NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

RDaSH Annual Report 2023-2024

Kepple's Column

Markaz ul Uloom Al Islamia, Rotherham

RDaSH nurturing the power in our communities

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2023/24

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PRESENTED TO PARLIAMENT PURSUANT TO SCHEDULE 7, PARAGRAPH 25(4)(a) OF THE NATIONAL HEALTH SERVICE ACT 2006

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PERFORMANCE REPORT

Overview of Performance

This section provides an introduction to the Annual Report from the Chief Executive and Chair. It describes the Trust and highlights some of the major achievements in the year, the risks we have faced and provides some facts and figures about the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

Chair's Introduction

It's been a very exciting and successful year for RDaSH despite the pressures nationally on the NHS.

In the last financial year, we have successfully completed a restructure with our senior managers and Toby, our Chief Executive, and I have completed just over a year in our job roles. As a Board of Directors we've completed Board development sessions, helping the Board mature, and we can see results from this work already.

I'd like to pay tribute to a range of people in this Annual Report. Firstly, to our Governors, who have set objectives for the Board. They have also worked with us and been incredibly enthusiastic about our new Clinical and Organisational Strategy from 2023-2028 and our 28 Promises. I'd like to thank Jo Cox, our Lead Governor, for the time she gives and her energy and passion.

Justin Shanahan, one of our Non-Executive Directors and our Audit Committee Chair has recently bid us farewell and I want to thank him for his dedication to our Trust and for the contributions he has made over the last seven years. I also want to thank Kathy Gillatt, who will take on the audit role going forward. Sheila Lloyd, our Deputy Chief Executive and Director of Nursing and Allied Health Professionals also retired. Such a loss for RDaSH and I also thank her for her duty and dedication to our trust. I'm so pleased we have recruited Steve Forsyth to the Chief Nurse role – Steve is also the UK's first male chief nurse who comes from a South Asian background. We have also welcomed Richard Chillery as our new Chief Operating Officer recently too. It's brilliant they have both chosen to work with us.

It's great to see that as our colleagues naturally leave us, we are able to replace them with equally good people. As other senior staff leave us in the coming year to go to pastures new, it gives me great assurance knowing that people see working here as a great place to come to work – whether on the Board of Directors or in our services.

I also want to stress how I value our Board members who have been with the Trust for many years. It's that mixture of experience and new recruits that makes our Board a very stimulating place.

The last financial year has seen us start to embed and develop our relationship with the communities we serve. We've still much more to do, but I'd like to thank the People Focussed Group (PFG) in Doncaster, the S62 and the Stag and Rose Court Patient Participation Group, both in Rotherham, for their energy, support and commitment to our direction of travel.

Our relationships in South Yorkshire and North Lincolnshire with our two Integrated Care Boards (ICBs) are also maturing. In South Yorkshire we are playing a big partnership role in the South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative. This system work is starting to grow and mature and I'm so pleased that RDaSH is committed to playing our part.

I'm so looking forward to the coming year. The 2023/24 financial year was one of planning and restructure and the coming year will be a year of making what we want to happen, happen! It was a tough year but we have worked through it together. Now we are ready to deliver our 28 Promises and it's great to see colleagues fired up about these and I'm looking forward to working together to develop and deliver them. The coming year is so exciting, and all of this work has been done to improve our offer to our patients and the communities we serve.

We won't be resting on our laurels – we have a lot of exciting work to move forward and we're in a great place to do this.

With best wishes,

Kathryn Lavery, Chair
11 July 2024

Chief Executive Introduction

Thank you for taking the time to read our annual report, along with, I hope, our Quality Account. These are the nationally mandated reports we are required to provide in a prescribed format. In addition, we have issued a more narrative description of 2023/24 and the year ahead – and some Easy Read material to go with that.

In 2023/24 we are proud to have co-produced and launched our five-year strategy – and within that the very recognisable 28 promises that we have made about our future. What matters most about those promises is that they help us to shift the balance of power in local healthcare decisively towards the local NHS responding to the needs of our communities. That does not always mean providing a health service, it may mean investing in a local voluntary sector group. During the last year we have had the opportunity to do that with S62 in Rotherham and with the People Focus Group across our neighbourhoods. In 2024 as we expand peer support worker numbers at the Trust, we will grow our voluntary sector partnerships further.

We made some big changes to services during the last year. Assertive outreach in Rotherham expanded its hours and saw many more people, and we were able to close some inpatient rehabilitation beds as a result. We have totally transformed how dementia care is delivered in the community in Doncaster, based on feedback organised by Healthwatch: our new partnership with The Alzheimer's Society is intended to better respond to both carers and patients. And in North Lincolnshire, this year has seen a transformation, working with local GP practices and with MIND, in access to physical health checks for local people with a serious mental illness.

In national and local media, NHS finances and waiting times dominate discussion. We report a deficit at year-end, but one significantly better than the original approved plan. That reflects the success of clinical leaders and many others in reshaping how we spend money. More of each pound is being spent on patient care. In 2023/24, for the first time since the pandemic, the Trust has met some of the national access standards, or targets (see Operational Performance section on pages 17 to 22). Our promises are very ambitious, seeking a maximum wait of no more than four weeks from April 2026. This summer we expect to deliver that for all children's services except neurodiversity diagnosis – and a significant investment to address unacceptable waits for those services will see waits reduce markedly during 2024.

It is important to be honest that not everything works well or works for the best every time. I am very grateful to those who have voiced complaints or spoken up in other ways. I hope we can evidence not simply that we have listened, but that changes have happened as a result. New communication handover arrangements in Crisis services are one example of that, arising from serious incidents. Our changes to what was once called 'disengagement' from services come directly from the tragic death of a local resident.

The Trust is changing how we are managed and how we lead. During 2023/24 we have restructured our organisation. This of course introduced a period of uncertainty, including for partners, and perhaps patients too. I very much hope now there is clarity, aided by our new website designed with patients, about who to contact and who can help. As we introduce a

product called Patient Opinion in the summer of 2024, we will certainly be more open to feedback in real-time.

Mavis is on the front cover of our strategy. That is because of her feedback on the benefits to her life and family from being looked after using our virtual care model. This service has been very successful in Doncaster over the last year, and the Trust is determined to expand that idea, in line with promises 13 and 20 of our strategy and introduce similar ideas into our mental health services.

The Trust's Board and leadership is determined to be open to different influences and voices in how we work. I am grateful for governors for their time and advice, and to those local people who are members or volunteers with us. You make a difference. Our staff networks are developing, this year has seen our new women's network, and we have colleagues who act as champions for a range of important initiatives including freedom to speak up and our environmental work. Health Education England have lauded the work done at RDaSH over the past two or three years to improve placements and education. Our research excellence is also regionally acknowledged. It is really important to those who work in our organisation, and to those we serve and care for, that these influences continue and are grown – we cannot deliver any of our promises unless we become fully staffed, with consistent teams learning together.

Toby Lewis, Chief Executive
11 July 2024

Our services

The Trust is registered with the CQC to provide safe care that is responsive and effective and as such provides a range of health and social care services across three localities through a Care Group model in Rotherham, Doncaster, North Lincolnshire.

A review of the Trust's governance structure was undertaken during the year in terms of the meeting and care group leadership structures. Implementation commenced in November 2023 with a revised care group model:

- Children's Care Group – providing a range of services for Children, Young People and Families including Children's Mental Health across the 3 localities, Doncaster, North Lincolnshire and Rotherham.
- Physical Health and Neurodiversity Care Group - providing Inpatient and Community Physical Health Services to the communities of Doncaster and ADHD across Doncaster, North Lincolnshire and Rotherham.
- Doncaster Mental Health and Learning Disabilities Care Group - providing Adult Mental Health Services, Older Peoples Mental Health Services, Drug and Alcohol Services, Forensic Services to the communities of Doncaster. In addition, Community Learning Disability Services are provided across Doncaster, North Lincolnshire and Rotherham.
- North Lincolnshire Adult Mental Health and Talking Therapies Care Group – providing Adult Mental Health Services, Older Peoples Mental Health Services to the communities of North Lincolnshire. In addition, Talking Therapies services are provided across Doncaster, North Lincolnshire and Rotherham.
- Rotherham Adult Mental Health Care Group - providing Adult Mental Health Services, Older Peoples Mental Health Services to the communities of Rotherham.

About Rotherham Doncaster and South Humber NHS Foundation Trust

The Trust was originally formed in October 1999 and in 2002, took on responsibility for the delivery of mental health services in Rotherham. On 1 August 2007, the Trust was authorised to operate as an NHS Foundation Trust under the NHS Act 2006.

On 1 October 2010, the transfer of tier 2 primary mental health child and adolescent mental health services (CAMHS) from Doncaster Council (DMBC) and tier 3 CAMHS from Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH) to the Trust took place.

Also in 2010, the Trust integrated with Doncaster Community Healthcare and Rotherham Community Health Services under the Transforming Community Services programme. The Trust was renamed Rotherham Doncaster and South Humber NHS Foundation Trust (formerly known as Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust) to reflect the range of services provided.

The Trust is the appointed Lead Provider for the Adult Eating Disorder Provider Collaborative within the South Yorkshire ICS and as such has commissioning responsibilities in respect of the Adult Eating Disorder Service across the whole of South Yorkshire.

The Trust provides a range of health and social care services across three localities, Rotherham, Doncaster, North Lincolnshire serving a population of over 740,400. The Trust operates from over 100 community and inpatient sites, employs 3,450 (whole time equivalent) staff and has an annual income of approximately £225million.

Trust Strategy

During the year the Trust launched its new Clinical and Organisational Strategy, following an extended period of consultation with stakeholders. This new five-year Clinical and Organisational Strategy, running through to 2028, sets out our ambition and is framed around five objectives:

1. Nurture partnerships with patients and citizens to support good health.
2. Create equity of access, employment, and experience to address differences in outcome.
3. Extend our community offer, in each of - and between – physical, mental health, learning disability, autism and addiction services.
4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.
5. Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.

The five objectives are underpinned by 28 Promises made to our community to be achieved during the lifetime of the Clinical and Organisational Strategy. This sets out what we stand for in terms of values and behaviours and the promises that we are making to our patients, people and communities about how we will behave for example to be an anti-racist organisation.

This Clinical and Organisational Strategy was written following significant engagement with and contributions from communities, patients, governors, partners and our own people. It shapes the Trust's priorities and ways of working over the next five years ensuring alignment to our vision.

The Clinical and Organisational Strategy and associated Promises are outlined for delivery through eight plans. The eight plans are: Quality and Safety, Equity and Inclusion, People and Teams, Learning and Education, Finance, Estates and Sustainability, Research and Innovation, and Digital. These eight plans are being developed and are expected to be finalised by June 2024.

There was no significant change to our operating environment in 2023/24. The Trust continues to improve its work with others to make sure various plans and pathways for patients are 'joined up'. The Trust works with others where it means that the Trust can achieve better, more effective, and more efficient patient care (whether that's at a system or place level). This includes working in collaboration with other providers.

Health Inequalities

The Trust is committed to reducing the health inequalities in our communities. Our work to address health inequalities is ingrained in a range of Promises made in our Clinical and Organisational Strategy 2023-2028. The Trust has developed an Equity and Involvement Plan to target in key areas and has formed a new Board subcommittee which focuses on public health and patient involvement. Some of the activity in 2023/24 has included:

- Working with primary care to increase the level of annual health checks for people with a Severe Mental Illness (Promise 7).
- Reviewing access and waiting times for diverse communities to our services using a 'Core20PLUS' lens to understand if inappropriate variations in access exist. We have used this information in our Talking Therapies service as a pilot to target activity at under-served communities, for example, older people (Promise 7).
- Working with partners on a programme to support homeless people in Doncaster with their health needs (Promise 9).
- Outreach work with the Gypsy, Roma and Traveller community to aid better access to health services (Promise 9).
- Working with the deaf or hard of hearing community to identify and address barriers to accessing services (Promise 8).
- Profiling of schools the Trust works in, so that interventions and support of children and young people receiving school nursing are better tailored to their needs (Promise 17).
- Introducing a new Trust website that better meets accessibility standards.
- Creating information in the top languages spoken across our communities.
- Profiling all of our services using the Core20PLUS approach.

We continue to develop the work programme as part of delivering our Promises:

- Programme of 'poverty proofing' all our services due to commence in June 2024 (Promise 6).
- Our current and future contribution to the 10 health improvements identified for children, young people and adults in the Core20PLUS5 programme (Promise 7).
- Implement the Patient and Carers Race Equality Framework (Promise 7).
- Implement specific recruitment and apprenticeship offers for refuges, citizens with learning disabilities, care leavers and those from other excluded communities (Promise 9).
- Work with partners to map prison discharge pathway to ensure our services can meet their health needs (Promise 10).
- Establish a homeless health team (Promise 10).
- Ensuring we deliver the NHS commitment to veterans and their families (Promise 11).
- Deliver integrated neighbourhood teams (Promise 15).

Whilst the Trust has started reporting information by ethnicity and deprived neighbourhoods, this is not yet systematic nor consistent and we will improve this during 2024. Also, we need to improve the analysis of data to better understand any discrimination or inequality in service offer, access and health outcomes.

Working with our integrated care boards

Integrated Care Boards (ICBs) are statutory bodies that are responsible for planning and funding most NHS services in the area. They are responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area. The Trust works across two ICBs, South Yorkshire and Humber and North Yorkshire respectively. In developing its Clinical and Organisational Strategy and Promises, the Trust took into account the ambitions and aspirations in the forward plans of the two ICBs that it works with setting out how they will meet the health needs of their population. The table below gives a simple explanation of how the ICB's forward plans are complimented by the Strategic Plan of the Trust and in more detail through the Promises to our community we have made.

Trust objectives	South Yorkshire joint forward plan objectives	Humber and North Yorkshire joint forward plan objectives (priorities for North Lincolnshire)
Nurture partnerships with patients and citizens to support good health. Create equity of access, employment, and experience to address differences in outcome. Extend our community offer, in each of - and between – physical, mental health, learning disability, autism and addiction services. Deliver high quality and therapeutic bed-based care on our own sites and in other settings. Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	Reducing health inequalities and creating a prevention first NHS. Improving access, quality and transforming care. Maximising the use of digital, data and technology and research and innovation. Making best use of our collective resources. Working in partnership and collaboration. Supporting and developing our entire workforce.	Mental health and wellbeing will thread through all that we do, across all ages. Innovation will be supported including digital tools that enable individuals to maximise health and wellbeing. Asset based community development will identify & work with the strengths of our communities to level up North Lincolnshire. The health inequalities gap will reduce across our wards. Healthy life expectancy will improve. Access to health and care takes account of rural challenges. The integrated practise model will be person centred. People with long term conditions will experience proportionately good health. There will be a single workforce strategy covering leadership and management, recruitment and retention, reward and recognition, career pathways and talent development.

The Trust works with the ICBs, at a system and place level, to develop performance and operational priorities, workforce development, capital programmes, and finances.

Our approach is also aligned with the Health and Social Care Act which places a legal duty to have regard towards the wider effect of our decisions which the ICBs also have a legal duty towards. This is to make sure we better meet a 'triple aim' of:

- Health and wellbeing of our population
- Quality of services provided
- Efficiency and sustainability in the use of resources.

Summary of principal risks

The Trust has a comprehensive risk management framework in place which enables informed management decisions in the identification, assessment, treatment and monitoring of risk. The Trust defines risk as the chance of something happening that will have an impact on business objectives and this can be in terms of both threats and opportunities.

The Trust's Board Assurance Framework (BAF) provides a structure for the effective and focused management of the principal risks in meeting the Trust's key objectives. It enables the identification of the controls and assurances that exist in relation to the Trust's key objectives and the identification of significant risks.

All risks included on the BAF have an Executive Director lead who have reviewed these risks and the associated actions in place on a regular basis to progress mitigation. The strategic risks in place during 2023/24 were:

- If the Trust fails to recruit and retain skilled staff for groups where there are shortages then this will impact on the delivery of safe services for our patients.
- If the Trust does not have quality leadership to embed compassionate care and a high performing culture then the right care will not be delivered.
- If the Trust does not achieve the planned budgeted deficit in year and does not return to a budgeted break-even position over the longer term, then it will impact on the long-term sustainability of the Trust and its ability to deliver services.
- If we do not work in partnership at System and Place then the Trust will fail to meet its duty to collaborate and or deliver integrated care for the benefit of our communities.
- If the Trust does not develop, approve and deliver the Clinical and Organisational Strategy, then this may impact on patient safety, patient experience, clinical effectiveness and regulatory compliance.
- If we do not have a robust governance process in place then this may lead to the Trust being ineffective, inefficient and compromise the well-led status of the organisation.
- If a significant destabilising event occurs then the delivery of services, financial performance and wellbeing of staff may be impacted.

As the year concluded, the Board was undertaking its review of the Board Assurance Framework to align the strategic risks with the clinical and operational strategy and the potential to impact on delivery of the strategic objectives.

Overall performance of the Trust in 2023/24

Category	Indicator	Performance	
		2022/23	2023/24
NHS England	NHS Oversight Framework segmentation (1-4 with 1 = maximum autonomy)	2	2
CQC	Overall rating (either 'inadequate', 'requires improvement', 'good' or 'outstanding')	Requires Improvement	Requires Improvement
		NB: No inspection since 2020 hence rating remains as per that given in 2020.	
Finance	The Group deficit was £2.3m for 2023/24, this included a reversal on valuation of impairments and other technical items that are removed from the Trust's control total for NHSE monitoring purposes. The Trust deficit for operational performance purposes was £3.5m compared to a planned deficit of £6.2m.		
National Targets	National target relevant to mental health and community services – see table below	Partially Compliant (5 out of 7)	Partially Compliant (4 out of 6)

Ref Number for 2023/24	Performance Metric – Provider Led Tong Term Plan Metrics Only	2023/24 Target	Actual	
			2022/23	2023/24
	The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral	60%	92%	97%
	Discharges Followed Up within 72 hours	80%	90%	96%
	Children and Young People (CYP) Eating Disorder Waiting Time – Urgent (within 1 week)	95%	100%	100%
	Children and Young People (CYP) Eating Disorder Waiting Time – Routine (within 4 weeks)	95%	95%	95%
LTP01	Number of adults and older adults (aged 18+) receiving two+ contacts with community mental health teams	8533	N/A	9403
LTP02a	Improving Access to Psychological Therapies (IAPT) Access (full year target)	22860	15468	17034
LTP02b	Improving Access to Psychological Therapies (IAPT) Access (Quarter 4 target)	5921	3837	4045
LTP03	Perinatal and Maternal Metal Health Access	617	545	742
LTP04	Children and Young People Access	9830	9039	9858
LTP05	Out of Area bed days – inappropriate (Quarter 4)	305	N/A	2484
LTP06	Virtual Ward - available beds	60	N/A	60

Further details can be found:

- NHS Oversight Framework – page 83
- CQC – page 82
- National Targets and Operational Performance – pages 17 to 22
- Financial Performance - pages 33 to 35

Going Concern

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Significant Events since year end and Overseas operations

There have been no important events since the end of the financial year affecting the Trust nor is there any overseas operations to report against.

Performance Analysis

How the Trust measures performance

The Board of Directors hold responsibility and accountability for setting and communicating the Trust's ambition, and for determining the direction of the Trust through the monitoring of adherence to national and local performance and access standards. The responsibility for performance was delegated to the Finance, Performance and Information Committee for the majority of 2023 however from January 2024 due to a change in the Committee Structures responsibility has been transferred to the Quality Committee. It is however noted that quality and performance is the responsibility of everyone working for and with the Trust, with overall accountability and leadership for quality and performance sitting with the Chief Executive and the Executive Team.

The underlying principle that quality and performance is everyone's responsibility relies heavily on effective appraisals enabling every staff member to be the best they can be and in ensuring that there is an understanding of what quality and performance means for them and their role. Objective setting provides the context for how performance will be measured, whether this is through a nationally mandated target, a locally defined measure or how an individual contributes to team/ward objectives. From January 2024 a key focus was on the delivery of the Trust Clinical and Organisational Strategy and the 28 promises. This will be the case for the next 4 years.

The Trust measures its performance primarily through monitoring compliance with 'The Big Six' metrics outlined below reference as LPT01- LPT06, a locally determined approach to deliver the 2023/24 Long Term Plan targets, the NHS Oversight Framework, and other key metrics which form the integrated quality and performance report (IQPR) which includes quality, workforce and finance information. The dashboard is overseen by the Clinical Leadership Executive (CLE), the CLE key subgroups and Delivery Reviews prior to escalation through to Board. The IQPR is a golden thread throughout the organisation.

From this year, bi-monthly delivery reviews, chaired by our Chief Executive, provide a targeted focus with Care Group individuals around the key areas of performance, quality and safety, our people and finance. These were introduced in November 2023.

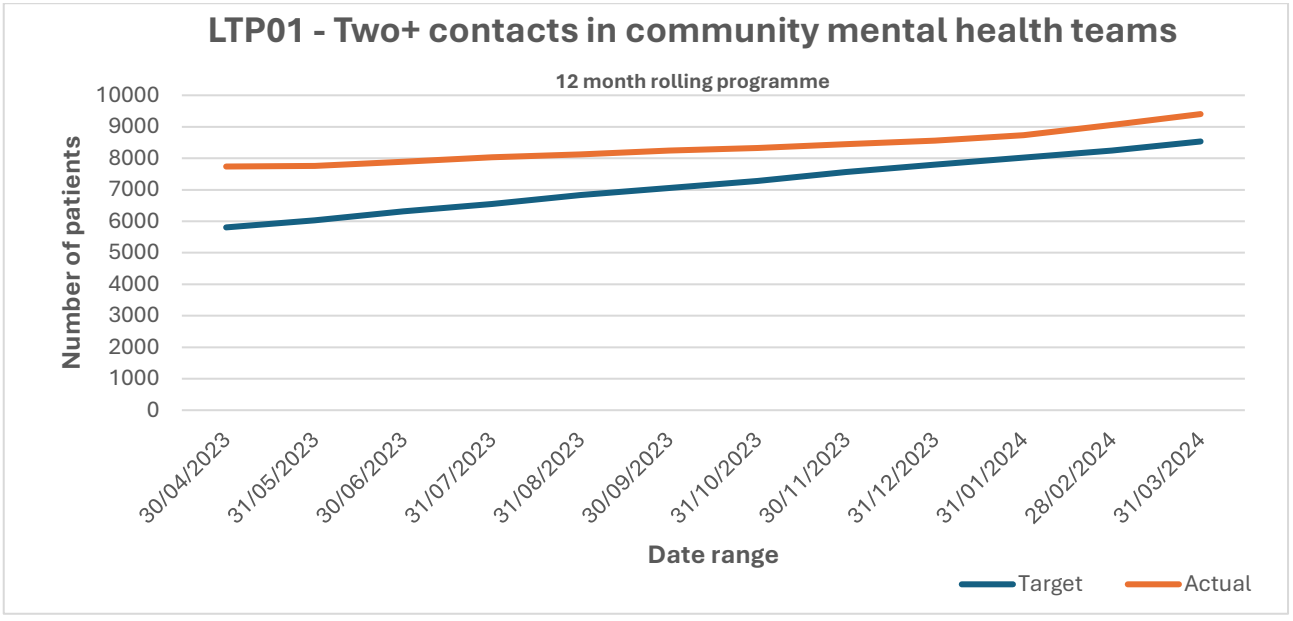
The Trust also has a comprehensive suite of service specific Key Performance Indicators within service contracts which are measured at a Care Group or service specific level.

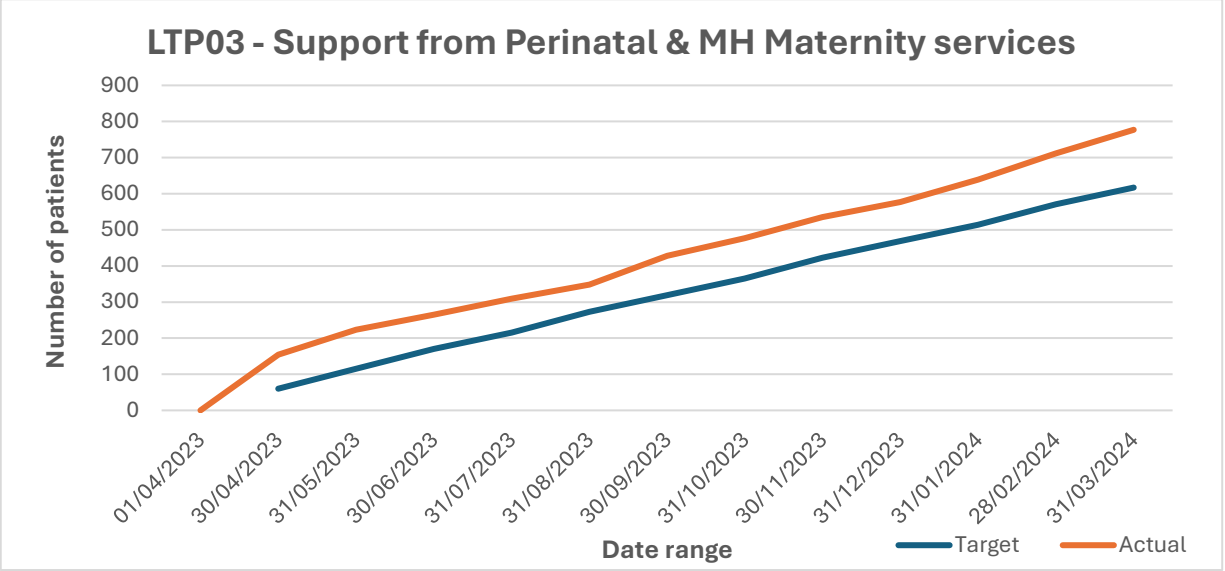
Operational Performance

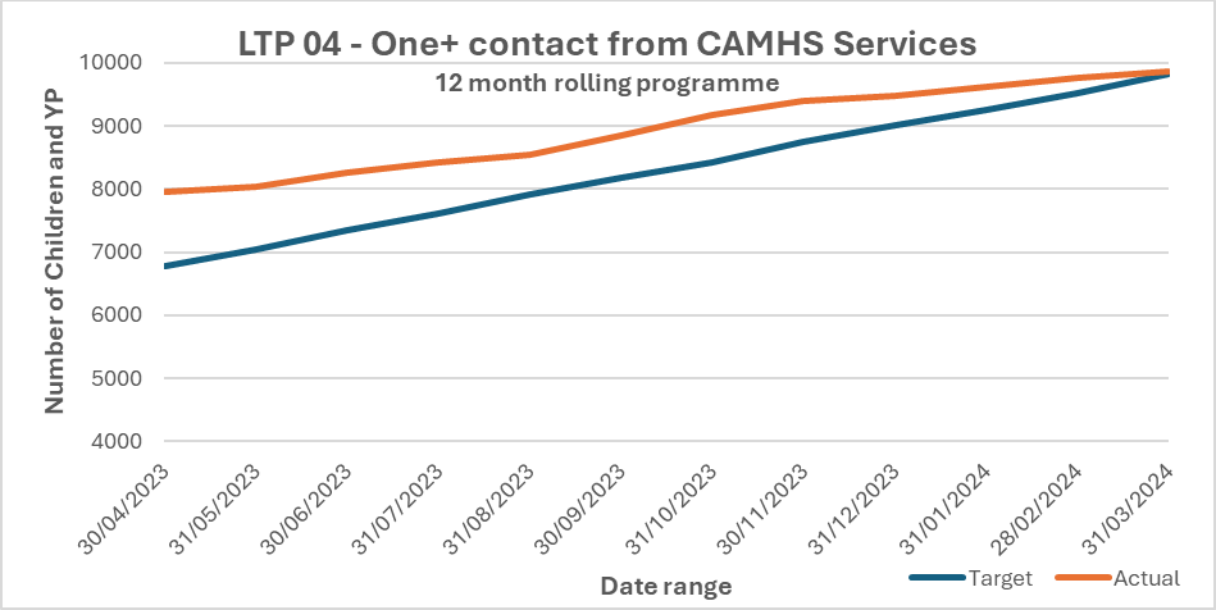
The Trust had a determined focus during 2023/24 to deliver against 'The Big Six' metrics with monthly Performance Clinics held from January 2024 providing additional oversight and a targeted approach and management of delivery. These were in addition to the Delivery Reviews which were in place for the entire year, monitoring performance at a Care Group level. Individual improvement plans and weekly performance monitoring and forecasting in quarter 4 supported the achievement of Children and Young People's Access (LTP04), Community Mental Health

Transformation 2 + contacts (LTP01) and Perinatal Access (LTP03) metrics. LTP01, LTP03 and LTP 04 are targets which require delivery from RDaSH and other providers to combine activity at a locality level. It is pleasing to report that once all RDaSH and place activity and activity which is delivered by other providers is factored into the reporting, all three of these metrics have exceeded expectations demonstrating we can deliver on national targets, and thereby increasing confidence in what we do with communities, partners and ourselves.

