depend on good financial and operational management and, once the COVID-19 outbreak is resolved, on-going delivery of efficiency savings and service improvements.

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

Kirsten Major
Chief Executive
12 June 2020

Accountability Report

Directors' Report

The Directors' report is presented in the name of the Directors of the Board of Directors.

Composition of the Board of Directors

Led by a Non-Executive Chair, the Board of Directors comprises of seven other Non-Executive Directors and up to seven Executive Directors, including the Chief Executive. The individuals occupying position on the Board during 2019/20, together with their attendance at Trust Board meetings is listed as:

Tony Pedder OBE, Trust Chair

Appointed to the Board: 1 January 2012

Board Attendances in 2019/20: 11/11

Tony joined the Trust as Chair in January 2012. He was previously the Chair of NHS Sheffield CCG and also the Chair of South Yorkshire and Bassetlaw Cluster of NHS Primary Care Trusts. As well as his NHS experience, Tony brings extensive management and operational experience in a variety of business organisations and markets. He was previously Chief Executive of Corus plc. Tony is currently also Pro-Chancellor and Chair of Council of The University of Sheffield.

Other Non-Executive Directors

Tony Buckham, Non-Executive Director

Appointed to the Board: 1 September 2015

Board Attendances in 2019/20: 10/11

Tony brings a wealth of experience from his time working within complex global organisations. He has provided strategic support to the HSBC Group Management Board Directors, with particular expertise within IT and Corporate Real Estate for over 10 years. Tony has led divisions of up to 7,000 staff with particular focus on people development to enable global transformational change. He has also made a significant contribution to mentoring and coaching programmes.

Candace Imison, Non-Executive Director (until 31 August 2019)

Appointed to the Board 1 September 2015

Board Attendances in 2019/20: 2/4

Candace took up her current position as Director of Strategy Development for the Nursing and Midwifery Council (NMC) in April 2019. Previously, she was Director of Workforce Strategy at the Nuffield Trust and, before then, Deputy Director of Policy at The King's Fund. Between 2000 and 2006 Candace worked on strategy and policy at the Department of Health, including the Wanless Review, the White Paper '*Our Health, Our Care, Our Say*' and '*Keeping the NHS Local*', setting out policy for the reconfiguration of hospital services.

Annette Laban, Non-Executive Director and Vice Chair

Appointed to the Board: 1 July 2013

Board Attendances in 2019/20: 11/11

Annette has more than 35 years' experience working within the NHS and local government in senior positions and throughout her career she has been responsible for overseeing many innovations which have directly impacted on frontline NHS care. Her past roles have included Chief Executive for NHS Doncaster, Director of Performance and Operations at NHS North of England - Strategic Health Authority and Executive Director of Performance and Delivery at NHS Yorkshire and the Humber.

Professor Chris Newman, Non-Executive Director

Appointed to the Board: 1 November 2017

Board Attendances in 2019/20: 7/11

Chris joined the Board in November 2017. He is Interim Vice President and Head, Faculty of Medicine, Dentistry and Health at the University of Sheffield, Dean of the Medical School, Professor of Clinical Cardiology and Honorary Consultant Cardiologist at the Trust. He also directs the National Institute for Health Research Sheffield Clinical Research Facility, a joint facility between the Trust and The University of Sheffield.

John O'Kane, Non-Executive Director

Appointed to the Board: 1 October 2014

Board Attendances in 2019/20: 9/11

John is an experienced Finance Director, with experience of managing change in a number of companies. He has worked as Group Finance Director at Redhall Group, Jarvis, Ecobat Technologies, Peterhouse Group and Kelda Group.

Rosamond Roughton, Non-Executive Director (from 1 December 2019)

Appointed to the Board: 1 December 2019

Board Attendances in 2019/20: 3/4

Rosamond is currently Director for Adult Social Care at the Department of Health and Social Care. Her previous roles have included; Director of NHS Commissioning at NHS England and Programme Director, Commissioning Development and Director of Commissioning Systems for Department of Health and NHS England.

Martin Temple, Non-Executive Director

Appointed to the Board: 1 July 2013

Board Attendances in 2019/20: 9/11

Martin is currently the Chair of the Health and Safety Executive and was also on the Board of The Great Exhibition of the North. Martin has served on the Boards of a wide range of companies around the world. He was Chairman of the Design Council, on the Council of the University of Warwick as well as the Chair of the Warwick Business School Advisory Board. He has also been Vice President of Avesta-Sheffield AB, Director-General of EEF and a Non-Executive Director and Chairman of The 600 Group PLC.

Martin has extensive experience covering senior roles in production, marketing, operations and strategy in an international context.

Shiella Wright, Non-Executive Director

Appointed to the Board: 1 April 2019

Board Attendances in 2019/20: 10/11

Shiella joined the Board in April 2019, bringing with her over 11 years' experience as a NHS Non-Executive Director. She has served on several public and voluntary sector boards, is the current Chair of Age UK Nottingham and Nottinghamshire and a Trustee of Improving Lives CIC.

Shiella is the former Deputy Chief Executive, Director of Operations of Nottinghamshire Probation Trust. She has developed and delivered transformational change, in particular organisational development, performance and leadership. She has also developed and delivered a mentoring scheme for underrepresented groups, which has been adapted by NHSI for its NExT Director Scheme.

Shiella hails from Sheffield and has worked in many executive roles across Yorkshire and Humberside.

Kirsten Major, Chief Executive

Board Attendances in 2019/20: 10/11

Kirsten joined Sheffield Teaching Hospitals in February 2011 as Director of Strategy and Planning. She was appointed as Deputy Chief Executive in 2017 and took up the position of Interim Chief Executive in August of 2018, prior to being appointed to the role substantively from March 2019.

She has held a number of director-level positions within the NHS, including Health Boards in Scotland and at the North West Strategic Health Authority. Kirsten is a health economist by profession and was active in a range of professional and research based collaborations.

Other Executive Directors

Anne Gibbs, Director of Strategy and Planning

Board Attendances in 2019/20: 11/11

Anne was appointed in post in February 2018, prior to which she worked for NHS Improvement in a joint role with Greater Manchester Health and Social Care Partnership. Previously, she has worked for a number of trusts in London and Birmingham at Board level.

Mark Gwilliam, Director of Human Resources and Staff Development

Board Attendances in 2019/20: 10/11

Mark is Director of Human Resources and Staff Development. He took up his original post as Director of Human Resources and Organisational Development in May 2009 bringing with him a wealth of experience.

He was previously an Associate Director of Human Resources at Central Manchester University Hospitals NHS Foundation Trust. Mark joined the NHS in 2004 through the Gateway to Leadership Programme and was assigned on placement at Sheffield Teaching Hospitals NHS Foundation Trust. Prior to this he worked in the fast moving consumer goods sector in numerous operational management and human resource management roles.

Michael Harper, Chief Operating Officer

Board Attendances in 2019/20: 11/11

Michael joined the Northern General Hospital from the General NHS Management Training Scheme in 2000. He has worked in a number of operational leadership roles in A&E, Medicine, Cardiothoracics, Orthopaedics and Surgical Services throughout the Trust since this time.

He became Chief Operating Officer in January 2015 and has attended Board meetings as a Participating Director since August 2018. From June 2019, the position of Chief Operating Officer has been an Executive member of the Board of Directors.

David Hughes, Medical Director

Board Attendances in 2019/20: 11/11

David joined the Trust in February 2005 as Consultant Histopathologist having previously worked as a Consultant at Chesterfield Royal Hospital and the Royal Orthopaedic Hospital, Birmingham. David has previously worked as Associate Medical Director - Cancer, Deputy Medical Director and Responsible Officer at the Trust and worked for the National Cancer Research Institute, Royal College of Pathologists, North Trent Cancer Network and National Cancer Action Team.

Chris Morley, Chief Nurse

Board Attendances in 2019/20: 10/11

Chris joined the Trust as Chief Nurse in October 2018 from The Rotherham NHS Foundation Trust where he also held the position of Chief Nurse. Prior to this Chris was Deputy Chief Nurse here at Sheffield Teaching Hospitals.

He has previously held a number of leadership roles in healthcare governance, patient safety and nursing management. Chris is a Visiting Professor in the Faculty of Health and Wellbeing at Sheffield Hallam University.

Neil Priestley, Director of Finance

Board Attendances in 2019/20: 11/11

Neil was appointed to the post of Director of Finance of the newly merged Sheffield Teaching Hospitals in February 2001. He had previously held the post of Head of Finance at the NHS Executive Trent Regional Office, from where he had been seconded to the Northern General Hospital as acting Director of Finance prior to the Trust merger.

Neil is a Fellow of the Chartered Association of Certified Accountants.

Other senior managers who attend Board as Participating Directors

Sandi Carman, Assistant Chief Executive

Board Attendances in 2019/20: 11/11

Sandi has over 25 years' experience working in NHS acute, community, and commissioning organisations. Sandi's career started in Occupational Therapy at the Northern General Hospital and she has since gained a wealth of experience in operational and managerial roles.

Sandi is a Non-Executive Director for South Yorkshire Housing Association, Director for Legacy Park Limited and a Joint Independent Audit Committee Member for the South Yorkshire Police and Crime Commissioner.

Jennifer Hill, Interim Medical Director (Operations) (from February 2020)

Board Attendances in 2019/2020: 2/2

Jennifer joined the Trust in 1999 as Consultant Respiratory Physician having trained in Nottingham, Leeds and Glasgow. Jennifer was Trust MDT (Multi-Disciplinary Team) lung cancer lead, Network lung cancer lead, Clinical Director for Respiratory Medicine and Deputy Medical Director before taking up her post of Interim Medical Director (Operations) in February 2020.

Julie Phelan, Communications and Marketing Director

Board Attendances in 2019/20: 10/11

Julie spent her early career as a journalist in both print and broadcast media before moving into public sector communication in local government and health. She was previously Head of Communications at Sandwell and West Birmingham Hospitals NHS Trust, Head of Communications for Birmingham Women's Hospital and Director of Communications for Worcestershire Acute Hospitals and Worcester Health Authority.

Before joining the Trust in June 2008, Julie was Director of Communications for University Hospitals Coventry and Warwickshire NHS Trust.

Statement on the balance, completeness and appropriateness of the membership of the Board

The Board of Directors' Nomination and Remuneration Committee has carried out an in-year review of the composition of the Board, in the context of current and anticipated issues and challenges impacting the Trust and the skills and qualities needed on the Board. This exercise is undertaken routinely as part of the process of considering appointments and reappointments to the Board.

As outlined in the above biographies, the Board comprises individuals with senior level experience in the public and private sectors, across a range of disciplines including clinical and patient care, finance, strategic and operational planning, commercial development, governance, risk management, human resources and change management.

The Board is satisfied that its current membership allows it to function effectively.

Board members Register of Interests and Gifts and Hospitality

Company directorships and other declarations including receipt of gifts and hospitality were declared by all Board members. The Trust has updated its Standards of Business of Conduct Policy to reflect guidance from NHS England and the full register of interests is available at: https://sheffieldthft.mydeclarations.co.uk/

The Board has determined that the current Chair and all Non-Executive Directors are independent in character and judgement. This includes the appointed representative of The University of Sheffield, Professor Chris Newman, Dean of the Medical School, notwithstanding the Trust's relationship during this reporting period with The University of Sheffield.

Arrangements in place to ensure that the Trust is well-led

Review of the effectiveness of the Board of Directors and the outcomes from assessment of performance, both collectively and of individual Board members as part of a formal annual appraisal system and the review and agreement of a Board work programme for the year, is used to inform ongoing development of the Board.

The Board of Directors keeps the performance of its committees under regular review and requires that each committee assesses how it discharges the responsibilities outlined in its terms of reference, reviews these annually and agrees any objectives for the forthcoming year.

Routine self-assessment is undertaken by the Board against governance best practice using well-led guidance[1] to inform the continued development of the Trust's governance arrangements.

The Board's most recent Well-led self-assessment in April 2018 involved facilitated self-assessment supported by our internal auditors. Board member survey work and one-to-one interviews with lead Executive Directors complemented a desktop review of evidence and generated for discussion with the Board a baseline assessment of Trust compliance for each Key Line of Enquiry.

This developmental review identified some clear areas for development. Focus was placed on these areas as part of preparation for the Trust's June 2018 CQC inspection and, in particular, the Well-led assessment component. The Trust continues to progress recommendations from each of these assessments and also uses ongoing consideration of the effectiveness of the Board and committee structure to continually develop its leadership and governance arrangements.

[1] Development reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (Jun 2017)

Financial and other public interest disclosures

Cost allocation and charging requirements

Sheffield Teaching Hospitals NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury. There are no additional charges made for material made available to meet the needs of particular groups of people, for example, in Braille or other languages. Following the introduction of the General Data Protection Regulation and the UK Data Protection Act 2018 in May 2018, fees, as set by the Information Commissioner's Office, are no longer chargeable for subject access requests for personal data, including copies of medical records. Similarly, no fees are chargeable for the supply of medical records of deceased patients under the auspice of the Access to Health Records Act 1990. The Trust does not impose any fees for responding to requests under the Freedom of Information Act unless the amount of information exceeds the appropriate limit as defined in section 12 of the Freedom of Information Act.

Political donations

There are no political donations to disclose.

Employee benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.6.2 of the accounts. Details of senior employee's remuneration can be found in the Remuneration Report section of this Annual Report.

Non-NHS income

As required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Directors confirm that the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

In addition to the above, the Directors confirm that the provision of goods and services for any other purposes has not materially impacted on our provision of goods and services for the purposes of the health service in England. Further details of the income sources to the Trust can be found in note 3.1 and note 3.4 of the accounts.

Payment of creditors

The Trust aims to comply with the Better Payment Practice Code. Performance for the financial year is set out in note 6 of the accounts.

Remuneration Report

The Remuneration Report outlines appointments and payments made to Trust Executive Directors and Non-Executive Directors in-year and includes the senior managers' remuneration policy.

Annual statement on remuneration

I am pleased to present the Remuneration Report for the financial year 2019/20 on behalf of the Board of Directors' Nomination and Remuneration Committee.

The Committee is responsible for making decisions on matters relating to the nomination, appointment, remuneration and terms and conditions of office of the Trust's Executive Directors and other individuals on locally-determined pay, including salary, pensions, termination and/or severance payments and allowances.

In discharging its responsibility for setting the remuneration and conditions of service for the Trust's most senior managers its key objective is to ensure that the remuneration packages are sufficient to recruit and retain individuals of the calibre required for the successful operation of the Trust, while avoiding paying excessively for this purpose.

There have been no changes made to the Trust's remuneration policy for senior managers in 2019/20. Decisions made in line with this policy during the past year are outlined here.

In June 2019, the Committee considered and approved a 2019/20 pay award consistent with that made to staff on Agenda for Change for very senior managers, staff on ad hoc spot salaries, and for application to management responsibility payments

It was also agreed that an equivalent cost of living uplift should be awarded to Executive Directors, with the exception of the recently appointed Chief Executive, Medical Director and Chief Operating Officer, whose remuneration had been subject to in-year evaluation and benchmarking on appointment. The Committee was also asked to consider addressing the inequality of annual leave entitlement for Executive Directors and agreed to bring this in line with annual leave entitlements for very senior managers and staff on national Agenda for Change terms and conditions.

There has been one change to the composition of Executive membership of the Board of Directors during 2019/20. Following the substantive appointment of Kirsten Major to the role of Chief Executive, the Committee gave consideration to the vacant position on the Board of Directors of Deputy Chief Executive. In May 2019, following a review of Executive portfolios, a proposal not to recruit to this position was agreed by the Committee and instead to make the post of Chief Operating Officer an Executive Director position, with effect from 1 June 2019.

Following assessment by the Chief Executive and Chair of suitability for a position on the Board of Directors the incumbent post holder, Michael Harper, was confirmed in this position from June 2019 and his remuneration increased to reflect Executive accountability. Remuneration was informed by benchmarking across similar roles in Shelford organisations.

In-year, the Committee also approved proposals to strengthen the senior management structures within both the Medical Director's Office and within the Chief Operating Officer's Office and made decisions around levels of remuneration for these new senior management posts.

To address a demanding operational agenda, recruitment to the position of Deputy Chief Operating Officer was approved by the Committee in October 2019 and remuneration agreed based on information obtained from independent job evaluation of executive and senior management positions (Hay Evaluation process).

In October 2019 the Committee also agreed a proposal to create a new post to facilitate the Medical Director to give more focused leadership to the expanding technology, research and innovation agendas. A one year secondment to a new role of Medical Director (Operations) was agreed to lead on the healthcare governance and

medical workforce aspects of the Medical Director portfolio. As a member of the Trust Executive Group this role will attend meetings of the Board of Directors as a Participating Director, while the Executive Director responsibilities for the portfolio will be retained by the Medical Director.

Contractual arrangements and remuneration for this new position of Medical Director (Operations) were agreed by the Committee taking into account the need for the salary range to reflect the fact that the post-holder would hold a consultant contract and attract a responsibility payment for the Medical Director (Operations) role. Recruitment took place in early 2020 and Jennifer Hill was appointed to the role from February 2020.

The Committee was also convened to give consideration to matters relating to the impact of pension tax changes on specific clinical staff.

Tony Pedder OBE

Chair of the Board of Directors' Nomination and Remuneration Committee

Senior managers' remuneration policy

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nomination and Remuneration Committee taking into account market levels, key skills, performance and responsibilities.

The Trust's overarching approach is to ensure that senior managers' remuneration supports delivery of our vision to be recognised as the best provider of healthcare, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region. As such, the principle underpinning the Trust's remuneration policy is that rewards to senior managers should enable the Trust to recruit, motivate and retain individuals with the necessary skills, experience and ability to support delivery of the Trust's strategic objectives.

Future policy table senior managers (other than Non-Executive Directors)

Executive Director Remuneration for 2019/20 was set at an appropriate level to recognise the significant responsibilities of directors in foundation trusts of similar size and complexity and to attract and retain individuals with the necessary skills, experience and ability.

The future policy table overleaf provides detail on each element of Executive Directors' remuneration packages for 2019/20, how the level of pay is determined, how change is enacted and how Executive Directors' performance is managed.

Fig: Future policy table

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to access performance
Base pay			
Base pay is determined using benchmarked data (reviewed annually) in order to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and priorities.	Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board's Nomination and Remuneration Committee, chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by the Nomination and Remuneration Committee.	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (senior managers are proportionally not treated more favourably than other staff).	The Chief Executive and the Executive Directors participate in annual performance reviews undertaken by the Trust Chair and Chief Executive respectively and the individual's agreed objectives are linked to the Trust's corporate objectives. The Trust does not operate a system of performance related pay. Failure to meet objectives is managed via our Trust policies and performance frameworks.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of directors to attract high-calibre staff to enable the Trust to meet its strategic objectives.	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider).	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with the HMRC method.	Not applicable.
On call payment			
Senior managers receive on call payment in line with on call responsibilities.			
Benefits			
The Trust operates a number of salary sacrifice schemes including childcare vouchers, white goods scheme and a car lease scheme. These are open to all members of staff.			
Travel expenses			
Appropriate travel expenses are paid for business mileage.			

Directors with remuneration (total) greater than £150,000

The Trust takes steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS foundation trusts and that this rate enables the Trust to attract and retain senior managers with the necessary abilities to lead and develop the Trust's activities fully for the benefit of patients. In making decisions about whether to pay any individual Executive Director more than £150,000[2] per annum, as outlined in guidance issued by the Cabinet Office, regard is paid to remuneration benchmarking data, the market conditions and the individual Director's level of experience and development of the role.

[2] *The threshold set out in NHSI guidance above which NHS foundation trusts should make a disclosure.*

Payments for loss of office

There is no entitlement to any additional remuneration in the event of early termination. During 2019/20 no senior manager (or past senior manager) received payments for loss of office*. ** subject to audit*

Statement of consideration of employment conditions elsewhere in the Trust

In determining the pay and conditions of employment for Executive Directors and senior managers, the Board of Directors' Nomination and Remuneration Committee takes account of national pay awards given to the medical and non-medical staff groups subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data from comparative teaching hospitals, particularly the Shelford Group, provided by NHS Providers, was used to determine the appropriate remuneration for Executive and Non-Executive Directors during the year.

Policy on diversity and inclusion used by the Nomination and Remuneration Committee

The Board is committed to ensuring that its composition comprises an appropriate balance of skills, knowledge and experience. Diversity is a vital part of the continued assessment and enhancement of board composition, and the Board recognises the benefits of diversity amongst its members.

Appointments to the Board of Directors are subject to a formal, rigorous and transparent procedure. While new appointments are always based on merit, careful consideration is given to the benefits of improving and complementing the diversity, skills, experience and knowledge of the Board.