Ref	Metric		Target 2023/24	Actual Performance	Variance
LTP01	Number of adults and older adults (aged 18+) receiving two+ contacts with community mental health teams (including both traditional and transformed integrated service activity) 12 Month Rolling	Mental Health	8,533	9,403	+871
LTP03	The number of women in the perinatal period who receive support from the Perinatal and Maternal Mental Health Service PLACE Target Includes SHSC MMHS Activity (214)	Mental Health	617	742	+125
LTP04	The number of children and young people aged 0-17 receiving one+ contact with mental health services PLACE Target includes Doncaster Kooth Activity (758) & North Lincs Mind Activity (61)	Mental Health	9,830	9,858	+28



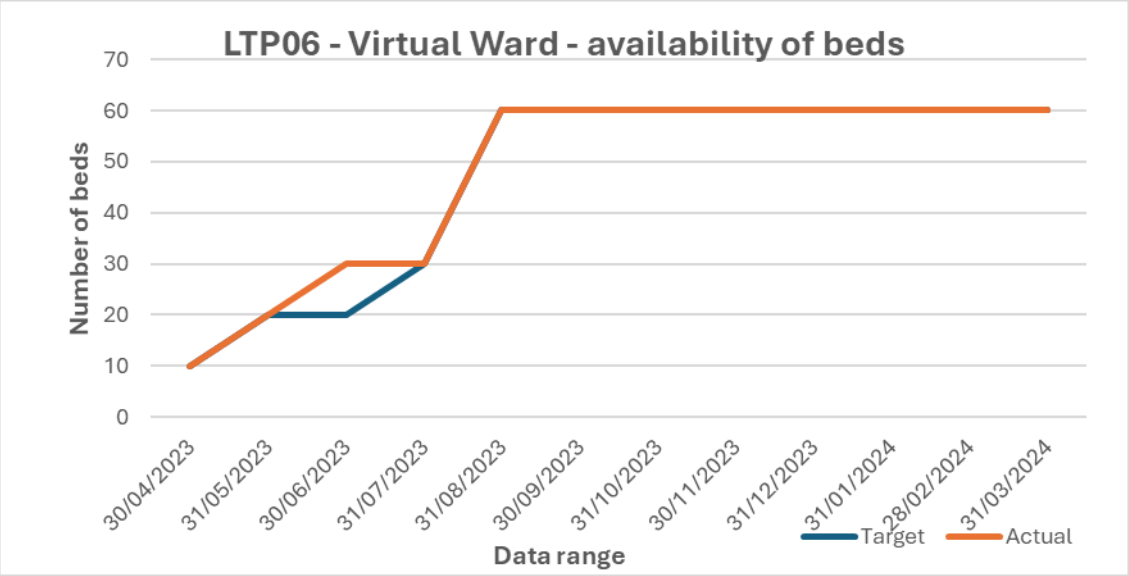




Within our Physical Health services in 2023/24 we saw the launch of the Virtual Ward (LTP06) metric also known as hospital at home which allows our patients to get the care, they need at home safely and conveniently, rather than being in hospital. On the 1st of September 2023 the Trust opened 60 virtual ward beds with occupancy in March 2024 peaking to 46 patients. As this a virtual ward, the word 'beds' is used to describe the metric but in reality, this means the service has capacity to care for up to 60 patients in their own home/care settings. When compared to other providers of Virtual Ward within Northeast and Yorkshire, RDaSH performed 7th out of 25 providers when considering overall capacity (60 beds). When considering utilisation of available capacity, 8 providers had lower capacity than Doncaster Place (provided by RDaSH) where occupancy rates were reported as 73%, slightly below the 2023/24 80% occupancy target. We continue to engage with our partners at Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust to further encourage increased referrals from our acute colleague consultants. For financial year 2024/25, our ambition is to explore options to further increase our virtual bed base to meet the 130 bed target by the end of March 2025. We are also continuing to develop new pathways in order to expand utilisation of the sixty available

beds. We are actively in discussion with our commissioners about securing funding for two of the winter pressure schemes which will include the Community Intravenous (IV) therapy service who are able to provide IV's to our patients outside of the inpatient hospital environment.

Ref	Metric		Target 2023/24	Actual Performance	Variance
LTP06	Virtual Ward - Available Beds	Physical Health	60	60	0



Within Childrens services, as noted above on page 10, we have achieved the children and young people (CYP) accessing services (LTP04) metric reporting 9,846 CYP receiving one clinical contact in a 12-month rolling period against the target of 9,830. As we move into the forthcoming year this target remains one of the key metrics and the dedicated task and finish group will continue to meet to ensure that future performance is sustained at this level. Our Children's Eating Disorder service continues to perform well with all of the most urgent cases received into the service seen within 1 week (OP15) and 94.57% of our children and young people referred into service are seen within 4 weeks (OP14), just short of the 95% target.

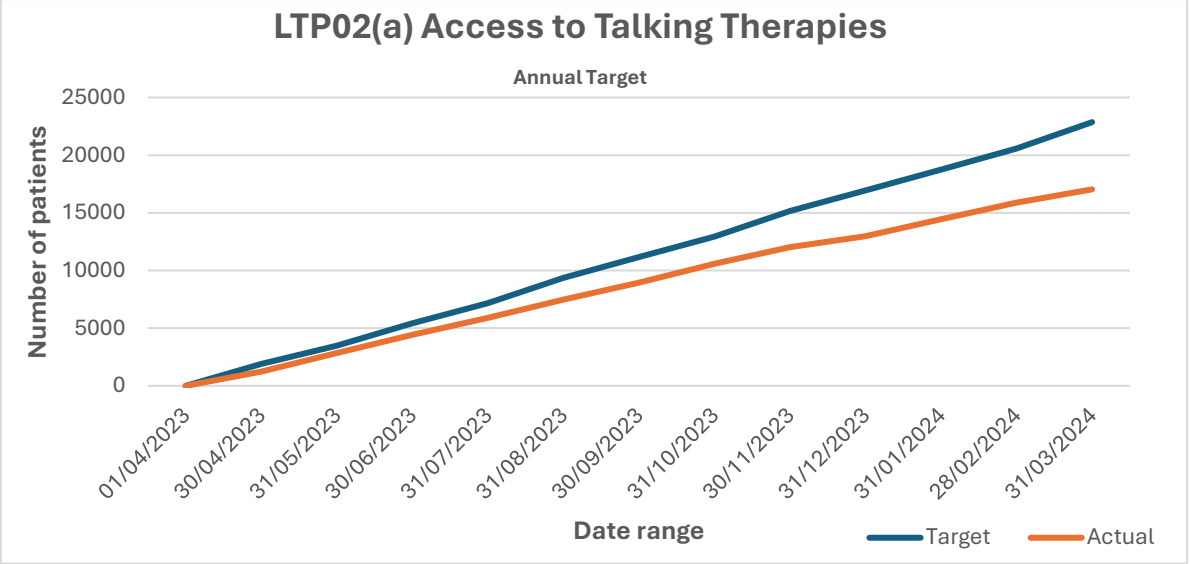
In terms of the LTP01, the metric relating to the number of adults and older people having received 2 clinical contacts, Trust wide we have over-achieved on the target, reporting 9,403 against the target of 8,533, in a 12 month rolling period within our community mental health services. Rotherham achieved 3,176, against a target of 2,900, Doncaster achieved 3,485 against a target of 3,041 and despite a significant stretch in North Lincolnshire the activity remained just 32 below the target, reporting 2,560 against a target of 2,592. In 2024/25 there is an amendment to this metric where the focus is on transformed services only, therefore we are seeking to align the targets to this change with the dedicated task and finish group continuing to meet to drive forward not only the activity but most importantly to support with ensuring that our patients receive key clinical interventions in order to improve their quality of care.

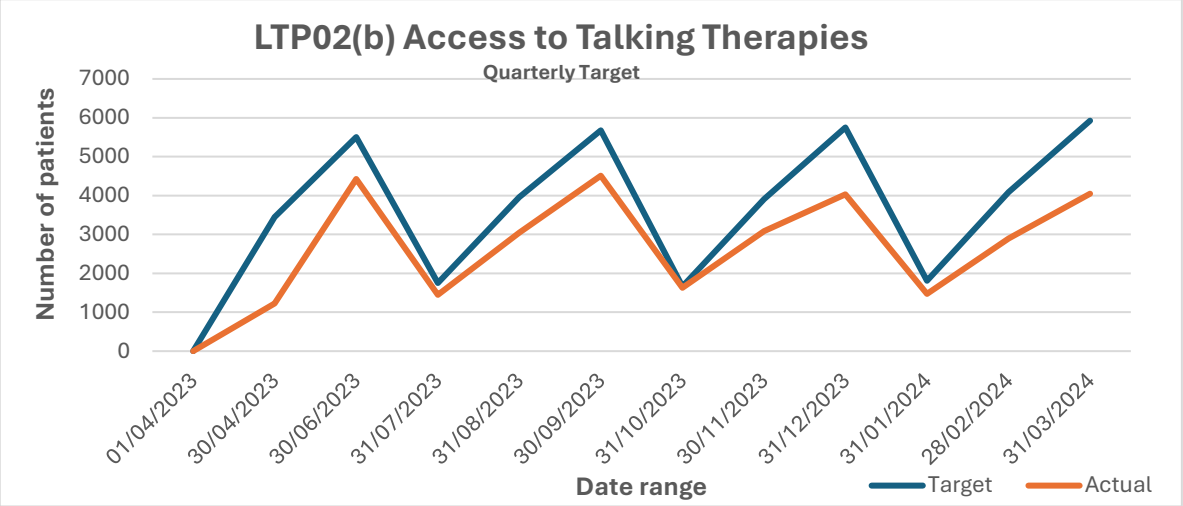
Our joint Perinatal and Maternal Mental Health Service with Sheffield Health and Social Care for Doncaster and Rotherham has seen the number of women receiving support higher than

ever since implementation of this service. During the 2023/24 period 777 women in the perinatal period received support against a target of 617. As we move into the forthcoming year this target remains one of the key metrics and the dedicated task and finish group will continue to meet to ensure that future performance is sustained at this level.

Concern continued with the Talking Therapies access rates (LTP02a and LTP2b) right up to the end of the year and despite active engagement with different communities to improve access and strengthening of pathways with other services, demand on this pathway remained below expectations with some localities unable to fill available assessment slots within some weeks. As we move through the 2024/25 financial year, the focus on accessing the services will continue with social media campaigns, the development of workshops to Support World Menopause Day and Long-Term Conditions Workshops, focusing on Managing Pulmonary Conditions and Pain Management.

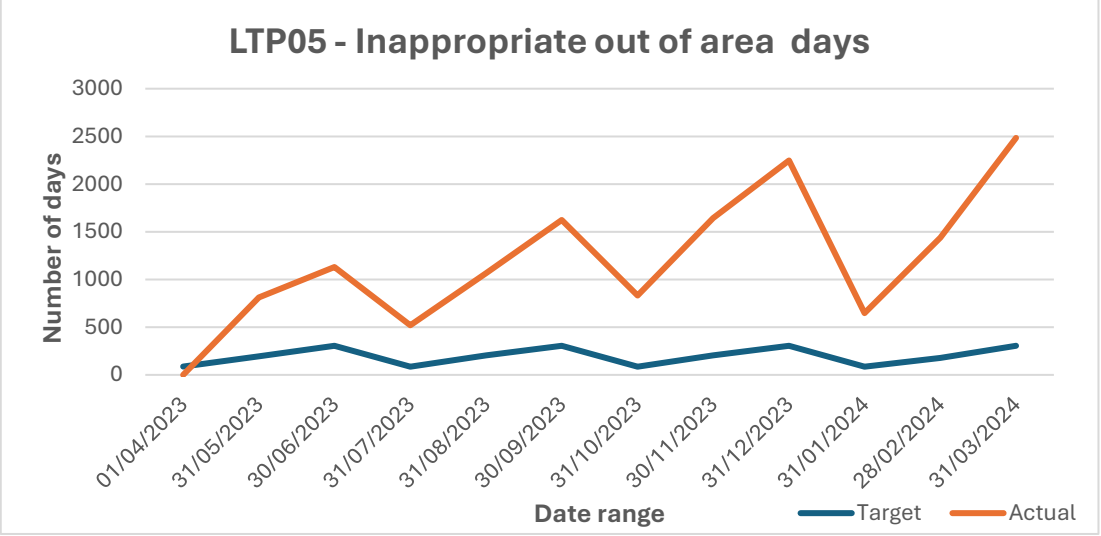
Ref	Metric		Target 2023/24	Actual Performance	Variance
LTP02 (a)	The number of people with common mental health problems accessing Talking Therapies Treatment Annual Target	Mental Health	22,860	16,930	-5,930
LTP02 (b)	The number of people with common mental health problems accessing Talking Therapies Treatment Quarterly Target	Mental Health	Q1 5,414 Q2 5,746 Q3 5,779 Q4 5,921	3,955	-1,966





The number of days individuals were placed inappropriate in an out of area placement was reported for the entirety of quarter 4 as 2,484 days against a target of 305. As we approached the end of March this equated to 23 patients who were receiving care in a provider outside of the RDaSH footprint. This remained an area of significant concern throughout the year, not only in the winter months, and during the financial year 2024/25, the Trust will look to address the whole patient pathway to seek to deliver on Promise 19, that we end out of area placements.

Ref	Metric		Target 2023/24	Actual Performance	Variance
LTP05	The total number of days adults inappropriately spend in out of area non specialist acute mental health beds	Mental Health	Q4 Target 305 days	Q4 - 2,484	2,179



As we move ahead into 2024/25, the Trust's IQPR is further evolving to align the metrics to the new requirements set out in the 2024/25 planning guidance. We will continue to support continuous improvement across our services by ensuring that we further embed the IQPR and other dashboards to ensure all within our organisation have access to qualitative and timely information to support performance management to be further embedded as everyone's business.

Quality Improvements Priorities

The Quality Priorities for 2024/2025 are outlined below:

Safety and quality priorities for 2024/25	
Priority	**How we will achieve?**
Deliver on our promises under strategic objective 1, with a focus on promise 4 to put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs	We will maximise the impact of use of SMS/digital to gather feedback, building on our work in Talking Therapies during 23/24 We will introduce, develop and evaluate Care Opinion as our main mechanism for gathering feedback from people in our communities' using services: this will ensure much faster and wider visibility for our employees of feedback from their patients. Each quarter, the Clinical Leadership Executive will discuss and act on a summary of feedback gathered through these methods. In early 2025 patient feedback will become a key measure within organisational management of its directorates within the delivery review process.
We publish our Quality and Safety Plan which will set out a series of safety measures, as always events, designed to improve the consistency of our care	The safety plan's successful implementation will demonstrate improvements in key measures of psychiatric and physical care including timely rights compliance, consenting, Malnutrition Universal Screening Tool (MUST) assessments, and Venous Thromboembolism (VTE) screening. The safety plan work will also see us improve the pace of assessment in community pathways, especially where urgent referrals have been made. Our quality plan implementation will see improvements initially in three areas: At Risk Mental State (ARMS) services as part of Early Intervention in Psychosis (EIP), work to improve toilet training among CYP teams' client groups, and improved speed of wound healing in district nursing services.
We will implement improvements to deliver a good rating under the CQC framework, including our work on culture of care within mental health inpatient settings	We will deploy our inpatient improvement plan in year, using external expertise to assess our progress, whilst working with the collaborative to ensure that we have learnt from local partners We will implement our safe staffing reporting improvement measures, reducing use of temporary staffing, staff sickness, and filling vacancies in the organisation We will ensure all inpatients have a personalised care plan
We will make progress to deliver promises 14 and 19 within our strategy	We will identify the route to meet our March 2026 four week wait guarantee, making initial progress in CAMHS, community nursing services, and memory clinics Waiting times for children and adult neurodiversity services will reduce significantly We will work to deliver our aim of no inappropriate out of area placements: with an initial intent to hold consistently below 15 the number of patients away from their local area for care

In 2023/24, we continued to address the ambitions and commitments identified in the Safety and Quality Delivery Strategy and made significant achievements as detailed in the tables below. Under each priority we have also included a short reflection regarding learning and change.

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
To improve the experience of care and the opportunities for involvement across all care groups and corporate departments • Q1/Q2: we will launch a coproduced experience plan (Patient Experience and Involvement Plan) that will include the 5 key pledges for improvement. • Q1/Q2: we will establish a programme plan and governance structure for the implementation of projects and activities that deliver each of the pledges and several We Will statements within each pledge. The plan will be led by a triple leadership framework; staff, patients, community. • Q1/Q2- We will develop Patient Experience Feedback Volunteer role descriptions for inpatient and community services, and launch local recruitment drives, in support of the Tendable system roll out, and other systems for patient feedback. • Q1-Q4: we will work with the South Yorkshire Integrated Care Partnership Strategy, to develop a coproduction framework for South Yorkshire • Q1-Q4: we will provide leadership support to the South Yorkshire Mental Health Learning Disabilities and Autism (MHLDA) Provider Collaborative to embed involvement and coproduction within the provider priorities.	We have completed a significant amount or work in terms of enhancing our patient, community and citizen engagement over the past year. We have not only linked through key Voluntary, Community and Social Enterprise (VSCE) partners in terms of mental health, physical health and learning disabilities support, but we have also conducted purposeful and targeted work with communities and community organisations that are often marginalised, including veterans' groups, community faith groups, LGBTQ+ community groups and traveller community groups. This purposeful work, and related outcomes, have helped contribute to and form the foundation of our Clinical and Organisational Strategy for the organisation, with the key elements of each pledge now featuring within the 28 promises, each of which is governed through the Clinical Leadership Executive and the 10 sub- groups. We have developed Patient Experience Feedback volunteers and have people recruited and ready to start in role. We are enhancing the ways we use digital interventions in the way we work, this includes the use of 'Tendable' which is a digital audit system and also via the use of digital feedback forums (i.e. Care Opinion). The South Yorkshire Integrated Care Partnership Strategy is developing a working with people and communities' strategy, currently out for consultation, and this includes the principles of coproduction. The People Focused Group, in partnership with the Trust-wide Peer Forum, and the Experts by Experience Alliance (associated with the RDaSH Change and Transformation team) are working effectively together to consider how we best co-produce with people and communities to develop services. This is central to promise 5 in our strategy: where patients will form part of our decision making at every level, usually through our work in communities. ***What have we learned? –*** In working beyond our traditional boundaries and with a more diverse range of communities we have learned how to improve the experience of care for the wider community rather than just focussed upon learning from and engaging people who are happy to provide feedback and attend standard feedback sessions provided. ***What changes have we made? –*** In our effort to listen differently we have made a number of changes, and our learning has informed our engagement plan moving forward. Two examples of changes made are – - We have progressed a digital engagement pilot which has generated which has demonstrated an 8% improvement in feedback. Learning from this pilot is informing our role out across the Trust. - Through discussions with different communities, we have identified additional groups that are provided on evenings and weekends. We have changed the working times of our experience team in order to engage at the times that communities wish to.

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
To implement a Trust wide quality accreditation process and ensure that 'CQC readiness' is 'business as usual' • Each care group and team will undertake our internal accreditation process which mirrors the CQC assessment framework. • Each area will have a peer review but also undertake a self-assessment. • Action plans will be produced, monitored and supported if there are any shortfalls.	Accreditation is part of a longer-term aim as CQC readiness becomes business as usual. We chose in year to focus on peer reviews rather than accreditation. Peer reviews in all inpatient areas have been completed. This has been an invaluable method of providing both insight into quality and safety of our services and organisational learning. Learning has been gained by both the wards being reviewed and the Review Team themselves. Teams consisted of trust staff (clinical and non-clinical), executive and non-executive directors, the FTSU Guardian, and Trust Governors, some of whom have lived experience. From 2024 all our reviews now include patients and carers. Action plans from peer reviews ensured that any issues identified were acted on and resolved. A full end of year evaluation took place, including feedback from the wards and review team members and was wholly positive. As a result, the inpatient reviews will be repeated in 2024/25 but with the addition of a pilot (and subsequent development) of reviews outside the hours of 9am-5pm, Monday to Friday to mirror the 24-hour nature of the services provided by wards. A self-assessment process for community teams has been launched and trialled. ***What have we learned? –*** In our peer reviews we have learned a number of things from our patients, staff and partners. These have related to the experience of our estate, the training needs we have and also in terms of the experience of the care provided. Each peer review has a learning log, with actions, and follow ups. We also cross reference learning when we have had peer reviews in similar services. ***What changes have we made? –*** We have made small and large changes as a result of our peer review processes. Two examples of small changes are – - Environmental repairs to inside and outsides of buildings - Changes in signage and notice board content, Examples of larger changes have been:- - The improvement and expansion of safety huddles. - Safety pod expansion and process review When changes are made, they are not only made in the areas where the peer reviews have occurred but then checked in terms of all other similar Trust settings.
To improve our complaints process • The complaints and investigation team are to be realigned to the care groups in order to promote and embed the new complaints standards.	A review was undertaken of the complaints and investigation teams. A new model was developed and agreed by staff. On 1 April 2024, the two functions split into a separate Complaints team and an Investigation team. During March 2024 a review was undertaken of the Friends and Family Test, Your Opinion Counts and the Patient Advice and Liaison Service

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
• There will be monitoring of the complaints recovery plan to include response times, training and action plans that may be required where care falls below the standard that is expected. • Through early 2023/2024 work will be undertaken to ensure that ethnicity and gender information is collected is collected more thoroughly for the patient (whether or not they are the complainant) and an analysis of the gender and ethnicity of patients/complainants as against our treated population and as against the resident population.	(PALS). The review proposed that the three functions moved from the complaints team to the Patient Experience team building on the Trust approach to capturing patient feedback. The transfer was completed on 1 April 2024 Throughout the year, we have a standard complaints procedure which has been followed. To improve this process, and aligned with the progress of PSIRF, we have reviewed the Trust complaints procedure and launched an improved model in January 2024. Complaints training was commissioned and delivered on 20 February and 18 March 2024 Ethnicity and gender have been captured as part of the complaints process. During Q1 2024/25, this will be mapped against our patient population and against the resident population. ***What have we learned? –*** Our complaints are often unique, however at times there are similar factors in multiple complaints, in changing our approach and enabling a more responsive model, we are more able to coordinate learning and identify cross cutting themes. ***What changes have we made? –*** we have made changes in individual services as a result of complaints: we have altered how referrals are triaged in our hospice; we have changed the information we provide to families waiting to be seen in neurodiversity services; we are finalising new policies on how to support children during family breakdown; and we have made changes to our smoking policy and food offer arising from feedback. Most importantly we are changing our disengagement policy to move to an engagement approach, which we will audit and revisit again in 2024/25.
To fully implement the Patient Safety Incident Response Framework (PSIRF) • In Q2 we will agree our incident priorities and identify appropriate learning response tools based on our patient safety data analysis, within RDaSH, Integrated Care Boards (ICB) and our regulatory partners. These priorities will be included in our Patient Safety Incident Response Plan (PSIRP) and will outline areas where we will undertake Patient Safety Incident Investigations (PSII). • In Q2/Q3 we will continue to engage with colleagues, patients, families, carers and	All preparation work was undertaken, and the Trust PSIRF policy and plan was developed. The Trust started to progress with Learning from Patient Safety Events (LFPSE) on 1 August23. A PSIRF workshop as held as part of the board development programme in October 2023. The PSIRF plan was subsequently approved by the Integrated Care Board (ICB) and Trust Board in November 2023, with a full launch of PSIRF trust-wide on 3 January 2024. PSIRF training has been accessed through the Healthcare Safety Investigation Branch (HSIB) and all Investigators have completed this training. Further training is required for others in the Trust which will be our focus in Q1 and Q2 2024/25. Through this the Trust will roll out internal training for the incident response tools. We now have a daily incident meeting, which means that we can be more responsive in terms of sharing our learning and also analysing actions. This is supplemented by a weekly incident “round up” which allow us to reflect and triangulate the learning across the week. Leadership circles and safety huddles let us learn locally and then share across Trust and nationally if appropriate. We have Schwartz rounds and

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
the wider public as to our incident priorities, our approach to learning response tools and how we will engage those affected by incidents and identify how we will measure effective engagement and satisfaction. • In Q2, we will launch the PSIRF training programme to allow for further insight and develop expertise in systems approach to patient safety incident investigations which will allow us to maximise learning. • In Q2, we will develop our PSIRP based on our patient safety incident profile, outlining our governance processes for signing off PSII, identify learning and support and share this across the organisation, working with our ICB. • In Autumn Q3, we will launch PSIRF and FPSE across the Trust. We will continue to embed and measure implementation of PSIRF in Q3/Q4, making any changes as they arise based on our feedback and measurables.	post incident reflective groups which support us to process learning and relationship dynamics in a "safe space" environment. ***What have we learned? –*** Although we have commenced our PSIRF journey and had some positive effect in terms of our daily incident meetings and risk triangulation, we have not progressed in all areas we would have liked during the first four months of 2024. We have made contact with other organisations who have progressed PSIRF to understand and learning from their journey and compare with ours, this has helped us identify gaps, which are then linked with our actions intended for our 2024/25 plan. We have also learned that there are inhibiting factors regarding risk reporting linked with the accessibility of the risk system, and in response to this learning we are now completing a review and consideration of our risk reporting system to enable the use of hand held devices and apps, which will help mitigate against the factors identified. ***What changes have we made? –*** We have made a number of changes in terms of progressing with our PSIRF journey, a few of these changes include:- - The production and circulation of daily incident reports which include all incidents in the past 24 hours. - The progress of daily incident meetings in which our clinical and backbone services work together to both respond to and also analysis any themes and trends in terms of incidents on a daily and weekly basis, this analysis then contributes to preventative work. - The publication of focussed clinical learning briefs that are shared with the entire organisation, these briefs are linked at times with our incidents but also can be linked to national learning (i.e. from national medication alerts) - We have sourced bespoke training for our investigators which enables a modernised approach to fact finding and investigation aligned with PSRIF. - We have increased our coproduction work with patients, families and staff in terms of establishing the parameters for reviews and investigations and also agreeing supportive timelines and updates.
To continue to improve the effectiveness of clinical audit within the Trust • A proposed clinical audit calendar is being agreed with the care groups. This will include mandated national audits. • Clinical audit is central to our quality improvement and care standards. Actions will be	The Audit Framework has continued to drive forward the audit activity in the organisation throughout 2023/24, providing the structure for clinical audit activity within the Trust. The proposed Trust wide forward clinical audit programme for 2024/25, has been presented and discussed with care group leads, quality committee and audit committee and the final forward programme will be aligned to the safety and quality plan. All audits have been conducted appropriately as planned. Where an audit has identified that a recovery plan is needed, support has been given to operational services by the Clinical Effectiveness Team. Where required, re-audits have been conducted to show recovery effectiveness; this is

<table>
<tr><th colspan="2">Safety and quality priorities for 2023/24</th></tr>
<tr><th>What is our priority? And what did we expect to achieve?</th><th>What did we achieve?</th></tr>
<tr><td>monitored and supported should any audits fall below the expected quality standards.</td><td>included in the annual Clinical Effectiveness Audit Report which is monitored through Quality Committee.

We also engage in an internal 360 audit programme, as well as a number of service and professionally focussed NHS Benchmarking exercises, all of which help us to consider our organisational intelligence and organisational learning.

What have we learned? – Our internal and clinical audit programmes help us to continually learn, both in terms of aspects of our delivery that are running well and aspects that require improvement.

Within the changes in our strategic model and operating model, we have enacted learning related to leadership behaviours regarding clinical outcomes and audit. We aim to expand this work within our 2024/25 education and learning plan.

What changes have we made? – A number of changes has been made in terms of improving where audits have shown shortfalls. As well as this our audits have also resulted in other changes, and example of change is:-
- Quick reference guides developed linked with a number of our clinical policies including infection control and prevention, to ease staff use.</td></tr>
<tr><td>Health and safety

• A health and safety calendar of audits is being developed and agreed with the care groups</td><td>There was a re-initiation of the Tendable application across the Trust in September 2023. As part of this work there was a focus on the audits and schedules that are currently a requirement:

<table>
<tr><th>Audit Title</th><th>Frequency undertaken</th></tr>
<tr><td>Environmental Daily Checklist</td><td>Daily</td></tr>
<tr><td>Kitchen Refrigerator Temperature Monitoring Recording</td><td>Twice weekly</td></tr>
<tr><td>Fire Manual Daily Inspections</td><td>Daily</td></tr>
<tr><td>Infrequently Used Water Outlets</td><td>Twice weekly for 10 minutes</td></tr>
</table>

A programme of inspections is scheduled to cover inpatient and community services. Including:
• Health and Safety Inspection
• Security Risk Assessment
• Ligature Risk Assessment
• Lone Worker evaluation/ Device management

All audits have been completed and are on track. All audits are in place as per policy. Inspections/audits are coordinated based on availability of care group employees to support and coordinate actions. There is a</td></tr>
</table>

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
	central log within the Health and Safety Team of inspections dates and actions that are monitored by the team. ***What have we learned? –*** In our checks we have learned more about our environments and how the occupancy and acuity we are seeing particularly in our inpatient settings is changing the risk dynamic in terms of our environment. ***What changes have we made? –*** An example of changes underway is related to our inpatient doors, regarding their accessibility, fitment and risk assessments. This has resulted in some immediate change, and also informed our capital spending plan for 2024/25.
To use data and triangulation of data to support quality improvements. • Quality improvement metrics will be agreed and will be monitored against	We have made a number of changes in terms of our data maturity over the past year. Actions in this area have ranged from the use of personal electronic devises to the progress of systems which help us view our data in a different way using SPC charts rather than single points which helps us with trend analysis. As well as the systems we use we have also continued our quality improvement training which has helped train our staff to consider the data available to them in different ways. Whether this is 1:1 patient observation data, case load data or data in terms of health profiles. ***What have we learned? –*** We are on a journey in terms of our use of data, and we have learned that equal focus upon the mechanics required (including devices and storage) are as important as our focus upon the dynamics (including our staff awareness and training) in order to achieve effective implementation. Our digital supporting plan is being coproduced, encompassing both of these aspects. ***What changes have we made? –*** We have developed and launched our Integrated Quality Performance Report (IPQR) which provides high board level quality metric data and is now running as business as usual. There is a run chart produced and narrative alongside any anomaly. We also produce bimonthly safety reports which support our organisational learning and are served in our Quality Committee. In terms of a future focus, FTSU information will be included alongside of our patient safety data in this report to support better triangulation of risk. During 2024/5 we expect to launch our safety plan indicators: driving towards always events in care pathways across community and mental health services.
To move from minimum safe staffing to optimal staffing on inpatient units and in community services.	Our current position meets core standards for the national safe staffing declaration requirements. We have a coherent policy which is adhered to and there are escalations aligned with the policy when required. Most importantly operationally staffing is adjusted to meet need on a shift by shift basis. However, there are areas of improvement we aim to see:

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
• Fully implement Mental Health Optimal Screening Tool (MHOST) across all services • Undertake analysis and provide evidence to support that inpatient flow has been improved. • Provide evidence of where and when minimum staffing has moved to optimal staffing	• We have issues with data use and compliance levels specifically in our Psychiatric Intensive Support Unit's (PICU); however, we have no evidence of significant harm in terms of these data or compliance issues. • Although our ward level analysis is conducted on a daily and weekly basis, our across Trust reporting does not yet include weekly data, but this is an intention for 2024/25 and there will be monthly oversight provided via the Chief Nursing Officer and Chief Executive in terms of this improvement. • Our safe staffing report also does not yet analyse bank/agency percentage of shift fill rates. This issue is managed at a local level support by the Nursing and Quality Team. Data visibility on this matter will improve early in 2024/25.
The Trust is fully engaged with the national inpatient quality standards programme. • We will be able to evidence where inpatient services have met the national standards. • We will evidence a reduction in the number of out of area placements. • We will evidence improved patient experience	Since the pandemic the acuity and occupancy levels in our inpatient services have increased. We have engaged with our ICB and national partners in terms of making improvements to our inpatient services in partnership. However, we remain challenged in this area, which is reflected in our occupancy levels, our out of areas placement levels and also our length of stay. The focus on improving inpatient care means that a very senior group of board leaders are currently meeting fortnightly to coordinate change efforts. ***What have we learned? –*** Our focussed work has considered three aspects – patient pathways, partnership working and also workforce. Whilst we know we have positive pathways in terms of the needs of many of the people accessing our services, we also have learned that people who present who have differing needs (in terms of neurodevelopmental needs for example) experience our inpatient services in different ways which is a challenge for recovery. Our learning in terms of partnership working is related to people who experience longer than average lengths of stay linked with different levels of community provision across our footprints. This has meant that we have focussed our efforts in terms of changes such as the development and enhancements of virtual ward provision, but we have also worked with VCSE partners in terms of crisis and out of hours mental health support. ***What changes have we made and are we planning? –*** We have made a number of changes, two examples are:- - The expansion of assertive outreach community care provision from a 9-5 – Monday to Friday services, to a 7 day per week service to better support patient needs and outcomes. - The Trust been successful in selection for the NHS England "culture of care" national programme, to which we are signed up. We commenced this programme at the end of Q4 2023/24,

Safety and quality priorities for 2023/24	
What is our priority? And what did we expect to achieve?	**What did we achieve?**
	and Saiqa Akhtar is our Senior Quality Improvement Advisor - National Collaborating Centre for Mental Health (NCCMH) - Royal College of Psychiatrists. The Executive Leads for this programme are the Chief Nurse and the Director for Psychological Professionals and Therapies. - We are looking forward to receiving additional improvement expertise and coaching form the national team to progress this work.

Patient Feedback

Patient feedback is received via the Patient Advice and Liaison Service (PALS) and local Your Opinion Counts forms:

Indicator	2022/23	2023/24
Patient Advice and Liaison Service (number of contacts)	613	695
Your Opinion Counts (number of returned forms)	1,490	1,189

In addition, the Trust takes part on the Mental Health Community Survey which is an independently administered national survey of patients receiving mental health care in community settings. The survey is comprehensive and provides valuable quantitative data to facilitate comparison with other Trusts and benchmark our services numerically against a range of indicators. The results are provided to the Trust as a whole trust and it is not possible to break this down by geographical area.

Overall results were encouraging, with most scores for the Trust sitting in the intermediate with a score of between 6 and 6.9 (out of 10). This is comparable with the previous year's results with the Trust also falling within this range in 2022/23.

The number of compliments recorded by the Trust has increased from 2022/23 by 69% (total of 628 in 2022/23 and 1058 in 2023/24). This is mainly due to an increase by the Children's Care Group reporting of their compliments, for which their reporting has increased by almost 246% in 2023/24.

North Lincolnshire Adult Mental Health and Talking Therapies Care Group has seen a drop in recorded compliments by 62% and Rotherham Adults Mental Health Care Group saw a drop of 80%. However, this system is reliant on staff recording compliments. This will be reviewed during 2024/25.

It has not been possible to separate the data for Doncaster Mental and Physical Health Care Groups prior to January 2024 as the system supporting this data could not provide this. Further changes to the care group structures were made in January 2024 and the system was

re-aligned at this point. However, overall Doncaster Care Groups recorded comparatively similar numbers of compliments (351 in 2022/23 and 355 in 2023/24).

Care Group	Number of compliments recorded	
	2022/23	2023/24
Children's	194	671
Doncaster: Q1 – Q3 2023/24	331	184
Doncaster Adult Mental Health and LD: Q4 2023/24	-	41
Doncaster Physical Health and Neurodiversity: Q4 2023/24	-	130
North Lincs Adult Mental Health and Talking Therapies	76	29
Rotherham Adult Mental Health	15	3
Corporate	12	0
Total	**628**	**1058**

Complaints handling

The Trust has continued to develop the complaints handling process and a recovery plan is in place and is being monitored by the Quality Committee.

Indicator	2022/23	2023/24
Number of complaints received	73	70
Number acknowledged within 3 working days	68	64
Number ongoing (still open)	20	40
Number upheld	2	2
Number partially upheld	19	12
Number not upheld	23	13
Number withdrawn	7	3
Number investigated to the Ombudsman	1	1
Number of clinical negligence claims raised which had previously been a complaint*	1	3

*The claim was raised in the current year but the complaint may have been raised in previous year.

The complaint which was taken to the Parliamentary and Health Services Ombudsman (PHSO) was still ongoing with the PHSO as at the end of 2023/24.

Of the 3 new clinical negligence claims made by complainants in 2023/24, 1 was unsuccessful and therefore resulted in nil damages and 2 remain ongoing as at the end of 2023/24.

At the end of 2023/24 the Trust had 40 formal complaints ongoing, 24 complaints were still in the time frame as per Trust policy. A review of the complaints process was completed by the 31 of March 2024 which will improve the response times to complainants.

The main three categories for complaints in 2023/24 and 2022/23 were:

2022/23		2023/24	
Category	Number	Category	Number
Patient Care	28	Patient Care	26
Communication	14	Communication	10
Clinical Treatment	7	Values and Behaviours	10

Actions and learning from complaints are shared via the patient safety dashboards which are discussed at the Care Group Quality Assurance meetings and via the Patient Safety Report. Learning is also shared in the clinical learning brief which goes out to all staff.

Financial Performance

The Group deficit was £2.3m for 2023/24, this included a net reversal on valuation of previously impaired Trust assets of £1.5m credited to operating expenses in year.

The position against which operational performance is measured by NHS England (NHSE) was a deficit of £3.5m. A reconciliation between the group deficit and the deficit for operational NHSE performance purposes is included on page 34.

Revenue

Total operating revenue in 2023/24 amounted to £226m (£219m in 2022/23), an increase on the prior year total of £8m. Revenue included £7.1m of notional income recorded in the accounts for additional pension contributions which have been paid directly to NHS pensions in year (compared to £6.4m in 2022/23). Around £192m (85%) of our income is received from NHS bodies for the purchase of healthcare activity. A further £20m (9%) is received from Local Authorities for public health activity.

Expenditure

Our operating expenditure excluding financing costs was £225m and the largest element of this was the pay bill for our staff costs of £181m (80%). Other significant components of the Trust's expenditure baseline are the purchase of healthcare services from other providers of £10m (4%), establishment and premise costs of £10m (4%) and supplies, service, and drugs costs of £12m (5%).

Capital and Cash

The Group had a cash balance of £34.4m (£40.3m in 2022/23) at the close of the financial year. Capital expenditure excluding lease additions in 2023/24 totalled £7m (£6.5m in 2022/23), of which £5.2m (74%) was spent on clinical refurbishment and reconfiguration, £1.4m (20%) on IT and £0.4m (6%) on estate maintenance.

Group Position and Underlying Position for NHSE monitoring purposes

The accounts included in the annual report reflect a group position which consolidates the Foundation Trust, Charitable Funds accounts and Flourish CIC. The Charitable Funds accounts had a net adverse movement in funds of £0.58m in the year 2023/24, with Flourish CIC finishing the year with a £2k surplus.

A reconciliation from the overall group position to the underlying deficit for NHSE operational performance purposes is shown below:

23-24 Group Position to 23-24 Underlying Deficit for NHSE Operational Performance	Surplus/(Deficit) £'000
RDaSH FT	(1,666)
Flourish CIC	2
Charitable Fund	(659)
Group Position	**(2,323)**
Remove impairment reversal credited to operating expenses	(1,451)
Adjustment to control total for changes made between 22/23 draft and final accounts	557
Remove capital donation and peppercorn lease impact	(217)
Remove actual IFRIC 12 scheme finance costs	1,220
Add back forecast IFRIC 12 scheme interest on an IAS 17 basis	(791)
Add back forecast IFRIC 12 scheme contingent rent on an IAS 17 basis	(1,062)
Remove PDC dividend benefit arising from PFI liability remeasurement	(220)
Remove non-cash pension movement	83
Remove Charitable Fund Deficit	659
Underlying Deficit for NHSE Operational Performance	**(3,545)**

Cost Allocation and Charging

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political Donations

No political donations were made in 2023/24 (none in 2022/23).

Better Payment Practice Code

The Trust adopts the Better Payment Practice Code in respect of invoices received from suppliers. The code requires the Trust to aim to pay all undisputed invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The table below shows the performance against this metric by NHS / Non-NHS supplier and shows the volume and value of invoices paid. The introduction of a new finance system in year which removed the ability to exclude any invoices in dispute or query has resulted in the reported figures showing a deterioration against this metric. The Trust is working with the software supplier to develop functionality to be able to reflect the position excluding disputed and queried invoices.

	By Number				By Value			
2023/24	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days
NHS	2,495	2,247	248	90.1%	11,199	9,727	1,472	86.9%
Non-NHS	28,359	23,453	4,906	82.7%	57,265	49,100	8,165	85.7%
Total	30,854	25,700	5,154	83.3%	68,464	58,827	9,637	85.9%

Interest Liability

No interest was accrued and paid by the Trust for failing to pay invoices within the 30-day period where obligated to do so.

Income generation

The Trust has not levied any fees and charges where the full cost exceeds £1 million or the service is otherwise material to the accounts.

In accordance with Section 43(2A) of the NHS Act 2006, the Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purposes. The Trust has, therefore, met this requirement.

Also, in accordance with section 43(3A) of the NHS Act 2006, the Trust can confirm that the other income received has had no impact on the provision of goods and services for the purposes of the health service in England.

Forward look to 2024/25

The financial outlook going into 2024/25 continues to be a challenging one, with the Trust submitting a deficit plan of £3.76m (£6.2m in 2022/23) and efficiency savings planned for 2024/25 of £6.6m (£10m in 2022/23).

The financial outlook is consistent with local, regional and national NHS systems and will require collaborative working with ICB partners to identify new ways of working and recurrent savings, whilst continuing to improve health outcomes for the population we serve.

Performance Report signed on behalf of the Board of Directors

Toby Lewis, Chief Executive
11 July 2024

ACCOUNTABILITY REPORT

Staff Report

The Trust values its employees and has 3,450 (average whole time equivalent) staff working across our geographical footprint.

Staff Costs	**Permanent £000**	**Other £000**	**2023/24 Total £000**	**2022/23 Total £000**
Staff and Executive Directors	127,464	7,935	135,331	130,053
Non-Executive Directors	154	0	154	127
Social security costs	13,782	0	13,782	11,949
Apprenticeship levy	668	0	668	578
Employer's contributions to NHS pensions	16,152	0	16,152	14,597
Pension cost - employer contributions paid by NHSE on provider's behalf	7,063	0	7,063	6,379
Pension cost - other	28	0	97	154
Other post-employment benefits	0	0	0	0
Agency	0	7,555	7,555	8,092
Total staff costs	165,311	15,490	180,801	171,929
Of which Costs capitalised as part of assets	75	0	75	68
Total staff costs excluding capitalised costs	**165,236**	**15,490**	**180,726**	**171,861**
Termination benefits	0	0	74	23

Average number of employees (WTE basis)		**Group**		
	Permanent Numbers	**Other Numbers**	**2023/24 Total Numbers**	**2022/23 Total Numbers**
Medical and dental	57	22	79	83
Administration and estates	920	0	920	889
Healthcare assistants and support staff	731	0	731	727
Nursing	1,129	0	1,129	1,098
Scientific and technical staff	509	0	509	425
Social care staff	0	0	0	0
Bank	0	39	39	70
Agency	0	44	44	36
Total Average numbers	**3,346**	**104**	**3,450**	**3,328**
Of which Average engaged on capital projects	2	0	2	2

Year-end analysis

As at 31 March 2024, the profile of staff in post was:

	2023/24		2022/23	
	Male	Female	Male	Female
Directors	9	9	8	10
Senior Managers (Band 8a and above)	33	100	36	117
Others	688	3,667	661	3,599
Total	730	3,776	705	3,726

	White	BME	Not stated	Blank
Directors	8	1	-	-
Senior Managers (Band 8a and above)	230	11	2	-
Others	3,771	424	5	1
Total	4,009	436	60	1

Sickness absence data

	2023/24	2022/23
Sickness Figure	5.9%	6.0%
WTE days lost	52,558	50,434
Average WTE	3,382	3,241
Days per employee (WTE)	15.54	15.56

During 2023/24 we have achieved a very slight reduction in our sickness absence levels. During 2024/25 we plan on launching our new policy which will focus on attendance at work with managers having increased accountability re the sickness levels within their teams/Directorates.

Staff policies and actions applied during 2023/24

The Trust is recognised as a Disability Confident Employer which demonstrates the organisation's commitments in relation to recruitment, retention, employment, and career development of disabled people.

As part of being a Disability Confident Employer, the Trust operates a guaranteed interview scheme as specified in the Appointment of Staff Policy for candidates who have a disability which falls within the definitions described in the Equality Act 2010 and subsequent amendments.

Candidates who have a disability will be offered an interview if they meet all the essential criteria detailed on the person specification for the post.

The Trust's Sickness Absence policy and procedures are applied consistently and support the continuing employment of and enable the provision of appropriate training or reasonable adjustments for employees who have become disabled persons during the period.

Following consultation and engagement with the Disability and Wellbeing Network (DAWN), it was agreed in May 2023 that funding of all reasonable adjustments would come out of one centralized budget. Alongside this a Reasonable Adjustment Toolkit, which includes a wellbeing passport and guidance for both managers and staff was introduced. This toolkit supplements other employment policies and clearly sets out intentions to support and value disabled people working in the Trust.

Staff engagement

Engagement with people who are our colleagues, volunteers, trainees and students is central to the successful delivery of high-quality healthcare.

The Trust approach to ensuring high-quality healthcare is delivered through meeting our vision and strategic objectives whilst following our values.

The Trust has continued to develop its staff networks; REaCH – Race Equality and Cultural Heritage, Lesbian Gay Bisexual Transgender + Ally (LGBTQ+), Disability and Wellbeing network (DAWN) and our newly formed Women's network.

We engage with our colleagues through a variety of means, face to face, digital – MS Teams, Email, Staff App and VLOGS. We have also supported a number of staff drop in sessions across all of our localities which are facilitated by the Executive Team. This year we have also launched the Trolley Dash to further support and engage colleagues whilst they are in the workplace.

Our people are our greatest asset and the Trust continues to invest in them to build on both capability and the culture for continuous improvement in quality and culture within everything that the Trust does.

The Joint Consultative Committee (previously known as Trust Staff Council) meets every 4 weeks and membership includes senior managers and nominated, local representatives of recognised trade unions and professional organisations. The purpose of the meeting is so that staff representatives are aware of strategic and operational planning decisions which have impact upon staff members; consulted on the development of employment policies which require a common approach across the Trust and consulted upon any change management proposals. It also provides staff representatives with a forum through which they can express their collective views on issues affecting the employment of staff members including job security and job environment. Through this forum a joint review can take place of commitments made to our colleagues in either strategic or annual service direction documents.

Our medical colleagues have a similar forum referred to as Joint Local Negotiating Committee, which meets every 12 weeks to discuss matters relating to the British Medical Association (BMA), General Medical Council (GMC) and other national and local agreements which impact the medical workforce.

Freedom to Speak Up

The Freedom to Speak Up (FTSU) guardian and the FTSU Champions as well as the Health and Wellbeing champions continue to promote a culture that is safe, open and healthy through ensuring that all colleagues have the psychological safety to speak up about issues relating to patient safety and colleague experiences.

The Trust has an established range of routes that our colleagues can take to speak up about issues that concern them and this includes speaking to line managers and clinical leads as well as the FTSU team, staff-side representatives, safeguarding team, spiritual care team and the health and wellbeing team. We have digital routes in which colleagues can raise issues, including an anonymous 'speak up' button on the staff intranet, text, email, and via virtual means such as MS Teams to support and promote flexibility as some colleagues work remotely. This collective approach has been critical in enabling the early detection and escalation of issues and in ensuring consistency in the approach and ease of access to support colleagues.

Once a concern is raised, it is appropriately and confidentially shared with relevant teams or members of staff within hours of receipt to ensure rapid action and risk triangulation with other patient and safety measures. Following initial identification and action, a personalised plan is agreed to manage the concern co-produced where possible with those who raised the concern. The FTSU guardian and champions provide support to individuals and teams until the point where mutual agreement to close the concern is reached, providing regular updates and supportive monitoring to ensure that concerns are managed in a timely manner where possible.

When concerns are raised options related to confidentiality are discussed and people's experience of 'speaking up' is monitored throughout the process and after concern closure via a written feedback form. This ongoing monitoring is to both ensure people feel supported, and also to ensure that any signs of detriment may be identified and also rapidly responded to. Our feedback shows that people in RDaSH have had a very positive experience of speaking up, and this is shown when national comparators are analysed.

Staff support

We continue to provide a range of services to ensure the workforce is supported to be well at work. This includes access to 'in the moment support' anytime day or night to talk to a trained counsellor for advice, support and reassurance. We continue to offer access to mental health interventions including counselling and psychological therapy. There is also a multitude of self-help books, online resources and webinars for colleagues to freely access. Across the organisation we continue to offer opportunities for coaching support, distance supervision, team effectiveness sessions, leadership support circles, Schwartz rounds and new starter networks, all of which are designed to create psychologically safe spaces where people can share and talk about work and their personal challenges and opportunities for learning.

Health & Wellbeing

The health and wellbeing of the workforce continues to be an essential focus and the action plan covers all the elements of wellbeing including physical, emotional, spiritual and mental wellbeing. The team are actively investing in the development and growth of our health and

wellbeing champions across the Trust, to ensure they can actively support colleagues in clinical and non-clinical roles. Throughout the year we have run a range of health and wellbeing campaigns and initiatives including stress awareness, increasing physical activity, financial wellbeing, menopause and men's health.

Policies in relation to countering fraud and corruption

The Trust is committed to applying the highest standards of ethical conduct and integrity in our business activities and every employee and individual acting on our behalf is responsible for maintaining the organisation's reputation and for conducting Trust business honestly and professionally.

The Board and senior management are committed to implementing and enforcing effective systems to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010. The Trust has ensured related policies including, the Counter Fraud, Bribery and Corruption Policy, Standards of Business Conduct and Whistleblowing outline our position on preventing and prohibiting bribery.

Colleagues and others acting for or on behalf of the organisation are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments. Business will not be conducted with service providers, agents or representatives that do not support the organisation's anti-bribery objectives.

Equality Diversity and Inclusion

The Equality Diversity and Inclusion team have focused their work on developing and building a culture where diversity is embraced, and people are welcomed and included at RDaSH. The team work on becoming an actively Anti-racist organisation where racism has no place and allyship is embedded. The team support a range of staff networks including the Reach, Dawn, LGBTQ+, and Women's network all of which offer peer support, share lived experience, a sense of community and offer ideas and challenge help to make the organisation a better and more inclusive place. The team work hard to ensure that all colleagues declaring a disability have their adjustment needs met and they can thrive at work.

Modern Slavery

Although the Trust is not classed as a "commercial organisation" for the purpose of the Modern Slavery Act 2015, a number of steps have been taken to ensure to the best of our knowledge that slavery and human trafficking is not taking place in any of our supply chains or in any part of our business through recruitment and payroll processes. The inclusion of statements in contracts that the Trust enters into with providers that states that the supplier agrees that it is responsible for controlling its own supply chain and that it shall encourage compliance with ethical standards, human rights, health and safety and environmental standards by any subsequent supplier of goods and services that are used by the supplier when performing its obligations under this agreement.

Staff Turnover

Turnover data is published by NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Survey

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

The response rate to the 2023/24 survey among our colleagues was 53% (2022/23: 51%).

2023/24, 2022/23 and 2021/22 - Scores for each indicator together with that of the survey benchmarking group (51 organisations across Mental Health/Learning Disability and Community Trusts) are presented below.

Indicators People Promise elements and themes	2023/24		2022/23		2021/22	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.63	7.58	7.7	7.5	7.7	7.5
We are recognsied and rewarded	6.41	6.41	6.5	6.3	6.5	6.3
We each have a voice that counts	7.06	7.01	7.2	7.0	7.1	7.0
We are safe and healthy	6.57	6.38	6.6	6.2	6.4	5.2
We are always learning	5.95	5.93	5.9	6.1	5.8	5.6
We work flexibly	7.09	6.84	7.1	6.7	6.9	6.7
We are a team	7.17	7.18	7.2	7.1	7.2	7.1
Staff engagement	7.19	7.11	7.3	7.0	7.2	7.0
Morale	6.38	6.17	6.4	6.0	6.3	6.0

A breakdown of the Trust's performance against the benchmarking group for the 9 key themes/areas in 2023/24 is detailed below:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.93	6.90	7.34	6.68	6.45	7.25	7.47	7.45	6.61
RDaSH	7.63	6.41	7.06	6.57	5.95	7.09	7.17	7.19	6.38
Average	7.58	6.41	7.01	6.38	5.93	6.84	7.18	7.11	6.17
Worst	7.14	6.04	6.23	5.84	5.17	6.23	6.90	6.46	5.21

A breakdown of the Trust's performance against the benchmarking group for the 9 key themes/areas in 2022/23 is detailed below:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
RDaSH	7.7	6.5	7.4	6.6	5.9	7.1	7.2	7.3	6.4
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2

A breakdown of the Trust's performance against the benchmarking group for the 9 key themes/areas in 2021/22 is detailed below:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
RDaSH	7.7	6.5	7.1	6.4	5.8	6.9	7.2	7.2	6.3
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5

Areas of focus for 2024/25

There are three areas that the Trust has scored statistically significantly lower than that it did in 2022, these areas are "we are compassionate and inclusive", "we each have a voice that counts" and "Staff Engagement". There has been an increase in colleagues reporting that they have experienced discrimination from their manager/team leader or work colleagues of the 134 respondents from ethnic groups (other than white) 25.3% had experienced harassment bullying or abuse and 20.9% had experienced discrimination. This is a startling statistic and all colleagues must work collectively to address this unacceptable behaviour. The Trust is clear in its commitment to becoming an anti-racist organisation by 2025 (Promise 26) and we will be working with our networks, colleagues, and partners to deliver the promise. In order to deliver the best standard of care to our patients it is important that our colleagues feel valued and respected in their roles and feel engaged with the organisation. It is for this reason that these areas have been identified as our areas of focus for this year.

We are Compassionate and Inclusive

Colleagues recommending RDaSH as a place to work has reduced by 2.6% since the 2022 survey. When looking at this in more detail several reasons for this are evident. There has been a decline in colleagues feeling that their immediate manager is interested in listening to them or will work with them to understand problems. In addition, we have seen a decline in people feeling that those they work with are kind to one another and respect one another.