Before any appointment is made to the Executive team, the Nomination and Remuneration Committee evaluates the balance of skills, knowledge, experience and diversity and in the light of the evaluation, reviews a description of the role and capabilities required for a particular appointment. The Committee ensures that the appointment process is designed to attract the best candidates, through the use of a range of open advertising or the services of external advisers to facilitate the search. With regard to the Trust's commitment to equality, diversity and inclusion, the Committee seeks to provide assurance that candidates fully reflect a wide range of backgrounds.

Likewise, at the outset of each and every Non-Executive Director recruitment and selection process, the Council of Governors' Nomination and Remuneration Committee reviews the composition of Board of Directors for balance of diversity, skills and experience to inform its search.

Annual report on remuneration 2019/20

Service contract obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. In order to attract Executive Directors of sufficient calibre, the Chief Executive and Executive Directors have permanent employment contracts with appropriate notice periods in line with employment law rather than a fixed term. This is in line with similar contracts in the sector. The process to recruit to Executive Director positions involves the Chair, Chief Executive and Non-Executive Directors.

The following table contains details of the service contracts in place during 2019/20 for Executive Directors.

Fig: Service contracts

Name	Date of service contract	Unexpired term	Notice period
Anne Gibbs	February 2018	Open ended	6 months
Mark Gwilliam	May 2009	Open ended	3 months
Michael Harper	June 2019	Open ended	6 months
David Hughes	February 2019	Open ended	6 months
Kirsten Major	March 2019	Open ended	6 months
Chris Morley	October 2018	Open ended	6 months
Neil Priestley	February 2001	Open ended	3 months

The Board of Directors' Nomination and Remuneration Committee

The Board of Directors' Nomination and Remuneration Committee is chaired by the Trust Chair and its membership includes all Non-Executive Directors.

The role of the Committee is outlined in its terms of reference which are annually reviewed and approved by the Board of Directors. Its responsibilities in relation to remuneration are to:

- Decide upon and review the terms and conditions of the office of the Trust's Executive Directors in accordance with all relevant Trust policies, including:
  - Salary, including any performance-related pay or bonus
  - Provision for other benefits, including pensions
  - Allowances
- Monitor and evaluate the performance of individual Executive Directors
- Adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective
- Advise upon and oversee contractual arrangements for Executive Directors, including (but not limited to) termination payments and agreements. This also relates to any matter that requires Treasury approval or any matter that may give rise to public concern
- Determine arrangements for annual salary review for all staff on Trust contracts

The Committee met a total of seven times during 2019/20, attendance at which was recorded.

Fig: Board of Directors' Nomination and Remuneration Committee membership and attendance

Name	Attendance (actual / possible)
Tony Pedder, Chair	7 from 7
Tony Buckham	7 from 7
Candace Imison	1 from 2
Annette Laban	7 from 7
Chris Newman	5 from 7
John O'Kane	4 from 7
Rosamond Roughton	0 from 2
Martin Temple	7 from 7
Shiella Wright	6 from 7

At the invitation of the Committee, meetings are attended by the Chief Executive, the Director of Human Resources and Staff Development and the Assistant Chief Executive, who acts as Committee Secretary. Executive Directors are not involved in any decisions or discussions regarding their own remuneration.

The remuneration of Non-Executive Directors is the responsibility of the Council of Governors' own Nomination and Remuneration Committee. The work of this Committee is outlined within the Governance section of this Annual Report.

Disclosures required by the Health and Social Care Act

Expenses for Executive and Non-Executive Directors

The expenses for Executive and Non-Executive Directors and Governors are reimbursed on a receipts basis, evidencing the business mileage or actual travel / subsistence costs incurred. Reimbursement rates for mileage are those applied to all Trust employees and do not exceed national guidelines.

Total expenses for 2019/20 are detailed in the table below

Fig: Expenses for Executive and Non-Executive Directors and Governors

	2019/20	2018/19
Executive and Non-Executive Directors		
Number who claimed expenses during the year	10	12
Number of Executives / Non-Executives who held office during the year	16	18
Amount claimed in total	**£8,441.77**	**£10,629.33**
Governors		
Number who claimed expenses during the year	13	13
Number of Governors who held office during the year	29	33
Amount claimed in total	**£5,095.76**	**£6,171.96**

Remuneration of Executive and Non-Executive Directors

In reporting on remuneration within the tables provided on pages 34 and 35, the Trust has applied the definition of senior managers as proposed within the NHS FT Annual Reporting Manual and included senior managers who influence the decisions of the Trust rather than the decisions of individual directorates or sections of the Trust. As well as referring to Executive and Non-Executive Directors, this extends to the Assistant Chief Executive, the Communications and Marketing Director and, from February 2020, the Medical Director (Operations).

Changes to the composition of Non-Executive Directors on the Board of Directors during 2019/20 include the stepping down of Candace Imison at the end of August 2019 and the appointment by the Council of Governors of Rosamond Roughton from December 2019. Shiella Wright, appointed by the Council of Governors in March 2019, took up her Non-Executive Director position on the Board of Directors from 1 April 2019.

*Table 1 - Single total remuneration for senior managers**

		SINGLE TOTAL REMUNERATION 2019/20			SINGLE TOTAL REMUNERATION 2018/19		
		Salary	All pension related benefits	Single Total Remuneration	Salary	All pension related benefits	Single Total Remuneration
Name	Title	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
Tony Buckham	Non-Executive Director	15 - 20		15 - 20	15 - 20		15 - 20
Sandi Carman	Assistant Chief Executive	110 - 115	22.5 - 25	135 - 140	115 - 120	62.5 - 65	175 - 180
Andrew Cash	Chief Executive *(until 31 July 2018)*				85 90		85 90
Hilary Chapman	Chief Nurse *(until 15 August 2018)*				70 - 75		70 75
Anne Gibbs	Director of Strategy and Planning	145 - 150	30 - 32.5	175 - 180	140 - 145	105 - 107.5	250 - 255
Mark Gwilliam	Director of Human Resources and Staff Development	170 - 175	37.5 - 40	210 - 215	170 - 175	100 - 102.5	270 - 275
Michael Harper[#]	Chief Operating Officer	130 - 135	65 - 67.5	200 - 205	80 85	52.5 - 55	135 - 140
Jennifer Hill[##]	Medical Director (Operations) (*from 1 February 2020*)	175 180	112.5 115	290 295	-		
David Hughes	Medical Director *(from 1 February 2019)*	170 - 175	302.5 - 305	475 - 480	25 - 30	72.5 - 75	100 - 105
Candace Imison	Non-Executive Director *(until 31 August 2019)*	5 - 10		5 - 10	15 20		15 - 20
Karen Jessop	Interim Chief Nurse *(16 August 2018 - 7 October 2018)*				15 - 20	107.5 110	125 130
Annette Laban	Non-Executive Director	15 - 20		15 - 20	15 - 20		15 - 20
Kirsten Major	Deputy Chief Executive *(until 31 July 2018)*, Interim Chief Executive *(from 1 August 2018 to 3 March 2019)*, Chief Executive *(from 4 March 2019)*	220 - 225	110 - 112.5	335 - 340	195 200	97.5 - 100	290 - 295
Dawn Moore	Non-Executive Director *(until 30 September 2018)*				5 - 10		5 - 10
Chris Morley	Chief Nurse *(from 8 October 2018)*	150 - 155	147.5 - 150	300 - 305	70 - 75	260 - 262.5	330 - 335
Chris Newman	Non-Executive Director	15 - 20		15 - 20	15 - 20		15 - 20
John O'Kane	Non-Executive Director	15 - 20		15 - 20	15 - 20		15 - 20
Tony Pedder	Chair	55 - 60		55 - 60	55 - 60		55 - 60
Julie Phelan	Communications and Marketing Director	115 - 120	30 - 32.5	145 - 150	110 - 115	40 - 42.5	155 - 160
Neil Priestley	Director of Finance	190 - 195		190 - 195	185 - 190		185 - 190
Rosamond Roughton[###]	Non-Executive Director *(from 1 December 2019)*				-		
Martin Temple	Non-Executive Director	15 - 20		15 - 20	15 - 20		15 - 20
David Throssell	Medical Director *(until 31 January 2019)*				140 145		140 - 145
Shiella Wright	Non-Executive Director *(from 1 April 2019)*	15 20		15 20			

[#]Michael Harper became a Participating Director of the Board of Directors under arrangements whereby Kirsten Major, Deputy Chief Executive assumed the position of interim Chief Executive, i.e. from August 2018. Michael continued as a participating Director of the Board of Directors for the remainder of 2018/19 and into 2019/20 when from June 2019 he was appointed to an Executive position of Chief Operating Officer.
[##] Jennifer Hill's remuneration reflects the fact that she holds a consultant contract with a salary of £167k and attracts a responsibility payment for the Medical Director (Operations) role.
[###]Rosamond Roughton has chosen to not receive remuneration for her Non-Executive role.

Notes on Table 1

No remuneration is paid to any Director by way of any taxable expense payment nor by any form of performance related pay or bonuses. Pension related benefits have been calculated using the HRMC method advised by NHSI in the Annual Reporting Manual. Table 1 was subject to audit.

Table 2 - Total pension benefits*

	Real increase in pension at pension age (£'000)	Real increase in pension lump sum at pension age (£'000)	Total Accrued pension at pension age @ 31.03.20 (£'000)	Lump sum at pension age related to accrued pension at 31.03.20 (£'000)	CETV @ 31.03.19 (£'000)	Real Change in CETV (£'000)	CETV @ 31.03.20 (£'000)
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	(£,000)	(£,000)	(£,000)
Sandi Carman Assistant Chief Executive	0-2.5	0-2.5	40-45	90-95	673	23	728
Anne Gibbs Director of Strategy and Planning	2.5-5	0-2.5	45-50	100-105	682	24	743
Mark Gwilliam Director of Human Resources and Staff Development	2.5-5	0-2.5	35-40	90-95	706	36	784
Michael Harper Chief Operating Officer	2.5-5	2.5-5	35-40	75-80	492	46	568
Jennifer Hill Medical Director (Operations) *(from 1 February 2020)*	0-2.5	0-2.5	60-65	150-155	1,113	20	1,287
David Hughes Medical Director	12.5-15	35-37.5	45-50	135-140	734	307	1,084
Kirsten Major Chief Executive	5-7.5	5-7.5	60-65	135-140	963	89	1,108
Chris Morley Chief Nurse	7.5-10	12.5-15	60-65	170-175	1,032	137	1,216
Julie Phelan Communications and Marketing Director	0-2.5	0-2.5	40-45	90-95	727	33	794

Notes on Table 2

The Trust is a member of the NHS Pension Scheme which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholders pension scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2019/20 and whose membership was active at 31 March 2020. CETV (Cash Equivalent Transfer Value) is the value of a member's pension fund at 31 March if he/she were to transfer that pension fund on that date. Benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud Judgement and the Guaranteed Minimum Pension (GMP) Judgement.

Table 2 was subject to audit.

Hutton Report Disclosure

The Trust is 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 at the reporting period end date on an annualised basis.

The banded remuneration of the highest-paid Director in the Trust in the financial year 2019/20 was £223,000 compared with £218,000 in 2018/19. This was 8.82 times the median remuneration of the workforce, which was £25,512.

Remuneration report signed by the Chief Executive

Kirsten Major, 12 June 2020

Table 3 - Fair Pay Multiple Statements

	2019/20	2018/19	2017/18
Band of Highest paid Director's total remuneration (midpoint banded remuneration in multiples of £5k)	£225.5k	£217.5k	£247.5k
Median total remuneration	£25,512	£25,934	£24,733
Ratio	8.82	8.48	10.01

Notes on Table 3

The HM Treasury Financial Reporting Manual (FReM), requires the Trust to disclose the median remuneration of the Trust staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director. This calculation is based on full-time equivalent staff of the Trust at 31 March 2020 on an annualised basis.

Table 3 subject to audit.

Staff Report

The staff and volunteers of Sheffield Teaching Hospitals NHS Foundation Trust are the reason for our continued success. Our 17,800 plus workforce is vital to ensuring we continue to deliver high quality care. Without them we would not be able to deliver the standard of care, or offer the range of clinical services, that we do.

Through continued commitment to deliver our People Strategy we are dedicated to ensuring that our staff experience at Sheffield Teaching Hospitals is a brilliant and personal place to work. Focused on 10 workstreams this strategy allows us to provide our staff with the best opportunities to put patients first.

We have continued to work with our PROUD values and to embed these into the Trust's ethos.

The PROUD values are:

- **Patients First -** Ensure that the people we serve are at the heart of what we do
- **Respectful -** Be kind respectful, fair and value diversity
- **Ownership -** Celebrate our successes, learn continuously and ensure we improve
- **Unity -** Work in partnership with others
- **Deliver -** Be efficient, effective and accountable for our actions

Our PROUD values and behaviours underpin the way in which we all work and deliver the best of service at all times. We strive to achieve exceptional engagement and leadership, ultimately delivering the best for our patients.

We continue to recognise the great work that individuals and teams carry out via our annual Thank You Awards, our Long Service Awards and our Give it a Go Week.

Working with our staff

Statement on approach to staff engagement

Staff engagement is a priority for the Trust. It is a vital part of our ability to deliver consistently high quality clinical services and is part of our underpinning workforce strategy to employ caring and cared for staff.

The Trust is committed to involving staff in decision-making, engaging them on key developments and keeping them informed of change across the organisation.

We use a range of well-established communications channels to ensure that all staff are aware of both internal and external developments that may affect the Trust. These include a regular briefing from the Chief Executive and a weekly email bulletin to all staff. Our Intranet pages provide access for staff to Trust policies, guidance and online resources and our Corporate Induction programme acts as a valuable source of information to all new starters within the Trust. The Trust Executive Group also holds monthly briefing meetings with members of the Clinical and Management Boards.

The Trust has a well-established Partnership Forum where management and union representatives meet to discuss Trust-wide workforce issues. Through this forum policies and procedures are formally agreed and wider views sought on a broad range of subjects that may affect staff, including formal consultation on areas of organisational change.

Our Council of Governors is another forum for consultation, membership of which includes staff representatives. This Annual Report

outlines the involvement of Governors in a number of areas including the development of our quality priorities.

We recently received the results of our 2019 Staff Survey and are actively reviewing this feedback to identify themes that we can work with our staff to improve their experience at work. More detail is included later in this report and our full survey results are available at www.nhsstaffsurveys.com

The Trust's Freedom to Speak Up Guardians, supported by the Freedom to Speak Up Steering Group, have focused on expanding our support infrastructure for employees wishing to raise concerns.

The Trust's two Freedom to Speak Up Guardians are supported by a number of Freedom to Speak Up Advocates who are located across the organisation. Their contact details can be found on the Human Resources intranet page and are publicised on posters across the organisation.

Regular communication bulletins including profiles of Guardians and Advocates have been issued to increase awareness of these roles across the Trust.

The Trust participates in the staff Friends and Family Test three times a year as well as undertaking a full census staff survey once a year. Engagement events have been held across the Trust, particularly in clinical areas, to discuss the findings of the Friends and Family Test results. The Trust Executive Group continues to spend time in clinical and non-clinical departments to take the opportunity to meet with staff and listen to their feedback. The Chair meets regularly with Staff Governors, and the Board of Directors meets staff and regularly recognises their efforts.

The Trust continues to hold a variety of events for staff to encourage staff involvement and promote the sharing of good practice including departmental timeouts, the Sharing of Good Practice Festival, Leadership Forums, Give It a Go Week and the Microsystems Academy Expo, to name a few.

National Staff Survey

As noted above, each year the Trust takes part in the National Staff Survey. This annual survey provides invaluable information to ensure that the views of staff are heard and appropriate responses to feedback are given.

The Trust is benchmarked in the combined acute and community trusts group.

Fig: Response rate to the NHS Staff Survey: Staff involvement

2019		2018	
Trust	National Average	Trust	National Average
45%	46%	46%	41%

The benchmarked findings of the 2019 survey are presented across a number of theme scores (scored out of 10) as outlined in the following table.

Fig: Staff survey results

	2019		2018		2017	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.2	9.2	9.3	9.2	9.3	9.2
Health and wellbeing	6.0	6.0	5.9	5.9	6.1	6.0
Immediate managers	6.9	6.9	6.8	6.8	6.8	6.8
Morale	6.3	6.2	6.3	6.2	Not available	Not available
Quality of appraisals	5.7	5.5	5.6	5.4	5.5	5.3
Quality of care	7.4	7.5	7.4	7.4	7.5	7.5
Safe environment – bullying and harassment	8.4	8.2	8.4	8.1	8.4	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.9	6.8	6.8	6.7	6.8	6.7
Staff engagement	7.1	7.1	7.0	7.0	7.1	7.0
Team working	6.5	6.7	6.5	6.6	6.6	6.6

For the 2019 Staff Survey an extra theme on 'Team working' was included. Questions from this theme along with equality, diversity and inclusion and bullying and harassment questions are included in the NHSE/I Oversight Framework. Of the 11 themes in the 2019 benchmarked report four scored above average.

These are:

- Morale
- Quality of appraisals
- Safe environment - bullying and harassment
- Safety culture

A further five scores were average:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Safe environment – violence
- Staff engagement

Only two themes scored below average:

- Quality of care
- Team working

No one theme showed any year on year deterioration.

The highest score overall was achieved in Safe environment – violence (9.5) and the lowest was in quality of appraisals (5.7), albeit this was still above the average of 5.5.

The Trust is close to the best in the benchmarking group for both the Safe environment – violence, and Safe environment - bullying and harassment score.

It was particularly pleasing to note in the survey that the percentage of staff recommending the Trust as a place to work to work increased by 1.4 per cent for the fifth year running to 69.3 per cent (well above the average of 64 per cent). The percentage of staff recommending the Trust as a place for treatment remains high at 81 per cent, well above the average.

The Staff Survey results will be used to update the directorate staff engagement action plans and at a Trust level the implementation of the 10 themes of the People Strategy continues which will also improve staff experience. This year we have worked to improve both health and wellbeing support and benefits for staff for example though the introduction of fruit and vegetable stalls at the Northern General Hospital and Royal Hallamshire Hospitals sites and expanding our range of salary sacrifice options to include gym membership. We were pleased to be finalists in both the national employee benefits awards and the NHSI / Burdett award retention awards.

Diversity and inclusion

The Trust aims to create a diverse and inclusive workforce that attracts and engages diverse, talented individuals and promotes creativity, celebrates difference and enhances the character, potential and culture of our organisation.

A key workstream of the People Strategy, 'Promoting and valuing difference' is leading a programme of work, overseen by the Equality, Diversity and Inclusion (EDI) Board. The Board provides oversight to the development of the Trust's strategic approach to meeting the relevant duties set out in the Equality Act 2010, and the duties embedded in the NHS Equality Delivery System.

With a diverse and broad membership including senior leaders, the Board reports to the Trust Executive Group and oversees any EDI work carried out in respect of workforce, patients and service delivery.

We have continued to be proactive in our focus and efforts to be an inclusive employer and promote equality and diversity for our patients and staff. Throughout the year our EDI Board has directed, supported and celebrated our progress. As a Trust we are continually building our capabilities to make this a brilliant personal place to work and improve the care that we provide for the communities we serve.

Our achievements over the past year have included:

- Strengthening of our EDI Board
- Investing in EDI posts
- Developing a calendar of EDI events
- Identifying EDI gaps and solutions analysis
- Establishing an EDI Strategy (6 Point Plan 2019-2022, including an overarching action plan)
- Reviewing and refreshing the Equality Impact Analysis (EIA) process
- Developing an EDI Performance Dashboard
- Establishing operational groups for the Accessible Information Standard (AIS), Equality Monitoring, Workforce data and EDI training
- Embedding EDI elements into leadership courses
- Coaching and mentoring of individual staff in relation to EDI
- Forming stronger links with the Voluntary Sector, specifically in relation to EDI
- Agreeing a plan for the implementation of Equality Delivery System 2 (EDS2)
- Launching the NHS Rainbow Pin Badges

The 'Promoting and valuing difference' workstream also oversees the development and delivery of the Workforce Race Equality Standard (WRES). The WRES Strategy and Action Plan and Sheffield Implementation Guide and data have been uploaded to the Trust's website and can be accessed at www.sth.nhs.uk/about-us/equality-and-diversity

The EDI Workforce Lead is overseeing the implementation of a number of staff networks which will provide peer support for staff, act as

a voice for the organisation on issues that impact on black, asian and minority ethnic (BAME), disabled and lesbian, gay, bisexual, transgender and queer (LGBTQ+) staff and provide advice and support on issues which are felt to be important to address.

Staff health and safety and incident management

The Trust's People Strategy theme 'Promoting wellbeing' commits to ensuring that we identify and proactively manage risks to the health, safety and wellbeing of our staff to prevent harm and promote long term health.

To achieve this we have in place robust health and safety management systems to ensure that risks to health and safety are identified, evaluated and controlled to minimise harm.

An annual health and safety performance report is presented to the Healthcare Governance Committee along with a six monthly report relating to staff incidents and employer and public liability claims.