Further work needs to be undertaken to understand the stories behind these results and this can be done through linking in with the Staff Network Groups and freedom to speak up champions. Each area manager has to understand their own results and by utilising an appreciative enquiry approach seek to listen and change what has been happening. Concerns raised about bullying, harassment and discrimination must not be taken lightly and should be reported and investigated appropriately as the HR data relating to concerns raised doesn't correspond with this level. Colleagues need to be encouraged to raise concerns and feel psychologically safe in doing so and this directly links with our second areas of focus, we each have a voice that counts.

Further work needs to be undertaken to promote the Trust's fully trained mediators who can help colleagues talk to each other in a facilitated way, hopefully preventing situations from escalating. As part of the leadership offer, managers will enhance their skills in handling difficult conversations, which should address concerns in a timelier manner and prevent escalation.

In order to understand how people are feeling across the organisation participation and promotion of the quarterly NHS Pulse Check will provide more regular feedback to the organisation on how colleagues are feeling and whether steps are being taken to improve the employee experience across the organisation.

In addition, colleagues are asked on what grounds they have experienced discrimination and the highest response with 31.2% is "other" with the second highest (30.6%) being on the grounds of ethnicity. As an organisation we need to understand what colleagues are indicating when they state they have experienced discrimination on the grounds of "other". Work has already begun to explore this with our staff network groups and the initial response is that people are concerned that the survey isn't anonymous and therefore they are ticking "other" so they cannot be identified.

We Each Have a Voice that Counts

This people promise has two elements: autonomy and control and raising concerns. Whilst there has been a decline in people feeling that they have autonomy in their role the decline is greater in colleagues' responses to the raising concerns questions. Focus needs to be placed on ensuring people feel safe to raise their concern and if they do that something will be done about it. We also need to reassure people that they are safe to raise their concerns and that the organisation will address their concern as a high number of people are unsure about how their concerns will be treated.

Information from the Staff Survey has been shared with both the patient safety group and the Freedom to Speak up Guardian so that they can consider whether there are any areas within

which the results are lower than expected as previously the Trust scored highly in this area. They can also work with care groups and directorates to promote the work they are doing and celebrate the changes that are being made due to colleagues raising concerns.

We also need to consider how outcomes are fed back to the concern raiser, how we thank colleagues for raising their concern and share the learning across the Trust to prevent similar situations.

Staff Engagement

The staff engagement score has decreased from 7.31 in 2022 to 7.19 in 2023. This score is devised from looking at the responses to questions focusing on, motivation, involvement and advocacy. This score is a good gauge of how people in the organisation are feeling and includes the responses to the questions, I look forward to going to work and I would recommend my organisation as a please to work.

There is more work to do, but initial work indicates that we have a high proportion of colleagues choosing the middle option i.e. “sometimes” or “neither agree nor disagree” therefore work needs to focus on understanding what would improve their work experience so that they enjoy work and would definitely recommend RDaSH to friends and family as a good place to work.

We can improve the retention of our staff if they enjoy coming to work and feel that their work is valued, this will be further explored as part of the People Promise Exemplar work.

Having seen a decline in responses in “we are compassionate & inclusive” and “we each have a voice that counts” it is not surprising that the overall staff engagement score has declined. It appears that the culture within the organisation is changing, people are reporting that colleagues aren’t kind to each other, they don’t feel supported by their manager and departments don’t work well together. A new governance structure was launched in January 2024 and it is hoped that this will have a direct positive impact on the 2024 results

Through leadership training that is due to commence in 2024/25 we can upskill managers and work with them to look at how they can support their staff in the workplace. Through the network groups we can share stories and take forward pieces of work that promote colleagues working together. The Organisational Development team have developed a Civility and Respect Workshop which has been delivered to 21 teams across the organisation, 316 colleagues, and a further 11 workshops are scheduled to take place.

Trade Union Facility Time

Total number of Trust employees who were relevant union officials during the relevant period (1 April 2023 to 31 March 2024):

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
9	7.62

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

Percentage of time	Number of employees
0%	3 individuals
1 – 50%	4 individuals
50-99%	0
100%	2 individuals

The information in the table below determines the percentage of the Trust total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period (2023/24):

Column 1	Figures
Total cost of facility time (Includes gross salary, employer pension contribution and national insurance contributions)	£57,916.95
Total Trust pay bill	£136,649,917.50
Percentage of the total pay bill spent on facility time is calculated as: (total cost of facility time ÷ total pay bill) x 100	4%

Total Pay Bill – this figure differs from the 'Total Staff Costs' presented on page 60. Total Pay Bill represents the expenditure of directly employed individuals and excludes costs such as those associated with agency staff, journaled expenditure and secondment arrangements. This means the calculation more closely aligns to the staff that the paid union staff represent.

Number of hours spent by relevant union officials on paid union activities as a percentage of total paid trade union facility time hours:

Column 1	Figures
Time spent on paid trade union activities as a percentage of total paid facility time hours is calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	3.3%

Details of the Trade Union Facility Time disclosures are published on the Trust's website at https://www.rdash.nhs.uk/about-us/public-declarations/facilities- information-data/

Expenditure on consultancy

As per note 6 to the accounts, the Trust spent a total of £250,000 on consultancy in the financial year (2022/23 - £258,000). The key pieces of consultancy work commissioned related to the Good Governance Institute, The Value Circle, and Shared Agenda. Reducing such spend forms part of our financial plan in 2024/25.

Off-payroll arrangements

Table 1: Highly paid off-payroll worker engagements as at 31 March 2024 earning £245 per day or greater

Number of existing engagements as of 31 March 2024	24
Of which...	
Number that have existed for less than one year at time of reporting.	24
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2024	53
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	53
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

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

Staff exit packages

The Trust actively manages services to ensure effective care for patients/service users within the resources available, which may necessitate organisational changes to the workforce as a result of the external environment or an internal review of service requirements. Where the redeployment of employees cannot be facilitated there are occasions when the efficiency programme leads to the need for redundancy payments.

Information below provides an analysis of exit packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the agenda for change terms and conditions.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,000 – £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	0	0
£100,000 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	0	0	0
Total resource cost	0	0	0

Exit packages: Non-compulsory departure payments

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval *	0	0
Total	0	0
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

Gender pay gap

In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, employers with 250 or more employees are required to publish information on the pay gap between male and female employees as of 31 March each year. This information must be published on the employer's website. The Gender Pay Gap Report is based on a snapshot date of pay of 31 March 2023. https://www.rdash.nhs.uk/documents/gender-pay-gap-report-2023/

RDaSH data can be compared to other organisations by using the government Gender Pay Gap reporting portal. https://gender-pay-gap.service.gov.uk/

Environmental Matters

Waste management

The Trust has a duty of care to manage its waste in accordance with the Environmental Protection Act (1990). A proactive approach is taken to waste management, last year we reported that approximately 54% of waste, including food waste, produced by the Trust is reused or recycled: this year this it remains at 54%. The remainder of this waste is sent for incineration into a local plant that has an award-winning district heating system, delivering 45MW of heat to over 140 buildings, and generates up to 21MW of electricity per year, enough to power more than 25,000 homes.

During 2023/24 the Trust reduced its food waste to 101 tonnes compared to 120 tonnes in 2022/23 which was in part due to the correct segregation of waste in Rotherham. The food that is wasted is sent to a local bio-mass plant where it is also used to generate electricity and, a by-product from the biomass process which is an organics liquid fertilizer.

We reported last year that during 2022/23 the Trust achieved its zero to land fill promise, and in 2023/24 we continued to do so.

Carbon Footprint

We have continued investing in charge points for electric vehicles across the main inpatient sites to encourage the use of hybrid and electric vehicles, and this will continue to grow. In 2023, we commissioned an additional 21 charge points across our sites, taking our new total from 22 to 43.

In relation to business travel, the geographically dispersed nature of the Trust and the activities of its staff lead to a high use of vehicles which has a significant contribution to the Trust's carbon consumption. A large part of business miles travelled is by clinicians travelling to see patients. We have invested in alternative means of service delivery such as teleconferencing and virtual online meetings which has reduced the need to travel and it is anticipated that this will continue. Our CO2 emissions for business travel in 2023/24 was 720 this compares to 736 in 2022/23.

Task force on climate-related financial disclosures (TFCD)

NHS England's NHS Foundation Trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24.

We reduced our emissions from 3,622 carbon tonnes in 2022/23 to 3,562 carbon tonnes in 23/24. A reduction of 1.66%.

In terms of examples of our actions, we have carried out the following:

- Incorporated the Social Value 10% evaluation criteria into all contracts we put out for tender.
- Integrated the Green Plan into the RDaSH Strategy 23-28, with a specific promise on sustainability (Promise 27).
- Commissioned a solar farm feasibility study, with a view to reducing our electricity emissions by approximately 25% if we proceed.
- Commissioned an additional 21 charge points across our sites, taking our new total from 22 to 43.
- Piloted reusable tourniquets in one of our services, with very positive feedback.
- Set up a Green Champions Network to improve awareness, share ideas and ensure our Green messages are being heard right across the organisation. This has been running since December 2023.
- All Green Champions are taking up Carbon Literacy training, with approximately 5 having taken it so far.
- Held a Green Summit in June 2023 hosted by our Chief Executive. This was attended by internal and external representatives and we discussed what was happening at RDaSH as well as in South Yorkshire and at the councils.
- Made progress on improving biodiversity across our sites by reducing the frequency of grass-cutting, allowing certain plants to grow and removing the use glyphosate and other harmful chemicals on our plants/trees/grass.
- Continued to use remote working and flexible rota arrangements as a means of reducing transport emissions amongst staff.
- Continued to offer online appointments to our patients if they prefer.

The Trust's management is responsible for ensuring that environmental management and sustainability are embedded throughout the organisation. The significant threat that climate change poses is recognised both to our environment, and to the health and wellbeing of our communities. Management has a responsibility to reduce carbon emissions, air pollution and waste to produce positive health outcomes in the region. There is acknowledgement that our environment is a social asset, and the Trust will continue to protect and enhance it to provide health and wellbeing benefits for the communities.

In 2024/25, the Trust will focus on a selection of actions to tackle the top 3 drivers of carbon emissions; gas usage, electricity usage and use of transport for business miles i.e. how we deliver our services. We will also align our actions to those of our three Local Authority partners' Climate Action Plans. Further work will be undertaken to adapt our services in each place in response to climate changes that we are already seeing e.g. increased flooding and periods of excessive heat.

With regards to the quantitative progress data of the carbon footprint, as an NHS foundation trusts we are not required to disclose or develop processes to disclose scope 1, scope 2 and scope 3 emissions under the 'metrics and targets pillar' in the HM Treasury guidance as emissions estimates for the NHS in England are derived centrally by NHS England.

The Heat Decarbonisation Plan has been finalised however, this was not within the NHS England mandated timeframe of 31 March 2024. To this, we are in the process of developing an estate plan to work alongside the Heat Decarbonisation plan to deliver that plan by 2040.

Board oversight changed during 2023/24 (see also 'The Role of the Board of Directors' on pages 59 to 62). The Equity and Inclusion plan includes promise 27 'Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service modes to climate change'.

The delivery of promise 27 is undertaken by the Sustainability Group and progress is overseen by the Estates and Sustainability Group which reports to Clinical Leadership Executive.

Progress on overall Equity and Inclusion Plan is formally reported into the Public Health, Patient Involvement and Partnerships Committee (PHPIP), which then reports progress into the Trust Board.

Directors Report

Board of Director Profiles

Kathryn Lavery - Non-Executive Chair
(term of office expires 30 November 2025)

Kath joined the Trust as Chair on 1 December 2022. She was first appointed to an NHS Board in 1998 and since then served as the Chair of West Hull Primary Care Trust and NHS Hull, as a Non-Executive Director of NAViGO (a community interest company which runs NHS mental health services in North East Lincolnshire) and as a Hull City Councillor.

Kath is currently also Chair ACCIA Yorkshire and Humber Panel, Chair of the Advisory Board Space2BHeard CIC HULL and Non-Executive Director at Locala Community Interest Company.

Dave Vallance – Non-Executive Director and Vice Chair
(term of office expires 13 December 2025)

Dave joined the Trust as Non-Executive Director on 12 December 2019 and was re-appointed in December 2022.

Dave built up a vast range of HR experience through working for over 20 years with Walgreen Boots Alliance, and was latterly HR Director, Global Brands.

He previously worked in the NHS for The Audit Commission for 5 years, evaluating the value for money of a range of health and local government organisations.

He has been a Trustee of one of the largest UK Pension schemes, a school governor and holds a Master of Business Administration (MBA) and a BA in Organisation Studies.

Dawn Leese – Non-Executive Director and Senior Independent Director
(term of office expires 30 November 2024)

Dawn joined the Board of Directors in November 2016 and was re-appointed by the Council of Governors in November 2018 and again in November 2021. She is an experienced nurse and clinical leader with extensive experience working at board level within the NHS as an Executive Director and with experience as a commissioner and provider.

Prior to joining RDASH Dawn was Director of Nursing and Quality at Leicester City Clinical Commissioning Group.

Dawn is a qualified RGN, RSCN, and holds a BSc in Advanced Professional Practice and an MSc in Managing Quality and Healthcare.

Justin Shannahan – Non-Executive Director and Audit Committee Chair
(term of office ended 31 March 2024)

Justin joined the Board of Directors in November 2016 and was re-appointed by the Council of Governors in November 2018 and again in November 2021. He has a broad finance and purchasing background and previously worked for over 20 years in a number of roles at Rolls-Royce, including Divisional Director of Finance.

Justin is also Non-Executive Director, Vice Chair and Chair of the Audit Committee at University Hospitals of Derby and Burton NHS Foundation Trust.

He holds a BA (Hons) in Accounting and Financial Management and is a member of the Institute of Chartered Accountants in England and Wales.

Pauline Vickers - Non-Executive Director
(term of office expires 31 March 2026)

Pauline joined the Board of Directors in April 2021 and was re-appointed by the Council of Governors in April 2023.

Prior to joining the Trust, she was a Non-Executive Director and Senior Independent Director with Bradford Teaching Hospitals NHS Foundation Trust. She worked for Royal Mail since graduating in 1985 across a range of leadership and commercial executive roles, most recently as Export Director for Royal Mail's International business. Pauline now enjoys a portfolio career as an accredited Executive Coach and is an end point assessor for the Business Sales Degree Apprenticeship courses at Leeds Trinity and Middlesex Universities.

She holds a degree in management science from the University of Manchester Institute of Science and Technology, a post graduate diploma in personnel training and development from Leeds Metropolitan University and is a Chartered Member of the Institute of Personnel and Development.

Sarah Fulton Tindall - Non-Executive Director
(term of office expires 31 December 2024)

Sarah joined the Trust as a Non-Executive Director on 1 January 2022.

She has a strong executive level professional services delivery background in the Higher Education sector. Sarah spent overs 20 years in a wide range of leadership roles at the University of Sheffield, and more latterly advising universities both in the UK and overseas.

Sarah has extensive experience in leading successful organisation-wide strategy, business transformation and people talent growth.

In addition to her current role, Sarah is also a member of the Patient Participation Group at a local GP practice and an Age UK Readers' Panel member.

Sarah holds a BA (Hons) in Politics and Social Policy from the University of Sheffield.

Janusz Jankowski - Non-Executive Director
(term of office expires 30 November 2025)

Janusz joined the Trust as a Non-Executive Director on 1 December 2022.

Janusz has holistic leadership experience having served in health roles including mental wellbeing in the UK, European Union, North America, the Middle East and the Pacific Region as Deputy Vice Chancellor, National Clinical Advisor, and Academic Consultant Physician.

He is a strong and effective advocate of mental health and disability services having supported appropriate guidelines from the National Institute for Health and Care Excellence (NICE). He is also a successful, experienced, executive coach and mentor who, has helped improve institutional culture and the subsequent Care Quality Commission inspection outcomes.

Kathryn Gillatt – Non-Executive Director
(term of office expires 31 March 2026)

Kathryn joined the trust on 1 April 2023 and became Chair of Audit Committee 1 January 2024.

Kathryn is a graduate of Nottingham University and is a Chartered Accountant by profession. Her career to date includes roles as a finance and corporate services director in a number of sectors including frontline NHS and children's services, the department for transport, community pharmacy services, the leisure industry, chemical manufacturing, audit and tax services. She is also a non-executive director at NHS Business Services Authority and chairs their Audit and Risk Committee.

Toby Lewis – Chief Executive
Toby joined the Trust on 13 March 2023 from The King's Fund where he has been a senior visiting fellow in health inequalities, with a focus on poverty and inclusion health. He joined the NHS in 1994 and began his career in Worksop. He has worked in primary care, mental and community health, and hospitals in London, West Yorkshire and the West Midlands.

After working in Downing Street, he joined his first NHS Board in 2005 and has served in executive roles since that time, including eight years as Chief Executive of an integrated care organisation in the Black Country. He helped establish a new medical school at Aston University and led work to use the apprenticeship levy to the benefit for often excluded populations, such as care leavers and those at risk of experiencing homelessness, creating jobs as a route to better health. He is a part time student in public health at Edinburgh University and holds degrees in occupational psychology and history from Oxford and London.

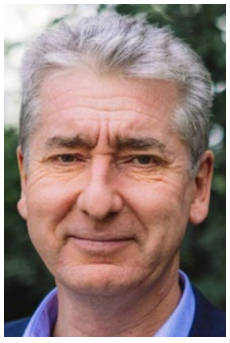
Sheila Lloyd – Executive Director of Nursing and Deputy Chief Executive
Sheila has over 33 years' experience in the NHS and has extensive experience in nursing, leadership, operational management, and clinical governance.

Immediately prior to joining the Trust, Sheila was Director of Nursing at the Florence Nightingale Foundation based in London, providing leadership development to nurses and midwives with a specific interest in supporting the recruitment, retention and pastoral care of internationally educated nurses. During the eight years prior to that, she was an Executive Nurse Leader within acute, specialist and mental health NHS organisations within the northwest and the midlands.

She has previously assisted the Care Quality Commission with hospital inspections, is a member of the national Black, Minority, Ethnic (BME) Executive Director of Nursing and Midwifery Group and is an active mentor and coach to NHS staff.

Dr Graeme Tosh – Executive Medical Director
Graeme took on the role of Executive Medical Director in April 2022, prior to that he was one of our Deputy Medical Directors and has been with the Trust as a General Adult Consultant Psychiatrist since 2012.

Graeme completed his training in a diverse variety of places including Derby, Mansfield, Scotland, the Isle of Wight and London; he has specialist training in Rehabilitation and Perinatal Psychiatry and was instrumental in setting up the Perinatal Mental Health services here at the Trust.



Ian Currell – Executive Director of Finance and Estates
Ian took up the post of Director of Finance and Performance on the 9 August 2021, following a role of Chief Finance & Deputy Chief Officer at NHS Kirklees Clinical Commissioning Group (CCG).

Ian started out in the NHS as a graduate finance trainee and went on to work in a range of provider and commissioner organisations including as Director of Finance at NHS England area teams and Deputy and Acting Director of Finance at Calderdale and Huddersfield NHS Foundation Trust.

Nicola McIntosh – Executive Director of People and Organisational Development

Nicola took up the position of Director of People and Organisational Development in August 2020, following a role as HR Operations Director at Sheffield Teaching Hospitals NHS Trust, which she held from 2016.

Nicola has previously held senior roles in HR, OD and Operations in FMCG environments including United Biscuits, Morrisons Supermarkets plc and Jet2.com.

Nicola has a BSc (Hons) degree and is a Chartered Fellow of the Institute of Personnel and Development. Nicola is a Trustee of Chorus Education Trust.

Richard Chillery – Executive Chief Operating Officer

Richard took up the post of Chief Operating Officer on the 9 October 2023, from his previous role where he was Deputy Chief Operating Officer for Lancashire and South Cumbria NHS Foundation Trust. For part of his time with Lancashire he was a Poverty Truth Civic Commissioner with the Morecombe Bay Poverty Truth Commission. He was also a Non-Executive Director with Sheffield Childrens NHS Foundation trust, so part of their Unitary Board from 1 June 2019 to 31 December 2023.

Prior to these roles Richard has had a range of senior NHS management roles within acute, community and mental health services and has been a Technical Advisor with Public Health England. He has worked in Public Services both in the UK and New Zealand, since 1989.

Richard remains a registered social worker and has a range of different psychosocial training for working with children, young people and their families and spent much of his clinical career working in Child & Adolescent Mental Health Services.

Richard Banks – Director of Health Informatics

Richard was appointed to his current role in 2016. Before this he was the Director of Business Assurance from 2009. He has had a number of senior roles since joining the Trust in 2000, including as the Director of Performance, Planning and Service Improvement, at the time the Trust achieved Foundation status in 2007.

Prior to joining RDaSH he worked in local government, the Sheffield FHSA, Health Authority and Community Health Sheffield, before joining RDaSH in 2000 as Head of Planning.

Richard has a degree in economic and social history, a post graduate certificate in managing health and social care and has completed the Kings Fund top manager programme. In 2016 he gained an MSc in Health & Social Care leadership.

Philip Gowland – Director of Corporate Assurance and Board Secretary

Philip was appointed as Director of Corporate Assurance in February 2016 having joined the Trust as Head of Corporate Affairs in 2007. He has been the Board Secretary since 2009.

Prior to joining the Trust Philip was Internal Audit Manager for a number of NHS organisations having worked for Internal Audit Consortia across both South and West Yorkshire.

Philip is a member of the Institute of Chartered Secretaries and Administrators (ICSA); a qualified accountant (Chartered Institute of Public Finance and Accountancy CPFA) and holds a degree in Accounting and Management Control from Sheffield Hallam

Joanne McDonough – Director of Strategic Development
Joanne joined the Trust in April 2011 when the Community Services transferred into the Trust from the Primary Care Trust in Doncaster.

Prior to that she worked with a range of public sector organisations on service improvement with the Audit Commission for 11 years including working with NHS Providers on improving mental health and physical health services.

Since joining the Trust, Joanne has held a number of roles including Deputy Director for Business Assurance, Head of Business Services Unit and Care Group Director for Doncaster. She moved into the Director of Strategic Development role in 2020 which includes responsibility for Communications. Joanne holds a Master of Business Administration (MBA).

Dr Judith Graham BEM QN – Director of Psychological Professionals and Therapies
After working as a clinical Consultant in the Trust for a number of years Judith joined the Board of Directors in 2016. Judith was appointed as Interim Director of People and OD in 2019 and progressed to the substantive Director for Psychological Professionals later that year. Since 2022 has had expanded portfolio with inclusion of wider therapeutic professionals including Allied Health Professionals and Social Work.

As well as her Trust role, Judith has also held a number of national positions related to the work of Health and Social Care. These have included Board Member on the NHS Confederations Mental Health Network Board, Clinical Fellow at NICE, Member of the FTSU National Advisory Panel and currently a Trustee at the Queens Nursing Institute.

Judith is a registered mental health nurse, holds a Post Graduate Bachelor's Degree in Forensic and Intensive Mental Health Care, a Post Graduate Master's Degree in Cognitive Behavioural Psychotherapy, a second Master's Degree in Advanced Clinical Practice, and a Professional Doctorate in Psychotherapy. Judith has chartered MCIPD status with the Chartered Institute of Personnel and Development, she has Accreditation as Master Practitioner and Executive Coach via the European Mentoring Coaching Council and has also completed the Kings Fund Top Managers programme.

During the year there was one change to the Board of Directors when the Interim Executive Chief Operating Officer, Marie Watkins departed from the Trust following the recruitment and commencement of the Executive Chief Operating Officer, Richard Chillery, who joined the Trust on the 9 October 2023. Marie was in post as Interim Executive Chief Operating Officer from 17 November 2022 to 8 October 2023. On 31 March 2024 Sheila Lloyd and Justin Shannahan left the Trust.

In 2023/24 the NExT Director scheme was introduced into the Trust and 2 successful candidates each commenced a 24-month placement. This scheme is a development programme created and designed to help find and support the next generation of talented

people who are currently under-represented on our NHS boards into the non-executive roles.

Jyoti Mehan – NExT Director

Jyoti joined the Trust as a NExT Director in April 2023. She has broad background in public and private sector healthcare provision, specifically in operational and performance improvement.

Alongside her role as NExT Director, Jyoti is the CEO of an at scale multi-site General Practice provider.

Jyoti holds a BA in Business Economics and is currently undertaking an MBA.

Lea Fountain – NExT Director

Lea joined the Trust as a NExT Director on 1 October 2023. She brings 25 years' experience in engaging communities, influencing change and building reputation, through roles in the media, the NHS and local government.

She is currently associate director of communications at Cambridgeshire Community Services NHS Trust. Her previous communication and engagement leadership roles include Sheffield Children's NHS Foundation Trust, Milton Keynes University Hospital FT and the Gibraltar Health Authority. She is a Chartered Institute of Public Relations (CIPR) chartered practitioner, committed to ethical working to bring meaningful changes to improve the experiences of service users and NHS staff.

Post year end the following directors left the organisation:

- Ian Currell, Executive Director of Finance and Estates left the Trust 14 July 2024. Izaaz Mohammed assumed the role Director of Finance and Estates following a recruitment process on the 1 July 2024.
- Nicola McIntosh, Executive Director of People and Organisational Development left the Trust on the 30 April 2024. Carlene Holden assumed the role Executive Director of People and Organisational Development on 1 May 2024.

Director Independence and Register of Interests

The Trust is committed to ensuring that the Board is comprised of a majority of independent Non-Executive Directors who objectively challenge management. Our Non- Executive Directors provide a wide range of skills and experience. They bring strong, independent oversight and judgement on issues of strategy, performance and risk through their contribution at Board and Committee meetings. In March 2024 the Board considered the independence status of the NEDs and confirmed them all to be independent in line with the guidance.

The Council of Governors is responsible for all decisions to reappoint Non-Executive Directors and is supported in its consideration by the recommendations it receives from the Chair and the Nominations Committee. Non-Executive Directors declare their interests and in the unlikely event that such interests conflict with those of the Trust, then the individual would be excluded from any discussion and decision relating to that specific matter.

All Board Directors are required to disclose their relevant interests as defined in our constitution. These are recorded in a publicly available register that is formally reported to the Board at the beginning of each meeting. A copy of the full register of declarations is available on the website https://www.rdash.nhs.uk/about-us/declaration-and-conformance/ or on request from the Director of Corporate Assurance/ Board Secretary at Woodfield House, Tickhill Road Hospital Site, Balby, Doncaster DN4 8QN or email rdash.doi@nhs.net.
During the year a review of the governance structure was undertaken and a new operating model was developed in terms of both the senior leadership within the care groups and the Trust meeting structure. Further detail is available on pages 59 to 62.

Role of the Board of Directors

The Board of Directors acts as a unitary board and has corporate responsibility for the decisions it makes. It is the legally responsible body for the delivery of high quality, effective services, and for making decisions relating to the strategic direction, financial control and performance of the Trust. It comprises both executive directors and non-executive directors:

- Eight non-executive directors (including the Chair) – bring independent judgement and scrutiny to the Board to make sure that sound and well-informed decisions are made.
- Six executive directors (including the Chief Executive) – responsible for implementing Trust policy and for the effective day-to-day running of the organisation.

In addition, the Director of Health Informatics, Director of Psychological Professions and Therapies, Director of Strategic Development and Director of Corporate Assurance/Board Secretary attend each Board of Directors meeting.

The composition of the Board of Directors is in accordance with our constitution and it is appropriately composed to fulfil its statutory and constitutional function and to meet the terms of the licence issued by NHS England.

The Chair is responsible for ensuring the Board of Directors focuses on the strategic development of the Trust and that robust governance and accountability arrangements are in place, as well as undertaking an evaluation of the performance of the Board of Directors, its Committees and individual Non-Executive Directors. The Chairman also chairs the Council of Governors meetings and ensures that there is effective communication between the Board of Directors and the Council of Governors and that, where necessary, the views of the governors are obtained and considered by the Board of Directors. Non-Executive Directors attend the Council of Governors meetings along with the Chief Executive and Director of Corporate Assurance. The Chair supported by the Senior Independent Director, also seeks to foster a strong, engaging relationship between the Board of Directors and the Council of Governors. There is frequent attendance at the Board of Directors and Committee meetings by governors and further details of Governors' involvement at the Trust are provided at pages 72 to 75.