The table below shows the number of incidents reported over the last three years involving staff (including bank / agency), members of the public, students and contractors. In addition to monitoring incident data centrally, it is monitored at directorate level via formal governance management processes.

Fig: Total number of incidents by work group

Total number of incidents by work group	2019/2020	2018/2019	2017/2018
Accident / Incident involving contractor	44	30	44
Accident / Incident affecting member of public	278	238	284
Accident / Incident involving student	52	60	48
Accident / Incident involving member of staff	2097	1742	1978
Total number of accidents / incidents	**2471**	**2070**	**2354**

The Occupational Safety and Risk Committee has continued to meet monthly reviewing reports, policies, risk assessments and incident data relating to occupational health and safety. The Committee has representation from across all clinical directorates along with relevant disciplines including Estates and Facilities. Staff Side representatives also attend these meetings.

Staff health and wellbeing

We have established an Employee Assistance Programme which is accessible 24 hours a day, seven days a week, ensuring that staff have the right level of support when they need it most. Since launching this scheme we have further developed the accessibility of information on staff engagement, rewards and benefits, and health and wellbeing initiatives, via our social media channels and online portals.

We are committed to developing more ways of supporting our staff and with the help of the Chaplaincy Department, have increased the range of mindfulness sessions for staff and managers together with health, wellbeing and resilience sessions. Staff are also able to access the Headspace mindfulness and meditation app. We have also continued to provide access to fast-track physiotherapy.

Countering fraud and corruption

The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates or any person or body acting on its behalf. Maintaining fraud levels at an absolute minimum ensures that more funds are available for patient care and services.

The Trust engages 360 Assurance as its Local Counter Fraud Specialist (LCFS) to support the Board of Directors' commitment to maintaining an honest and open culture, ensuring that all concerns involving potential fraud have been identified and rigorously investigated. In all cases appropriate civil, disciplinary and / or criminal sanctions have been applied, where guilt has been proven. This supports the embedding of deterrence and prevention measures across the organisation.

The Trust's Audit Committee agrees the annual work plan for the LCFS and receives routine reports on progress against its delivery. The Committee has agreed the Trust's policy for dealing with suspected fraud, bribery and corruption and the Trust's Standards of Business Conduct Policy.

Staff analysis

Staff numbers

Fig: Average number of persons employed (contracted whole time equivalent basis)

	2019/20			2018/19		
	Permanent	Other	Total	Permanent	Other	Total
Medical and Dental staff	1,830	54	**1,884**	1,742	44	**1,786**
Administration and Estates staff	3,080	38	**3,117**	2,973	29	**3,002**
Healthcare Assistants and other Support staff	1,617	260	**1,877**	1,645	221	**1,866**
Nursing, Midwifery and Health Visiting staff	5,706	134	**5,840**	5,569	109	**5,678**
Scientific, Therapeutic and Technical staff	2,630	18	**2,649**	2,574	21	**2,595**
Healthcare Science staff	148	-	**148**	155	-	**155**
Total average numbers	15,011	504	**15,516**	14,658	424	**15,082**

Information in figure was subject to audit

Gender of staff

On 31 March 2020 the Trust Board of Directors had 15 voting members, 10 male and five female. Women represent 65.1 per cent of senior staff at band 8 and above.

The current Trust headcount at 31 March 2020 was 17,816. Female employees comprised 76.9 per cent of the workforce and 23.1 per cent were male.

It became mandatory for public sector organisations with over 250 employees to report annually on their Gender Pay Gap. Analysis for 2019 indicates that for our Trust there is an average hourly pay gap in favour of men of 21.7 per cent, which is a two per cent improvement on data for 2018 (23.7 per cent). This pay gap is largely accounted for by the fact that we have a male dominated workforce in senior medical (consultant) posts.

High level actions in place to address this gap include:

- Continue to deliver on our People Strategy which prioritises equality, diversity and inclusion
- Continue to work with Athena Swan and Sheffield Women in Medicine (SWIM) and develop women in our medical workforce
- Consider how we can attract more men into the organisation to work in unregistered roles to create a more gender balanced workforce
- Raise awareness of shared parental leave entitlements and flexible working opportunities for all
- Continue to provide career developments opportunities for all staff

Information on Trust information on the gender pay gap can be found on the Cabinet Office website at https://gender-pay-gap.service.gov.uk/

Staff sickness absence data

Data for average sick days per full time equivalent (FTE) provided by the Department of Health and Social Care is published by NHS Digital at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff costs

Fig: Analysis of staff costs

	2019/20			2018/19
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	550,989	18,553	569,542	541,436
Social security costs	49,464		49,464	46,990
Apprenticeship levy	2,669		2,669	2,545
Employer's contributions to NHS Pensions Scheme	93,829		93,829	62,428
Pension cost – others	400		400	230
Agency / contract staff		11,248	11,248	9,757
Total	**697,351**	**29,801**	**727,152**	**663,386**

Notes
The above figure of £727,152k is net of the amount of £1,071k (2018/19 £1,435k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1 to the accounts).

(Information in figure subject to audit)

Exit packages

The table below summarises the total number of exit packages agreed during the year.

Fig: Compensation scheme - exit packages

Staff exit packages	2019/20			2018/19		
Exit package cost band (including any special payment element)	Compulsory redundancies	Other departures agreed	Total exit packages	Compulsory redundancies	Other departures agreed	Total exit packages
< £10,000	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	2	0	0
£25,001 - £50,000	1	0	1	0	0	0
£50,001 - £100,000	0	0	0	1	0	0
£100,001 - £150,000	0	0	0	1	0	0
Total number by type	**1**	**0**	**1**	**4**	**0**	**0**
Total resource cost (£000)	**45**	**0**	**45**	**238**	**0**	**0**

Notes:
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this table are the full costs of departures agreed in the year. Where Sheffield Teaching Hospitals NHS Foundation Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

There were no non-compulsory departures / departure payments in either 2019/20 or 2018/19.

(Information subject to audit)

Trade union facility time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of trade union facility time within their organisation.

Fig: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
76	14,784.34

Fig: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	32
1 - 50%	39
51 - 99%	3
100%	2

Fig: Percentage of total pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	Figures
Total cost of facility time	£294,073
Total pay bill	**£661,009,851**
Percentage of the total pay bill spent on facility time, calculated as: *(total cost of facility time ÷ total pay bill) x 100*	**0.045%**

Fig: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 1146 hours / 16940 hours	Per cent
Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	10.6%

Off payroll engagements

The Trust has identified seven off-payroll engagements remunerated at more than £245 per day which have lasted for between one and five years up to 2019/20. In addition, a further seven engagements have been identified which are new for 2019/20. Of these new engagements, all were assessed as within the scope of IR35. In all cases, assurances and appropriate actions have been taken to ensure the appropriate declaration of income tax and national insurance are made to HMRC.

A total of 19 individuals have been deemed 'Board members and / or senior officials with significant financial responsibility' during 2019/20, all of which were on-payroll engagements

Fig: For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2020	**14**
Of which	
Number that have existed for less than one year at time of reporting	7
Number that have existed for between one year and two years at time of reporting	2
Number that have existed for between two years and three years at time of reporting	2
Number that have existed for between three years and four years at time of reporting	0
Number that have existed for between for four or more years at time of reporting	3

Fig: For all new off-payroll engagements, or those that reached six months duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reach six months in duration, between 1 April 2019 and 31 March 2020	**9**
Of which	
Number assessed as within the scope of IR35	9
Number assessed as not within the scope of IR35	0
Number engaged directly (via Personal Service Company contacted 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

Fig: For all off-payroll engagements of Board members, and / or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of Board members, and / or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed Board members and / or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	19

Code of Governance Report

Our Council of Governors

The Council of Governors advises the Trust on how best to meet the needs of patients and the wider community we serve. It has a number of statutory duties, including holding the Non-Executive Directors to account for the performance of the Board of Directors and representing the interests of Trust Members and members of the public.

The Council of Governors works with the Board of Directors to shape the Trust's future strategy and is responsible for providing feedback from the Membership and stakeholders on proposed strategic developments. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance through formal council meetings.

Comprised of elected and nominated Governors, as detailed below, the Council of Governors has decision-making powers defined by statute. These powers are outlined in the Trust's constitution and principally refer to the appointment, removal and remuneration of the Trust Chair and Non-Executive Directors; the appointment and removal of the Trust's external auditors; the approval of the appointment of the Chief Executive; and receiving the Trust's annual accounts, any report of the auditor on the accounts and the Annual Report.

While the Council of Governors is responsible for holding the Board, and in particular, the Non-Executive Directors, to account and ensuring that it is acting in a way that means that the Trust will meet its obligations, it continues to remain the responsibility of the Board of Directors to oversee the running of the Trust.

The Council of Governors discharges its statutory responsibilities through a combination of formal Council meetings, standing committees and working groups. While it typically holds four formal meetings a year, during 2019/20 it was necessary to put alternative arrangements in place for two of these meetings.

Council of Governors meetings are held in public and therefore, in line with public health advice around the COVID-19 outbreak, the meeting that had been scheduled to take place on 31 March 2020 was cancelled.

Despite this cancellation and separate circumstances requiring the meeting scheduled for 24 September 2019 to be held on an informal basis, the Council of Governors has still been able to deliver its annual work plan for 2019/20.

Moving forward into 2020/21, arrangements have been put in place to ensure that members of the Council of Governors remain informed and engaged in Trust business during COVID-19 social distancing restrictions, and the Standing Orders of the Council of Governors are allowing the Council to conduct business by video conferencing link.

A record of attendance by individual Governors at formal meetings of the Council of Governors is presented in the following tables. These tables outline membership of the Council of Governors during 2019/20.

Composition of the Council of Governors 2019/20

As at 31 March 2020 there were 33 seats on the Council of Governors: 13 to represent public Members, seven to represent patients, six to represent staff Members and seven seats for Governors nominated by partner organisations. There are three vacant seats on the Council of Governors, two Staff Governor seats and one Public Governor seat.

Fig: Council of Governors membership and attendance 2019/20

	Elected / Re-elected from	Attendance (actual / possible)[3]
Patient Governors		
Barbara Bell	1 July 2017	1 from 3
George Chia	1 July 2018	2 from 3
David Foster	1 July 2019	2 from 2
Steve Jones	1 July 2017	2 from 3
Kath Parker	1 July 2018	1 from 3
Harold Sharpe	1 December 2019	2 from 3
Fiona Tatton	1 July 2019	1 from 3
Public Governors		
Mick Ashman	1 July 2019	2 from 3
Steve Banks	1 July 2019	1 from 3
Wendy Bradley	1 July 2017	1 from 3
Michelle Cook	1 July 2017	0 from 3
Sally Craig	1 July 2017	3 from 3
Martin Hodgson	1 July 2019	3 from 3
Joyce Justice	1 July 2018	2 from 3
Ian Merriman	1 July 2018	3 from 3
Brendan Molloy	1 July 2018	3 from 3
Lewis Noble	1 July 2018	1 from 3
Joe Saverimoutou	1 July 2018	2 from 3
Chris Sterry	1 July 2019	2 from 2
Sue Taylor	1 July 2019	2 from 3
Neville Wheeler (to 30 June 2019)	1 July 2016	0 from 1
Staff Governors		
Emily Edmunds (to 24 June 2019)	1 July 2018	0 from 2
Irene Mabbott	1 July 2018	1 from 3
Cressida Ridge	1 July 2017	3 from 3
Karen Smith	1 July 2017	2 from 3
Pete Tanker	1 July 2018	1 from 3
Appointed Governors	**Appointed**	
Amanda Forrest	21 April 2015	2 from 3
Angela Foulkes	10 December 2018	1 from 3
Tim Furness	1 February 2018	1 from 3
Luc de Witte	1 November 2017	3 from 3

Governors are required to declare interests which are relevant and material to the business of the Trust.

[3] *Attendance is recorded for the three Council of Governors meetings held during 2019/20 (25 June 2019, 24 September 2019 and 17 December 2019). No formal business was conducted at the September 2019 meeting due to the late distribution of papers. A fourth meeting scheduled for 31 March 2020 was cancelled following COVID-19 public health advice and social distancing restrictions.*

The Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee of the Council of Governors makes recommendations to the Council on the appointment and remuneration of Non-Executive Directors and considers and contributes to the appraisal of the Chair and Non-Executive Directors.

At an extraordinary meeting of the Council of Governors held on 30 October 2019 approved the Committee's recommendation to appoint Rosamond Roughton as a Non-Executive Director.

The Committee has commenced the recruitment and nomination process to appoint a new Trust Chair and this will be a focus of the Committee's workplan into 2020/21.

Remuneration of Non-Executive Directors

The Council of Governors did not change the amount of remuneration paid to the Non-Executive Directors or the Chairman during 2019/20.

In giving consideration to the advertisement of a Non-Executive Director vacancy, the Nomination and Remuneration Committee of the Council of Governors considered levels of Non-Executive Director remuneration using national benchmarking data.

Elections held within the reporting period

Council of Governor Elections took place between May and June with the results declared on 20 June 2019. Nominations were sought for 10 seats across six constituencies.

Eleven nominations were received from people who wished to stand for election, including four current Governors seeking reappointment.

Two constituencies were contested: South West Sheffield (public) and Sheffield South East (public).

All elections are held in accordance with the election rules set out in our constitution. Turnout in the contested seats was as follows:

- Public South West Sheffield - 20.4 per cent
- Public Sheffield South East - 12.1 per cent

Four new Governors and four reappointed Governors officially started their terms of office on 1 July 2019. No nominations were received for two seats and these remain vacant.

Full details of the composition of the Council of Governors and of the most recent election results are posted on our website at https://www.sth.nhs.uk/members/elections and https://www.sth.nhs.uk/members/meet-the-governors

In the event of an elected Governor's seat falling vacant for any reason before the end of a term of office it shall be filled by the second placed candidate in the last election held for that seat.

Lead Governor

In line with the Foundation Trust Code of Governance, the Council of Governors elects one of the Public Governors to be 'Lead Governor'. This is to act as the main point of contact for NHS Improvement (NHSI) should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.

In 2017 a formal nomination process for the position of Lead Governor was held, through which Patient Governor, Kath Parker, was appointed as Lead Governor.

Strengthening links between the Board and Governors and Members

The Board of Directors is committed to working collaboratively with the Council of Governors. Executive and Non-Executive Directors value the role and contribution of Governors and work openly and transparently with the Council.

Although not members of the Council of Governors, Directors attend Council meetings and listen and respond to Governors' views. The Chair of the Board of Directors also chairs the Council of Governors, providing a link between the two.

To strengthen the relationship further the Chair and Non-Executive Directors are invited to attend the quarterly Governors' Forum meetings.

Governors attend the Board of Directors' meetings held in public and are invited to meet monthly with the Chair to review and discuss items debated by the Board in its private session. Governors are invited to observe committees of the Board of Directors to widen their knowledge of Trust business and to support them in fulfilling their statutory duty of holding the Board of Directors to account and assist in their assessment of the performance of Non-Executive Directors.

Directors also attended the Annual Members' Meeting which was held on 17 September 2019.

Non-Executive Directors are invited to join Governors on visits to wards and departments and to attend presentations and seminars arranged for Governors.

Fig: Attendance by Directors at Council of Governors meetings

Name		Attendance (actual / possible)
Tony Pedder	Chair	3 from 3
Tony Buckham	Non-Executive Director	3 from 3
Anne Gibbs	Director of Strategy and Planning	3 from 3
Mark Gwilliam	Director of Human Resources and Staff Development	2 from 3
Michael Harper	Chief Operating Officer	3 from 3
David Hughes	Medical Director	3 from 3
Candace Imison	Non-Executive Director (to 31 August 2019)	0 from 1
Annette Laban	Non-Executive Director	3 from 3
Kirsten Major	Chief Executive	2 from 3
Chris Morley	Chief Nurse	3 from 3
Chris Newman	Non-Executive Director	3 from 3
Neil Priestley	Director of Finance	3 from 3
John O' Kane	Non-Executive Director	3 from 3
Rosamond Roughton	Non-Executive Director (from 1 December 2019)	1 from 1
Martin Temple	Non-Executive Director	3 from 3
Shiella Wright	Non-Executive Director	3 from 3

There has also been continued focus on involving the Council of Governors in key developments and issues impacting the Trust. Governors attend monthly Governors' Board Briefing meetings and quarterly Finance Briefings, as well as attending meetings to discuss the Car Park Strategy. They receive regular updates on the IT Strategy and bi-annual updates from the Director of Human Resources and Staff Development.

Individual Governors attend a range of Trust Committees including:

- Patient Experience Committee
- Infection, Prevention and Control Committee
- Mental Health Committee
- Psychology Board
- Patient-Led Assessments of the Care Environment (PLACE)
- Travel and Transport Strategy Group
- Clinical Effectiveness Committee
- Equality, Diversity and Inclusion (EDI) Board
- End of Life Care Group
- PROUD Forum
- Food Management Group
- Emergency Planning Operational Group
- Pharmacy Board

Visits to departments around the Trust were organised for Governors to take part in. These included visits to the Stroke Rehabilitation Centre, Laundry, Patient Booking Hub, Central Production, Diagnostics Cardiology Department and Physio Works.

Governors also attended presentations from staff regarding Trust services and issues affecting the Trust. During 2019/20 these have included presentations on Genomics, the work of Trust Volunteers and an update on the Robert Hadfield Building and on Mortality Metrics.

Membership

The Trust considers its Membership to be a valuable asset, which helps guide its work and the decisions it makes, while also holding the organisation to account and ensuring we adhere to NHS values. It is one of the ways the Trust communicates with patients, the public and staff.

The Trust has four Membership categories:

- Patients: anyone aged 12 years or over who has been a patient of the Trust
- Public: residents of Sheffield 12 years or over
- Public Outside Sheffield: residents of England and Wales, outside Sheffield, aged 12 years or over
- Staff: employees contracted to work for the Trust for at least one year

The Trust recognises the value and importance of a broad engagement strategy and has set up an Engagement Network to enhance its existing patient and public feedback activities, seeking to create new opportunities for local people to have a say about the Trust's services, get involved in research and innovation, become volunteers and consider standing for election as a Governor. Young People are also encouraged to join the Trust's Youth Forum.

The Engagement Network is linking with local community groups / organisations, Governors and Foundation Trust Members. By liaising with existing groups and networks it is envisaged that it will grow to represent all the communities that the Trust serves.

As in previous years, all Members were invited to our Annual Members' Meeting (AMM).

Fig: Membership breakdown at 31 March 2020

Constituency	Sub-constituency	Number of members
Patient Membership		**3,866**
Public Membership	North Sheffield	2,028
	Sheffield South East	2,263
	Sheffield South West	1,950
	West Sheffield	2,108
	Outside Sheffield	536
	Sub-total	**8,885**
Staff Membership	(sub divided into sub-constituencies listed)	**17,816**
	Medical and Dental	
	Nursing and Midwifery	
	Allied Health Professionals, Scientists and Technicians	
	Administration, Management and Clerical	
	Ancillary, Works and Maintenance Staff	
	Primary and Community Services Staff	
	Grand total	**30,567**

Meetings of the Board of Directors and its committees

The Board of Directors is the decision-making body for strategic direction and the overall allocation of resources. It delegates decision making for the operational running of the Trust to the Trust Executive Group. The Board take decisions consistent with the approved strategy.

The Board's role is to promote the success of the organisation so as to maximise the benefits for the Members of the Trust as a whole and for the public. It does this by:

- ensuring compliance with its licence, its constitution and statutory, regulatory and contractual obligations
- setting the strategic direction within the context of NHS priorities which provides the basis for overall strategy, planning and other decisions
- monitoring performance against objectives
- providing robust financial stewardship to ensure the Trust functions effectively, efficiently and economically
- ensuring the quality and safety of healthcare services, education and training and research
- applying best practice standards of corporate governance and personal conduct
- promoting effective dialogue between the Trust and the local communities we serve

The Board delegates decision-making for the operational running of the Trust to the Trust Executive Group in accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Trust's Standing Orders set out matters which are reserved for the Board of Directors to decide. These relate to regulation and control, appointments, strategic and business planning and policy development, direct operational decisions, financial and performance reporting arrangements, audit arrangements and investment decisions. During 2019/20 Board of Directors' meetings have been scheduled monthly, with the exception of the month of August. It meets in public, although part of the meeting is held in private to deal with matters of a confidential nature. The agenda and papers for the section of the meeting held in public are published on the Trust's website.

The Board has established a committee structure with each of its standing committees chaired by a Non-Executive Director. This Board committee structure includes the statutory committees of Audit, Board Nomination and Remuneration and Healthcare Governance, as well as Finance and Performance and Human Resources and Organisational Development.

More detail of the Board's committee structure and the role of its committees is outlined within the Annual Governance Statement.

Audit Committee

The Audit Committee is appointed by the Board of Directors and comprise of four Non-Executive Directors, one of whom - John O'Kane, Committee Chair – has recent and relevant financial experience. Other Non-Executive Directors, who chair other Board committees, have a standing invitation to attend meetings of the Audit Committee.

Fig: Member attendance at meetings of the Audit Committee 2018/19

NED membership	Attendances (actual / possible)
John O'Kane, Chair	5 from 5
Tony Buckham (to March 2020)	4 from 4
Annette Laban (from January 2020)	2 from 2
Chris Newman	0 from 5
Shiella Wright (from January 2020)	1 from 2

Meetings of the Audit Committee are attended by senior representatives of the Trust's internal and external auditors, the Trust's local counter fraud specialist, as well as the Director of Finance and Assistant Chief Executive. The Chief Executive and the Trust Chair are invited to attend the meeting at which the annual accounts are presented.

Both the internal and external auditors have the opportunity to meet with Audit Committee members in private (without Trust Executives present) to discuss any concerns relating to the performance of the senior management team. The Committee provides the Board of Directors with an independent and objective review of the effectiveness of the system of internal control (both financial and non-financial). It is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek information it requires from staff to fulfil its functions.

Copies of the Committee's terms of reference are published on the Trust's website on their annual review by the Board of Directors.

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

The Trust's internal audit service is provided by 360 Assurance, a consortium principally serving a number of foundation trusts and clinical commissioning groups in the region. Through detailed testing of the Trust's internal control systems, this service fulfils a key role in the Trust's assurance processes.

Local counter fraud provision is commissioned from 360 Assurance. The Trust's local counter fraud service supports the Trust to create an anti-fraud culture, deterring, preventing and detecting fraud, investigating suspicions as they arise and seeking to apply appropriate

sanction and redress in respect of any monies obtained through fraud.

The Audit Committee is responsible for making a recommendation to the Council of Governors in respect of the appointment and approval of the Trust's external auditors.

In September 2016, following a competitive tender exercise, Mazars LLP was appointed by the Council of Governors as the Trust's external auditor for a three-year period commencing with the 2016/17 audit cycle (subject to annual satisfactory evaluation) with an option to extend for two further years.

In September 2017 and September 2018, on the basis of a satisfactory evaluation of the external audit service received by the Trust, the Audit Committee presented a recommendation to Governors that Mazars LLP be reappointed as the Trust's external auditors for the next audit cycle. These annual reappointments have been confirmed at Council of Governors meetings.

In January 2019, in advance of the end of the initial three-year contract, the Audit Committee undertook an interim assessment of external auditor performance to provide adequate time to undertake a competitive tender exercise, should this be required. In effect, the result of the assessment warranted a recommendation to Governors to extend the contract, with this approved at the March 2019 Council meeting. This also confirmed the reappointment of Mazars LLP for the 2019/20 audit cycle.

The Committee routinely receives progress reports from Mazars LLP, including updates on key emerging issues / developments.

The statutory audit fee for the 2019/20 audit was £54,000 and a further £2,000 (both inclusive of VAT) for preparatory work relating to the audit of the Trust's 2019/20 Quality Report.

Mazars LLP provides its services within the Audit Code of NHS foundation trusts. The Audit Committee has delegated authority from the Board to commission additional investigative and advisory services outside this code. The provision of non-audit services by the external auditor would include work relating to the assurance report on the Trust's annual Quality Report.

In March 2020, NHSE/I confirmed that external assurance work on 2019/20 Quality Reports should be stopped to allow providers and commissioners to prioritise work focused on managing the response to the COVID-19 pandemic. Other than preparatory work referred to above, there has been no provision of non-audit services undertaken by the Trust's External Auditors on the 2019/20 Quality Report.

Principal areas of review and significant issues considered by the Audit Committee during 2019/20

The following outlines key matters considered by the Committee, reflecting key duties / areas of responsibility set out by its terms of reference. The reporting period has been extended to June 2020 in line with the extension by NHSE/I of the deadlines for preparation and audit of financial accounts for 2019/20 due to the impact of COVID-19.

Internal control and risk management

Reviewing the Integrated Risk and Assurance Report (IRAR) on behalf of (October 2019 and March 2020) or in advance of presentation to the Board (July 2019 and January 2020) and overseeing development of revised standard operating processes, including implementation of a programme of IRAR Deep Dive reviews through the Board Committee Structure.

- Supporting the routine annual review of a Risk Appetite Statement to articulate the level of risk that the Board is willing or unwilling to take in order to achieve the Trust's strategic aims (October 2019).

- Reviewing the annual financial statements, with particular focus given to major areas of judgement and any changes in accounting policies (January 2020) and the Board's determination that the 2019/20 annual accounts be prepared on an 'ongoing concern' basis. This followed consideration of the planned financial position for 2020/21 and how it has arisen, the context

of the overall NHS position, the future issues created, the Trust's position to cover income and expenditure deficits in cash terms during 2020/21 and the need for future health services in Sheffield.

- Receiving assurance around the effectiveness of risk management and internal control, including receipt of the risk management annual report in July 2019 and Register of Interests Annual Report, also in July 2019.

- Informed by its oversight of the Trust's systems of integrated governance, reviewing the adequacy of all risk and control related disclosure statements within the Trust's Annual Report (specifically, the Annual Governance Statement).

Internal audit

- Agreeing at the start of the year the internal audit work plan for 2019/20 taking into account risk assessment work undertaken by 360 Assurance and with the Trust Executive Group, and informed by Public Sector Internal Audit Standards.

- Through the course of the year, routinely receiving findings from individual reviews within the internal audit work plan, including reviews focused on contracting, stock management, bed management, IT asset management, IT planning and contracting, learning from deaths, medicines management, complaints, pre-employment checks and consultant's job plans. Monitoring management's responsiveness to internal audit recommendations and providing oversight of follow up completion rates.

- Receiving in June 2020 the Internal Audit Annual Report for 2019/20, including the Head of Internal Audit Opinion 2019/20, noting that the report found significant assurance on the Trust's system of internal controls.

- Undertaking annual review of the effectiveness of the internal audit function.

Local counter fraud

- Approving and overseeing progress against the annual fraud, bribery and corruption risk assessment and work plan through consideration of routine progress reports from the Trust's local counter fraud specialist and receiving in June 2020 the counter fraud annual report for 2019/20.

External audit

- Noting an agreed protocol for liaison between external audit and internal audit presented to the Committee in October 2019.

- Agreeing at the start of the 2019/20 audit cycle in January 2020, the Audit Strategy Memorandum (audit plan) setting out an analysis of the external auditor's assessment of significant audit risks, the proposed elements of the financial statements audit and its reporting timetable and other matters.

- Undertaking effectiveness review of the external audit service to inform recommendations to the Council of Governors as noted earlier in this section of the report.

The Chief Executive, as the Trust's Accounting Officer, is responsible for the preparation of the financial statements prior to them being audited by the external auditors. These responsibilities are detailed within the statement of Accounting Officer's responsibilities and in the Independent Auditor's report.

The Audit Committee gives full consideration to any significant risks and areas of audit focus raised in the external audit plan. In 2019/20 the three areas of audit focus related to land and building valuations, revenue recognition and management override of controls.

In each of these areas the Committee has been able to place reliance on work undertaken by the external auditors, Mazars LLP, as part of the work that they have undertaken to enable them to develop their audit opinion.

Compliance with NHS Foundation Trust Code of Governance

Sheffield Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply and 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.

The Trust continues to seek to comply with the NHS Foundation Trust Code of Governance (the Code) which is issued to assist NHS foundation trust boards develop their governance arrangements in line with best practice.

The Code operates on a 'comply or explain' basis and foundation trusts are required to report on how they apply the Code within their Annual Report. While there is a requirement to adhere to main principles of the Code, so long as reasons for any deviation from individual code provisions are explained and that alternative arrangements reflect the main principles of the Code, non-compliance is permitted.

The Board considers the Trust compliant with main principles of the NHS Foundation Trust Code of Governance. Details of how the Trust has applied the Code principles and complied with its provisions are set out in relevant sections of this Annual Report. In seeking to continually develop its governance arrangements, where action has been identified to further strengthen compliance against a Code provision this has also been described.

The disclosures required by the Code in relation to the roles and activities of the Board of Directors, its statutory committees and the Council of Governors and Membership are outlined earlier in this section. Required statements of disclosure relating to the functioning of the Board Nomination and Remuneration Committee are contained within the Remuneration Report.

A review of compliance against individual code provisions has been undertaken. Explanations for areas of non-compliance are outlined here:

B.7.4 *Non-Executive Directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 Act provisions relating to the removal of a director.*

The Standing Orders for the practice and procedure of the Board of Directors set out the term of office for the Chair and the Non-Executive Directors. These are reviewed regularly and it has been agreed to maintain the term of office at four years, rather than the three years as recommended in the Code.

The Board of Directors and the Council of Governors agree that this provides the Board with additional stability and continuity without compromising independence.

Arrangements are in place for a review of independence to be undertaken routinely as part of each second term re-appointment and a statement is made within the Annual Report by the Board of Directors with regard to each Director's independence.

In May 2018 the Council of Governors gave early consideration to the end of current Chair's second four-year term of office which was due to expire on 31 December 2019. While paying due regard to current length of tenure in respect of determining independence, the Council of Governors resolved to extend the tenure of Tony Pedder by a one year extension from 1 January 2020.

This recommendation by the Council of Governors' Nomination and Remuneration Committee was made on the basis of exceptional circumstances and the need to maintain stability on the Board in light of the planned retirement of the Chief Executive and Chief Nurse.

D.2.3 *The Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a Non-Executive.*

The Council of Governors has not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors but the Trust participates in NHS Providers remuneration surveys and other industry benchmarking exercises. This benchmarking data is used by the Council of Governors' Nomination and Remuneration Committee when making recommendations to the Council of Governors in relation to the remuneration of the Chair and the Non-Executive Directors.

B.6.2 *Evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years.*

While not commissioning an independent review, the Board has undertaken facilitated self-assessment of its leadership and governance arrangements using the Well-Led framework.

Supported by its Internal Auditors, this developmental review undertaken in 2018/19 identified some clear areas for development, focus on which was placed in preparation for the Trust's July 2018 CQC inspection and its Well-Led component.

Regulatory ratings

Single oversight framework

NHS England and NHS Improvement's Single 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 one to four, where 'four' reflects providers receiving the most support, and 'one' reflects providers with maximum autonomy. A Foundation Trust will only be in segments three or four where it has been found to be in breach, or suspected breach, of its licence.

Segmentation

NHS Improvement has reviewed the Trust's performance and information available to it and placed the Trust in Segment 2. This segmentation information is the Trust's position as at April 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Fig: Finance and use of resources scorings

Area	Metric	2019/20 Scores				2018/19 Scores			
		Q4	Q3	Q2	Q1	Q1	Q2	Q3	Q4
Financial stability	Capital service capacity	1	1	2	2	1	1	2	2
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	Income and Expenditure (I&E) margin	2	2	2	4	1	2	3	4
Financial controls	Distance from financial plan	1	1	1	1	1	1	2	1
	Agency spend	1	1	2	2	1	1	1	1
Overall scoring		**1**	**1**	**2**	**3**	**1**	**1**	**2**	**3**

Accountability Report signed by the Chief Executive in capacity as Accounting Officer

Kirsten Major
Chief Executive
Date: 12 June 2020

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Sheffield Teaching 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 Sheffield Teaching 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 Sheffield Teaching 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 Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy, and
- prepare the financial statements on a Going Concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all 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

Kirsten Major
Chief Executive
12 June 2020

Annual Governance Statement 2019/20

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching 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 Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors is responsible for reviewing the effectiveness of the system of internal control and for ensuring that the Trust has effective systems and structures in place for managing all types of risk that threaten the Trust's ability to meet its aims and objectives, and the achievement of it values.

The Trust's framework for risk management has been further developed during 2019/20. To support an integrated approach to risk management the framework defines the structures and processes in place to identify, manage and eliminate or reduce risks to a tolerable level. It clarifies accountability arrangements for the management of risk within the Trust from 'Board to Ward', setting out the responsibility of Executive Directors and Senior Managers in respect of leadership in risk management and confirms the role that all staff within the organisation have in relation to responsibility for the identification and reporting of risks and incidents.

The committee structure of the Board of Directors provides assurance on, and challenge to, the Trust's risk management process. Each chaired by a Non-Executive Director to enhance independent scrutiny, these committees are the key structures in ensuring quality, safety and management of risk, and provide the mechanism for managing and monitoring risk throughout the Trust and for assurance reporting to the Trust Board of Directors. Executive Directors provide leadership on the management of key areas of risk commensurate with their roles and are represented across the Board committee structure.

The Trust Executive Group (TEG) is responsible for the implementation of risk management and related assurance mechanisms. Individual Executive Directors are responsible for overseeing a programme of risk management activities in their areas of responsibility and TEG brings together the corporate, workforce, clinical, information, research, reputational and governance risk agendas.

With delegated authority from the Board of Directors, the Audit Committee has overall responsibility for integrated governance, risk management and internal control. It oversees

the system of internal control and governance and overall assurance process associated with managing risk to ensure that risks to the delivery of the Trust's services are identified and addressed. Strategic risks are reported to the Board of Directors and Audit Committee via the Integrated Risk and Assurance Report (IRAR).

Structured around principal risks to delivery of the Trust's strategic aims that have been identified and risk assessed by the Trust Executive Group, the IRAR reports the controls in place to mitigate and manage the risks, and the assurances available to indicate that the controls are effective. Detailed scrutiny of controls and assurances is performed by a relevant Board Committee. The Healthcare Governance Committee, Finance and Performance Committee, Human Resources and Organisational Development Committee each has oversight responsibility for sections of the IRAR within the remit of their own terms of reference. Via their Non-Executive Chair, each reports formally to the Board of Directors, to confirm delivery of assurance or escalate matters as necessary. Focus has been placed during 2019/20 on embedding a programme of IRAR Deep Dive reviews through the Board committee structure and on using conclusions drawn from these to further inform and drive the Board's assurance framework.

Local risks are reported and entered onto the Trust's Risk Register via directorate governance boards (or equivalent) and Trust management committees. In year accountability and reporting arrangements have been reviewed and from March 2020 a refreshed structure for the cascade of risk, escalation and assurance reports has been implemented within which sits a newly formed Safety and Risk Committee which has responsibility for ensuring robust and effective arrangements are in place for the management and monitoring of matters relating to safety and risk across the Trust. Membership includes senior-level representation from corporate and clinical directorates and from the Patient and Healthcare Governance and Corporate Governance Departments. A redefined Safety and Risk Forum provides a networking and information sharing forum for directorate risk and governance leads. Other specialist risk groups with specific risk management responsibilities, for example, the Infection Prevention and Control Committee, Radiation Safety Steering Group and Information Governance Committee also support this practice.

Staff training and guidance on the management of risk

Mandatory risk management and health and safety awareness training are incorporated within the Trust's induction programme for all new starters. The frequency and level of risk management training is identified through training need assessments, ensuring that individual members of staff have the relevant training to equip them for their duties and level of responsibility.

Additionally, a range of policies is in place and available to staff via the Trust's intranet which describe the roles and responsibilities in relation to the identification, management and control of risk. Staff are made aware of these policies and are actively encouraged to access them to ensure that they understand their own roles and responsibilities. The Patient and Healthcare Governance Department provides additional support, guidance and expert advice to staff on risk management. The department assists risk owners in identifying, assessing and managing and reviewing risks. Specifically, it supports all areas of the Trust in the use of the Datix Risk Management System as the electronic Trust-wide Risk Register.

The Trust takes all opportunities to learn from good practice and has a breadth of mechanisms in place to support this. These range from clinical supervision, reflective practice, peer review work and clinical audit. Learning from root cause analysis investigations and information such as trends in incidents, complaints and claims is used to continually enhance and improve standards of patient care by feeding into our quality improvement programme. Major reports from healthcare regulators are also routinely used

to identify learning from significant incidents and events in other healthcare organisations.

The risk and control framework

Risk management policy – Framework for risk management

As referred to above, the Trust's Framework for Risk Management describes the Trust's overall risk management process, within which the operation of an Integrated Risk and Assurance Report (IRAR), and Trust-wide Risk Register ensure that risk management is an integral part of clinical, managerial and financial processes across the Trust.

The framework defines the role of all staff in managing risks with associated procedural documents clearly outlining a systematic approach to the identification, evaluation and control of risk, which commences with a structured risk assessment process. The use of a standard assessment tool to identify risks ensures a consistent approach is taken to the evaluation and monitoring risk across the Trust. Additionally, the use of a grading matrix of likelihood and consequence to produce a risk score enables risks to be prioritised against other risks on the Risk Register. Local risks with a score of three or below are managed in the area in which they are identified; with all risks graded as above three are entered onto the Trust's Risk Register.

A target risk score is assigned to each risk to ensure that risks are controlled within a timely manner and to an acceptable level. The Board of Directors has developed a risk appetite statement that clearly articulates what risks it is willing or unwilling to accept in order to achieve the Trust's strategic aims. This acknowledges that risk is inherent in the provision of healthcare and sets out as a general principle that the Trust has a low tolerance for all risks that have the potential to expose patients, staff, visitors and other stakeholders to harm, that compromise the Trust's ability to deliver operational services, that adversely impact the reputation of the Trust, have severe financial consequences or result in non-compliance with law and regulation. The statement then defines tolerances for balancing different elements of risk, including patient safety, reputation, workforce and financial / value for money, based on how much, or little the Trust wishes to commit in terms of risk. Reviewed by the Board of Directors annually, reflections on its practical application in agreeing risk mitigations and on the Trust's current strategic environment led to a small number of modifications being agreed in December 2019.

Risk control measures are identified and implemented through action plans to achieve the target level of risk. Oversight of these action plans takes place in line with the newly articulated structure for the reporting, escalation and assurance of risks. These arrangements involve the consideration of all locally approved new and existing risks scored as eight and above by the Trust's Risk Validation Group (RVG). This group reviews each risk to validate the risk score; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan.

RVG reports to the Safety and Risk Committee whose membership includes senior-level representation from both corporate and clinical directorates and considers risk aggregation and the need for the development of cross-cutting risk (parent risk) assigned to a committee member or relevant senior Trust lead. Onward reporting to TEG of aggregated operational risks and those with a risk score of 15 or more, forms part of the standing operating procedure for the management of the Integrated Risk and Assurance Report (IRAR).

The IRAR is a mechanism for proactively assessing risk and control at the very highest level and seeks to provide assurance that there is effective management of key risks to the delivery of the Trust's strategic aims.

COVID-19 risk architecture

The Trust's response to the COVID-19 pandemic is being managed through a full Major Incident Command and Control Structure which entails the organisation being run through Bronze, Silver and Gold Commands. This command structure covers all aspects of the organisation and provides a

robust and transparent method of mitigating, preparing and responding to the demands of the COVID-19 pandemic. It forms the structure within which risks relating to the Trust's ability to respond effectively to COVID-19 and its impact on the delivery of the Trust's services are being managed.

As such a risk log process has been implemented with a chain of risk escalation from Bronze Command (operational) to Silver Command (tactical) to Gold Command (strategic). While managed through this highly dynamic emergency planning structure, the COVID-19 risk architecture is operating in parallel to the Trust's 'business as usual' risk management and assurance arrangements.

Management of COVID-19 related risks involves assurance and oversight functions performed by the Trust Executive Group and the Board of Directors and all identified strategic risks are being mapped onto Principal Risks recorded on the IRAR.

The COVID-19 pandemic is a clear example of a significant event that impacts on the Board's appetite and tolerance of risk. In agreeing arrangements for the management of COVID-19 related risks within the emergency command structure, a formal review of the risk appetite statement was undertaken outside its annual cycle in April 2020. While acknowledging that the pandemic would result in a heightened risk portfolio across the Trust, after careful consideration it was agreed that there was no need to amend the current risk appetite statement. A further review will be undertaken during the first quarter of 2020/21.

Quality governance arrangements

The Trust's quality governance and leadership structure ensures that the quality and safety of care is being routinely monitored across all services. The robust quality performance, risk management processes and reporting mechanisms in place to review and challenge performance and variation can be outlined as follows:

- Board oversight of quality issues through the Healthcare Governance Committee; a formal committee of the Board providing assurance that adequate quality governance structure, processes and controls are in place across the Trust for the continuous monitoring and improvement of safe and effective patient care.
- A clear and embedded framework described within a Healthcare Governance Arrangements Policy and Framework for Delivery which ensures consistency of structures, systems and processes for local governance and risk management arrangements across clinical and corporate directorates.
- A Board-approved Quality Strategy 2017-2020 setting out a structure and process for selecting and overseeing the implementation of annual quality priorities with involvement from patients, staff, Governors and other key stakeholders.
- Well embedded reporting arrangements to the committee structure of the Board via a supporting framework of Executive-led sub committees and management groups. This involves monthly consideration of an Integrated Performance Report (IPR) presenting RAG rated performance and exception narrative for national and local performance standards at a Trust and directorate level. From November 2018, reporting arrangements have included quarterly consideration of an Integrated Quality Report bringing together incidents, claims, inquests, patient

feedback, complaints, risk and clinical audit data.