This engagement helps ensure that all parties maintain an understanding of the views and aspirations of the Trust and our members and contribute to the future development of the organisation.

While the Executive Directors are responsible for the day-to-day operational management of the Trust, the Non-Executive Directors share the corporate responsibility for ensuring that the

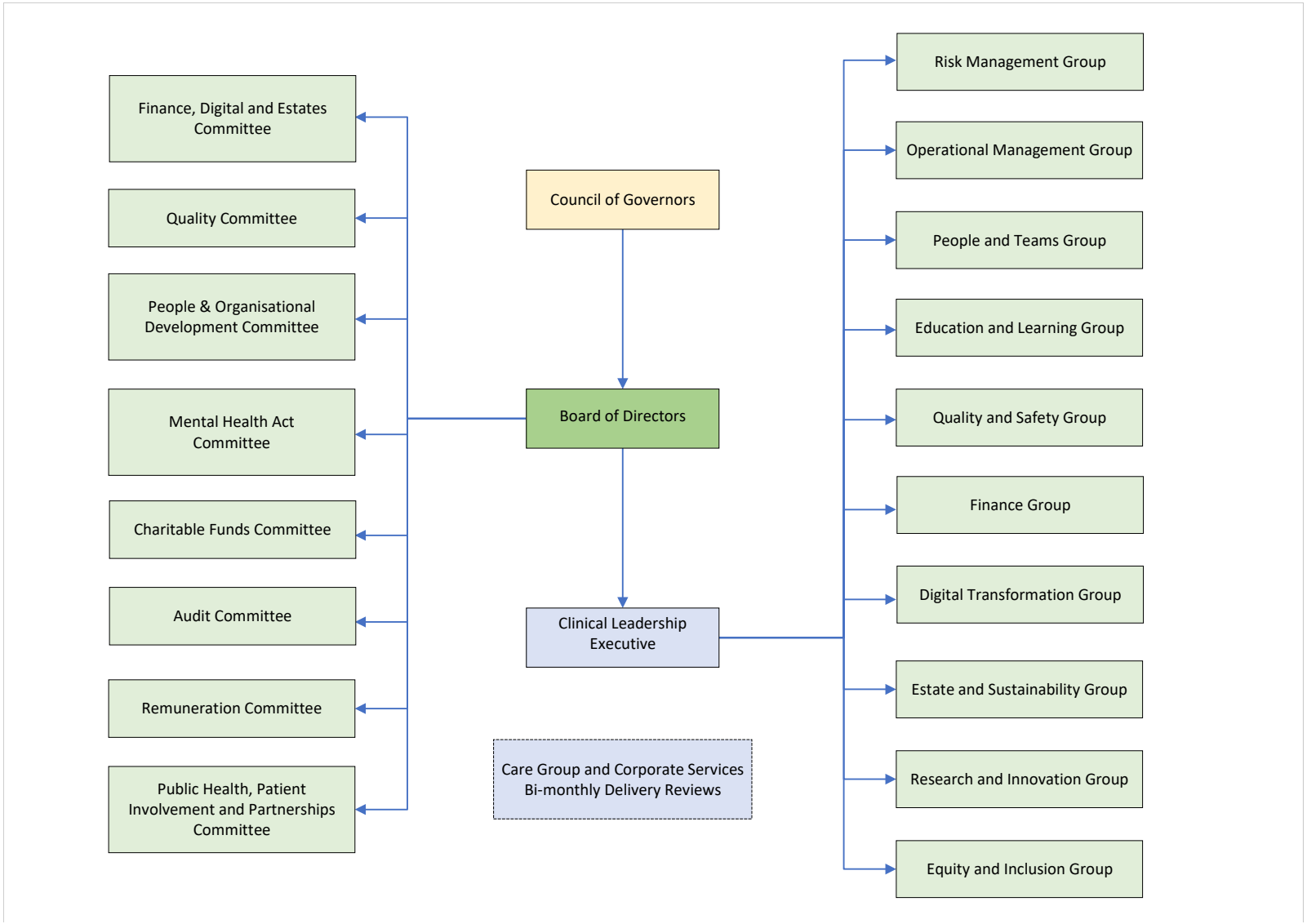
organisation is run efficiently, economically and effectively. Non-Executive Directors use their expertise, interest and experience, and attend the meetings of the Board and its Committees to achieve this. Regular involvement in the Peer Review process and service and site visits are undertaken by all Directors in order to gain a more rounded understanding of the services being delivered and the issues faced by our colleagues in those services. Brief details of the expertise and experience of each Director are presented from page 52.

The Chair and Chief Executive continue to review the Board of Directors balance, completeness and appropriateness, and ensure that this is maintained when new appointments are made.

Throughout the year the Board of Directors has undertaken a thorough review of the effectiveness of the governance structure and internal control, responding where appropriate to best practice and specific recommendations made for example by Internal Audit, but also establishing a new operating model with clearer roles and responsibilities and accountability within new terms of reference. During the year, our performance - clinically and financially - was closely monitored by the Board of Directors through the presentation and discussion of key performance information at every one of its meetings, in the Integrated Quality Performance Report (IQPR).

The Board of Directors acknowledges its responsibility for preparing the annual report and accounts and considers that, taken as a whole, they are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. As far as the Board of Directors are aware, there is no relevant audit information of which the External Auditors are unaware. Each of the directors has taken all the steps they ought to have taken as directors, in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information. Attendance by Directors at the Board's meetings in the year is presented in the Board of Directors' attendance table at the end of this section.

As part of the new operating model a Clinical Leadership Executive meeting and a range of supporting groups were introduced, the Terms of Reference of the Board and its committees were restated and refocused in line with new Clinical and Organisational Strategy and the forward trajectory of the Trust. This included the introduction of new committee, Public Health, Patient Involvement and Partnerships in January 2024 and dissolvement of the Commissioning Committee in April 2024. The new meeting structure is depicted in the diagram overleaf.



The table overleaf shows the attendance of the Board of Directors at the Board, its Committees during the 2023/24 financial year. Details on the Council of Governors is available on pages 72 to 75.

Director	Title	Board of Directors	Audit	Remuneration	Mental Health Act	Charitable Funds	Commission-ing	Quality	People and Organisational Development	Finance, Digital and Estates	Public Health Patient Involvement and Partnerships
Kathryn Lavery	Chair	6 out of 6		4 out of 4		1 out of 1					
Dave Vallance	Non-Executive Director / Vice Chair	5 out of 6	1 out of 1	4 out of 4				5 out of 6	6 out of 6		2 out of 2
Dawn Leese	Non-Executive Director	6 out of 6	6 out of 6	2 out of 4			4 out of 4	6 out of 6			2 out of 2
Justin Shannahan	Non-Executive Director	5 out of 6	5 out of 5	2 out of 4	3 out of 4	2 out of 2				2 out of 2	1 out of 1
Pauline Vickers	Non-Executive Director	6 out of 6	6 out of 6	4 out of 4		4 out of 4	4 out of 4		4 out of 6	6 out of 6	
Sarah Fulton Tindall	Non-Executive Director	6 out of 6		4 out of 4	4 out of 4	2 out of 2			6 out of 6	6 out of 6	
Janusz Jankowski	Non-Executive Director	5 out of 6		4 out of 4	4 out of 4		4 out of 4	5 out of 6			
Kathy Gillatt	Non-Executive Director	6 out of 6	4 out of 6	3 out of 4		1 out of 1				4 out of 6	
Toby Lewis	Chief Executive	6 out of 6			0 out of 1	1 out of 1					2 out of 2
Sheila Lloyd	Executive Director of Nursing and AHPs/Deputy CE	5 out of 5			0 out of 3		2 out of 4	5 out of 6	4 out of 6		
Dr Graeme Tosh	Executive Medical Director	5 out of 6			4 out of 4			5 out of 6	4 out of 6		2 out of 2
Ian Currell	Executive Director of Finance and Estates	5 out of 6	4 out of 6			2 out of 4	3 out of 4			6 out of 6	
Nicola McIntosh	Executive Director for People and Organisational Development	6 out of 6				3 out of 3		4 out of 4	6 out of 6	1 out of 1	2 out of 2
Marie Watkins	Interim executive Chief Operating Officer	3 out of 3			0 out of 2			2 out of 3	3 out of 4	4 out of 4	
Richard Chillery	Executive Chief Operating Officer	3 out of 3			1 out of 1			3 out of 3	2 out of 3	2 out of 3	
Richard Banks	Director of Health Informatics	6 out of 6						2 out of 2		6 out of 6	
Philip Gowland	Director of Corporate Assurance/Board Secretary	6 out of 6	6 out of 6				4 out of 4	4 out of 4	5 out of 5	5 out of 5	
Joanne McDonough	Director of Strategic Development	4 out of 6				3 out of 4	4 out of 4			3 out of 5	2 out of 2
Dr Judith Graham	Director of Psychological Professionals and Therapies	6 out of 6			1 out of 1	1 out of 1		5 out of 6			

Remuneration Report

In accordance with the requirements of the HM Treasury Financial Reporting Manual and reporting requirements issued by NHS England, this report is in three parts:

- **Annual statement on remuneration** describes the major decisions on senior managers' remuneration as well as any substantial changes to senior managers' remuneration which were made during the year and the context in which those changes occurred and decisions taken.
- **Senior managers' remuneration policy** sets out information about the Trusts policy.
- **Annual report on remuneration** includes details about senior managers' service contracts and sets out other matters such as committee membership, attendance and the business transacted.

A 'senior manager' is defined as 'Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Foundation Trust.' For the Trust, the report covers eight Non-Executive Directors (including the Chair), six Executive Directors (including the Chief Executive), the Director of Health Informatics, Director of Corporate Assurance, Director of Psychological Professions and Therapies and the Director of Strategic Development – these are the 'senior managers'

Whilst the Annual Report is prepared on a group basis, Flourish CIC and the Charity are not considered to be material and as such none of the senior managers of Flourish CIC meet the definition of senior manager above and are not therefore included in this Remuneration Report. Similarly, given their informal role with the Trust, the two named NExT Directors are also not considered to be within the definition of 'senior manager' for the purposes of this Remuneration Report.

Details of the Directors including their start date in their role and their relative experience and expertise are on pages 52 - 58. For detail on the number of meetings attended please refer to page 62.

Annual statement on remuneration

The Trust has two committees responsible for reviewing the remuneration of the senior managers:

- Nominations Committee of the Council of Governors – Chair and Non-Executive Directors
- Remuneration Committee – Execuitve Directors and other Directors (as stated)

The two committees aim to ensure that senior managers' remuneration is set appropriately taking into account relevant market conditions and to ensure that the senior managers are fairly rewarded for their individual contribution to the Trust, having proper regard for affordability based on the corporate performance of the Trust.

In setting the remuneration, the Committees take due account of any guidance issued for NHS staff regarding the level of pay inflation which may be awarded, for example the annual Agenda for Change and Very Senior Manager (VSM) guidance but does not consult with those employees. The Committee also takes due account of national benchmarking data collated

particularly that distributed annually by NHS Providers. This allows for sector and geographical comparisons to be made.

The remuneration of the Chair and Non-Executive Directors has, since 2019, been in line with the guidance document entitled *"Structure to align remuneration for chairs and Non-Executive directors of NHS trusts and NHS foundation trusts Implementation document: November 2019"*. This guidance resulted in an initial amendment to the remuneration rates paid, but it also sought to apply consistency in future years such that there was a uniform approach taken within the sector. No review of the Chair and Non-Executive Director remuneration has since taken place. The Trust, and specifically the Nominations Committee of the Council of Governors, awaits a further update to that guidance, although at the present time no agreed date for such has been published.

During 2023/24 there were no new appointments to the roles of Chair or Non-Executive Directors. One re-appointment was approved by the Council of Governors in April 2023, when Pauline Vickers was re-appointed for a further three-year term. As stated above, there was no review undertaken of the remuneration of the Chair or Non-Executive Directors. The only remuneration related matter was as a result of the change in the Audit Committee Chair, a role that attracts an additional £2,000pa payment. This transferred in the year from Justin Shannahan to Kathy Gillatt.

The Remuneration Committee met on 4 occasions during 2023/24. The key matters discussed at the meetings included:

- The appointments of the Chief Operating Officer, Richard Chillery who joined the Trust in October 2023 and Chief Nurse, Steve Forsyth who joined the Trust in April 2024.
- The consideration of the annual pay review.
- Changes to the Executive Group, progress with PDRs and objectives

In 2023/24, 16 board members received expenses and the total amount reimbursed was approximately £10,845.

Senior managers' remuneration policy

In any recruitment process undertaken, the Trust utilises open, widely advertised recruitment processes, with on occasion external professional support, to ensure the best candidates are identified and appointed.

Non-Executive Directors

The component of the remuneration packages for the Non–Executive Directors is shown in the table below:

Element	Policy
Fee Payable	A 'spot fee' which is in line with the guidance document entitled *Structure to align remuneration for chairs and Non-Executive directors of NHS trusts and NHS foundation trusts* November 2019.
Additional Fee	The Senior Independent Director receives an additional £1,000; the Vice Chair receives an additional £1,000; and the Chair of the Audit Committee an

Element	Policy
	additional £2,000. The total additional fees of £4,000 are in line with the guidance document entitled *Structure to align remuneration for chairs and Non-Executive directors of NHS trusts and NHS foundation trusts* November 2019.
Percentage uplift (cost-of-living increase)	The current remuneration is line with the guidance document entitled Structure to align remuneration for chairs and Non-Executive directors of NHS trusts and NHS foundation trusts November 2019. No uplift has been considered or actioned since 2020.
Travel	Travel and subsistence expenses are reimbursed and paid with remuneration via payroll.
Pension Contributions	Non-Executive Directors do not have access to the NHS Pension scheme.
Other remuneration	None.

The Chair and Non-Executive Directors do not have a notice period.

The letters of appointment include no provisions or obligations which could give rise to, or impact on, remuneration payments or payments for loss of office.

For information on the Policy for Equality Diversity and Inclusion please refer to page 40 within the Staff Report.

Executive Directors

The component of the remuneration packages for these senior managers is shown in the table below:

Element	Policy
Salary	A 'spot' salary which is reviewed annually. The setting of that salary and the subsequent review are undertaken with reference to relevant guidance and other related information as described above. This is the maximum amount that will be paid. There are no provisions for the recovery of sums paid or for the withholding of the payments.
Salary (Medical Director)	The current post holder's total remuneration comprises of a 'spot' salary, for the role of Medical Director, together with a Level 3 Clinical Excellence Award and separate contract for clinical duties performed for the Rotherham Adult Mental Health Care Group (including a 3% on-call allowance).
Salary (Deputy Chief Executive)	Additional remuneration paid on an annual basis in respect of the fulfilment of the Deputy Chief Executive role.
Percentage uplift (cost-of-living increase)	Reviewed annually by the Remuneration Committee taking into consideration national pay awards, benchmarking data and the related financial implications.
Taxable benefits	Travel and subsistence expenses are reimbursed and paid with salary via payroll
Annual performance related bonuses	No performance related bonuses are paid. The Chief Executive's contract includes 10% of earn-back pay (a requirement to meet agreed performance objectives to earn back an element of base pay placed at risk; subject to an annual review and agreement between the Chair and the Chief Executive with the outcome reported to the Remuneration Committee)
Long-term performance related bonuses	No long-term performance related bonuses are paid.
Pension-related benefits	Executive Directors and Directors can access the NHS Pension scheme.

The current senior managers are on substantive contracts that incorporate a six-month notice period, except for the Director of Health Informatics, Director of Strategic Development, Director of Psychological Professions and Therapies and the Director of Corporate Assurance / Board Secretary who have a three-month notice period.

The contracts include no provisions or obligations which could give rise to, or impact on, remuneration payments or payments for loss of office.

Annual Report on Remuneration

The Council of Governors has responsibility for the appointment, re-appointment, remuneration and appraisal of the Chair and Non-Executive Directors. The work to discharge that responsibility is undertaken by the **Nominations Committee** which comprises seven governors (four service user/carer or public governors and three appointed or staff governors).

The Nominations Committee is chaired by the Lead Governor, Joan Cox, Community Services, Carer and is supported administratively by the Director of Corporate Assurance / Board Secretary.

Non-Executive Directors are appointed for a fixed term of office, following an open, advertised recruitment campaign in which representatives of the Nominations Committee join the Chair and an external assessor to form an interview panel that recommends an appointment to the full Council of Governors.

The **Remuneration Committee** is chaired by Kath Lavery, Chair. The remaining members of the Committee are the other Non- Executive Directors. By invitation from the Chair of the Committee, the Chief Executive attends meetings as does the Director of Corporate Assurance / Board Secretary and the Executive Director for People and Organisational Development.

The Committee has delegated responsibility for all aspects of remuneration and terms of service for the Executive Directors and Directors. Its responsibility includes all aspects of salary, provision for other benefits including pensions, arrangements for termination of employment, and other contractual terms.

The Chief Executive and the Medical Director are remunerated at a level greater than £150,000 (this equates to the Prime Minister's ministerial and parliamentary salary). The remuneration paid to these two Directors is considered to be reasonable for the posts given the relative position in terms of benchmarking with similar foundation trusts.

During the year, the Committee did not seek nor receive advice or services from any person that materially assisted its consideration of these matters.

Name and title	2023/24						
	Salary and fees paid by RDASH (bands of £5,000) £000	Salary and fees - associated to director role at RDASH (bands of £5,000) £000	Taxable benefits (Rounded to the nearest £100) £s	Annual Performance related bonuses (bands of £5,000) £000	Long-term Performance related bonuses (bands of £5,000) £000	Pension related benefit (bands of £2,500) £000	Total (bands of £5,000) £000
Kathryn Lavery – Chair	40-45	40-45	0	0	0	0	40-45
Toby Lewis - Chief Executive	185-190	185-190	0	0	0	0	185-190
Sheila Lloyd - Director of Nursing and Deputy Chief Executive	145-150	145-150	0	0	0	77.5-80	225-230
Graeme Tosh - Medical Director	175-180	175-180	0	0	0	0	175-180
Ian Currell - Director of Finance and Estates	140-145	140-145	0	0	0	0	140-145
Richard Chillery - Chief Operating Officer (from 9 October 2023)	65-70	65-70	0	0	0	15-17.5	80-85
Marie Watkins – Interim Chief Operating Officer (1 April 2023 to 8 October 2023)	70-75	55-60	0	0	0	37.5-40	95-100
Judith Graham - Director of Psychological Professionals and Therapies	90-95	90-95	0	0	0	0	90-95
Nicola McIntosh - Director of People and Organisational Development	110-115	110-115	0	0	0	30-32.5	140-145
Joanne McDonough - Director of Strategic Development	105-110	105-110	0	0	0	0	105-110
Richard Banks - Director of Health Informatics	100-105	100-105	0	0	0	0	100-105
Philip Gowland - Director of Corporate Assurance and Board Secretary	100-105	100-105	0	0	0	0	100-105
Dave Vallance - Non Executive Director	10-15	10-15	0	0	0	0	10-15
Dawn Leese - Non Executive Senior Independent Director	10-15	10-15	0	0	0	0	10-15
Justin Shannahan - Non Executive Director	10-15	10-15	0	0	0	0	10-15
Pauline Vickers - Non Executive Director	10-15	10-15	0	0	0	0	10-15
Sarah Fulton Tindall - Non Executive Director	10-15	10-15	0	0	0	0	10-15
Janusz Jankowski - Non Executive Director	10-15	10-15	0	0	0	0	10-15
Kathryn Gillatt - Non Executive Director	10-15	10-15	0	0	0	0	10-15

This information has been audited.

Name and title	2022/23						
	Salary and fees paid by RDASH (bands of £5,000) £000	Salary and fees - associated to director role at RDASH (bands of £5,000) £000	Taxable benefits (Rounded to the nearest £100) £s	Annual Performance related bonuses (bands of £5,000) £000	Long-term Performance related bonuses (bands of £5,000) £000	Pension related benefit (bands of £2,500) £000	Total (bands of £5,000) £000
Alan Lockwood, Chair (1 April to 30 June 2022)	10-15	10-15	0	0	0	0	10-15
Kathryn Lavery, Chair (from 1 December 2022)	10-15	10-15	0	0	0	0	10-15
Dave Vallance, Non–Executive Director	25-30	25-30	0	0	0	0	25-30
Dawn Leese, Non-Executive Director/SID: Interim Vice Chair (1 July to 30 November 2022)	10-15	10-15	0	0	0	0	10-15
Justin Shannahan, Non-Executive Director	15-20	15-20	0	0	0	0	15-20
Pauline Vickers, Non-Executive Director	10-15	10-15	0	0	0	0	10-15
Sarah Fulton Tindall, Non-Executive Director	10-15	10-15	0	0	0	0	10-15
Sarah Fatchett, Non-Executive Director (1 April to 6 June 2022)	0-5	0-5	0	0	0	0	0-5
Prof. Janusz Jankowski, Non-Executive Director (from 1 December 2022)	0-5	0-5	0	0	0	0	0-5
Kathryn Singh, Chief Executive (1 April to 31 December 2022)	120-125	120-125	0	0	0	0	120-125
Toby Lewis, Chief Executive (from 13 March 2023)	5-10	5-10	0	0	0	2.5-5	10-15
Sheila Lloyd, Executive Director of Nursing/Deputy CE (Interim CE from 1 December 2022 to 12 March 2023)	155-160	155-160	0	0	0	0	155-160
Dr Graeme Tosh - Executive Medical Director	160-165	160-165	0	0	0	197.5-200	360-365
Ian Currell, Executive Director of Finance and Estates	130-135	130-135	0	0	0	52.5-55	185-190
Izaaz Mohammed, Interim Executive Director of Finance (from 11 October 2022 to 31 January 2023)	65-70	35-40	0	0	0	2.5-5	40-45
Kate McCandlish, Interim Executive Director of Nursing and AHP (from 1 December 2022 to 12 March 2023)	85-90	30-35	0	0	0	25-27.5	60-65
Marie Watkins, Interim Executive Chief Operating Officer (from 17 November 2022)	90-95	40-45	0	0	0	2.5-5	40-45
Michelle Veitch, Executive Chief Operating Officer (1 April 2022 to 28 February 2023)	110-115	110-115	0	0	0	0	110-115
Nicola McIntosh, Executive Director for People and OD	105-110	105-110	0	0	0	27.5-30	135-140
Joanne McDonough, Director of Strategic Development	95-100	95-100	0	0	0	22.5-25	120-125
Richard Banks, Director of Health Informatics	95-100	95-100	0	0	0	25-27.5	125-130
Philip Gowland, Director of Corporate Assurance/Board Secretary	95-100	95-100	0	0	0	25-27.5	120-125

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The real increase has been apportioned to only reflect the amount estimated to relate to employment at RDaSH.

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

This information has been audited.

Name and title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31March 2024 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2024 £'000	Normal retirement age
Toby Lewis - Chief Executive*	0	30-32.5	70-75	190-195	1358	56	1576	SPA
Sheila Lloyd - Director of Nursing and Deputy Chief Executive*	2.5-5	20-22.5	55-60	155-160	1007	239	1367	SPA
Graeme Tosh - Medical Director*	0	35-37.5	40-45	100-105	553	180	809	SPA
Ian Currell - Director of Finance and Estates*	0	35-37.5	60-65	165-170	1130	177	1440	SPA
Richard Chillery - Chief Operating Officer (from 9 October 2023)*	0-2.5	0-2.5	45-50	130-135	1047	23	1219	SPA
Marie Watkins – Interim Chief Operating Officer (1 April to 8 October 2023)*	0-2.5	5-7.5	15-20	45-50	309	76	443	SPA
Judith Graham - Director of Psychological Professionals and Therapies*	0	20-22.5	20-25	55-60	302	102	447	SPA
Nicola McIntosh - Director of People and Organisational Development	0-2.5	0	15-20	0	169	49	250	SPA
Joanne McDonough - Director of Strategic Development*	0	0	25-30	0	325	59	431	SPA
Richard Banks - Director of Health Informatics*	0	20-22.5	45-50	125-130	907	88	1100	SPA
Philip Gowland - Director of Corporate Assurance and Board Secretary*	0	22.5-25	35-40	100-105	647	121	847	SPA

*Is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance has been used in the calculation of 2023 to 24 CETV figures.

Payments for loss of office

In the year to 31 March 2024, no payments were made by the Trust to senior managers for loss of office. This is the same as for 2022/23.

Payments to past senior managers

In the year to 31 March 2024, no payments were made by the Trust to past senior managers. This is the same as for 2022/23.

Fair pay disclosures

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration for the highest-paid director in the organisation in the financial year 2023-24 was £185k - £190k (2022-23, £175k - £180k). This is a change between years of 6%.

For employees of the Trust as a whole, the range of remuneration in 2023-24 was from £311,695 to £15,350 (2022-23 £297,754 to £16,232). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 0.7%. 11 employees received remuneration in excess of the highest-paid director in 2023-24 (11 in 2022-23).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2023/2024	25th percentile	Median	75th percentile
Salary component of pay	24,336	34,581	42,618
Total pay and benefits excluding pension benefits	25,147	34.581	42,912
Pay and benefits excluding pension: pay ratio for highest paid director	7.46:1	5.42:1	4.37:1

2022/2023	25th percentile	Median	75th percentile
Salary component of pay	24,331	31,114	42,750
Total pay and benefits excluding pension benefits	25,492	33,357	42,899
Pay and benefits excluding pension: pay ratio for highest paid director	6.96:1	5.32:1	4.14:1

Toby Lewis, Chief Executive
11 July 2024

The Council of Governors

The Council of Governors comprises 41 seats for members of the public, service users/patients, carers, colleagues and representatives from partner organisations.

Governors have responsibility for:

- Advising the Trust on its strategic direction.
- Representing the interests of members and partner organisations.
- Regularly feeding back to their constituency.
- Appointing (and removing) of the Chair and Non-Executive directors.
- Approving the appointment of the Chief Executive.
- Appointing the Trust's auditor and receiving the Annual Accounts, Auditor's Report and Annual Report.
- Informing NHS England of any unresolved issues.

The Council of Governors provides an important link between the Trust, the local community and key organisations, sharing information and views that can be used to develop and improve services. The Council of Governors is chaired by Kathryn Lavery, who ensures that there are strong links between the Council of Governors and the Board of Directors. The Lead Governor Joan Cox, Community Services, Carer, took up the Lead Governor position in June 2021 having been in the Governor role since August 2017.

The Board of Directors is responsible for the operational management of the Trust, the delivery of high quality, effective services, and for making decisions relating to the strategic direction, financial control and performance of the Trust. The Board of Directors takes account of the views of the Governors, and members of the Board of Directors have attended Council of Governors meetings in the last year. The table below sets out the composition of the Council of Governors.

Composition of the Council of Governors		
Public 12 governors	**Service users** 7 governors	**Carers** 7 governors
4 Rotherham	3 mental health	3 mental health
4 Doncaster	2 community services	2 community services
2 North Lincolnshire	1 learning disabilities	1 learning disabilities
1 North East Lincolnshire	1 specialist services	1 specialist services
1 Rest of England		

Staff 6 governors	**Partner organisations** 9 governors
1 nursing	1 Doncaster Clinical Commissioning Group (CCG)
1 allied health professionals /psychology	1 Rotherham CCG
1 medical and pharmacy	1 North Lincolnshire CCG
1 social care	1 City of Doncaster Council
1 nonclinical	1 Rotherham Metropolitan Borough Council
1 community nursing	1 North Lincolnshire Council
	1 University 1 Community voluntary sector
	1 GP

At the start of the year, 23 governors were in post. Over the year there have been a number of changes to those holding positions on the Council of Governors, resulting in 21 seats being filled at the year end. Elections were called to fill the following vacancies in 2023.