- A deep dive analysis of performance on an agreed specific topic of interest presented to each Board of Directors meeting held in public.
- Open and honest culture of reporting of incidents, risks and hazards promoted by the Board of Directors and supported by structured processes including online reporting systems for incident reporting and the investigation of Serious Incidents.
- There are also clear and transparent processes for sharing lessons learned following investigation with reports shared at directorate and Trust-wide level through relevant committees and groups. Learning from complaints, clinical audits, external visits, inspections and accreditations and from patient feedback is also cascaded from 'ward to board', across clinical and non-clinical areas through the Safety and Risk Forum, the Safety and Risk Committee (formerly the Patient Safety and Risk Committee and Occupational Safety and Risk Committee) and the Healthcare Governance Committee.
- Observations of the quality of care undertaken through visits made by Board Members and Governors to clinical and non-clinical departments.

Assurance on Care Quality Commission (CQC) compliance

The Trust's risk and performance management arrangements inherently support the monitoring of ongoing compliance with the requirements for registration set by the CQC. Any risk to compliance identified through routine performance monitoring is escalated through the Trust's risk management framework and entered, as appropriate, onto the IRAR as a risk to the delivery of a Trust strategic aim.

A range of mechanisms is in place to monitor compliance with the CQC's five domains of safe, effective, caring, responsive and well-led.

The Board of Directors reviews a range of metrics on patient experience, clinical effectiveness and patient safety reported within the quarterly Integrated Quality Report presented to the Healthcare Governance Committee. This Committee also receives a monthly report on CQC compliance which provides updates on delivery of the Trust's own CQC action plans and reports the publication of findings from external CQC reviews and CQC national surveys.

The Trust was inspected by the CQC in June 2018 and maintained an overall rating of 'Good' with many services rated as 'Outstanding'. The inspection report identified some areas for improvement and a programme of work is in place to address these, with reporting of progress against this action plan integrated into the Trust's monitoring and assurance process and oversight provided by the Healthcare Governance Committee.

Well-led framework

The Board of Directors undertakes self-assessments against the 'well-led framework' (NHSI, June 2017) and uses this as a key instrument to critically evaluate the Trust's quality governance arrangements. The Trust's most recent review, undertaken in 2018/19, involved facilitated self-assessment supported by our internal auditors. Board member survey work and one-to-one interviews with lead Executive Directors complemented a desktop review of evidence and generated for discussion with the Board of Directors a baseline assessment of Trust compliance for each Key Line of Enquiry.

This review identified some clear areas for development. Focus was placed on these areas as part of preparation for the Trust's June 2018 Care Quality Commission (CQC) inspection and, in particular, the well-led assessment component. The Trust has progressed recommendations from each of these assessments, and from its own internal Board effectiveness review work, and is continually developing its leadership and governance arrangements.

Managing risks to data security

The reporting and management of both data and security risks are supported by ensuring that all employees of the Trust are reminded of their data security responsibilities through education and awareness. Information governance training forms part of mandatory training requirements. Regular reminders and lessons learned are shared through staff communications, including where identified as a requirement following local incident reviews and risk assessments.

In addition to mandatory staff training, a range of measures is used to manage and mitigate information risks, including, physical security, data encryption, access controls, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is taken annually as part of the data security and security and protection toolkit and further assurance is provided from internal audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Committee. This includes details of any personal data-related Serious Incidents, the Trust's annual Data Security and Protection Toolkit score and reports of other information governance incidents and audit reviews.

Information governance

There are robust and effective systems, procedures and practices in place to identify, manage and control information risks. Whilst the Board of Directors is ultimately responsible for information governance, it has delegated authority to the Information Governance Committee which is accountable to the Healthcare Governance Committee and is chaired by the Medical Director, (who is also the Trust's Caldicott Guardian). The Board appointed Senior Information Risk Owner (SIRO), is the Informatics Director.

The Information Governance Management Framework brings together all the statutory requirements, standards and best practice in conjunction with the Trust's Information Governance Policy and is used to drive continuous improvement in information governance across the organisation. The development of this framework is informed by the results from the Data Security and Security and Protection Toolkit assessment and by participation in the Information Governance Assurance Framework.

Supported by relevant policies and procedures, notably the Procedures for the Transfer of Person Identifiable Data (PID) and Other Sensitive and Confidential Information, and the Confidentiality - Staff Code of Conduct, the Trust has an ongoing programme of work to ensure that PID is safe and secure when it is transferred within and outside the organisation. The Internet - Acceptable Use Policy and the Confidentiality - Staff Code of Conduct have been reviewed and updated to ensure robust information governance in response to the changing use of social network sites.

All Trust laptops and USB data sticks issued to and used by staff are encrypted. The introduction of port control and an approved list of removable storage media are planned to be introduced as part of the actions to protect the Trust IT systems from malware and cyber-attack.

In accordance with the Information Asset Policy, a centralised major information asset register is in place which supports the role of the Trust's Information Asset Owners who report to the SIRO. Any concerns identified through the registration and management of the Information Assets will be pursued through the recognised and accepted managerial line. Failure to deal with a concern through that route will be taken up by the SIRO with the appropriate Information Asset Owner within the Trust.

There were no Serious Incidents relating to information governance classified as level two (2) during 2019/20.

Principal in-year risks

The principal risks to delivery of the Trust's strategic aims are recorded in the IRAR and monitored through the Board committee structure. The inclusion of relevant high level operational risks entered onto the Trust's Risk Register identifies current operational risks which could impact on the delivery of strategic aims. In 2019/20 Principal Risks described on the IRAR included:

- *Failure to create capacity in line with demand impacts on waiting times, safety and patient experience leading to underperformance against national quality and performance standards and impacts on patient outcomes.*

Increasing demand and constraints in clinical capacity for a number of specialties are impacting on the delivery of key targets.

Through our 'Making it Better' transformation programmes for improvement and sustained change we continue to streamline processes and work towards improving and sustaining performance against necessary thresholds. Alongside these workstreams, routine capacity and activity planning, including workforce planning for times of sustained operational pressures and our performance management, escalation and reporting arrangements involving operational reporting of quality, operational and patient experience key performance indicators support the mitigation of risks to providing patient centred care and the best clinical outcomes.

- *A national staffing shortage in key professions affects our ability to attract, recruit and retain a workforce sufficient in both numbers and capability to deliver safe, efficient care for our patients.*

As is the case across the NHS, a key challenge is recruiting sufficient numbers of appropriately qualified clinical staff in some professions and roles.

One example is in nursing where we continue to safely mitigate nurse vacancy levels through proactive reviews of staffing to ensure that each ward area is staffed according to real-time need and with reference to best practice staffing models. The Trust has also embarked on new models of working, for example, Integrated Wards initiative, enabling Therapists and Nurses to deliver collaborative care by sharing core competencies and skills. We are also undertaking continual recruitment for Registered Nurses and Midwives and trialling alternative methods to attract new employees. This includes an increased use of rotational roles, the trialling of one-stop-shop recruitment events, and improved clarity in how we promote the Trust as an employer of choice.

As part of the Trust's annual business planning cycle, the planning of our workforce identifies staffing pressures, proposed service changes and other factors affecting our workforce provision. A key element of our People Strategy is our Workforce Redesign, Innovation and Planning (WRIP) workstream.

- *Failure to care for patients in the appropriate setting and provide the right infrastructure to support safe, efficient and co-ordinated delivery of care could compromise patient outcomes and lead to services falling below reasonable public expectations.*

To mitigate the potential risk of poorly coordinated care across local patient pathways we are actively engaged in partnership working including the 'Why Not Home. Why Not Today?' Programme Board, the Delayed Transfer of Care Transformation Programme and the Urgent and Emergency Care Transformation and Delivery Board. During 2019/20 we have engaged external partner support to the Accident and Emergency Department to further improve overall performance. We are also developing the application of IT systems for improved patient flow monitoring to support oversight and assurance arrangements in place for the operational management of patient flow across the entire pathway of provision.

- *Failure to develop, resource and implement an effective IM&T Strategy impacts on our ability to harness the benefits of technology to support efficient delivery of healthcare and to effect necessary transformational change to deliver future models of care.*

During 2019/20 we began to plan for the procurement of a fully comprehensive

Electronic Patient Record to support digital and technological maturity. While this has had to be paused due to the COVID-19 outbreak, we plan to resume this workstream during 2020/21.

- *Failure to develop sustainable financial plans which deliver our income, efficiency and cost control targets and mitigate the impact of system-wide changes to national policy / planning guidance and commissioning arrangements, the financial stability of the Trust is threatened leading to potential regulatory intervention.*

Through robust financial controls and cost improvement plans we have ensured that we achieved our 2019/20 financial plan.

Other key risks during 2019/20

Temporary closure of Robert Hadfield Building

In last year's Annual Report we reported that the Trust had faced an unexpected risk in 2018/19 when the Robert Hadfield Building had to be temporarily closed and we had to temporarily relocate patients to other parts of the Trust. Over the last twelve months we have continued to mitigate the potential operational, workforce and financial risks associated with this. New wards have been built on site while rectification works take place and risk monitoring continues.

EU Exit

During 2019/20 the Trust put in place emergency planning arrangements in response to the UK leaving the European Union. Associated risks were identified relating to potential significant disruption to the supply of goods and services, in particular medicines and devices, as well as staff shortages.

COVID-19

The COVID-19 outbreak also had a significant impact in March 2020 and this will clearly carry on for much of 2020/21. As described above, the Trust's response to the COVID-19 pandemic is being managed through a full Major Incident Command and Control Structure within which risks relating to the Trust's ability to respond effectively to COVID-19 and its impact on the delivery of the Trust's services are being managed.

These provide examples of the Trust enacting its emergency preparedness, resilience and response arrangements. In respect of the COVID-19 pandemic, in particular, the Trust's emergency planning preparations have assisted the deployment of a prompt response to a significant change in circumstances. Immediate business continuity planning for COVID-19 extended to include a review of arrangements for Board assurance and governance. This was undertaken with acknowledgement that a strong system of governance, even in times of crisis is essential to ensure decision making continues to be undertaken within agreed frameworks. Approved by the Board of Directors in April 2020, these arrangements balance the need to ensure that resources are focused on necessary clinical and operational matters to enable safe and sustainable service delivery, while maintaining the robustness of decision making in a fast moving environment and providing the appropriate level of Board assurance

Major risks 2020/21

The principal strategic risks for the organisation in 2020/21 remain the same as for 2019/20 but clearly a significant additional factor will be the ongoing impact of COVID-19.

Maintaining quality of care

We know that delivering high quality care into 2020/21 while responding to and managing the impact of COVID-19 will require significant changes in the way we work. The provision of care and our interactions with our patients in the future is likely to be profoundly different from how it was before the emergence of this new virus and disease. A key focus for 2020/21 will be to carefully manage and develop this approach and our well embedded quality governance and leadership arrangements will be key to supporting this.

External environment

Our external strategic landscape continues to be driven by government policy, focused on the importance of managing systems rather than organisations, recognising the need to integrate services around the needs of the patient and the importance of out-of-hospital care.

We are actively engaged in regional partnership work. We will need to keep under review the financial risks and opportunities that arise from new collaborative working arrangements; in particular the implementation of shared governance and financial structures and the Board of Directors' focus continues to be placed on this.

National commissioning changes also present significant risk to the Trust and we will continue to review and manage the impact of financial pressures arising from our responses to these changes.

A further uncertainty is how leaving the European Union will impact on the Trust's strategy, partnerships, investments and commercial activities.

Delivery of transformation

Significant productivity and efficiency savings were again achieved in 2019/20 to underpin our financial and operational performance. 2020/21 will be a very different year in terms of transformation as we seek to redesign services to cope with the COVID-19 implications and support directorates to identify and deliver savings opportunities where this is still possible.

We continue to drive transformation through our 'Making it Better' improvement programme and also look to deliver benefits by working with other organisations within the South Yorkshire and Bassetlaw area.

Compliance and validity of the NHS Foundation Trust condition 4 (FT Governance): Corporate Governance Statement

The Board of Directors annually considers the Corporate Governance Statement with a view to confirming compliance with condition FT(4) of the provider licence. To assure validity of this statement, a schedule of evidence of compliance with each element of the declaration is prepared by the Trust Executive Group for review by the Board of Directors prior to final approval.

All statements were confirmed in the May 2020 review with no unmitigated risks to compliance identified.

The Trust believes that effective systems and processes are in place to maintain and monitor the following:

- The effectiveness of governance structures
- The responsibilities of Directors and Board committees
- Reporting lines and accountabilities between the Board of Directors, its committees and the Trust Executive Group
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence
- The degree and rigour of oversight the Board of Directors has over the Trust's performance.

Engagement with public stakeholders in risk management

The Trust engages public stakeholders in identifying and managing risks which may impact on them in a number of ways:

- As a Foundation Trust the organisation aims to make best use of its Membership and of its Council of Governors. Through relevant working groups, Governors are kept apprised of proposed changes, including how potential risks to patients will be minimised. We also take opportunities to engage the Council of Governors on key

issues and risks by consulting them on the development of our annual Operational Plan.

- Through a Quality Board, reporting into the Healthcare Governance Committee, which incorporates stakeholder membership including staff, Governors, Healthwatch Sheffield and voluntary and community sector representation.
- The Trust employs a wide range of methods to capture feedback from patients, their families and carers including comment cards, national and local surveys, social media, complaints, and the Friends and Family Test, acknowledging the value of this feedback as an early warning mechanism within its risk management processes.

Assurance that staffing processes are safe, sustainable and effective

Our staffing governance processes are safe, sustainable and effective and have been developed in line with National Quality Board guidance and recommendations within '*Developing Workforce Safeguards*', (NHSI 2018). This is to ensure that the Trust deploys sufficient suitably qualified, competent, skilled and experienced staff, that there is a systematic approach to determine staffing levels and that this reflects current legislation and guidance.

Optimal staffing on our wards and departments is critical to providing safe, high quality care to our patients. We keep staffing levels and skill mix under constant review to ensure that each ward area is staffed according to real-time need and with reference to best practice staffing models. The Trust's Nursing and Midwifery Staffing Escalation Policy clearly defines the dynamic systems and processes that function daily to ensure that any shortfalls in staffing are mitigated and these are further supported by daily nurse staffing meetings to consider plans for staffing over the next 24 hours and an on-site senior nurse 24 hours a day.

During 2019/20 we displayed both the actual and planned staffing levels on all our wards on a shift by shift basis, publishing this information on our website. In line with national guidance, an exception report is presented through the Human Resources and Organisational Development Committee to the Board of Directors setting out those wards where staffing capacity and capability fall short of the plan, the reasons for the gap and the impact and actions being taken to address it. From 2019/20, we have refreshed our monthly reporting to allow updated quality metrics to be triangulated with staffing deployment.

Continuous monitoring of patient outcomes and quality indicators inform establishing nurse staffing levels and we use a range of tools to do this including a nursing and midwifery quality dashboard and ward monitoring systems. Twice a year each inpatient clinical area assesses the care needs of patients in their ward / department, using an evidence-based tool to help determine the Nurse / Midwifery staffing required to provide safe, compassionate and effective care. In Nursing the tool is the Safer Nursing Care Tool (SNCT) and in Midwifery it is Birthrate+. Informed further by professional judgement and evaluation of outcome measures, this establishment review is reported twice a year through the Human Resources and Organisational Development Committee to the Board of Directors, with the most recent report presented in March 2020.

As part of the Trust's annual business planning cycle, the planning of our workforce identifies staffing pressures, proposed service changes and other factors affecting our workforce provision. In July 2018, the Trust launched its People Strategy; a key element of which is our Workforce Redesign, Innovation and Planning (WRIP) workstream. Any planned workforce redesign or introduction of new roles is the subject of a full quality impact assessment review. Examples of where impact assessment reviews have taken place have included the development of Nursing Associates and Physician Associate roles.

Recognising the value of all clinical staff the Trust regularly undertakes capacity and demand reviews to ensure the sufficiency of staff and has methods of escalation in place

should any concerns regarding staffing levels be raised. All identified risks are assessed and logged onto the Trust's Risk Register with mitigations put in place and closely monitored.

Recruiting sufficient numbers of appropriately qualified clinical staff, particularly nursing staff to be able to treat our growing number of patients, has been identified as a potential strategic risk to the delivery of the Trust's strategic aims and as such our IRAR provides a mechanism for escalation of operational staffing risks to be escalated to the Board of Directors.

Compliance statements

Care Quality Commission (CQC) compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) and its current registration status is unconditional. The CQC has not taken enforcement action against the Trust during 2019/20.

Register of Interests

The Trust has published on its website an up-to-date Register of Interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance[4] (NHSE, 2018).

This can be accessed at:
https://sheffieldthft.mydeclarations.co.uk/home

Pension scheme

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

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with including our commitment to implementing the Equality Delivery System 2 and our active and on-going participation in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

We have established an Equality, Diversity, and Inclusion (EDI) Board to oversee the development and implementation of the Trust's strategic approach to meeting the relevant duties and obligations set out in the Equality Act, 2010 and relevant NHS policy.

Comprising a diverse and broad membership, including senior leaders, and reporting into the Trust Executive Group, this Board oversees all EDI work carried out in respect of workforce, patients and service delivery.

Assessing the organisation's impact on the environment

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

We monitor the impact of the Trust's activities on the environment and through the delivery of our Board-approved Estates Strategy we continue to invest in major infrastructure schemes which reduce energy consumption and emissions.

Our plans to help identify waste reduction opportunities, deliver financial savings and reduce carbon emissions underpin Trust strategy for the development of our facilities and estate. Business plan documents describe our strategic approach to meeting our

[4] www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff -and-organisations/

statutory and mandatory obligations in respect of sustainable development.

Emergency preparedness, resilience and response

The Trust has a key role to play in responding to large scale emergencies and ensuring it can continue to deliver high quality patient services if a major and/or business continuity incident occurs. Throughout the year the emergency planning team has worked with the Emergency Services and other health and social care providers to ensure that the Trust is adequately prepared for any such event including, but not limited to, mass casualties, 'flu pandemic, utility failure, seasonal demand and city-wide public events. In the likelihood of such an event, the Trust is assured that appropriate plans and systems are in place to maintain services for patients.

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

The following processes are in place to ensure that resources are used economically, efficiently and effectively:

- Development of detailed plans through the annual planning cycle which reflect service and operational requirements and financial targets in respect of income and expenditure and capital investment and incorporate required efficiency savings.
- Monthly monitoring of delivery of the Board-approved financial plan and at Trust level by Board of Directors / Finance and Performance Committee and via a performance management / escalation framework incorporating directorate reviews led by the Trust Executive Group.
- Monthly reporting to the Board of Directors via its committees on key performance indicators including finance, efficiency savings, activity, capacity, quality, performance, human resource management and risk. These reports are aggregated from detailed directorate level reports which support active management of resources at operational level.
- As noted above, implementation of a robust performance management framework which is critical to the early identification of any variance from operational or financial plans and for ensuring effective corrective action is put in place. In giving particular, attention to financially challenged directorates, support is provided internally through the performance management framework with external input as required.
- Monitoring of the use of capital resources against a Board-approved capital plan by the Capital Investment Team which reports quarterly to the Board of Directors.
- The 'Making it Better' (MIB) transformation and improvement programme which aims to deliver the Trust's overall strategy, and in particular, maximise efforts on improvement and transformation to help secure improved quality and sustainable finances in a challenging context. A key element to this programme is the development of information and performance management systems, including use of the national Model Hospital and 'Getting it Right First Time' (GIRFT) metrics.
- A planned, systematic approach to improving organisational effectiveness through the alignment of strategy, people and processes. This has brought together a number of workstreams including equality, diversity and inclusion activities, service improvement, leadership and development and workforce redesign to form an Organisational Development function which the Trust recognises as being key to supporting the delivery of transformation.
- Continued work with partners supported by The Health Foundation to deliver its Microsystem Coaching Academy (MCA). Through this, the Trust has

developed staff members to become MCA trained coaches, equipped to use structured improvement methodologies to support frontline teams to understand their systems and processes and to identify and make improvements.

- The wider use of national and peer benchmarking to ensure best value for money in delivery of services by informing and guiding service redesign, leading to improvements in the service quality and patient experience as well as financial performance.
- Development of Service Line Reporting (SLR) and Patient Level Costing systems to better understand income and expenditure and various levels, therefore facilitating improved financial and operational performance. By also feeding into performance management and budget setting, SLR information informs the development of action plans to address deviation from directorate financial plans.
- Assessment of efficiency schemes for their impact on quality as part of a formal quality impact assessment process.