Public	Service User / Patients	Carer	Partner (appointed not elected)
2 Doncaster	3 Mental Health	1 Mental Health	1 North Lincolnshire Council
2 North Lincolnshire	1 Specialist Services	1 Specialist Services	1 Community voluntary sector
1 Rest of England	2 Community Services	1 Community Services	
		1 Learning Disabilities	

Whilst there were several new Governors elected as a result of these elections, there remains a number of gaps on the Council of Governors. These will be the focus of renewed efforts in 2024/25 to re-engage with the Trust's stakeholder and membership and to seek to support individuals to put themselves forward to undertake this opportunity. Establishing a greater number of Governors will also contribute towards the delivery of Promise 4 as Governors are to be the 'patient voice' within the operating model.

Over the last year, the Governors have continued to demonstrate their commitment and to show their enthusiasm in their role. Since April 2023, the Council of Governors has held five formal meetings: one via MS Teams and four hybrid (in person or via teams). Four meetings were chaired by the Chair of the Trust and one by the Board Secretary. Meetings were attended by members of the Board of Directors. The Governors and their attendance at the meetings are shown in the table below:

Name	Constituency	No. of Council meetings attended	Term expired
Ruth Sanderson	Public: Doncaster	4 out of 5	November 2025
Maureen Young	Public: Doncaster	5 out of 5	November 2024
Joy Bullivant	Public: Doncaster	1 out of 2	November 2026
Richard Rimmington	Public: Doncaster	5 out of 5	November 2026
Sally French	Public: Rotherham	3 out of 5	November 2024
Mohammed Suleman	Public: Rotherham	2 out of 5	November 2025
Kamlesh Vatish	Public: Rotherham	4 out of 5	November 2024
David Vickers	Public: Rotherham	4 out of 5	November 2025
Mark Johnson	Service User: Learning Disabilities	3 out of 5	November 2025
Ann Llewellyn	Service User: Mental Health	2 out of 2	November 2026
Ian Spowart	Service User: Mental Health	2 out of 2	November 2026
Alex Haig	Carer: Community Services	2 out of 5	November 2025
Joan Cox	Carer: Community Services	5 out of 5	November 2026
Ruth O'Shea	Carer: Mental Health	3 out of 5	November 2025
Mohammed Ramzan	Carer: Mental Health	1 out of 5	November 2024
Michael Seneviratne	Staff: Medical and Pharmacy	2 out of 5	November 2025
James Dickinson	Staff: Non-Clinical	3 out of 5	November 2024
Lee Golze	Partner: DMBC	1 out of 5	November 2026
Dean Eggitt	Partner: LMC	2 out of 5	February 2026
David Roche	Partner: RMBC	1 out of 5	February 2026
Roxanne Kirby	Partner: North Lincolnshire Council	0 out of 2	September 2026

Governors that served during 2023/24 but have now stepped down/ term expired are listed below – we thank them al for their contribution whilst in the role.

Name	Constituency	No. of Council meetings attended / possible total	Term expired
George Baker	Public: North East Lincolnshire	1 out of 3	November 2023
John Barber	Partner: Voluntary	1 out of 3	June 2026
Mark Collins	Partner: University	0 out of 3	June 2026
Marie McClay	Public: Doncaster	0 out of 4	November 2023
Diana Foster	Carer: Mental Health	1 out of 3	November 2023
Christine Smith	Partner: Universities	0 out of 3	February 2026
Helen Ward	Service User: Mental Health	3 out of 4	November 2023
Rachel Bradley	Staff: AHP	3 out of 4	November 2024

The Council of Governors meets four times a year for its planned business but during the year met on one additional occasion in order to make timely decision, regarding the reappointment of a Non-Executive Director.

Governors have also attended four meetings chaired by the lead governor:

- Governor priorities - The priorities set by the governors are embedded in the Trust Clinical and Organisational Strategy and link directly to RDaSH promises 1, 3, 4, and 5. The governors' priorities are: Volunteering, Health promotion and Patient and public engagement / Foundation Trust Membership.
- Two meetings held to review the governor sections of the Constitution - Following the restructure of RDaSH the constitution required refreshing. The governors made recommendations to the board to update the content.
- CoG Agenda review / planning - A meeting held in advance of the Council of Governors meeting to consolidate or review agenda items.

The Trust also invited Governors to attend virtual and in person briefings which have included the Patient Safety and Response Framework Briefing, a visit to our Grounded Research Hub and the Winter Plan Launch. The Trust has distributed to Governors written updates on the Trust's activities and challenges, both at meetings and through regular email correspondence. Governors are also provided with the Trust's monthly newsletter.

Governors have throughout the year also been represented at the Board of Directors meetings held in public in person and virtually and likewise at the Committee meetings of the Board. This has allowed several Governors to keep much more aware of the challenges faced, the responses and action being taken and more generally about the overall position of the Trust. It also affords them a great opportunity to see the Non-Executive Directors undertaking their role at the Trust.

Governors have also been invited to attend several external events including NHS Providers Governor Focus 2024, Autumn Virtual Governor Workshops, conferences, regional and national workshops. Within the Trust they have attended the Staff Networks AGM and the Trust Awards Celebration.

Register of interests

The interests for the Council of Governors are presented to the Council of Governors at each meeting and are part of the Register of Interests. The Register of Interests is a public document and is available via the Trust's website.
https://www.rdash.nhs.uk/about-us/declaration-and-conformance/

Expenses

Governors receive no remuneration for their role. However, the Trust provides appropriate reimbursement, for example to cover travel expenses for Governors who participate in events or activities arranged by the Trust. In 2023/24, four governors received expenses and the total amount paid/reimbursed to support their attendance was approximately £125.00. In 2022/23 there were no direct reimbursement to the Governors.

How to contact your Governor

Governors represent the members of their respective constituencies. If you have any comments, concerns or questions, or if you have any other need to speak to the governor who represents you, contact can be through the Corporate Assurance Team:

Telephone: 07929656113
Post: Corporate Assurance Team,
Woodfield House, Tickhill Road, Balby, Doncaster, DN4 8QN.
Email: rdash.corporate-assurance@nhs.net

Foundation Trust Membership

Becoming a member of the Trust offers local people a unique opportunity to have their say and to be involved in how the Trust and its services are developed. The Trust wants to build a meaningful and representative membership.

New employees automatically become members of the Trust. As with all members, they can influence plans for the Trust and its services for the benefit of service users and carers. They can elect to the Council of Governors and stand for election themselves. All our colleagues are encouraged to be actively involved as members and to spread the word, highlighting the benefits of membership.

The Trust continued its engagement with members in the wider community (patients, service users, carers and public) through attendance at a range of community events such as The Rotherham Show and PRIDE Events in both Doncaster and North Lincolnshire. Members are also invited to the Annual Members Meeting held by the Trust. These are great opportunities to speak to the members and hear from them about their experiences with the Trust and its services. They also allow for suggestions and information sharing. The Trust has also engaged members during the Governor election process and on a more regular basis through its website, social media such as Twitter, Facebook and Instagram and via the new Trust App.

Membership constituencies

Anyone aged 16 or over is eligible to become a member. The Trust has four membership constituencies:

Public

To be eligible for membership to one of our public constituencies, people should live in the four electoral areas of either:

- Rotherham Metropolitan Borough Council
- City of Doncaster Council
- North Lincolnshire Council
- North East Lincolnshire Council

Or

- Rest of England (Rather than defining a further boundary for those living in close proximity to our localities, the Trust chooses to add a 'Rest of England' to include those people in neighbouring boroughs who may be interested).

Service users

To be eligible for membership of the service user/patient constituency, a person should have accessed within the last five years any of our services as a service user/patient in any of the following areas:

- Mental Health (incorporating Adult Mental Health, Older People's Mental Health and Children and Young People's Mental Health Services)
- Learning Disability Services (including Forensic Services)
- Specialist (e.g. Drug and Alcohol Services)
- Children, Young People and Families' Services
- Long Term Conditions Services for Adults
- Doncaster Psychological Therapy Service (formerly IAPT)
- New Beginnings and the Drug Intervention Programme (DIP)
- End of Life Services, including St John's Hospice

Carers

To be eligible for membership to the carer constituency, you should have within the last five years cared for a service user in any of the services listed above for service user/patient membership.

Staff

A member of the staff constituency is a person who is employed by the Trust under a contract of employment which has no fixed term, or a fixed term of at least 12 months, or who has been continuously employed by the Trust for at least 12 months. New members of staff automatically become members of the Foundation Trust, although they are given the opportunity to opt out if they wish. Members of the staff constituency are allocated to the following areas:

- Non-clinical
- Social care
- Medical and pharmacy

- Allied Health Professionals
- Nursing
- Community nursing

As at 31 March 2024, the Trust had a total membership of 9,297.

Membership size and movements				
	At year start (April 1)	New members	Members leaving	At year end (31 March)
Public constituency	4,619	176	154	4,635
Staff constituency	3,859	616	543	3,932
Patient/Carer constituency	737	10	17	730

Analysis of current Public membership		
	Number of members	Eligible membership*
Age (years):		
0-16	5	175,131
17-21	15	47,434
22+	4,165	683,092
Not stated	450	0
Ethnicity:		
White	3,978	824,533
Mixed	30	26,916
Asian or Asian British	173	31,325
Black or Black British	16	8,437
Other	24	8,929
Not stated	414	0
AB	980	51,265
C1	1,299	100,711
C2	900	100,101
DE	1,376	139,112
Gender		
Male	1,549	446,086
Female	2,747	459,571
Transgender	1	0
Unspecified	338	0

* For the purposes of the table, the eligible membership is taken as those members of the public that live in the Trust's principal geographical locations – Doncaster, Rotherham and North Lincolnshire. There is, however, Rest of England membership constituency which effectively means that any member of the public in England can be a member.

NHS Code of Governance Disclosures

The purpose of the Code of Governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but imposes some disclosure requirements.

Rotherham Doncaster and South Humber NHS Foundation Trust has applied the principles of the code on a comply or explain basis. The Board of Directors and Council of Governors are committed to continuing to operate according to the highest standards of corporate governance, and support and agree with the principles set out in the Code.

Provision	Requirement
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.
Comply - We are involved in several provider collaboratives. As well as being the lead provider for South Yorkshire Adult Eating Disorder Provider Collaborative. We actively seek opportunities to collaborate with other providers, and we do this through the MHLDA Alliance, networking, and fostering relationships with other mental health and community providers. The strategic development team reviews opportunities that align with our objectives as outlined in the Trust's 23-28 Clinical and Organisational Strategy. In 2023/2024, we implemented a new operating model that includes a revised governance structure and operating mode. This supports the delivery of our strategic objectives, ambitions, and 28 promises included within the 2023-2028 Clinical and Organisational Strategy. See also 'Role of the Board' on page 59.	
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.
Comply – Health & Wellbeing on pages 39-40	
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
Comply - Stake holder relations on pages 91-92	
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years

Provision	Requirement
	• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Comply - Board of Director Profiles on pages 52-58, Director Independence and Register of Interests on page 58, Remuneration Report on pages 63-71.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.
Comply – Attendance table on page 62.	
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
Comply – The Council of Governors on pages 72-75.	
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Comply – Expenditure on consultancy on page 46.	
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
Comply – Annual Report on Remuneration on pages 63-71.	
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
Comply - Board of Director Profiles on pages 52-58.	
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.
Comply - Well led Framework on pages 81-82.	
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives

Provision	Requirement
	• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.
Comply - Board member recruitment at our organization is conducted through a nationwide search, overseen by an Executive Recruitment company. This ensures that a diverse range of expertise is present across the Board, which is essential for effectively executing their duties. The process of Board recruitment is in-depth and multi-step. Recruitment executives conduct the initial vetting of candidates, who are then interviewed by stakeholder panels consisting of Governors, partners, senior colleagues, and other relevant parties before undergoing a formal interview. Our Board is committed to creating equity of access, employment, and experience, ensuring that more people from diverse communities have opportunities within the Trust. Strategic Objective 2 reflects this commitment. We are dedicated to ensuring that our Board is reflective of our population, and we are pleased to report that the current Board is progressively more diverse than previous ones. Succession planning and talent management are also of paramount importance to the Trust and are included in our current People and OD Delivery Plan. We are committed to delivering the highest standards of care and service, and we believe that our workforce's diversity and inclusivity are central to this goal. See also Executive Directors on pages 52-58, Staff policies on pages 37-38, Year end analysis on page 37.	
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Comply – The Council of Governors on pages 72-75.	
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
Comply – Role of the Board of Directors on pages 59-62.	
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Comply – Role of the Board of Directors on page 59-62.	
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Comply – Annual Governance Statement (pages 87-100) and Summary of principle risks (page 14) confirm the use of the Risk Management Framework to establish and manage the principal risks to the organisation.	
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
Comply – Annual Governance Statement on pages 87-100.	

Provision	Requirement
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.
Comply - Going Concern on page 16.	
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.
N/A	
App B Para. 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
Comply – The Council of Governors on pages 72-75.	
App B Para. 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.
Comply - Council of Governors on pages 72-75.	
App B Para. 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, ego through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.
Comply – Role of the Board of Directors on pages 59-62.	
Additional Requirement of the Foundation Trust Annual Reporting Manual	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trusts or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)
N/A	

There are no provisions within the NHS Code of Governance that we did not comply with for the period 1 April 2023 to 31 March 2024.

NHS England Well-led Framework

NHS England's well-led framework identifies the characteristics required of good provider organisations that ensure quality services are provided:

- Leadership capacity and capability.
- Clear vision and credible strategy.
- Culture of high quality care.

- Clear responsibilities, roles and systems of accountability.
- Clear and effective processes for managing risks.
- Robust and appropriate information effectively processed and challenged.
- People using services, the public, staff and partners engaged and involved.
- Robust systems and processes for learning, continuous improvement and innovation.

The Trust has robust quality and corporate governance arrangements in place to ensure the quality of services it provides. Quality governance and quality performance are covered in detail in the Annual Governance Statement as well as in the performance section of the annual report.

The Board undertakes regular reviews of its performance and effectiveness as this provides a useful opportunity to step back and reflect. This includes:

- The Chair conducts individual performance evaluations of the Non-Executive Directors and the Chief Executive, as well as Executive Directors in relation to their duties as Board members.
- The Senior Independent Director conducts a performance evaluation of the Chair having collectively met with all other Non-Executive Directors and received feedback from Governors and Executive Directors.
- The Chief Executive conducts performance evaluations of the Executive Directors.
- The Board had an externally facilitated development programme in year.

In October 2022, the Trust had an externally independent commissioned well led review which resulted in a report and recommendations. This was utilised in part to inform the development of the new operating model during the year. As the new operating model was implemented the trust has commissioned a review by the Good Governance Institute looking at the structure of the top level care group meetings, tier 2 groups committees and the Board. Work commenced Quarter 3, 2023/24 and will be completed in Quarter 1 2024/25 with an evaluation report being provided for consideration by the Trust.

Care Quality Commission (CQC)

The Trust is required to register with the CQC and its current registration status is ‘Registered with no conditions applied’. The CQC has not taken enforcement action against the Trust during 2023/24.

The latest inspection by the CQC was a ‘Well-led’ inspection of the Trust that took place in November 2019 and the inspection report was published in February 2020. The Trust received an overall rating of 'Requires Improvement', with ratings of 'Good' in the domains of Caring and Responsive and a rating of 'Requires Improvement' in the domain of Safe, Effective and Well Led.

The CQC identified 33 Must Do actions and 44 Should Do actions as a result of their inspection and an action plan developed to address these. All actions have been implemented following a pause in 2020 due to the COVID pandemic.

The Trust has not participated in any reviews during 2023/24.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

During 2023/24 the Trust was assessed in Segment 2 (2022/23 Segment 2).

No enforcement action has been taken by NHS England against the Trust.

This segmentation information is the trust's position as at 31 March 2024. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Counter Fraud, Bribery and Corruption

The NHS Counter Fraud Authority provide the framework through which Trust's sought to minimise losses through fraud. The Chief Executive and Director of Finance and Estates are jointly responsible for ensuring the Trust meets its obligation and are supported by the local Counter Fraud Specialist (LCFS). A work plan has been completed in the year by the LCFS. The work plan addresses the requirements of the Trust's Counter Fraud, Bribery and Corruption Policy. The key aims are to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and to ensure that allegations of fraud are appropriately investigated.

Regular reports are received throughout the year by the Audit Committee as well as an annual report. Reported concerns have been investigated by our LCFS specialists in liaison with the NHS Counter Fraud Authority (CFA) and the police as necessary. The Audit Committee reviewed the levels of fraud reported and detected, and the arrangements in place to prevent, minimise and detect fraud and bribery.

Further information on policy is provided with the staff report – see page 40.

Statement of Accounting Officer's Responsibilities

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 England.

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

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

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

aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Toby Lewis, Chief Executive
11 July 2024

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Rotherham Doncaster and South Humber 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 Rotherham Doncaster and South Humber NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As the Accountable Officer, I am accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. I have overall responsibility for the management of risk and for maintaining a sound system of internal control.

Leadership arrangements for risk management are detailed in the Trust's Risk Management Framework and further supported by the Board Assurance Framework and individual job descriptions. The Risk Management Framework, refreshed as the year closed, outlines our approach to risk and the accountability arrangements including the responsibilities of the Board and its committees, Clinical Leadership Executive and its groups – especially the newly formed Risk Management Group, Executive Directors and all staff. Active leadership from all managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance.

The Director of Corporate Assurance/Board Secretary has delegated responsibility for the Trust's Board Assurance Framework and for ensuring the implementation of the risk management framework within services. All Executive Directors have responsibility to identify and manage risk within their specific areas of control in line with the management and accountability arrangements in the Trust.

The Audit Committee monitors and oversees both the internal control issues and the processes for risk management. Both Internal and External Auditors attend the Audit Committee.

The management of strategic and operational risk is detailed in the revised and refreshed Board approved Risk Management Framework, which also contains the agreed Trust Risk Appetite statement - "The Trust recognises that its long-term sustainability depends on the delivery of its strategic objectives and, its relationships with its communities, including service users and families, the public and partners. Patient and staff safety is paramount and as such the Trust will not accept risk that materially provide a negative impact on quality and governance. The Trust acknowledges the challenging business environment in which it operates and has a greater appetite to take considered risks in terms of the impact to achieve innovation and excellence".

The Trust ensures that staff are equipped to manage risk in a variety of ways and at different levels of strategic and operational function. All policies are available to staff via the Trust's website and undergo an equality impact assessment and is part of the approval process along with consultation. All operational risks are recorded in the risk module within 'Ulysses'. During 2023/24, the number of risks recorded has significantly increased as a result of a concerted effort to raise the profile of risk management across the Trust. Key decision making is also now rooted within a risk-based process: including the management of financial choices to reduce or increase budgets, and to allocate capital. Risk module training and general risk training is provided to identified risk leads, and this is being significantly increased in 2024/25: risk registers, mitigations and concerns are addressed directly with the executive in bi-monthly delivery reviews.

The Trust learns from a range of sources including patient and staff feedback and the outcomes of reported incidents and innovations. The Trust has established an Education and Learning group, as part of its new decision-making structure, which will undertake a stocktake on the 'what and the who' is undertaking learning, and develop a Trust wide approach around the 4 pillars of learning:

- Learning to know
- Learning to do
- Learning to live together
- Learning to be

During 2024/25 we will continue to review the approach and systems by which we learn internally to consider innovations for learning, and measurement of impact, including the introduction of mandated learning half days across the Trust from September – a major endeavour which will significantly increase the capacity to spread learning inside the organisation in every team, clinical and non-clinical.

The risk and control framework

The Trust considers risk management to be an intrinsic part of its governance and quality frameworks that enhances strategic planning and prioritisation, assists in achieving objectives and strengthens the ability to be agile to respond to the challenges that we face. Risk

management is an essential and integral part of planning and decision-making so that the Trust can meets its objectives successfully, improve service delivery and achieving value for money.

The Risk Management Framework explains how risks are identified, evaluated, scored and monitored within the organisation. The Trust has in place a risk scoring matrix, which is used to evaluate all risks. Once agreed, operational risks are included in the relevant Risk Registers. Up to December 2023 were monitored by the relevant Board Committee in accordance with allocated theme associated with the BAF. Oversight and management of operational risk moved to the Risk Management Group (a decision-making group of CLE) in January 2024 when the group was established as part of the new operating model. This monthly group, chaired by the Chief Nurse, directly advises the Clinical Leadership Executive and provides significantly enhanced visibility of risk – and a more direct route to mitigate it. We would expect risks identified at '12'/'15' to grow, and risk velocity to increase markedly.

The Trust manages its most significant current and future potential strategic risks to the achievement of our strategic objectives through the Board Assurance Framework that provides a structure for the effective and focused management of the principal risks. Risks are assessed by using a 5 x 5 risk matrix where the total score is an indicator as to seriousness of the risk. Each risk is allocated an Executive Director lead and a lead committee of the Board. Following the new Trust strategy in July 2023, the Board asked that for an interim period the reporting of risk against the prior BAF was moved to a 'by exception' model, which occurred, pending approval of a revised BAF in March 2024 and May 2024. Regular review and update of each risk and the associated action continued throughout the year. I am satisfied that Board members have been fully involved with BAF related risks throughout the year, and I cannot concur with the concerns speculated on by the head of internal audit opinion, as they have not manifested themselves – and I am satisfied that had risks arisen, our approach fully provided for them to be addressed. The most labile strategic risk in the 2023/24 BAF related to finance – and the Trust's in year and underlying financial position has substantially improved over the period.

During 2023/24 it should be recognised that:

- The risk management framework has been fully revised
- Risk reporting has been changed and risks identified have grown, and their source diversified

  The BAF has been developed across the Board, whilst the extant BAF has been suitably monitored

There remains further work to do to ensure that risks manifesting themselves through other sources of concern, including incident reporting, and primary care alerts, are recognised and moved into risk registers even where local teams overlook this. This work will occur in 2024.

The Trust has also developed a range of guidelines, policies and procedures to assist managers in the assessment, control and investigation of risks. These procedures set out the levels of risk and identify where in the organisation each should be managed. The key policies and procedures are:

- Incident reporting policy
- Learning from deaths policy the right thing to do
- Being open policy (incorporating and duty of candour)

- Clinical Risk Assessment and Management policy
- Listening and responding to concerns and complaints policy
- Freedom to speak up policy: raising concerns (whistleblowing) policy

The Trust is registered with the CQC with no conditions applied and the statement of purpose is regularly updated and changes reported to the CQC.

The Trust is committed to supporting patient safety by ensuring information is accessible, its integrity is protected against loss or damage, and confidentiality is maintained. The Trust recognises that information handling represents a corporate risk in that failures to protect information properly, or to use it appropriately, can have a damaging impact on the safety of our patients and the reputation of the organisational.

Information risk management is monitored via our information risk management framework. As part of this, information risks are clearly recognised, and the appropriate controls implemented through the risk management framework. The Senior Information Risk Owner (SIRO) is responsible for overseeing the development and implementation of the information risk management framework. The SIRO is supported in this by the Information Governance (IG) team and by the Information Asset Owners (IAO) within each business area. IAO's are responsible for managing information risks to the assets within their control.

Quality of data is overseen by the Information Quality Work Programme, which audits and kitemarks key performance metrics set by the trust as part of its floor to board assurance and reported via the Integrated Quality & Performance Report. Metrics assessed and kitemarked are reported to FDE each quarter. More broadly the Performance Team and the Data Support Officers who are embedded in operational services undertake regular data quality samples of the performance data reported both internally and externally.

NHS Foundation Trust License Condition Compliance

As an NHS Foundation Trust, the Trust is required by its license to apply relevant principles, systems and standards of good corporate governance (FT4). To discharge this requirement the Trust has a Board of Directors and committee structure with responsibilities set out in formal terms of reference. The Board and its Committees have associated reporting lines, performance and risk management systems. Each Committee is chaired by a Non-Executive Director and has an associated executive team member as its executive lead. The work plans of the committees are reviewed annually with the Terms of reference.

A self-assessment of compliance against the Trust's licence is undertaken by the Director of Corporate Assurance and reviewed by the Board of Directors. The Board of Directors has not identified any principal risks to compliance with provider licence condition FT4 and is satisfied with the timeliness and accuracy of information to assess risks to compliance with the provider licence and degree of rigour of oversight it has over performance.

The Trust also has a comprehensive programme of internal audit in place aligned to key areas of potential financial and operational risk. This will increasingly be examined, set, and managed alongside our clinical audit programme, as we look to work on an integrated basis.

Stakeholder relations

The Trust recognises the importance of working in partnership with others including statutory organisations, voluntary sector and communities. During 2023/24 we have reviewed our key partnerships with stakeholders in Rotherham, Doncaster and North Lincolnshire and across the two Integrated Care systems that we work in. A new approach to managing stakeholder relations and partnerships has been developed which will involve Executive Directors taking a Relationship Manager role with each key partner in 2024/25. The Trust has adapted its governance structures to establish a new Board Committee which focuses on our partnerships and will assess the effectiveness and quality of our partnership working on a regular basis. Feedback from partners bodies has been overwhelmingly positive about the changes made, and the improved visibility of the organisation as an effective partner.

The Trust has a Social Enterprise called "Flourish". Flourish was formed in 2014 and is a wholly owned subsidiary of the Trust. It is incorporated as a Community Interest Company and is registered with Companies House. Flourish currently trades and provides vocational pathways across 3 business areas from St. Catherine's House, Woodfield Park in Doncaster. The Trust is represented at the Directors meetings by the Director of Corporate Assurance. He maintains oversight over the delivery of Flourish's strategy, financial plans, business continuity, risk management and operational performance, reporting through a Board committee.

The Trust is also the 2023/24 Lead Provider for the South Yorkshire Adult Eating Disorder Provider Collaborative. This includes commissioning beds from Independent Sector Providers that is supported by financial and quality oversight: this is delivered through a joint agreement with other providers in South Yorkshire. Funding is provided via NHS England's Specialist Commissioning Team. The purpose is to provide the highest quality eating disorder care that is person centred, supports recovery, is responsive and is delivered as close to home as possible. By doing this we are reducing the need of people to need care in hospital and support people to lead successful lives supported in their local community.

The Trust has a range of patient and public involvement activities and consultation with its communities and empowering them. There are many examples of this. We work with our voluntary and charity sectors to deliver our Aspire drug and alcohol services. This includes a strong peer support model. In Rotherham we have invested fully in community resources to support individuals beyond traditional service boundaries. Local community groups were micro-commissioned and funded according to the needs of our service users and were provided in communities across Rotherham. This included peer support, befriending, activity and exercise.

The People Focused Group (PFG) working in the voluntary sector are our Patient Participation Partner and together we engage with many parts of our communities to work with them on designing and delivering services. This work is across the whole RDaSH geography.

PFG deliver services for people experiencing a mental health crisis by providing the Safe Space service in Doncaster. The service is delivered by a large network of peer support workers and provides much needed care to our communities. Peer support workers in reach into Trust wards – and the strategy commits to growing this work.

Close working with voluntary sector partners who provide support for those living with dementia has been at the centre of our approach to ensuring the best experience for patients and carers. This includes setting up an advisory panel who set their own terms of references and areas of focus. Our recently established partnership with the Alzheimer's Society will also enable us to focus more on working with our communities on an equal footing.

The Trust has commissioned/supported a number of initiatives in conjunction with the voluntary community and social enterprise sector during 2023/24. Over £623k has been invested in this regard and have included giving support to the following organisations:

- The People's Focus Group for work across all areas in respect of community, inpatient and waiting list initiatives as well as community development and lived experience.
- S62 Rotherham for community development work
- MIND, Helping Hands and Mindful Activities in respect of winter pressures
- Citizen's Advice Bureau and Voluntary Action Rotherham in respect of Community Mental Health Team Transformation (experts by experience)
- Rotherham Rise, GROW and Rotherham ADS in respect of the Trauma Resilience Service

Safer staffing and workforce development

The Trust continue to invest heavily in the health and wellbeing of our colleagues and is focusing more on our commitment to be a compassionate and inclusive organisation, which has a Restorative Just and Learning Culture and where the Trust is an Employer of Choice. We have been successful in our international recruitment across a number of staff groups, and we are looking at new role and developing our colleagues to excel in their roles and the patient care they deliver.

E-Rostering is used to monitor clinical staffing levels primarily in our clinical services. The national Electronic Staff Record (ESR) is utilised to manage budgeted establishments and actual establishments and provide detailed information in relation to skill mix, vacancies, and turnover. ESR is also utilised for monitoring professional registration, statutory employment checks, statutory and mandatory training compliance, and professional development review compliance. In addition, the Trust has an in-house Staff Portal which is utilised to monitor clinical and managerial supervision compliance and the Trust and each directorate is provided with data from all of these systems on a monthly basis to ensure compliance is monitored and actioned. This year we launched the Staff App to provide colleagues with a choice as to what information they access, how they access it and when they access it.

The numbers of our colleagues on our wards are monitored and managed operationally through the Chief Operating Officer and the Care Group structures. The safe staffing requirements are determined and monitored by the Chief Nurse and locally at 'place level' by locality Care Group Nurse Directors. Staffing levels are published on our website. Safe staff reporting is a requirement for health trusts and has been published the data in line with national requirements set by NHS England.

In 2023/24 we have undertaken a stocktake of our current safer staffing framework. Our recently appointed Chief Nursing Officer has set a direction of exciting operational, tactical, and strategic plans to take forward the trust on a journey to workforce excellence. This includes

governance, controls and mechanisms to ensure oversight of staffing issues on a daily, weekly, monthly, bi-annual and annual basis. This will include changing to forward-view reporting including our fill rates, quality indicators and clinical narrative so our local communities are fully informed of our staffing position. We are implementing exciting digital innovations as enablers to support productivity through e-roster optimisation. All with the ambition to ensure there is a visibility of staffing levels across the trust, and that we are safe and compliant with the NQB workforce safeguards in delivering outstanding care to those who are in receipt of our services. All delivered with the context of a workforce plan which is relevant and considers the backdrop of the national and global workforce context including staffing shortages. This will include a flexible and efficient bank offer in partnership with NHS Professionals. We will take forward plans to be a local market leader, with a local, regional and national innovative recruitment plan and a retention plan which is meaningful to our staff at the point of care with quality outcomes which demonstrates impact.

There is a dedicated People Plan Steering group that meets to progress focussed work streams, identify areas of improvement and change, and also work upon interventions to ensure a more sustainable workforce.

Key focus areas over the past year have been the enhancement of nursing career pathways assisted by a number of colleagues who have completed their training programmes, such Trainee Nurse Associates, Nursing Associates, Nurse Top up programmes and the newly introduced CAP roles. We have further increased our Apprenticeship Levy spend and we have a clear commitment by 2025 to utilise our full levy allocation, whilst supporting local recruitment. Trajectories to recruit to all roles within our Trust are being set alongside our budgets in 2023/24. Unambiguously recruiting to our funded roles is the basis for the Trust's Operating Plan 2024/25 and to significantly reduce our agency spend.

Compliance Statements

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation 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 twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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.

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

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS

programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Finance, Digital and Estates Committee (FDEC) and ultimately the Board of Directors ensure through a series of robust review mechanisms, that the use of resources is planned in an efficient and effective manner, and that our financial position is monitored and scrutinised. They oversee the monthly position against the approved financial plan for the year though their primary focus is underlying financial viability on a multi-year basis.

I have responsibility for ensuring that the resources used in the day-to-day operational activities of the Trust are done so in an economic, efficient and effective manner. This is discharged through two formal systems. A sub-group of the Clinical Leadership Executive oversees financial performance. Every month by rotation our Care Groups and each Corporate Directorate undertake a delivery review, where alongside safety, workforce and wider delivery matters, financial control is discussed, and relevant actions taken. In 2023/24 every single Care Group met its budgetary obligations, despite a 5% cost improvement programme. This is testimony to local control and has benefitted too from central and corporate support.

In addition to the monthly budgetary control system, the Trust ensures economy, efficiency and effectiveness as well as value for money through the implementation of a suite of effective and consistently applied financial controls, effective tendering procedures and procurement practices, robust establishment controls and continuous service improvement and modernisation programmes. Our Standing Financial Instructions have been reviewed and revisited in-year through the Board.

We have a bi-monthly Audit Committee that includes reports from Internal and External Audit. The Auditors provide their respective views to the Committee on our overall governance and control processes. FDEC and the Audit Committee are two of the eight committees put in place by the Board of Directors as part of its governance structure. For further details on the structure and the attendance of directors at meetings of the Board – see page 62. The annual assessment of compliance statement with the Corporate Governance Code is provided in the Annual Report – see pages 78-81.

Information governance

The Trust has a nominated Senior Information Risk Officer (SIRO) at executive level who has been nominated responsibility for information risk. The Data Protection Officer (DPO), overseas Data Protection compliance throughout the Trust and provides independent advice to the Trust.

Information Governance incidents are monitored through the Information Governance Group (chaired by the SIRO) on a monthly basis. During 2023/24 there have been 543 incidents reported (515 incidents were reported in 2022/23) of which 4 required notifications to the Information Commissioner via Data Security & Protection toolkit (during 2022/23 there were two incidents). Details for the incident are summarised in the table below:

No.	Month/Year	Summary of Breach	Action Taken by the ICO
1.	April 2023	Audits were undertaken within the Trust's Electronic Staff Record (ESR) regarding a staff member who was working their notice within the Workforce Department. Evidence was found of inappropriate access to three staff members Tax information. Further investigation has found evidence of pay slips being sent to the staff members personal email account on two occasions.	Recommendations provided but no further action taken by the ICO.
2.	October 2023	A member of staff from a different organisation (contract, Information Sharing Agreement etc. in place) has inappropriately accessed the medical records of approximately two patients.	No action taken, ICO happy with actions taken by RDaSH and other organisation.
3.	October 2023	Staff member sent a person's copies of identification in error to the incorrect person.	No action taken by ICO.
4.	March 2024	Identified Student nurse on placement with Trust had been inputting patient names into CHAT GPT to utilise the AI forum to create written documentation for both course material and patient record keeping.	Recommendations provided but no further action taken.

Data quality and governance

The Trust has published a Data Quality Policy, Management Information Guide and Quality Assurance and Performance Framework Flow Chart, these three documents support the coproduction of reports through development to sign off, which includes data quality testing. The management information guide also set out ongoing responsibilities for the oversight and escalation of Data Quality. In addition, the Data Quality Group (monthly meeting) is a forum for data quality issues to be escalated, explored and corrected. The Data Quality group reports into the Digital Transformation Group which subsequently reports to the Clinical Leadership Executive (CLE).

In terms of elective waits, the trusts Access and Waiting Times Policy outlines the services for which it applies the principles of RTT. In year we identified some discrepancies within the application of that policy and a revised approach to waiting list management was discussed with the Board. It has been applied effective 1 April 2024.

The Information Quality Team audit and kitemark the waits in scope of national RTTs which are also monitored internally through the IQPR.

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 and its committees. The Audit Committee provides the Board of Directors with an independent and objective view of arrangements for internal control and risk management within the Trust and ensure that the internal audit service complies with mandatory auditing standards. It approves the annual audit plans for internal and external audit services, receives regular progress reports and ensures that recommendations arising from audits are actioned proportionately.

It will be apparent that I disagree with, and reject, the views offered by both the Head of Internal Audit and within the External Audit Value for Money opinion. This is highly unusual. I set out the detail here of that disagreement, before, more importantly explaining the strengths and weaknesses of the Trust's controls which have informed my opinion.

- Both external and internal auditors have confirmed that, to the extent that it is within their responsibilities, they have identified no additional, or significant, risks or consequences arising from the claimed gaps in control. Moreover, data within this annual report on the organisation's safety, workforce, finance, and operating performance shows improvement from prior years.

- The issues identified by the auditors have occurred in prior years when different, less limited, opinions have been offered and, for the reasons I outline below, I am assured that the underlying functions, arrangements, and outcomes have not deteriorated and, in some instances, positively reflect the hard work undertaken by my staff. The Auditors' note that the BAF issue is a new and transitional one and highlight that the timeliness of audit recommendation responses has been an ongoing concern for some time (notwithstanding extremely good performance in 2022/23).

Turning to the specific concerns raised by the auditors.

- The external audit opinion draws on the head of internal audit opinion, is concerned by a lack of documentation over the interim approach the BAF, and take a view, with which I disagree, over progress with the finance development plan. I am satisfied, as is the Audit Committee with progress on the latter. The Chair, audit committee and I are content with the interim BAF arrangements in place.

- The internal audit opinion relies on three views: firstly that the Board made a mistake in choosing to change the BAF approach and manage the BAF in-year in a different way; secondly that 85% internal audit recommendations completed represents a limited level of performance because only 60% occurred on time; and thirdly that the huge increase in identified risks within the Trust is not indicative of improved approaches to risk management because the risk management framework was not reagreed at the Board until January 2024 (though the new approach to risk has been deployed from June

2024). I consider that 85% represents reasonable practice, that the BAF management has been situationally suitable, and that the approach to risk is objectively better than in any year at the Trust since the onset of the pandemic.

It is important that the above comments are not read defensively. The Trust has significant weaknesses in systems, and these are outlined here openly. They are not the weaknesses highlighted within audits. Moreover, whilst very positive about our staff survey performance, especially at a time of change, we do not believe that a rating of Requires Improvement is acceptable.

2023/24 has been a year of transition. The full Board took the view that prior systems of control lacked for data and for delivery mindset. The Operating Model introduced in mid-2023/24, with assistance from two separate external advisors, has not simply replaced prior systems, but introduced new systems and processes to address the deficits highlighted. This has necessarily led us, and in every case in a planned and known way, to give less emphasis to certain processes, whilst addressing more important consequential matters. There remain gaps and deficits which I outlined in the prior year's Annual Governance Statement and rediscuss below.

The work of internal audit is monitored via the Audit Committee, from which further assurances, through their objective and independent view of the system of internal control, have been received. Plans to address any weaknesses identified through these audits are subject to regular follow up by the Corporate Assurance Team and are overseen by the Audit Committee. Based on the work undertaken during 2023/24 the Head of Internal Audit has stated in their Head of Internal Audit Opinion of Limited assurance as detailed below:

I am providing an opinion of limited assurance that there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.

- Strategic risk management and Board Assurance Framework (BAF) – I am providing an opinion of limited assurance. Since the appointment of a new Chief Executive in March 2023, the Trust has undergone a significant programme of change including the launch of a new strategy, a revised operating model and a restructure of its Care Groups. During this time, the Board took the decision to report BAF risks by exception whilst new arrangements were put in place, including the development of a new BAF to support strategic delivery which remains in progress. As a result of the reduced level of reporting, we were unable to sufficiently evidence the review and management of strategic risk during 2023/24.
- Internal Audit outturn – I am providing an opinion of moderate assurance for this element. Of the 11 assurance opinion reports issued since our 2022/23 opinion, four provided limited assurance and three provided moderate assurance.
- Implementation of Internal Audit actions – I am providing an opinion of limited assurance for the implementation of actions. The Trust implemented 60% of its actions in accordance with agreed timescales. At the time of concluding my opinion, one high risk and eight medium risk actions were overdue. A further high risk action was implemented beyond the original due date.

My opinion takes into account third party assurances received by the organisation.

External Audit report to the Trust on the findings from their audit work, in particular their audit of the financial statements and the Trust's arrangement for the secure economy, efficiency and effectiveness in its use of resources. For 2023/24 an unmodified audit opinion has been issued in respect of the financial statements but with specific weaknesses identified in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

During 2023/24 the Quality Committee approved the annual audit plan for clinical audit services, received regular progress reports on outcomes and around the implementation rates for actions arising from the recommendations made. Going forward this role will be undertaken by the Audit Committee to enable a broader oversight of the delivery of clinical audits alongside the internal audit programme.

In 2023/24 I identified four areas of underlying system weakness, whilst accepting that they were not significant internal control issues and therefore do not require a disclosure statement. I report on progress since and comment on new limitations which we will look to address in the future.

Data for care: our data quality remains well governed, and there is clearly with our IQPR, improved data visibility not only within the Board, but across the organisation. The timeliness and immediacy of this data needs to further improve, and the safety plan identified in our quality account as a priority for 2024/25 will rely on that improvement for its effectiveness. The Trust has further work to do, impeded by personnel changes in 2023/24, to finalise its top-level scorecard of safety and quality indicators.

Financial improvement: delivery on both revenue and capital in year, and most importantly the substantially improved distributed and delegated leadership of each, suggests real transformation on this matter in year. We have for our main cost, pay, better oversight going into 2024/25 and this gives us confidence on delivery of the agency gains which underpin our CIP. Our non-pay controls are strong, but information sharing associated with medicine and non-pay spend will need to improve further.

Data about staffed teams: It has taken a lot of work to improve this and that work has come to fruition in quarter 4 of the year. At a very local level there is good grip of hiring decisions and wider line management. Aggregation of data and its use to plan workforce reform has taken time to systematise. The significant changes made in practice suggest that we are now using this data well to make decisions. The transfer to NHS Professionals will further enhance this work as we have a flexible working partner in place. Benchmarking work continues, and intelligence on our supervision, appraisal, placement and educational models informs my positive view of our capability for the two years ahead, including implementation of the national workforce plan.

Delivery capability: We have entirely restructured our frontline management, and much of our corporate management during the year. We are investing to support those leaders and finding a balance between internal expertise and new recruits where skills gaps exist. External advisers make clear the progress and difference seen, but recognise as I do, the fragility of change. We

are working better with place partners but have more work to do to support primary care partners. I am satisfied that our delivery skills are improving, as evidenced by the Trust meeting three of the national access standards in 2023/24 – a step forward from past practice.

These four issues remain a focus in 2024/25. Two other issues will be crucial to supporting our strategy, and therefore our control of risk at a strategic level, and trust as a day to day level:

- Our ability to translate into practice our commitment to work with patients, carers and communities in co-production. This is not an add-on to our governance but at its heart. This will be difficult to do and the Board is very aware that it may require us to change transitional practice, systems and language to make these collaborations effective. Processes including those of audit and regulation will need to be wisely managed mindful of that ambition.
- Our culture must adapt yet retain the longstanding strengths valued in our excellent staff survey results. That adaptation will include challenges the weaknesses in that and other data, notably in relation to discrimination and racism. Our intent to deliver must not overlook the diverse needs of employees, managers, and partners. The new BAF focuses hard on cultural alignment as a key risk for the future. Managing culture, curating it, and shaping it is a capability we will need to work to deliver.

The Trust's oversight of operational delivery and financial obligations has been improved during 2023/24. I have confidence that a similar trajectory of transformation is in place for safety and quality and people and teams. The choice to focus on these matters in 2024/25 does not indicate secondary importance, but rather the need to have key capabilities in place so that improvement can be secured and can endure.

I note that the two additional issues identified here are threaded through the approved Board Assurance Framework risks for 2024 - 2027, which are cultural in nature and focus on our partnership working - consistent with a system-first NHS. These are:

1. Cultural competence: If our 'changed ways of working' with the diverse population (including among excluded communities) are not delivered by 2027, **because of the leadership's inability to identify, communicate and engage** then it will lead to a loss of confidence locally and likely non-delivery of strategic objective one.

2. Data for insights: If we do not execute plans to consistently create, use and respond to data inside our services (and with others) **because our leaders lack the time, skills, or diligence to see through specific changes or are distracted by 'wider system' priorities** then this will lead to a lack of precision in how the Trust reshapes services.

3. Joined up care: If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at PHCT/PCN/neighbourhood level **because there is not the mutual skill to change, or confidence to experiment by both parties, or funding models are restrictive, then we cannot deliver our new community offer** with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.

4. Patient-first working models: If seven-day working and other bed-based service alterations are not implemented fully **because of resistance, inflexibility, or affordability - with colleagues able to move elsewhere** (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.

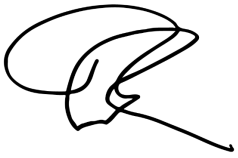
5. Leadership capability: If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027, **because we do not develop and practice the skillsets required to make change occur**, then the Trust's strategy will not achieve what it has promised, and we will face reorganisation, frustration, and turnover among employees.

The Board has confidently 'retired' the prior BAF risks in Q4 2023/24 having concluded that they are no longer the most relevant risks to the Trust's work or delivery of the new strategy. Indeed, those previous BAF risks are largely situational, replicative of other NHS Trusts, and do not describe material issues impacting patient care at RDaSH.

Conclusion

I confirm that the Trust has an adequate and effective system of internal control, and any specific internal control issues are being addressed through robust actions. We are revising wholly our approach to the issues highlighted by Internal Audit, with oversight from the audit committee chair and myself – and I am confident that performance on the specific issues they identify will improve during 2024. Matters raised by the External Audit opinion will be formally considered at the Audit Committee on August 7th, and management will be directed by their conclusions as to whether changes are needed in response.

There are no significant internal control issues identified during the period from 1 April 2023 to 31 March 2024 that require disclosure in this statement.



Toby Lewis, Chief Executive
11 July 2024

AUDITORS REPORT

Independent auditor's report to the council of governors and board of directors of Rotherham Doncaster and South Humber NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Rotherham Doncaster and South Humber NHS Foundation Trust (the 'foundation trust' or the 'trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2024 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the consolidated and parent statement of financial position;
- the group and trust statements of changes in taxpayers' equity;
- the group and trust statements of cash flows; and
- the related notes 1 to 39.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (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

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. 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.

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

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.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

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 FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management and internal audit about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, pensions and IT regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address them are described below:

- the judgemental nature of key assumptions used in property valuations: we engaged our property specialists to assess the assumptions and methodology used to value the estate.

- overstatement of trade creditors and accruals and the timing of their recognition at year-end is subject to potential management bias: we tested a sample to supporting documentation to assess whether the liability had been incurred as at 31 March 2024.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006
In our opinion:
• the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
• the information given in the Performance Report and the Accountability 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

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 26 June 2024 we reported to the foundation trust the existence of two significant weaknesses in the foundation trust's governance arrangements.

The significant weaknesses reported were:

- in respect of the arrangements to deliver strategic risk management and to report regularly on the Board Assurance Framework. We noted that the Trust has received an overall conclusion of "limited assurance" from the Head of Internal Audit, with the Board Assurance Framework, specifically receiving a "limited assurance" conclusion. Additionally, we observed that that strategic risks were not routinely reported to the Board throughout the year ended 31 March 2024 solely on a "by exception" basis. Our recommendations for improvement include the need to ensure that there is clear and consistent reporting of the Trust's strategic risks; that the debate, judgements and conclusions over strategic risks are captured; and
- in respect of the Trust's arrangements to react to recommendations from internal and external audit and to take timely action. Through our audit we noted that a number of external audit recommendations raised in the prior year had not been effectively addressed and we further noted that Internal Audit has drawn attention to the lack of timely implementation of agreed recommendations as an factor in concluding that only limited assurance could be given in respect of the overall system of control in the Head of Internal Audit Opinion. Our recommendations for improvement include the need to monitor and respond to findings raised by internal and external audit on a timely basis and for those charged with governance to hold the Trust to account for timely delivery.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation 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 foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:
• any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
• any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation 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.

We have nothing to report in respect of these matters.

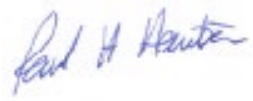
Certificate of completion of the audit

We certify that we have completed the audit of Rotherham Doncaster and South Humber NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Rotherham Doncaster and South Humber NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Paul Hewitson (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle upon Tyne, United Kingdom
11 July 2024

ACCOUNTS

Foreword to the accounts

Rotherham Doncaster and South Humber NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Rotherham Doncaster and South Humber NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Toby Lewis**
Job title **Chief Executive**
Date **11 July 2024**

Consolidated Statement of Comprehensive Income for the year ended 31 March 2024

		Group	
		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	3	212,521	205,135
Other operating income	4	12,738	12,424
Operating expenses	6	(226,162)	(219,184)
Operating (deficit) from continuing operations		**(903)**	**(1,625)**
Finance income	11	2,157	983
Finance expenses	12	(1,602)	(1,909)
PDC dividends payable		(1,992)	(1,584)
Net finance costs		**(1,437)**	**(2,510)**
Other losses	13	17	(156)
(Deficit) for the year from continuing operations		**(2,323)**	**(4,291)**
(Deficit) for the year		**(2,323)**	**(4,291)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(4,959)	(2,352)
Revaluations	16 & 17	6,847	8,457
Remeasurements of the net defined benefit pension scheme liability / asset	32	(244)	933
May be reclassified to income and expenditure when certain conditions are met:			
Fair value (losses)/gains on financial assets mandated at fair value through OCI	20	84	(215)
Other comprehensive income for the year, net of tax		**1,728**	**6,823**
Total comprehensive (expense)/income for the period		**(595)**	**2,532**
(Deficit)/surplus for the period attributable to:			
Rotherham Doncaster and South Humber NHS Foundation Trust		(2,323)	(4,291)
TOTAL		**(2,323)**	**(4,291)**
Total comprehensive (expense)/income for the period attributable to:			
Rotherham Doncaster and South Humber NHS Foundation Trust		(595)	2,532
TOTAL		**(595)**	**2,532**

Consolidated and Parent Statement of Financial Position as at 31 March 2024

		Group		Trust	
		31 March 2024	31 March 2023	31 March 2024	31 March 2023
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15	2,058	2,361	2,058	2,361
Property, plant and equipment	16	91,910	86,134	93,130	87,305
Right of Use Assets	19	11,580	11,589	11,580	11,589
Investment property	18	3,579	3,549	3,129	3,099
Other investments / financial assets	20	2,082	2,527	22	22
Receivables	24	98	129	98	129
Pension asset	32	143	470	143	470
Total non-current assets		**111,450**	**106,759**	**110,160**	**104,975**
Current assets					
Inventories	23	620	505	602	487
Receivables	24	6,339	13,470	6,667	13,447
Cash and cash equivalents	25	34,411	40,295	33,447	39,590
Total current assets		**41,370**	**54,270**	**40,716**	**53,524**
Current liabilities					
Trade and other payables	26	(16,010)	(22,359)	(15,744)	(22,017)
Borrowings	28	(2,768)	(2,185)	(2,768)	(2,185)
Provisions	29	(87)	(241)	(87)	(241)
Other liabilities	27	(403)	(1,385)	(291)	(1,385)
Total current liabilities		**(19,268)**	**(26,170)**	**(18,890)**	**(25,828)**
Total assets less current liabilities		**133,552**	**134,859**	**131,986**	**132,671**
Non-current liabilities					
Borrowings	28	(29,588)	(25,242)	(29,588)	(25,242)
Provisions	29	(857)	(990)	(857)	(990)
Total non-current liabilities		**(30,445)**	**(26,232)**	**(30,445)**	**(26,232)**
Total assets employed		**103,107**	**108,627**	**101,541**	**106,439**
Financed by					
Public dividend capital		42,530	40,855	42,530	40,855
Revaluation reserve		37,613	35,725	38,383	36,446
Income and expenditure reserve		20,672	29,180	20,628	29,138
Charitable fund reserves	22	2,292	2,867	-	-
Total taxpayers' equity		**103,107**	**108,627**	**101,541**	**106,439**

The notes on pages 116 to 157 form part of these accounts.

Name: Toby Lewis
Position: Chief Executive
Date: 11 July 2024

Statement of Changes in Equity for the year ended 31 March 2024 - (Group)

Group	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward		**40,855**	**35,725**	**29,180**	**2,867**	**108,627**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	35	**-**	**-**	**(6,600)**	**-**	**(6,600)**
(Deficit) for the year		-	-	(1,664)	(659)	**(2,323)**
Net Impairments	7 & 16	-	(4,959)	-	-	**(4,959)**
Revaluations	16 & 17	-	6,847	-	-	**6,847**
Fair value (losses) on financial assets mandated at fair value through OCI		-	-	-	84	**84**
Remeasurements of the defined net benefit pension scheme liability/asset	32	-	-	(244)	-	**(244)**
Public dividend capital received		1,675	-	-	-	**1,675**
Taxpayers' and others' equity at 31 March 2024		**42,530**	**37,613**	**20,672**	**2,292**	**103,107**

Statement of Changes in Equity for the year ended 31 March 2023 - (Group)

Group	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward		**40,735**	**30,267**	**31,518**	**2,842**	**105,362**
Implementation of IFRS 16 on 1 April 2022				**613**		**613**
(Deficit) for the year		-	-	(4,531)	240	**(4,291)**
Other transfers between reserves		-	(647)	647	-	**-**
Net Impairments	7	-	(2,352)	-	-	**(2,352)**
Revaluations	17	-	8,457	-	-	**8,457**
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	(215)	**(215)**
Remeasurements of the defined net benefit pension scheme liability/asset	32	-	-	933	-	**933**
Public dividend capital received		120	-	-	-	**120**
Taxpayers' and others' equity at 31 March 2023		**40,855**	**35,725**	**29,180**	**2,867**	**108,627**

Statement of Changes in Equity for the year ended 31 March 2024 Trust

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward		**40,855**	**36,446**	**29,138**	**106,439**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	35	-	-	(6,600)	**(6,600)**
(Deficit) for the year		-	-	(1,666)	**(1,666)**
Impairments	16	-	(4,959)	-	**(4,959)**
Revaluations	16	-	6,847	-	**6,847**
Remeasurements of the defined net benefit pension scheme liability/asset	32	-	-	(244)	**(244)**
Public dividend capital received		1,675	-	-	**1,675**
Other - Trust only Investment Property classification		-	49	-	**49**
Taxpayers' and others' equity at 31 March 2024		**42,530**	**38,383**	**20,628**	**101,541**

Statement of Changes in Equity for the year ended 31 March 2023 Trust

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward		**40,735**	**30,267**	**31,471**	**102,473**
Implementation of IFRS 16 on 1 April 2022				**613**	**613**
(Deficit) for the year		**-**		(4,527)	**(4,527)**
Other transfers between reserves		-	(647)	647	**-**
Impairments	7	-	(2,352)	-	**(2,352)**
Revaluations	17	-	8,457	-	**8,457**
Remeasurements of the defined net benefit pension scheme liability/asset	32	-	-	933	**933**
Public dividend capital received		120	-	-	**120**
Other - Trust only Investment Property classification			721		**721**
Taxpayers' and others' equity at 31 March 2023		**40,855**	**36,446**	**29,138**	**106,439**

Information on reserves

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

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

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

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 22.