All of these arrangements / initiatives are underpinned by the Trust's Scheme of Reservation and Delegation of Powers approved by the Board of Directors setting out the decisions, authorities and duties delegated to officers of the Trust, and by the Trust's Standing Financial Instructions detailing the financial responsibilities, policies and procedures adopted by the Trust. These are designed to ensure that an organisation's transactions are carried out in accordance with the law, government policy and good practice in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The Board of Directors has gained assurance from the Audit Committee and the Finance and Performance Committee in respect of financial and budgetary management across the organisation. The Audit Committee receives, as standing items on its agenda, reports regarding losses, special payments and compensations, write-off of bad debts and contingent liabilities.

The Trust also makes use of both internal and external audit functions to support governance arrangements, deliver economic, efficient and effective use of resources and ensure that controls are effective. Internal audit continues to review systems and processes in place during the year and publishes reports detailing specific actions to ensure the economy, efficiency and effectiveness of the use of resources is maintained. The outcome of these reports and the recommendations therein are also graded according to their perceived level of risk to the organisation, therefore assisting prioritisation of management action.

During 2019/20 these have included internal audit reports on key financial systems – accounts payable, accounts receivable, recruitment, IT asset management, IT planning and contracting, stock management, beds management, pre-employment checks and medicines management. These have all been reported to the Audit Committee.

Assurance around the accuracy of data

Quality of performance information

The Trust's Data Quality Steering Group ensures a continued focus on data quality issues. In setting the direction of the Trust's Data Quality Programme and overseeing its delivery, this group receives regular progress reports from the Data Quality Operational Group and monitors Trust performance against the national Data Quality Maturity Index (DQMI).

The Group promotes whole organisation engagement in good data quality, receives and approves remedial action plans where lapses in data quality have occurred, and monitors action plan progress and effectiveness. Reporting into the Trust Executive Group and the Audit Committee, the Group undertakes regular reviews of strategic risks associated with data quality and escalates these as necessary.

Reviews of data quality and the accuracy, validity and completeness of Trust performance information are also considered by the Audit Committee through in-year review work undertaken by internal and external audit. During 2019/20 there has been focus within the internal audit plan on specific areas of data quality including a data quality review of ambulance handover data.

Programmes to improve data quality

The Trust has a number of programmes in place to improve data quality. These include:

- A well-established Electronic Patient Record and Data Quality Team to support and drive forward a coordinated data quality agenda across the organisation.
- Reporting dashboards to support improvement to data quality, including the Administrative Patient Safety Dashboard.
- Integration of Trust Systems Trainers within the Performance and Information function, to support users in learning from errors, and to further improve training to focus on data quality.
- Launch of the Administrative Profession Programme which aims to ensure all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

The Trust has strong governance arrangements in place for the management and oversight of elective waiting time data. The Elective Care Working Group meets on a monthly basis to review performance, service themes and data validation. A performance report, supported by operational reports, details the activities underway to ensure that elective waiting time data is accurate. Assurance is provided to the Waiting Times Performance Overview Group which also meets monthly.

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 their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Healthcare Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control has been reviewed and modified in the past year. The Trust committee structure provides balance between the three areas of quality, finance and performance management. Internal audit has been routinely used to clarify issues where assurance is required.

In accordance with NHS internal audit standards, the Head of Internal Audit is required to provide an overall annual opinion statement to the Trust, based upon, and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. This is one component that is taken into account in making this Annual Governance Statement.

The Trust has received a statement from its internal auditors that based on work undertaken in 2019/20, significant assurance can be given that there is generally a sound system of internal control, designed to meet

the Trust's objectives, and that controls are generally being applied consistently.

During 2019/20, 24 internal audit reports have been reported to the Audit Committee. No high risks issues have been identified from internal audit reports issued in 2019/20, although recommended actions are still being progressed to address two high risk actions which are outstanding from 2018/19 reports. These both relate audit work to review Mental Health Act Compliance and Mental Capacity Act Compliance and planned actions have been revised in-year to ensure that arrangements to ensure Trust policy compliance are aligned to recent updates to legislation in this area.

The Head of Internal Audit opinion statement also references a review of risk management arrangements undertaken in quarter four 2019/20 notes that the Trust has reviewed its framework for risk management in response to points raised by the CQC in November 2018 and internal audit work in 2019. The review acknowledges that the revised framework has been agreed and sets out a more transparent process for risk escalation and review for implementation throughout 2020/21..

In considering the internal audit statement and on presentation with internal audit reports across the course of the year, members of the Audit Committee have noted a number of internal audit reports issued with limited assurance opinions. Recommendations within the reports are welcomed by members of the Trust Executive Group. Focus continues to be placed on tracking actions against recommendations through reports submitted to the Audit Committee and the reporting arrangements in place across the committee structure supports the escalation of matters between committees.

Internal audit work has been supplemented by the External Audit reports which provide assurance on the Trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources as part of the value for money element of its annual audit work.

The Board of Directors also received assurances on the use of resources from outside agencies including NHS England and NHS Improvement (NHSE/I) and the CQC. NHSE/I require the Trust to self-assess on a monthly basis.

My review is also informed by:

- the Integrated Risk and Assurance Report
- regular Executive reporting to Board of Directors and escalation processes through the Board committees
- audit reports prepared independently by both the internal and external audit agencies. In particular, the ISA260 Audit Completion Report produced by Mazars LLP, our external auditor
- the published results of the quarterly performance management processes undertaken by NHSE/I under the Single Oversight Framework including the Trust's quarterly risk ratings and segmentation
- the Trust's compliance with annual performance indicators published by the Department of Health and Social Care
- ongoing compliance with CQC fundamental standards for all regulated activities across all Trust sites, as part of the registration process and reports on its visits and inspections, including the inspection report following their announced visit in June 2018
- external visits, inspections, accreditations and peer reviews
- clinical audit reports
- investigation reports and action plans following Serious Incidents and learning events and deep dive reviews
- user feedback such as monitoring of patient experience, complaints and claims
- national Patient Survey results including the Friends and Family Test
- the results of the NHS Staff Survey

Conclusion

The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the Annual Report and Accounts.

In summary, I am assured that the NHS Foundation Trust has an overall sound system of internal control in place, which is designed to manage the key organisational objectives and minimise the NHS Foundation Trust's exposure to risk. There are no significant control issues identified; however, actions are in place to address recommendations for improvement to this system made within internal audit reports issued with a limited assurance opinion. We also continue to review and update the governance assurance processes to further strengthen arrangements to ensure our services are well-led. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed

Kirsten Major
Chief Executive
12 June 2020

Auditor's Report

Independent auditor's report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit, and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue recognition The Trust recognised £1,197m of revenue from activities in the Statement of Comprehensive Income. The Trust's primary source of revenue is through contracts with commissioning bodies in respect of the provision of acute and community healthcare services. Notes 3.1 and 3.4 provide further information on the nature and source of the Trust's revenue. Auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting leading to material misstatement and means we are unable to rebut the presumption. We consider specific risks in relation to income recognition to be in the following areas: • recognition of income and receivables around the year end; and • recognition of Provider Sustainability Fund (PSF) income during the year. Furthermore, the Trust recognised additional income of circa £2m from the Department of Health and Social Care (DHSC), to fund the Trust's expenditure incurred to respond to the Covid-19 pandemic in 2019/20. We consider there to be a further specific risk in relation to this funding because of the incentive and opportunity to claim for the reimbursement of expenditure that is not Covid-19-related.	Our audit procedures included, but were not limited to: • evaluating the design and implementation of controls in place to mitigate the risk of income being recognised in the wrong year. • testing of a sample of income and year end receivables for accuracy and occurrence; • testing a sample of receipts in the pre and post year end period to ensure they have been recognised in the correct financial year; • reviewing intra-NHS reconciliations and data matches provided by the DHSC and challenging management and seeking direct confirmation from third parties as required; • testing of PSF income to year end confirmation from NHS Improvement; and • testing a sample of expenditure items for which the Trust has recognised additional funding from the DHSC to obtain assurance that these were correctly recorded as Covid-19-related expenditure items. There were no significant findings arising from our work on revenue recognition.
Land and building valuations Note 9 to the financial statements discloses information on the Trust's holding of property, plant and equipment (PPE) which includes £313m of land and buildings held at current value at 31 March 2020. Land and buildings are the Trust's highest value assets accounting for £313m of the Trust's £390m PPE balance. These assets are subject to periodic revaluation in line with the requirements of the Group Accounting Manual (GAM). Note 1.11 to the financial statements describes the Trust's accounting policy with respect to the valuation of land and buildings and Note 9 discloses further information on the balance.	Our audit procedures included, but were not limited to: • assessing the scope and terms of engagement with Cushman and Wakefield; • assessing how management use Cushman and Wakefield's report to value land and buildings in the financial statements; • reviewing the valuation methodology used, including testing the underlying data and assumptions; • assessing the competence, skills and objectivity of Cushman and Wakefield;

Key audit matter	Our response and key observations
Land and building valuations (continued) Management engages Cushman and Wakefield as an expert to assist in determining the current value of land and buildings to be included in the financial statements. Such valuations are subject to a significant degree of estimation and judgement. Changes in the value of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual. The significant risk of material misstatement is further increased due to the additional estimation uncertainty arising from the Covid-19 pandemic and Note 9.7 of the financial statements discloses a 'material valuation uncertainty' in relation to this uncertainty.	• considering the reasonableness of the valuation by comparing the valuation output with market intelligence and challenging the Trust and the valuer where required; and • assessing the effect of the valuation uncertainty disclosed by the Trust's valuer and the adequacy of disclosure in Note 9.7 of the financial statements. There were no significant findings arising from our work on the valuation of land and buildings.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£20m
Basis for determining materiality	Approximately 1.8% of operating expenses from continuing operations
Rationale for benchmark applied	Operating expenses from continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.
Performance materiality	£16m
Reporting threshold	£0.3m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items. There were no changes to the scope of the current year audit from the scope in the prior year.

Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year;
- discussions with the Trust's internal auditor; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud (other than the Key Audit Matter on revenue recognition outlined above). The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under 'Key audit matters' within this report.

Other information

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

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

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2019/20; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2019/20; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

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

Certificate

We certify that we have completed the audit of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mark Dalton,

Key Audit Partner
For and on behalf of Mazars LLP

5th Floor,
3 Wellington Place
Leeds
LS1 4AP

16 June 2020

Financial Statements

Foreword to the accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2020 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, operating as NHS Improvement, has, with the approval of the Secretary of State for Health, directed, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of that Act.

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Signed

Kirsten Major
Chief Executive
12 June 2020

Statement of comprehensive income for the year ending 31 March 2020

	Note	2019/20 £'000	2018/19 £'000
Operating Income from continuing operations	3.1	1,197,065	1,135,341
Operating Expenses from continuing operations	4.1	(1,203,960)	(1,129,579)
OPERATING (DEFICIT) / SURPLUS		**(6,895)**	**5,762**
Finance Costs:			
Finance income	7.1	881	646
Finance expense - financial liabilities	7.2	(2,946)	(3,034)
Finance income / (expense) - unwinding of discount on provisions	19	16	(9)
Public Dividend Capital Dividends payable	29	(8,032)	(8,991)
Net Finance Costs		**(10,081)**	**(11,388)**
Gains on disposal of assets		408	65
(DEFICIT) FROM CONTINUING OPERATIONS		**(16,568)**	**(5,561)**
Other comprehensive income:			
Impairments		(3,235)	(12,928)
Revaluation		1,094	19,434
Other reserve movements		0	1
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(18,709)**	**946**

The notes on pages 88 to 123 form part of these accounts.

All income and expenditure is derived from continuing operations, and the deficit is attributable to the owners of the Trust (the Taxpayer).

Statement of financial position

	Note	31 March 2020 £'000	31 March 2019 £'000
Non-current assets:			
Intangible assets	8.1 & 8.2	6,858	8,402
Property, plant and equipment	9.2	390,019	391,218
Investments	11	0	0
Trade and other receivables	13.2	6,343	6,268
Total non-current assets		**403,220**	**405,888**
Current assets:			
Inventories	12.1	14,672	13,812
Trade and other receivables	13.1	64,645	68,532
Current asset investments	14	0	0
Cash	21	90,775	94,033
Total current assets		**170,092**	**176,377**
Current liabilities:			
Trade and other payables	15.1	(110,752)	(104,281)
Borrowings	16.1	(2,465)	(2,427)
Provisions due within one year	19	(2,974)	(2,983)
Other liabilities	17.1	(19,539)	(15,866)
Total current liabilities		**(135,730)**	**(125,557)**
Total assets less current liabilities		**437,582**	**456,708**
Non-current liabilities:			
Borrowings	16.2	(35,075)	(36,873)
Provisions due after one year	19	(3,127)	(2,975)
Other liabilities	17.2	(1,324)	(2,169)
Total non-current liabilities		**(39,526)**	**(42,017)**
TOTAL ASSETS EMPLOYED		**398,056**	**414,691**
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		331,634	329,560
Revaluation reserve	20	35,179	38,370
Income and expenditure reserve		31,243	46,761
TOTAL TAXPAYERS' EQUITY		**398,056**	**414,691**

The financial statements on pages 83 to 123 were approved by the Board on 12 June 2020 and were signed on behalf of the Board by

Kirsten Major, Chief Executive

Date: 12 June 2020

Statement of changes in Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
		£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2019		414,691	329,560	38,370	46,761
(Deficit) for the year		(16,568)			(16,568)
Transfers between reserves	20	0		(1,050)	1,050
Impairments	20	(3,235)		(3,235)	
Revaluation gains on property, plant and equipment	20	1,094		1,094	
Public Dividend Capital received		2,074	2,074		
Other Reserve Movements		0			0
Taxpayers' Equity at 31 March 2020		**398,056**	**331,634**	**35,179**	**31,243**
Taxpayers' Equity at 1 April 2018		413,447	329,262	32,949	51,236
(Deficit) for the year		(5,561)			(5,561)
Transfers between reserves	20	0		(1,085)	1,085
Impairments	20	(12,928)		(12,928)	
Revaluation gains on property, plant and equipment	20	19,434		19,434	
Public Dividend Capital received		298	298		
Other Reserve Movements		1			1
Taxpayers' Equity at 31 March 2019		**414,691**	**329,560**	**38,370**	**46,761**

Statement of Cash Flows

	Note	2019/20 £'000	2018/19 £'000
Cash flows from operating activities			
Operating (deficit) / surplus from continuing operations		(6,895)	5,762
Non-cash income and expenditure:			
Depreciation and amortisation	4.1	23,295	23,608
Net Impairments	4.1	23,064	33,480
Income recognised in respect of capital donations (cash and non-cash)	3.1	(1,013)	(1,387)
Decrease / (Increase) in Trade and other Receivables		3,532	(17,027)
(Increase) in Inventories		(860)	(640)
Increase in Trade and other Payables		5,208	8,652
Increase in Other Liabilities		2,828	1,612
Increase in Provisions		159	2,295
Other operating cashflows		(367)	(1,212)
Net cash generated from operations		**48,951**	**55,143**
Cash flows from investing activities:			
Interest received		909	624
Purchase of investments		(595,000)	(105,000)
Proceeds from settlement of investments		595,000	105,000
Purchase of intangible assets		(865)	(1,209)
Purchase of Property, Plant and Equipment		(42,300)	(24,682)
Sales of Property, Plant and Equipment		408	65
Receipt of Cash Donations to purchase capital assets		367	1,212
Net cash used in investing activities		**(41,481)**	**(23,990)**
Cash flows from financing activities:			
Public Dividend Capital received		2,074	298
Loans repaid		(1,445)	(1,446)
Capital element of finance lease rental payments		(417)	(456)
Capital element of Private Finance Initiative obligations		(574)	(624)
Interest paid		(935)	(997)
Interest element of finance lease		(65)	(72)
Interest element of Private Finance Initiative obligations		(1,949)	(1,967)
Public Dividend Capital Dividend paid		(7,865)	(8,476)
Cash flows from other financing activities		448	1,706
Net cash used in financing activities		**(10,728)**	**(12,034)**
(Decrease) / Increase in cash and cash equivalents		**(3,258)**	**19,119**
Cash and Cash equivalents at 1 April	21	94,033	74,914
Cash and Cash equivalents at 31 March	21	**90,775**	**94,033**

Accounting policies for the year ending 31 March 2020

1. Accounting policies

NHS Improvement in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2019/20, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.2 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 and certain financial assets and financial liabilities.

1.3 Basis of consolidation

With effect from 1 April 2017, Sheffield Hospitals Charity became an independent charity, rather than being an NHS Charity. The Trust has established that it is not a corporate Trustee of any of its supporting or linked Charities and does not have the power to exercise control so as to obtain economic benefits, meaning consolidation is not appropriate. Additionally the transactions and balances are immaterial in the context of the Trust operations.

The Trust has a number of minor interests (<£400k) in the following entities, none of which are material to the Trust's operations, and are thus not consolidated on the grounds of materiality:

Name	Nature of Relationship
Epaq Systems Ltd	Minor share-holding in low net worth company
Zilico	Minor share-holding in low net worth company
Elaros 24/7 Ltd	Minor share-holding in low net worth company
Better Hygiene Ltd (formerly Wetwash Ltd)	Minor share-holding in low net worth company
Devices for Dignity Ltd	No return to the Trust
Medipex Ltd	No return to the Trust
Legacy Park Ltd	No return to the Trust

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

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

• Basis of consolidation/Interests in other entities – see note 1.3.

1.4.2 Sources of estimation uncertainty

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

• Plant, property and equipment valuations and useful economic lives

The Trust has used valuations carried out at 31 March 2020 by its expert valuers to determine the value of property. These property valuations and useful lives are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health and Social Care. Further details are provided in paragraph 1.11 and note 9.5 of the accounts.

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

• Revenue estimates

Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on agreements with the main commissioning bodies. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so. Further details are provided in paragraph 1.5.

• Estimation of payments for the PFI and service concession assets, including finance costs

The assets and liabilities relating to the PFI scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health and Social Care's financial model as required by the Department of Health and Social Care guidance. The models also provide estimates for interest payable and contingent rent as disclosed in note 18 of the accounts.

• Impairment of receivables

The Trust is required to judge when there is sufficient evidence to impair individual receivables; this is undertaken on the aged profile and class of the receivable. The Trust adopts a prudent policy of increasing the expected credit loss, with the increasing ageing of the receivable. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so. Further details are provided in paragraph 1.24 and note 13.3 of the accounts.

• Provisions

Provisions are a matter of judgement, with a best estimate made based information available at the time. Once realised, provisions can be different to the original estimate, but not materially so. Further details are provided in paragraph 1.20 and note 19 of the accounts.

1.5 Revenue

In the application of IFRS 15 (Revenue from contracts with customers) a number of practical expedients offered in the Standard have been employed. These are as follows;

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

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the

year end, revenue relating to the partially completed spell is accrued on a basis agreed with the main commissioning bodies.

Where income is received for a specific performance obligation that is to be satisfied in the following financial year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is based on the average speciality tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.

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.

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

1.6 Employee benefits

1.6.1 Short-term employee benefits

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

1.6.2 Retirement benefit costs NHS pensions

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years with approximate assessments in intervening years.

The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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%, and the Scheme Regulations were amended accordingly.

Details of the benefits payable under, and rule of, the NHS Pension Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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

1.8 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT.

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

1.10 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their activities.

1.11 Property, plant and equipment

1.11.1 Recognition

Property, Plant and Equipment is capitalised if:

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

Property, plant and equipment assets are also capitalised where they form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

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

1.11.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus (with no plan to bring it back into use) are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

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

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

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

expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income /net expenditure in the Statement of Comprehensive Income.

1.11.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

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.

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are set out in note 9.5 to the accounts.

1.12 Intangible assets

1.12.1 Recognition

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

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

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for Property, Plant and Equipment.

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in note 8.4 to the accounts.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated / amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their

estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 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.

1.16.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.16.2 The Trust as lessor

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.

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.

1.17 Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance

with IAS 17, the underlying assets are recognised as Property, Plant and Equipment at their current value, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.17.1 Services received

The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.17.2 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is firstly apportioned to service charges and life cycle costs and the residual amount is treated as contingent rent and is expensed as incurred.

1.17.3 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) cost formula.

1.19 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.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018/19: positive 0.29%) in real terms.

All general provisions are subject to four separate (nominal) discount rates according to the expected timing of cash-flows from the Statement of Financial Position date:

Period	Period Definition for expected cash flows	2019/20 Nominal Rate (%)	2018/19 Nominal Rate (%)
Short term	Up to and including 5 years	+0.51%	+0.76%
Medium term	Over 5 years and up to and including 10 years	+0.55%	+1.14%
Long term	Over 10 years and up to and including 40 years	+1.99%	+1.99%
Very long term	Exceeding 40 years	+1.99%	+1.99%

1.21 Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 19, but is not recognised in the Trust's accounts.

1.22 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 as and when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed (in note 24.1), unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed (in note 24.2) where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 Financial assets

Recognition and de-recognition, measurement and classification

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices where possible.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

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

1.24.2 Financial assets at fair value through other comprehensive income

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

1.24.3 Financial assets at fair value through profit and loss

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

1.24.4 Impairment

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

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

Invoiced contract receivables and Non-invoiced contract receivables are largely with other public sector bodies where the risk of credit losses are low and where income and receivable balances are subject to nationally agreed processes and timetables as outlined below. Credit losses on other contract assets, which are not material, are assessed on a case by case basis as relevant and appropriate.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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

1.25 Financial liabilities

Recognition and de-recognition, and measurement

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.25.1 Financial liabilities at fair value through profit and loss

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

1.25.2 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans, that would be the nominal rate charged on the loan.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets)
- any assets procured in relation to COVID-19 activity
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

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

1.27 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling (the functional currency) at the spot exchange rate on the date of the transaction.

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 27 to the accounts.

1.29 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the

Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.30 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entities' accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the new assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.31 Early adoption of standards, amendments and interpretations

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

1.32 Accounting standards that have been issued but have not yet been adopted

1.32.1 IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the 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 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

1.32.3 IFRS 17 Insurance Contracts

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, with adoption by the FReM from 1 April 2023: early adoption is not therefore permitted. The Trust does not expect the adoption of this standard to have a material impact on the Accounts of the Trust.

2. Segmental analysis

The Trust has determined that the Chief Operating decision maker (as defined by IFRS8: Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

The Board reviews the operating and financial results of the Trust on a monthly basis and considers the position of the Trust as a whole in its decision making process, rather than as individual components which comprise the total, in terms of allocating resources. Consequently the Board of Directors considers that all the Trust's activities fall under the single segment of provision of healthcare, and no further segmental analysis is therefore required.

3. Income

3.1 Operating income from activities (by nature)

	2019/20	2018/19
	£'000	£'000
Operating income from activities		
Elective income	180,952	173,699
Non Elective income	219,557	199,066
Outpatient income	127,316	121,166
A&E Income	25,396	22,890
Other NHS Clinical income*	366,237	335,215
Income re Community Services	67,880	67,171
Private Patient Income	3,328	3,374
Additional Pension Contribution**	28,536	0
Agenda For change Pay Award Central Funding	0	11,244
Total operating income from activities	**1,019,202**	**933,825**
Other operating income		
Research and development	38,564	41,302
Education and training	52,643	53,638
Received from NHS Charities - Donation of physical assets (non-cash)	0	0
Received from other bodies - Cash donations for capital acquisitions	160	63
Received from NHS Charities - Receipt of grants / donations for capital acquisitions	207	1,149
Received from other bodies - Receipt of grants / donations for capital acquisitions	646	175
Non-patient care services to other bodies	56,507	51,609
Provider Sustainability Funding income	15,440	40,100
Other***	12,645	12,497
Operating lease income	1,051	983
Operating lease income - contingent rent	0	0
Total other operating income	**177,863**	**201,516**
Total operating income	**1,197,065**	**1,135,341**

**Other NHS Clinical Income consists mainly of high cost drugs (£151,433k), Non drugs cost per case income (£31,178k), Critical Care Income (£47,121k), COVID-19 funding (£2,038k), with the balance of £134,467k relating to sundry block contract income across a range of specialties.*

***The recent revaluation of public sector pensions schemes resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.*

However in 2019/20 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf.

**** Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites. The largest individual components (covering 54% of the other total income) relate to the provision of car-parking, catering and nursery facilities.*

3.2 Income from Commissioner related services

Commissioner related services for the year totalled £1,066,217k (2018/19 £979,440k).
Non Commissioner related services were £130,848k (2018/19 £155,901k).

3.3 Operating lease income

	2019/20 £'000	2018/19 £'000
Rents recognised as income in the period	1,051	983
Contingent rents recognised as income in the period	0	0
	1,051	**983**

Future minimum lease payments due	**2019/20 £'000**	**2018/19 £'000**
Re land		
- not later than one year;	38	29
- later than one year and not later than five years;	150	108
- later than five years.	715	269
Total	**903**	**406**
Re buildings		
- not later than one year;	763	870
- later than one year and not later than five years;	2,694	2,805
- later than five years.	4,893	5,518
Total	**8,350**	**9,193**
Total - all categories		
- not later than one year;	801	899
- later than one year and not later than five years;	2,844	2,913
- later than five years.	5,608	5,787
Total	**9,253**	**9,599**

3.4 Operating income from activities (by source)

	2019/20 £'000	2018/19 £'000
Clinical Commissioning Groups and NHS England*	1,004,415	907,574
NHS Foundation Trusts	82	83
NHS Trusts	1	0
Department of Health and Social Care (DHSC)	710	11,244
Local Authorities	5,095	5,064
NHS Other	2,149	1,887
Non NHS: Private patients	2,426	2,726
Non NHS: Overseas patients (non-reciprocal)	902	648
NHS injury scheme (formerly the Road Traffic Act Scheme)	3,029	4,219
Non NHS: Other**	393	380
Total operating income from activities by source	**1,019,202**	**933,825**

**The recent revaluation of public sector pensions schemes resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.*

However in 2019/20 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf.

***Non NHS Other income from activities comprises income from prescription charges.*

3.5 Overseas Visitors (relating to patients charged directly by the Trust)	2019/20 £'000	2018/19 £'000
Income recognised in year	902	648
Cash payments received in year (relating to invoices raised in current and previous years)	167	340
Amounts added to provision for impairment of receivables (relating to invoices raised in current and previous years)	484	232
Amounts written off in year (relating to invoices raised in current and previous years)	6	97

4. Operating expenses

4.1 Operating expenses by nature:

	2019/20 £'000	2018/19 £'000
Purchase of Healthcare from NHS and DHSC Bodies	20,239	20,014
Purchase of Healthcare from non NHS and DHSC bodies	24,347	22,549
Staff and Executive Directors' costs*	727,152	663,386
Non-Executive Directors' costs	178	178
Drugs costs	167,974	155,278
Supplies and services – clinical	100,591	98,409
Supplies and services - general	8,338	8,142
Establishment	9,025	8,549
Research and Development	24,513	29,501
Transport	987	929
Premises	42,809	39,313
Movement in credit loss allowance	840	505
Change in provisions discount rate	239	(42)
Depreciation on property, plant and equipment	20,605	20,725
Amortisation of intangible assets	2,690	2,883
Net Impairments of property, plant and equipment	23,029	33,420
Net Impairments of intangible assets	35	60
Operating lease costs	952	960
Audit services - statutory audit (Note 4.2)	54	54
Other auditor remuneration - audit related assurance purposes - quality report review (Note 4.2)	2	9
Clinical negligence	18,044	13,699
Legal fees	1,414	1,486
Consultancy costs	1,638	1,038
Internal audit costs	159	154
Training, courses and conferences	3,448	3,224
Redundancy	45	238
Charges to operating expenditure for on-SoFP for IFRIC 12 Schemes	649	633
Insurance	446	781
Other Services	2,930	2,737
Losses, ex gratia & special payments	29	29
Other	559	738
Total operating expenses	**1,203,960**	**1,129,579**

**The recent revaluation of public sector pensions schemes resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.*

However in 2019/20 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf.

4.2 Auditor's liability	2019/20 £'000	2018/19 £'000
Limitation on Auditor's liability	Unlimited	Unlimited

An analysis of the work of the Auditors and the associated fees for the respective work is included above and on page 53 of the Annual Report. Fees and Remuneration above are stated inclusive of VAT.

4.3 Arrangements containing an operating lease - current year expenditure	2019/20 £'000	2018/19 £'000
Minimum lease payments	1,450	1,174
Contingent rents	0	0
Less sub-lease payments received	(498)	(214)
Total	**952**	**960**

4.4 Arrangements containing an operating lease - future years' commitments	2019/20 £'000	2018/19 £'000
Future minimum lease payments due:		
Within 1 year	1,889	1,210
Between 1 and 5 years	4,002	2,266
After 5 years	1,086	265
Total	**6,977**	**3,741**

5. Staff costs

5.1 Employee expenses	2019/20 £'000	2018/19 £'000
Salaries and wages	569,542	541,262
Social Security Costs	49,464	46,990
Apprenticeship Levy	2,669	2,545
Employer contributions to NHSPA	65,293	62,428
*Pension Cost - employer contribution paid by NHSE on providers' behalf	28,536	0
Other pension costs	400	230
Agency / contract staff	11,248	9,931
Total	**727,152**	**663,386**

**The recent revaluation of public sector pensions schemes resulted in a 6.3% increase (14.38% to 20.68% including administration levy) in the employer contribution rate for the NHS Pensions Scheme. A transitional approach was agreed whereby an employer rate of 20.68% applies from 1 April 2019.*

However, in 2019/20 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf.

The above figure of £727,152k is net of the amount of £1,071k (2018/19 £1,435k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1).

Further details of staff numbers and costs can be found within the Staff Report on pages 41 and 42 of the Annual Report.

5.2 Early retirements due to ill health

	2019/20	2018/19
	Number	Number
Number of early retirements agreed on the grounds of ill health	12	11
	£'000	£'000
Cost of early retirements agreed on grounds of ill health	659	827

These costs were borne by the NHS Pensions Agency.

6. Performance on payment of debts

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against this code is set out below:

	2019/20	2018/19
	Number	Number
Number of non NHS invoices paid	219,424	215,342
Number of non NHS invoices paid within 30 days	211,606	206,235
Percentage of invoices paid within 30 days	96.44%	95.77%
	£'000	£'000
Value of non NHS invoices paid	453,515	410,976
Value of non NHS invoices paid within 30 days	435,759	396,843
Percentage of invoices paid within 30 days	96.08%	96.56%
Amounts included within Interest Payable (Note 7.2) arising from claims made under the Late Payment of Debts (Interest) Act 1998	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

7. Financing

7.1 Finance income

	2019/20	2018/19
	£'000	£'000
Bank account interest	550	601
Investment interest	331	45
Total	**881**	**646**

7.2 Finance costs – interest expense

	2019/20	2018/19
	£'000	£'000
Capital loans from the Department of Health and Social Care	932	996
Finance Lease interest	65	72
Finance costs in PFI obligations		
Main Finance Costs	1,088	1,125
Contingent Finance Costs	861	841
Total	**2,946**	**3,034**

7.3 Impairment of assets

	2019/20	2018/19
	£'000	£'000
Loss or damage from normal operations	326	151
Abandonment of assets in course of construction	44	93
Changes in market price	23,188	55,754
Reversal of impairments	(494)	(22,518)
Net impairments charged to operating expenses	**23,064**	**33,480**

During 2018/19, the above value includes impairment charges in relation to the Hadfield block.

8. Intangible non-current assets

8.1 Intangible non-current assets 2019/20

	Total	Intangible assets under construction	Software Licenses
	£'000	£'000	£'000
Gross cost at 1 April 2019	20,015	0	20,015
Additions - purchased / internally generated	1,181	0	1,181
Impairments charged to operating expenses	(22)	0	(22)
Additions – donated	0		0
Reclassifications	0	0	0
Disposals	0		0
Gross cost at 31 March 2020	**21,174**	**0**	**21,174**
Amortisation at 1 April 2019	11,613		11,613
Provided during the year	2,690		2,690
Impairments	13		13
Reversal of Impairments credited to operating expenses	0		0
Reclassification	0		0
Disposals	0		0
Amortisation at 31 March 2020	**14,316**	**0**	**14,316**
Net Book Value at 31 March 2020	**6,858**	**0**	**6,858**

8.2 Intangible non-current assets 2018/19

	Total	Intangible assets under construction	Software Licenses
	£'000	£'000	£'000
Gross cost at 1 April 2018	18,719	0	18,719
Additions - purchased / internally generated	1,619	1,613	6
Impairments charged to operating expenses	(61)	(61)	0
Additions – donated	0		0
Reclassifications	0	(1,552)	1,552
Disposals	(262)		(262)
Gross cost at 31 March 2019	**20,015**	**0**	**20,015**
Amortisation at 1 April 2018	8,993		8,993
Provided during the year	2,883		2,883
Impairments	3		3
Reversal of Impairments credited to operating expenses	(4)		(4)
Reclassification	0		0
Disposals	(262)		(262)
Amortisation at 31 March 2019	**11,613**	**0**	**11,613**
Net Book Value at 31 March 2019	**8,402**	**0**	**8,402**

8.3 Analysis of intangible non-current assets

	2019/20	2018/19
	£'000	£'000
Net Book Value		
- Purchased	6,857	8,399
- Donated	1	3
Total 31 March	**6,858**	**8,402**

8.4 Economic life of intangible non-current assets

	Min Life Years	Max Life Years
Software licences	5	8

9 Property, Plant and Equipment - Non-Current Assets

9.1 Property, Plant and Equipment 2019/20

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2019	520,861	11,187	317,904	2,093	13,437	137,282	1,232	26,824	10,902
Additions - purchased	43,475	0	1,620	0	37,279	3,060	63	1,290	163
Additions - leased assets	88	0	0	0	0	0	0	88	0
Additions - donated	646	0	0	0	0	646	0	0	0
Additions - assets purchased from cash donations	367	0	0	0	204	144	0	0	19
Impairments charged to operating expenses	(23,235)	0	(23,188)	0	(44)	0	0	(3)	0
Impairments charged to revaluation reserve	(3,235)	0	(3,235)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	494	0	494	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	24,533	0	(28,073)	2,513	0	459	568
Revaluations	(16,134)	0	(16,134)	0	0	0	0	0	0
Disposals	(4,839)	0	0	0	0	(2,762)	(75)	(891)	(1,111)
Cost or valuation at 31 March 2020	**518,488**	**11,187**	**301,994**	**2,093**	**22,803**	**140,883**	**1,220**	**27,767**	**10,541**
Accumulated Depreciation at 1 April 2019	129,643	0	8,652	95	0	90,357	993	22,797	6,749
Provided during the year	20,605	0	8,888	64	0	9,343	69	1,379	862
Impairments charged to operating expenses	296	0	0	0	0	296	0	0	0
Reversal of impairments credited to operating expenses	(8)	0	0	0	0	(8)	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	(17,228)	0	(17,107)	(121)	0	0	0	0	0
Disposals	(4,839)	0	0	0	0	(2,762)	(75)	(891)	(1,111)
Depreciation at 31 March 2020	**128,469**	**0**	**433**	**38**	**0**	**97,226**	**987**	**23,285**	**6,500**

9.2 Analysis of Property, Plant and Equipment

Net book value									
- Purchased at 31 March 2020	359,671	10,516	276,280	1,639	22,760	40,048	233	4,400	3,795
- Finance Leases at 31 March 2020	928	0	0	0	0	856	0	72	0
- PFI at 31 March 2020	1,746	0	1,746	0	0	0	0	0	0
- Government granted assets at 31 March 2020	2,656	0	2,648	0	0	0	0	0	8
- Donated at 31 March 2020	25,018	671	20,887	416	43	2,753	0	10	238
Total at 31 March 2020	**390,019**	**11,187**	**301,561**	**2,055**	**22,803**	**43,657**	**233**	**4,482**	**4,041**

The Trust has undertaken a full site revaluation of the land and property estate at 31st March 2020 based on an alternative site valuation model with its expert advisors, Cushman & Wakefield as members of the Royal Institute of Chartered Surveyors, providing an updated valuation estimation which is compliant with RICS standards. See also note 9.7.

9 Property, Plant and Equipment - Non-Current Assets

9.3 Property, Plant and Equipment 2018/19

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2018	547,624	10,097	336,449	1,880	23,040	137,429	1,151	26,955	10,623
Additions - purchased	21,354	36	1,989	0	17,248	1,487	109	59	426
Additions - donated	175	0	0	0	0	175	0	0	0
Additions - assets purchased from cash donations	1,212	0	11	0	174	1,027	0	0	0
Impairments charged to operating expenses	(55,786)	(1,536)	(54,095)	(123)	(32)	0	0	0	0
Impairments charged to revaluation reserve	(12,944)	(288)	(12,316)	(340)	0	0	0	0	0
Reversal of impairments credited to operating expenses	22,518	1,194	21,173	151	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	16	0	16	0	0	0	0	0	0
Reclassifications	0	0	20,821	33	(26,993)	3,590	0	1,557	992
Revaluations	6,033	1,684	3,857	492	0	0	0	0	0
Disposals	(9,341)	0	(1)	0	0	(6,426)	(28)	(1,747)	(1,139)
Cost or valuation at 31 March 2019	520,861	11,187	317,904	2,093	13,437	137,282	1,232	26,824	10,902
Accumulated Depreciation at 1 April 2018	131,508	0	13,332	146	0	87,112	948	23,002	6,968
Provided during the year	20,725	0	8,607	64	0	9,534	73	1,542	905
Impairments recognised in operating expenses	152	0	0	0	0	137	0	0	15
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other Revaluations	(13,401)	0	(13,286)	(115)	0	0	0	0	0
Disposals	(9,341)	0	(1)	0	0	(6,426)	(28)	(1,747)	(1,139)
Depreciation at 31 March 2019	129,643	0	8,652	95	0	90,357	993	22,797	6,749

9.4 Analysis of Property, Plant and Equipment

Net book value									
- Purchased at 31 March 2019	358,492	10,516	281,617	1,593	13,371	43,284	234	4,015	3,862
- Finance Leases at 31 March 2019	1,199	0	0	0	0	1,199	0	0	0
- PFI at 31 March 2019	2,587	0	2,587	0	0	0	0	0	0
- Government granted assets at 31 March 2019	2,806	0	2,793	0	0	0	0	0	13
- Donated at 31 March 2019	26,134	671	22,255	405	66	2,442	5	12	278
Total at 31 March 2019	391,218	11,187	309,252	1,998	13,437	46,925	239	4,027	4,153

9.5 Economic life of property, plant and equipment

	Minimum Life (Years)	Maximum Life (Years)
Land	Infinite	Infinite
Buildings excluding dwellings	0	58
Dwellings	17	28
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	10	10

9.6 Non-property valuations

Depreciated historical cost is the basis for determining fair value for the Trust's non-property assets. This is not considered to be materially different from fair value.

9.7 Property valuations

Net book value of assets covered by valuation method	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000
Modern Equivalent Asset (no Alternative Site)	0	0	0
Modern Equivalent Asset (Alternative Site)	11,187	301,561	0
Market value in existing use	0	0	2,055
Fair value (surplus PPE land and buildings)	0	0	0
Total at 31 March 2020	**11,187**	**301,561**	**2,055**

The Trust has undertaken a revaluation of the land and property estate at 31st March 2020 based on an alternative site valuation model with its expert advisors providing an updated valuation estimation which is compliant with RICS standards. (See also note 9.1)

The valuation exercise was carried out in March 2020 with a valuation date of 31st March 2020. In applying the Royal Institute of Chartered Surveyors (RCIS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in the markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

10. Non-current assets for sale and assets in disposal groups 2019/20

There were no non-current assets for sale and assets in disposal groups in either financial year.

11. Non-current assets investments

The Trust has holdings in the following companies that are commercially developing intellectual property. The Trust's holdings in these companies carry a minimal value (less than £100k) at the Statement of Financial Position date (31 March 2020 and 31 March 2019). None of the entities are material to the Trust's operations, nor classified as subsidiaries, associates or joint ventures under relevant accounting standards.

Companies in which the Trust owns shares	**Shareholding**
Epaq Systems Ltd	43.59%
Elaros 24/7 Ltd	11.90%
Better Hygiene Ltd (Formerly Wetwash Ltd)	5.00%
Zilico ltd	3.86%

Companies limited by guarantee	
Devices for Dignity Ltd	Member
Medipex Ltd	Member
Olympic Legacy Park Ltd	Member

12. Inventories

12.1 Inventories by category

	2019/20 £'000	2018/19 £'000
Drugs	6,336	5,829
Energy	315	304
Other (implantable devices, etc.)	8,021	7,679
Total Inventories	**14,672**	**13,812**

12.2 Inventories recognised in expenses

	2019/20 £'000	2018/19 £'000
Inventories recognised in expenses *	290,504	279,783
Write down of inventories recognised as an expense	62	64
Total inventories recognised in expenses	**290,566**	**279,847**

** Comparative restated for consumption in 2018/19.*

Given the social distancing restrictions brought about by COVID-19 at 31st March 2020, physical stock-counts in most areas were not performed at the year-end date. However, individual areas of significant stock-holding are managed by electronic stock systems (and account for over half of the inventory year-end balance). These systems are subject to regular physical reconciliation checks during the year, ensuring robust reliance can be placed on system counts. The Trust held no inventory for Nightingale Hospitals at the 31st March 2020, nor had any significant inventory write down due to expired stock from COVID implications during 2019/20.

13. Receivables

13.1 Trade and other receivables falling due within one year

	2019/20 £'000	2018/19 £'000
Contract receivables - NHS and Other DHSC Bodies	52,504	60,897
Contract receivables - Trade and Non DHSC Bodies	10,267	8,016
Contract assets	0	0
Allowance for impaired receivables (note 13.3)	(5,948)	(5,133)
Prepayments	6,406	3,490
Interest receivable	28	56
Public Dividend Capital dividend receivable	209	376
VAT receivable	857	423
Other receivables	322	407
Total falling due within one year	**64,645**	**68,532**

13.2 Trade and other receivables falling due after more than one year

Contract receivables - NHS Injury Scheme	6,343	6,268
Total falling due after more than one year	**6,343**	**6,268**
Total Trade and Other Receivables	**70,988**	**74,800**

13.3 Allowances for credit losses (doubtful debts)

	Total £'000	Contract receivables and Contract assets £'000	All other receivables £'000
At 1 April 2019	5,133	5,133	0
New allowances arising	1,262	1,262	0
Reversals of allowances	(422)	(422)	0
Utilisation of allowances	(25)	(25)	0
Total allowance for credit losses at 31 March 2020	**5,948**	**5,948**	**0**
Loss recognised in expenditure	840	840	0

13.4 Credit losses and impairment of receivable

The Trust has no material category of receivable which requires generic expected credit losses to be recognised.

Receivables are impaired when there is evidence to indicate that the Trust may not recover, in full, sums due. This can be on the basis of legal advice, insolvency of debtors, or other economic factors. Impaired receivables are written off only when all reasonably possible means of recovery have been exhausted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

NHS receivables are considered recoverable because the majority of trade is with Clinical Commissioning Groups (CCG's) as commissioners for patient care services.

As CCG's are funded by the Government to purchase NHS patient care services, credit scoring is not considered necessary. Similarly, other receivables with related parties are with other Government bodies, so credit scoring is not considered necessary.

The Trust has considered its exposure to potential credit losses in light of the Covid-19 pandemic and does not consider itself exposed to any significant greater risk; taking this into consideration, its approach to the impairment of receivables remains largely unaltered.

Prepayments and accrued income are neither past their due date, nor impaired.

Other trade receivables become due immediately as the Trust does not offer extended credit terms.

14. Current asset investments

	2019/20 £'000	2018/19 £'000
Additions	595,000	105,000
Disposals	(595,000)	(105,000)
Cost or valuation at 31 March	0	0

Current asset investments reflect short-term deposits with the National Loan Fund within the Government Banking Service

15. Payables

15.1 Trade and other payables

	2019/20 £'000	2018/19 £'000
Amounts falling due within one year:		
NHS payables	14,274	14,547
Trade payables	29,755	24,745
Trade payables – capital	9,004	7,741
Other payables	9,584	9,014
Accruals	34,599	35,143
Social Security and other taxes	13,536	13,091
Public Dividend Capital payable	0	0
Total current trade and other payables	**110,752**	**104,281**
Amounts falling due after more than one year:		
Total non-current trade and other payables:	0	0
Total noncurrent trade and other payables	**0**	**0**
Total trade and other payables	**110,752**	**104,281**

15.2 Early retirements and outstanding pension contributions included in payables above

	2019/20 Number	2018/19 Number
- Number of cases involved	0	0
	£'000	£'000
- To buy out the liability for early retirements over 5 years	0	0
Outstanding Pensions Contributions at 31 March	9,317	8,730

16. Borrowings

16.1 Current borrowings

	2019/20 £'000	2018/19 £'000
Capital Loans from the DHSC	1,466	1,469
Obligations under finance leases	531	384
Obligations under Private Finance Initiative contracts	468	574
Total current borrowings	**2,465**	**2,427**
16.2 Non-current borrowings		
Capital Loans from the DHSC	17,509	18,954
Obligations under finance leases	938	823
Obligations under Private Finance Initiative contracts	16,628	17,096
Total non-current borrowings	**35,075**	**36,873**
Total borrowings (current and non-current)	**37,540**	**39,300**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. This announcement does not affect the DHSC loans above, which are normal course of business loans, rather than interim loans. The long term nature of the loans above therefore does not change.

17. Other liabilities

17.1 Current other liabilities

	2019/20 £'000	2018/19 £'000
Deferred income	19,539	15,866
Total current other liabilities	**19,539**	**15,866**

17.2 Non-current other liabilities

Deferred income	1,324	2,169
Total non-current other liabilities	**1,324**	**2,169**
Total other liabilities (current and non-current)	**20,863**	**18,035**

18. Finance obligations

18.1 Finance lease obligations

	2019/20 £'000	2018/19 £'000
Gross lease liabilities	1,553	1,320
of which liabilities are due		
- not later than one year;	578	439
- later than one year and not later than five years;	975	881
- later than five years.	0	0
Finance charges allocated to future periods	(84)	(113)
Net lease liabilities	**1,469**	**1,207**
Ageing of net lease liabilities		
- not later than one year;	531	384
- later than one year and not later than five years;	938	823
- later than five years.	0	0
	1,469	**1,207**

18.2 Liabilities arising from financing activities

	Total £'000	DHSC Loans £'000	Finance Lease with non-DHSC group counterparty £'000	PFI £'000
Carrying value at 1 April 2019	39,300	20,423	1,207	17,670
Financing cash flows - principal	(2,436)	(1,445)	(417)	(574)
Financing cash flows - interest	(2,088)	(935)	(65)	(1,088)
Additions	679	0	679	0
Interest charge arising in year	2,085	932	65	1,088
Carrying value at 31 March 2020	37,540	18,975	1,469	17,096

18.3 Private Finance Initiative (PFI) Obligations (on Statement of Financial Position)

	2019/20	2018/19
	£'000	£'000
Gross PFI liabilities	28,139	29,801
of which liabilities are due		
- not later than one year;	1,520	1,662
- later than one year and not later than five years;	6,505	6,351
- later than five years.	20,114	21,788
Finance charges allocated to future periods	(11,043)	(12,131)
Net PFI liabilities	**17,096**	**17,670**
Ageing of PFI liabilities		
- not later than one year;	468	574
- later than one year and not later than five years;	2,628	2,327
- later than five years.	14,000	14,769
	17,096	**17,670**

18.4 Amounts included in operating expenses payable to service concession

Operator	2019/20 £'000	2018/19 £'000
Interest charge	1,088	1,125
Repayment of finance lease liability	574	624
Service element	649	633
Capital lifecycle maintenance	629	484
Contingent rent	861	841
	3,801	**3,707**

18.5 Amounts included in operating expenses in respect of PFI transactions deemed to be in the categories listed below

	2019/20 £'000	2018/19 £'000
Service element	649	633
Depreciation	54	55
	703	**688**

18.6 Finance charges in respect of PFI transactions

Finance charges in respect of PFI transactions are shown under note 7.2.

18.7 PFI scheme details

Estimated capital value of PFI scheme	£1,746K
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	16 years, 9 months
Contract end date	December 2036

18.8 The Trust is committed to make the following payments for the total service element for on SoFP PFI service concessions for each of the following periods

	2019/20	2018/19
	£'000	£'000
Hadfield Block:		
- Within one year	664	648
- 2nd to 5th years (inclusive)	2,828	2,759
- Later than 5 years	10,109	10,843
	13,601	**14,250**

18.9 Total future payments committed in respect of PFI

	2019/20	2018/19
	£'000	£'000
Hadfield Block:		
- Within one year	3,895	3,800
- 2nd to 5th years (inclusive)	16,579	16,175
- Later than 5 years	59,210	63,509
	79,684	**83,484**

The PFI scheme is a scheme to design, build, finance and maintain a medical ward block on the Northern General Hospital site (Sir Robert Hadfield Block). The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement.

The contract contains payment mechanisms which provide for deductions in the unitary payment made by the Trust in instances of poor performance and unavailability. These mechanisms have been enacted during the 2018/19 financial year in cash terms, pending contractual resolution.

The unitary charge for the scheme is subject to an annual uplift for future price increases. The operators are responsible for providing a managed maintenance service for the length of the contract, after such time these responsibilities revert to the Trust.

Future unitary charge payments will be uplifted based on actual changes in RPI. In terms of assessing future commitments it is assumed that future indexation will be 2.5% p.a. for all remaining years of the contract.

19 Provisions for liabilities and charges

	Current		Non Current	
	2019/20	2018/19	2019/20	2018/19
	£'000	£'000	£'000	£'000
Pensions relating to former staff	218	213	3,087	2,935
Legal claims	358	430	40	40
Agenda For Change	0	0	0	0
Other	2,398	2,340	0	0
Total	**2,974**	**2,983**	**3,127**	**2,975**

	2019/20						2018/19
	Total	Pensions relating to former staff	Legal claims	Agenda For Change	Redundancy	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April	5,958	3,148	470	0	0	2,340	3,654
Change in discount rate	239	239	0	0	0	0	(42)
Arising during the year	1,129	163	460	0	0	506	3,458
Utilised during the year	(870)	(229)	(193)	0	0	(448)	(541)
Reversed unused	(339)	0	(339)	0	0	0	(580)
Unwinding of discount	(16)	(16)	0	0	0	0	9
At 31 March	**6,101**	**3,305**	**398**	**0**	**0**	**2,398**	**5,958**
Expected timing of cashflows							
Within one year	2,974	218	358	0	0	2,398	2,983
Between one and five years	923	883	40	0	0	0	884
After five years	2,204	2,204	0	0	0	0	2,091

Pensions relating to former staff represents the liability relating to staff retiring before April 95 (£497k) and Injury Benefit Liabilities (£2,808k).

Injury Benefits are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority.

The value shown is the discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown.

Legal claims relate to -
- Claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by NHS Resolution who provide an estimate of the Trust's probable liability.
- Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by NHS Resolution and not included above. The provision for such cases totals £323k.
- A number of other legal cases, not being handled by the NHS Resolution, are also recorded under this heading. These total £75k.

Other Provisions
- The Trust has recognised a provision of £2,260k in respect of potential future pension liabilities which will be charged by the NHS Pensions Agency in respect of final pay controls.
- The Trust has recognised in-year a provision of £138k in respect of sundry employment related issues (relating to three discrete categories of case under which liabilities may arise).

£354,648k is included in the provisions of NHS Resolution at 31/03/2020 in respect of clinical negligence liabilities of the Trust (31/3/2019 £356,637k).

20. Revaluation Reserve

	Total Revaluation Reserve £'000	Revaluation Reserve - intangibles £'000	Revaluation Reserve - property, plant and equipment £'000
Revaluation reserve at 1 April 2019	38,370	0	38,370
Transfer by absorption	0	0	0
Impairments	(3,235)	0	(3,235)
Revaluations	1,094	0	1,094
Transfers to other reserves	(1,050)	0	(1,050)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2020	**35,179**	**0**	**35,179**
Revaluation reserve at 1 April 2018	32,949	0	32,949
Transfer by absorption	0	0	0
Impairments	(12,928)	0	(12,928)
Revaluations	19,434	0	19,434
Transfers to other reserves	(1,085)	0	(1,085)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2019	**38,370**	**0**	**38,370**

21. Cash and cash equivalent

	2019/20 £'000	2018/19 £'000
At 1 April	94,033	74,914
Net change in year	(3,258)	19,119
At 31 March	**90,775**	**94,033**
Analysed as cash held:		
- At Commercial Banks and in hand	121	1,163
- At Government Banking Service	90,654	92,870
Cash and cash equivalents as in the Statement of Financial Position	**90,775**	**94,033**

22. Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position Date were £17.6m (31 March 2019, £23.9m)

The major components of these commitments are as follows:	**Property, Plant & Equipment 2019/20** £'000
Scheme:	
Theatre Refurbishment - A Floor, Royal Hallamshire Hospital	2,866
Theatre Refurbishment - Firth Wing, Northern General Hospital	2,322
Lift Refurbishment - Royal Hallamshire Hospital	2,201
8th Linear Accelerator	1,764
Expansion of Clinical Immunology & Allergy Unit	1,438
Plain Film Rooms	649
Conversion of 5 Beech Hill Road (Block 4)	439
Minor Medical Equipment (inc Haemodialysis Machines, Critical Care Monitoring)	1,361
Other	4,567
Total	**17,607**

The reduction in Capital Commitments of £6.3m between financial year ends is mainly driven by Trust capital planning and business case approval timings. There is no significant impact from the impact of COVID-19 on the placement of Trust contractual commitments.

23. Events after the reporting period

On 12 March 2020 the World Health Organisation announced a global pandemic in relation to COVID-19. These financial statements include additional expenditure of £2m in relation to COVID needs during March 2020, along with offsetting income. Significant additional COVID-19 expenditure will continue to be incurred during 2020/21, along with expected offsetting income.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for Providers. As per note 16, existing Trust DHSC loans are normal course of business loans, not interim loans, and hence consideration of this event after the reporting period does not change the timing of existing loan repayment schedule for the Trust.

There are no other events after the reporting period to highlight.

24. Contingencies

24.1 Contingent liabilities

	2019/20 £'000	2018/19 £'000
Gross value	(189)	(180)
Amounts recoverable	0	0
Net contingent liability	(189)	(180)

Quantified contingencies shown above represent the consequences of losing all current third party legal claim cases, however, the likelihood of this is considered remote. Note 19 quantifies those cases which have been provided for (£398k) where it is considered more likely that liabilities will crystallize.

There are potential contingent liabilities relating to certain employment issues which are yet to be confirmed and quantified by future legal considerations, including an appeal to the Supreme Court. As at the date of production of the Annual Accounts there is no review date set for this appeal. If the undetermined outcome of this appeal found in favour of the initial ruling, there is uncertainty as to whether the obligation would be statutory or contractual and therefore the potential liability cannot be accurately estimated.

The potential liability has numerous outcomes and values that could range between £Nil and £2.5m.

There are also unquantifiable contingent liabilities in relation to future pension payments, which will be due to Trust staff; the volume and value of which is not yet known to the Trust. However, these liabilities will be offset by contingent assets from DHSC.

24.2 Contingent assets

The Trust is currently involved in an ongoing contractual dispute which may result in future economic benefits relating to past events. Income has been recognised in the financial statements only when it meets the criteria detailed in the Department Of Health and Social Care Group Accounting Manual. The ongoing dispute may result in additional future economic benefits, however these have not been recognised in the financial statements due to uncertainty around the amount of these economic benefits, given the present status of the contractual dispute.

25. Related party transactions

Sheffield Teaching Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sheffield Teaching Hospitals NHS Foundation Trust. Details of Directors' remuneration and pension benefits can be found in the Remuneration Report in the Annual Report. The Declaration of Directors' interests is to be found on page 26 of the Annual Report.

The Department of Health and Social Care is regarded as a related party. During the year Sheffield Teaching Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

In addition, the Trust has had a number of material transactions with other joint enterprises, government departments and other central and local government bodies. Most of these transactions have been with the Department of Education in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises. Income from the University of Sheffield and Sheffield City Council totalled £4,805k and £4,987k respectively. Expenditure on goods and services was in the sum of £14,695k from the University of Sheffield and £6,036k from Sheffield City Council. At 31 March 2020 £3,961k was owed to the Trust by the University of Sheffield, whilst £6,224k was owed.

The Trust considers other NHS Foundation Trusts and NHS bodies to be related parties, as they and the Trust are under the common control of Monitor (NHS Improvement from 1 April 2016), and the Department of Health and Social Care. During the year the Trust contracted with certain other

Foundation Trusts and Trusts for the provision of clinical and non-clinical support services.

Some other entities with whom the Trust trades are considered related parties. These entities are to an extent controlled and / or influenced by certain Non-Executive Directors by the nature of their engagement with that body. Mr Tony Pedder, Chairman, is Pro-Chancellor and Chair of Council, University of Sheffield. Mr Chris Newman, Non-Executive Director, is Dean of the Medical School, University of Sheffield. As mentioned in the Directors' Report, a full Register of Directors' Interests is maintained by the Assistant Chief Executive.

During the year the Trust purchased healthcare from Thornbury Private Hospital in the sum of £3,982k and from Claremont Hospital in the sum of £5,852k. Certain of the Trust's clinical employees have an interest in these companies. Clinical services were provided to these organisations.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely. These Governors represent the views of the staff and of the organisations with and for whom they work. This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charity of whom Mr John O'Kane, Non-Executive Director, is a trustee. Grants received in the year from this Charity amounted to £2.3m (2018/19 £2.3m).

26. Financial instruments

26.1 Financial assets

Carrying values of financial assets as at 31 March 2020 under IFRS 9	**Held at amortised cost** £'000	**Held at fair value through P&L** £'000	**Held at fair value through OCI** £'000	**Total** £'000
Receivables excluding non-financial assets	63,516	0	0	63,516
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2020)	90,775	0	0	90,775
Total at 31 March 2020	**154,291**	**0**	**0**	**154,291**

Carrying values of financial assets as at 31 March 2019 under IFRS 9	**Held at amortised cost** £'000	**Held at fair value through P&L** £'000	**Held at fair value through OCI** £'000	**Total** £'000
Receivables excluding non-financial assets	70,511	0	0	70,511
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2019)	94,033	0	0	94,033
Total at 31 March 2019	**164,544**	**0**	**0**	**164,544**

26.2 Financial liabilities by category

Carrying values of financial liabilities as at 31 March 2020 under IFRS 9	Held at amortised cost £'000	Liabilities at fair value through the SoCI £'000	Total £'000
Borrowings excluding Finance lease and PFI liabilities	18,975		18,975
Finance lease obligations	1,469		1,469
Obligations under Private Finance Initiative contracts	17,096		17,096
Trade and other payables excluding non-financial assets	87,632		87,632
Provisions under contract	0		0
Total at 31 March 2020	**125,172**	**0**	**125,172**

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £'000	Liabilities at fair value through the SoCI £'000	Total £'000
Borrowings excluding Finance lease and PFI liabilities	20,423		20,423
Finance lease obligations	1,207		1,207
Obligations under Private Finance Initiative contracts	17,670		17,670
Trade and other payables excluding non-financial assets	82,176		82,176
Provisions under contract	0		0
Total at 31 March 2019	**121,476**	**0**	**121,476**

26.3 Maturity of financial liabilities

	2019/20 £'000	2018/19 £'000
In one year or less	90,097	84,603
In more than one year but not more than two years	2,460	2,316
In more than two years but not more than five years	6,887	6,616
In more than five years	25,728	27,941
Total	**125,172**	**121,476**

26.4 Fair values of financial assets and liabilities at 21 March 2020

The fair value of the Trust's financial assets and liabilities at 31 March 2020 equates to the book value. The book value of financial assets and liabilities is shown in notes 26.1 and 26.2.

Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups, and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by 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 Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust has borrowings for capital expenditure, but is subject to affordability as confirmed by the FT Financing Facility. The borrowings are for a maximum remaining period of seventeen years and nine months (17 years, 9 months), in line with the associated assets, and interest is charged at 4.80% and 4.59%, fixed for the life of the respective loans. The Trust therefore has low exposure to interest rate fluctuations in this area. The Trust also has borrowings in respect of leasing and its PFI contract which incur fixed interest rates of 4.00% and 6.32% respectively. Exposure to interest rate risk is therefore low as these borrowings are fixed.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the Trade and other receivables note. Owing to the architecture of its financial regime, the Trust does not consider itself to be exposed to any significant greater credit risk as a result of the Covid-19 pandemic.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with Clinical Commissioning Groups, or the Department of Health and Social Care, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks. As with credit risk, the Trust does not consider itself to be exposed to any significant greater liquidity risk as a result of the Covid-19 pandemic.

27. Third party assets

The Trust held £1,530 at bank and in hand at 31 March 2020 (£5,001 at 31 March 2019), which related to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts (see note 21).

28. Losses and special payments

	2019/20		2018/19	
	Number	Value £'000	Number	Value £'000
Losses				
Cash Losses	3	0	5	0
Fruitless payments and constructive losses	1	0	0	0
Bad debts and claims abandoned	84	24	133	126
Stores losses (including damage to buildings and property)	4	68	14	100
	92	**92**	**152**	**226**
Special payments				
Extra-contractual payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	1	3	2	26
Special severance payments	0	0	0	0
Ex-gratia payments	68	13	69	15
	69	**16**	**71**	**41**
Total losses and special payments	**161**	**108**	**223**	**267**

No individual items exceeding £300,000 were incurred in either year. These losses are reported on an accruals basis.

29. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets, and to pay a dividend based on this rate to HM Treasury. The rate of 3.5% is applied to the Trust's net relevant assets, which are abated by the value of donated assets, COVID-19 required assets, any dividend payable or receivable (where appropriate), and by average daily cleared balances held with the Government Banking Service. This resulted in a dividend of £8,032k (2018/19 £8,991k). There were no COVID-19 assets within the Trust asset base at 31 March 2020. COVID-19 acquisitions are expected during early 2020/21.

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