Statements of Cash Flows

	Note	Group 2023/24 £000	Group 2022/23 £000	Trust 2023/24 £000	Trust 2022/23 £000
Cash flows from operating activities					
Operating (deficit)		(903)	(1,625)	(160)	(1,793)
Non-cash income and expense:					
Depreciation and amortisation	6	6,122	5,978	6,122	5,978
Net impairments	7	(1,451)	4,022	(1,451)	4,022
Income recognised in respect of capital donations		(217)	-	(217)	-
Non-cash movements in on-SoFP pension liability		83	76	83	76
Decrease/(Increase) in receivables and other assets		7,161	(9,230)	6,811	(9,229)
(Increase)/decrease in inventories		(115)	6	(115)	6
(Decrease)/Increase in payables		(6,533)	4,881	(6,503)	4,815
(Decrease) in other liabilities		(982)	(221)	(1,094)	(68)
(Decrease) in provisions		(287)	(947)	(287)	(947)
Movements in charitable fund working capital		(46)	18	-	-
NHS Charitable Funds: Other movements in operating cash flows		-	(238)	-	-
Other movements in operating cash flows		2	(3)	1	(2)
Net cash flows from operating activities		**2,834**	**2,717**	**3,190**	**2,858**
Cash flows from investing activities					
Interest received		1,989	839	1,988	839
Purchase of intangible assets		(271)	(103)	(271)	(103)
Purchase of PPE and investment property		(6,425)	(6,677)	(6,425)	(6,677)
Receipt of cash donations to purchase assets		25	-	25	-
Net cash flows from charitable fund investing activities		169	69	-	-
Net cash flows (used in) investing activities		**(4,513)**	**(5,872)**	**(4,683)**	**(5,941)**
Cash flows from financing activities					
Public dividend capital received		1,675	120	1,675	120
Movement on loans from DHSC		(363)	(363)	(363)	(363)
Capital element of lease liability repayments		(1,311)	(1,253)	(1,311)	(1,253)
Capital element of PFI, LIFT and other service concession payments		(1,647)	(539)	(1,647)	(539)
Interest on loans		(158)	(171)	(158)	(171)
Interest element of lease liability repayments		(144)	(138)	(144)	(138)
Interest paid on PFI, LIFT and other service concession obligations		(661)	(1,524)	(661)	(1,524)
Net cash flows from charitable fund financing activities		445	-	-	-
PDC dividend (paid) / refunded		(2,041)	(1,111)	(2,041)	(1,111)
Net cash flows (used in) financing activities		**(4,205)**	**(4,979)**	**(4,650)**	**(4,979)**
(Decrease) in cash and cash equivalents		**(5,884)**	**(8,134)**	**(6,143)**	**(8,062)**
Cash and cash equivalents at 1 April - brought forward		**40,295**	**48,429**	**39,590**	**47,652**
Cash and cash equivalents at 31 March	25	**34,411**	**40,295**	**33,447**	**39,590**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern

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

Note 1.3 Consolidation

NHS Charitable Fund

The Trust is the corporate trustee to the Rotherham Doncaster and South Humber NHS charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients, and staff from its involvement with the charitable fund and could affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March each year in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities, and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses

Charitable Fund key accounting policies
The accounts are prepared under the historical cost convention, with the exception of investments which are included at market value. The fund comprises:

Unrestricted funds - funds which the trustee is free to use for any purpose in furtherance of the charitable objectives. Restricted funds - funds which must be used for the specific purpose set out by the donor.

Gains and losses on investments are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between the sale proceeds and the opening market value, or purchase date if later. Unrealised gains and losses are calculated as the difference between the market value at the year-end and the opening market value, or purchase value.

Other subsidiaries

Flourish Enterprises Community Interest Company (Flourish) is a wholly owned subsidiary of the Trust.

Subsidiary entities are those over which a trust is exposed to, or has rights to, variable returns from its involvement with the entity and can affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the financial statements of the subsidiary for the year ended 31 March 2024.

Flourish prepares its financial statements in accordance with Financial Reporting Standard 102.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102), then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.4 Revenue from contracts with customers

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

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

Payment is typically received within thirty days of the satisfaction of the performance obligations and as such has no impact on contract balances.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts

The Trust also receives income from commissioners under the Commissioning for Quality Innovation (CQUIN) scheme. Delivery under this scheme is part of how care is provided to patients. As such CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Mental health provider collaboratives
NHS led provider collaboratives for specialised mental health, learning disability and autism services involve an NHS lead provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. As lead provider for the South Yorkshire Adult Eating Disorder Provider Collaborative, the Trust is accountable to NHS England and as such recognises the income and expenditure associated with the commissioning of services from other providers in these financial statements. Where the Trust is the provider of commissioned services, this element of income is recognised in the provision of services, after eliminating internal transactions.

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

Note 1.5 Other forms of income

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

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

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

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

Measurement

Valuation

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

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

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

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss (if any). Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

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

Assets which are not sufficiently low value and/or do not have sufficiently short lives are valued at depreciated historic cost as a proxy for current value in existing use.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Local Government Pension Scheme
There are Trust employees that are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Private Finance Initiative (PFI)
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition
In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy 1.14).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI, LIFT and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Land	Infinite	Infinite
Buildings, excluding dwellings	5	90
Dwellings	23	23
Plant & machinery	5	25
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

Note 1.9 Intangible assets

Recognition

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

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

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

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

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

Amortisation
Intangible assets are amortised over their expected useful lives, on a straight line basis, in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	2	10

Note 1.10 Inventories

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

In 2023/24, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits held with established financial institutions claimable 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 establishment and that are readily convertible to cash with insignificant risk of change in face value.

In the Statement of Cash Flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand if claimed. Cash, bank, and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets are classified as subsequently measured at amortised cost or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Impairment of financial assets

The Trust's financial assets which are measured at amortised cost, are in respect of contract and other receivables. At the Statement of Financial Position date, the Trust assesses whether any receivables are impaired. Financial receivables are impaired and credit losses recognised if, and only if, there is objective evidence of impairment because of one or more events which occurred after the initial recognition of the asset and which has an impact on future cash flows of the asset

For financial assets measured at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying value and the expected future cash flow from the asset.

The Trust assess potential credit loss on an ongoing basis and makes provision based on actual credit loss. A review of historic credit loss provides evidence that such losses are not material and therefore the Trust does not make provision for expected general credit loss.

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

Derecognition

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

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

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

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

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic 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.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior Year Rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	Exceeding 10 years	4.72%	3.51%
Very long-term	Exceeding 40 Years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior Year Rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme for which the Trust pays an annual contribution. NHS Resolution in turn settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed on note 29.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of these claims, are charged to operating expenditure when liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed on note 30 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.18 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.19 Value added tax

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

Note 1.20 Corporation tax

All activities of the Trust are exempt from corporation tax. Flourish, the subsidiary of the Trust, is subject to corporation tax at the rate of 25% (2022/23:19%). The Corporate tax rates changes with government budgets.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. The Trust has very few foreign currency transactions.

Note 1.22 Third party assets

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

Note 1.23 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 arise outside the expected norms of operating services. 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 accrual basis.

Losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis except where they are provisions for future known losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated without preconditions and expectations of any returns. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

The Trust received no gifts in this or the previous reporting period.

Note 1.25 Early adoption of standards, amendments, and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

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

The following are recently issued IFRS Standards and amendments that have not yet been adopted within the FREM, and are therefore not applicable to DHSC Group accounts in 23/24.

- IFRS 14 Regulatory Deferral Accounts - Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC Group bodies.

- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023. Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.

Note 1.27 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 accounting policies and that have the most significant impact on the amounts recognised in the financial statements:

Property values are kept up to date and an annual review carried out on all lands and buildings; the frequency of valuations depends on the volatility of asset values. Building indices are reviewed regularly to ensure that the carrying value of assets is not materially different from what they would be at the end of the reporting period.

Provision for credit losses

All long outstanding debts are reviewed regularly, and judgements made, based on individual circumstances and the quantum of the debt, as to whether provisions should be made for expected losses through default.

Note 1.28 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:

Property valuation and asset lives

Property valuations are undertaken by an independent external valuer. These values are subject to market conditions and market values. Asset lives are also estimated by the external valuer and are subject to their professional judgement.

Accruals

Estimates of accruals are based on the best available information. This is applied in conjunction with historic experience and individual circumstance.

Provisions

Estimates of the outcome and financial impact of provisions are based on management experience, reports and external expert opinions. Uncertainties surrounding the amount to be recognised as a provision are dealt with by various means in line with circumstances existing at the time of providing for expense/income. Where the provision being measured involves more than one outcome, the obligation is estimated by weighing all possible outcomes by their associated probabilities - the expected value of the outcome. Where there is a range of possible outcomes and each point in the range is as likely as the other, the mid-point of the range is used. Where single outcomes are measured, the individual most likely outcome is the best estimate of the liability.

Local government pension scheme

Estimation of the net liability of the local government pension fund depends on several complex judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in retirement ages, mortality rates and the expected return on pension fund assets. A firm of consulting actuaries is engaged through South Yorkshire Pension Fund to provide the Trust with expert advice on the assumptions used.

Note 2 Operating Segments

Most of the activity of the Rotherham Doncaster and South Humber NHS Foundation Trust is healthcare. The Board of Directors is considered to be the chief operating decision maker (CODM); management information provided to the CODM reports activities as a whole and not segmentally.

Note 3 Operating income from patient care activities (Group)

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

Note 3.1 Income from patient care activities (by nature)

	2023/24 £000	2022/23 £000
Mental health services		
Income from commissioners under API contracts*	128,960	125,037
Income for commissioning services in a mental health collaborative	4,370	2,863
Other clinical income from mandatory services	4,627	5,186
Community services		
Income from commissioners under API contracts*	47,524	38,931
Income from other sources (e.g. local authorities)	19,939	19,646
All services		
National pay award central funding**	38	7,093
Additional pension contribution central funding***	7,063	6,379
Total income from activities	**212,521**	**205,135**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	12,050	17,523
Clinical commissioning groups	-	37,558
Integrated care boards	175,546	125,222
Other NHS providers	4,627	4,264
Local authorities	19,939	19,646
Non NHS: other	359	922
Total income from activities	**212,521**	**205,135**

Note 4 Other operating income (Group)

	2023/24	2022/23
	£000	£000
Research and development	757	621
Education and training (excluding notional apprenticeship levy income)	6,493	6,079
Non-patient care services to other bodies	1,483	1,150
Reimbursement and top up funding	-	300
Income in respect of employee benefits accounted on a gross basis	1,529	1,560
Education and training - notional income from the apprenticeship fund	577	571
Peppercorn leased assets recognised	192	-
Cash donations for the purchase of capital assets - received from NHS charities	25	-
Charitable and other contributions to expenditure received from other bodies	-	32
Contributions to expenditure - consumables (inventory)donated from DHSC group bodies for COVID response	19	129
Rental revenue from operating leases	587	606
Charitable fund incoming resources	218	644
Other contract income	858	732
Total other operating income	**12,738**	**12,424**

Note 5.1 Income from activities arising from commissioner requested services

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

	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	192,582	185,489
Income from services not designated as commissioner requested services	32,677	32,070
Total	**225,259**	**217,559**

The income from activities arising from commissioner requested services is in respect of the consolidated income of the Trust and Flourish and excludes charitable fund income of £237,000 (2022/23 £654,000).

Note 5.2 Profits and losses on disposal of property, plant and equipment

There were no sales of property, plant or equipment in 2023/24 or 2022/23.

Note 6 Operating expenses (Group)

	2023/24 £000	2022/23 £000
Purchase of healthcare from NHS and DHSC group bodies	13	0
Purchase of healthcare from non-NHS and non-DHSC bodies	5,789	6,375
Mental health collaboratives (lead provider) purchase of healthcare - from NHS bodies	61	267
Mental health collaboratives (lead provider) purchase of healthcare - from non-NHS bodies	4,276	2,513
Staff and executive directors costs	180,498	171,711
Remuneration of non-executive directors	154	127
Supplies and services - clinical (excluding drugs costs)	6,363	3,218
Supplies and services - general	2,319	3,737
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,170	3,125
Consultancy costs	250	258
Establishment	2,299	2,177
Premises - business rates paid to local authorities	665	457
Premises - other	7,017	7,105
Transport (including patient travel)	2,896	2,166
Depreciation on property, plant and equipment and right of use assets	5,548	5,370
Amortisation on intangible assets	574	608
Net impairments	(1,451)	4,022
Movement in credit loss allowance: contract receivables / contract assets	7	46
Change in provisions discount rate(s)	(60)	(92)
Audit fees payable to the external auditor *		
audit services- statutory audit *	338	237
charitable fund independent examination	-	6
Internal audit costs	116	98
Clinical negligence	765	689
Legal fees	279	567
Insurance	210	176
Research and development non staff	26	-
Education and training	1,044	1,082
Expenditure on short term leases (current year only)	91	99
Education and training - notional expenditure funded from the apprenticeship fund	577	571
Redundancy	74	23
Car parking & security	251	131
Losses, ex gratia & special payments	64	50
Other NHS charitable fund resources expended	962	466
Other	977	1,799
Total	**226,162**	**219,184**

Audit fees payable to the external auditor *		
audit services- statutory audit *		
All below fees are inclusive of non recoverable VAT		
Contracted fee	219	204
Additional fees in relation to 22/23 paid in 23/24	119	0
Additional fees in relation to 21/22 paid in 22/23	0	33
Total	**338**	**237**

Note 6.1 Other auditor remuneration (Group)

Note 6.2 Limitation on auditor's liability (Group)

The limitation on the auditor's liability for external audit work is £1m (2022/23: £1m).

Note 7 Impairment of assets (Group)

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Land onerous lease impairment	-	4,398
Changes in market price	(1,451)	(376)
Total net impairments charged to operating surplus / deficit	**(1,451)**	**4,022**
Impairments charged to the revaluation reserve	4,959	2,352
Total net impairments	**3,508**	**6,374**

As at 31 March 2024 land and buildings were valued using an alternative site methodology. This resulted in a net reversal of impairment to operating expenses of £1,451k (2022/23 £376k) and a net impairment to the revaluation reserve of £4,959k (2022/23 £2,352). During the year of implementation of IFRS 16 in 2022/23 an impairment of £4,398k was made to a land Right of Use asset since it was assessed to be an onerous lease - there was no such cost in 23/24.

Note 8 Employee benefits (Group)

	2023/24	2022/23
	Total	Total
	£000	£000
Staff and executive directors costs	135,331	130,053
Non - executive directors	154	127
Social security costs	13,782	11,949
Apprenticeship levy	668	578
Employer's contributions to NHS pensions	16,152	14,597
Pension cost - employer contributions paid by NHSE on provider's behalf	7,063	6,379
Pension cost - other	97	154
Temporary staff (agency)	7,555	8,092
Total gross staff costs	**180,802**	**171,929**
Included within		
Costs capitalised as part of assets	75	68
Total employee benefits excluding capitalised costs	**180,727**	**171,861**
Termination benefits - redundancy	74	23

Note 8.1 Retirements due to ill-health (Group)

During 2023/24 there were 8 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £255k (£26k in 2022/23).

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates

Local government pension scheme

Some employees are members of the Local Government scheme, which is a defined benefit scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's financial statements. The assets are measured at fair value and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan is recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

NEST pension scheme

Some employees are members of the NEST pension scheme, a scheme set up by Government to enable employers to meet their pension duties and is free for employers to use. Employee and employer contribution rates were a combined minimum of 5% (with a minimum of 2.1% contributed by the Trust) up to October 2018; from 2018 the combined contribution is 8% (with a minimum of 3% contributed by the Trust).

Employer contributions in 2023/24 were £97k (22/23: £154k).

Note 10 Operating leases (Group)

This note discloses income generated in operating lease agreements where Rotherham Doncaster and South Humber NHS Foundation Trust is the lessor.

Note 10. 1 Operating leases income (Group)

	2023/24	2022/23
	£000	£000
Operating lease revenue		
Minimum lease receipts	587	606
Total	**587**	**606**

Note 10.2 Future lease receipts (Group)	31 March 2024 £000	31 March 2023 £000
Future minimum lease receipts due in:		
- not later than one year	899	928
Total	**899**	**928**

Note 11 Finance income (Group)

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

	2023/24	2022/23
	£000	£000
Interest on bank accounts	2,072	915
NHS charitable fund investment income	85	68
Total finance income	**2,157**	**983**

Note 12 Finance expenditure (Group)

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	155	171
Interest on lease obligations	144	138
Main finance costs on PFI and LIFT schemes obligations	661	710
Contingent finance costs on PFI and LIFT scheme obligations	-	814
Remeasurement of the liability resulting from change in index or rate*	559	-
Total interest expense	**1,519**	**1,833**
Other finance costs	83	76
Total finance costs	**1,602**	**1,909**

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 33.

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

No payments were made in 2023/24 under the late payment of commercial debts (interest) Act 1998. (2022/23: nil)

Note 13 Other gains / (losses) (Group)

	2023/24	2022/23
	£000	£000
Fair value (losses) on investment properties	17	(156)
Total other gains / (losses)	**17**	**(156)**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for the period was £1.666m (2022/23: £4.527m deficit). The Trust's total comprehensive income for the period was £0.022m deficit (2022/23: £2.512m surplus).

Note 15 Intangible assets - 2023/24

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023	**5,616**	**-**	**5,616**
Additions	271	-	**271**
Valuation / gross cost at 31 March 2024	**5,887**	**-**	**5,887**
Amortisation at 1 April 2023	**3,255**	**-**	**3,255**
Provided during the year	574	-	**574**
Amortisation at 31 March 2024	**3,829**	**-**	**3,829**
Net book value at 31 March 2024	**2,058**	**-**	**2,058**
Net book value at 1 April 2023	**2,361**	**-**	**2,361**

Note 15.1 Intangible assets - 2022/23

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2022	**5,087**	426	**5,513**
Additions	103	-	**103**
Reclassifications	**426**	**(426)**	**-**
Valuation / gross cost at 31 March 2023	**5,616**	**-**	**5,616**
Amortisation at 1 April 2022	**2,647**	**-**	**2,647**
Provided during the year	608	-	**608**
Amortisation at 31 March 2023	**3,255**	**-**	**3,255**
Net book value at 31 March 2023	**2,361**	**-**	**2,361**
Net book value at 1 April 2022	**2,440**	**426**	**2,866**

Note 16 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	**4,857**	**74,948**	**170**	**3,760**	**2,161**	**103**	**10,775**	**536**	**97,310**
Additions	-	5,228	-	-	151	-	1,134	166	**6,679**
Additions - assets purchased from cash donations/grants	-	-	-	-	25	-	-	-	**25**
Impairments	-	(1,293)	-	-	-	-	-	-	**(1,293)**
Impairments charged to the revaluation reserve	-	(4,959)	-	-	-	-	-	-	**(4,959)**
Reversals of impairments	218	2,526	-	-	-	-	-	-	**2,744**
Revaluations	32	1,029	(10)	-	-	-	-	-	**1,051**
Reclassifications	-	3,730	-	(3,750)	7	-	-	-	**(13)**
Valuation/gross cost at 31 March 2024	**5,107**	**81,209**	**160**	**10**	**2,344**	**103**	**11,909**	**702**	**101,544**
Accumulated depreciation at 1 April 2023	**-**	**3,050**	**10**	**-**	**1,074**	**103**	**6,527**	**412**	**11,176**
Provided during the year	-	2,727	9	-	143	-	1,346	29	**4,254**
Revaluations		(5,777)	(19)						**(5,796)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**1,217**	**103**	**7,873**	**441**	**9,634**
Net book value at 31 March 2024	**5,107**	**81,209**	**160**	**10**	**1,127**	**-**	**4,036**	**261**	**91,910**
Net book value at 1 April 2023	**4,857**	**71,898**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**86,134**

Note 16 (continued) Property, plant and equipment - 2023/24

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	4,857	76,119	170	3,760	2,161	103	10,775	536	**98,481**
Additions	-	5,228	-	-	151	-	1,134	166	**6,679**
Additions - assets purchased from cash donations/grants	-	-	-	-	25	-	-	-	**25**
Impairments	-	(1,293)	-	-	-	-	-	-	**(1,293)**
Impairments charged to the revaluation reserve	-	(4,959)	-	-	-	-	-	-	**(4,959)**
Reversals of impairments	218	2,526	-	-	-	-	-	-	**2,744**
Revaluations	32	1,029	(10)	-	-	-	-	-	**1,051**
Reclassifications	-	3,779	-	(3,750)	7	-	-	-	**36**
Valuation/gross cost at 31 March 2024	**5,107**	**82,429**	**160**	**10**	**2,344**	**103**	**11,909**	**702**	**102,764**
Accumulated depreciation at 1 April 2023	-	3,050	10	-	1,074	103	6,527	412	**11,176**
Provided during the year	-	2,727	9	-	143	-	1,346	29	**4,254**
Revaluations	-	(5,777)	(19)	-	-	-	-	-	**(5,796)**
Accumulated depreciation at 31 March 2024	**-**	**0**	**-**	**-**	**1,217**	**103**	**7,873**	**441**	**9,634**
Net book value at 31 March 2024	**5,107**	**82,429**	**160**	**10**	**1,127**	**-**	**4,036**	**261**	**93,130**
Net book value at 1 April 2023	**4,857**	**73,069**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**87,305**

Note 16.1 Property, plant and equipment - 2022/23

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022	**5,125**	**67,104**	**160**	**1,037**	**1,693**	**103**	**10,617**	**517**	**86,356**
Additions	-	-	-	6,471	-	-	-	-	**6,471**
Impairments	(92)	(1,171)	-	-	-	-	-	-	**(1,263)**
Impairments charged to the revaluation reserve	(274)	(2,078)	-	-	-	-	-	-	**(2,352)**
Reversal of impairments	63	1,576	-	-	-	-	-	-	**1,639**
Revaluations	-	8,447	10	-	-	-	-	-	**8,457**
Reclassifications	35	1,070	-	(3,748)	481	-	931	19	**(1,212)**
Disposals / derecognition	-	-	-	-	(13)	-	(773)	-	**(786)**
Valuation/gross cost at 31 March 2023	**4,857**	**74,948**	**170**	**3,760**	**2,161**	**103**	**10,775**	**536**	**97,310**
Accumulated depreciation at 1 April 2022	**-**	**608**	**2**	**-**	**947**	**103**	**5,835**	**381**	**7,876**
Provided during the year	-	2,442	8	-	140	-	1,465	31	**4,086**
Disposals / derecognition	-	-	-	-	(13)	-	(773)	-	**(786)**
Accumulated depreciation at 31 March 2023	**-**	**3,050**	**10**	**-**	**1,074**	**103**	**6,527**	**412**	**11,176**
Net book value at 31 March 2023	**4,857**	**71,898**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**86,134**
Net book value at 1 April 2022	**5,125**	**66,496**	**158**	**1,037**	**746**	**-**	**4,782**	**136**	**78,480**

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022	5,125	67,104	160	1,037	1,693	103	10,617	517	**86,356**
Additions	-	-	-	6,471	-	-	-	-	**6,471**
Impairments	(92)	(1,171)	-	-	-	-	-	-	**(1,263)**
Impairments charged to the revaluation reserve	(274)	(2,078)	-	-	-	-	-	-	**(2,352)**
Reversals of impairments	63	1,576	-	-	-	-	-	-	**1,639**
Revaluations	-	8,447	10	-	-	-	-	-	**8,457**
Reclassifications	35	2,241	-	(3,748)	481	-	931	19	**(41)**
Disposals / derecognition	-	-	-	-	(13)	-	(773)	-	**(786)**
Valuation/gross cost at 31 March 2023	**4,857**	**76,119**	**170**	**3,760**	**2,161**	**103**	**10,775**	**536**	**98,481**
Accumulated depreciation at 1 April 2022	-	608	2	-	947	103	5,835	381	**7,876**
Provided during the year	-	2,442	8	-	140	-	1,465	31	**4,086**
Disposals / derecognition	-	-	-	-	(13)	-	(773)	-	**(786)**
Accumulated depreciation at 31 March 2023	**-**	**3,050**	**10**	**-**	**1,074**	**103**	**6,527**	**412**	**11,176**
Net book value at 31 March 2023	**4,857**	**73,069**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**87,305**
Net book value at 1 April 2022	**5,125**	**66,496**	**158**	**1,037**	**746**	**-**	**4,782**	**136**	**78,480**

Note 16.2 Property, plant and equipment financing - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2024									
Owned - purchased	5,107	55,678	160	10	1,127	-	4,036	261	**66,379**
On-SoFP PFI contracts and other service concession arrangements	-	25,531	-	-	-	-	-	-	**25,531**
NBV total at 31 March 2024	**5,107**	**81,209**	**160**	**10**	**1,127**	**-**	**4,036**	**261**	**91,910**

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2024									
Owned - purchased	5,107	56,898	160	10	1,127	-	4,036	261	**67,599**
concession arrangements	-	25,531	-	-	-	-	-	-	**25,531**
NBV total at 31 March 2024	**5,107**	**82,429**	**160**	**10**	**1,127**	**-**	**4,036**	**261**	**93,130**

Note 16.3 Property, plant and equipment financing - 2022/23

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2023									
Owned - purchased	4,857	54,997	160	3,760	1,087	-	4,248	124	**69,233**
On-SoFP PFI contracts and other service concession arrangements	-	16,901	-	-	-	-	-	-	**16,901**
NBV total at 31 March 2023	**4,857**	**71,898**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**86,134**

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2023									
Owned - purchased	4,857	56,168	160	3,760	1,087	-	4,248	124	**70,404**
On-SoFP PFI contracts and other service concession arrangements	-	16,901	-	-	-	-	-	-	**16,901**
NBV total at 31 March 2023	**4,857**	**73,069**	**160**	**3,760**	**1,087**	**-**	**4,248**	**124**	**87,305**

Note 17 Revaluations of property, plant and equipment

The Trust carried out a revaluation of land and buildings as at 31 March 2024. The valuation was performed by an independent RICS registered valuer from DVS Property Specialists. The valuation was that of an alternative site basis. The revaluation is hypothetical and assumes that clinical and support services will be delivered from three sites, Swallownest in Rotherham; Great Oaks in North Lincolnshire and Tickhill Road in Doncaster.

The Doncaster PFI is valued exclusive of VAT (as opposed to the Trust owned land and buildings which are valued gross of VAT) and is therefore valued as a separate asset.

The valuation of the Trust owned land and building resulted in an increase in value of £2.8m. The valuation of the PFI resulted in an increase in value of £0.5m.

Note 18 Investment Property

Group and Trust

	Group		Trust	
	2023/24	**2022/23**	**2023/24**	**2022/23**
	£000	**£000**	**£000**	**£000**
Carrying value at 1 April	**3,549**	**2,493**	**3,099**	**2,493**
Fair value (losses) taken to SoCI	17	(156)	17	(156)
Reclassifications to/from PPE	13	1,212	13	762
Carrying value at 31 March	**3,579**	**3,549**	**3,129**	**3,099**

Note 18.1 Investment property income and expenses (Group)

	2023/24	**2022/23**
	£000	**£000**
Direct operating expense arising from investment property which generated rental income in the period	-	(23)
Total investment property expenses	**-**	**(23)**
Investment property income	386	309

IAS 40 defines investment property as property that is held by the owner to earn rentals or for capital appreciation or both. Investment properties are measured at fair value and are categorised at level 3 of the fair value hierarchy. The fair value is measured using the price per square metre for a building from observable market data (for example, prices derived from observed transactions involving comparable buildings in similar locations), adjusted to reflect differences in physical characteristics such as the quality of interior finishes, size and parking.

The Trust carried out a revaluation of investment property as at 31 March 2024. The valuation was performed by an independent RICS registered valuer from DVS Property Specialist.

The valuation resulted in a hypothetical increase of £17k.

Note 19 Leases Rotherham Doncaster and South Humber NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has a lease for land with The Rotherham NHS FT for the provision of an older people's unit. It commenced in October 2009 and is for 99 years with a minimum lease term of 60 years.

All other leases are short term and are reviewed in accordance with service provision. These include buildings, lease cars, transport vehicles and other leases

Note 19.1 Right of use assets - 2023/24

Group and Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**12,651**	**222**	**12,873**	**11,309**
Additions	348	-	**348**	0
Remeasurements of the lease liability	1,205	-	**1,205**	1,205
Disposals / derecognition	(337)	-	**(337)**	-
Valuation/gross cost at 31 March 2024	**13,867**	**222**	**14,089**	**12,514**
Accumulated depreciation at 1 April 2023 - brought forward	1,148	136	**1,284**	1,037
Provided during the year	1,219	75	**1,294**	1,110
Disposals / derecognition	(69)	-	**(69)**	-
Accumulated depreciation at 31 March 2024	**2,298**	**211**	**2,509**	**2,147**
Net book value at 31 March 2024	**11,569**	**11**	**11,580**	**10,367**
Net book value at 31 March 2023	**11,503**	**86**	**11,589**	**10,272**
Net book value of right of use assets leased from other NHS providers				0
Net book value of right of use assets leased from other DHSC group bodies				10,367

Note 19.2 Right of use assets - 2022/23

Group and Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation - adjustments for existing operating leases / subleases	17,048	222	**17,270**	15,706
Impairments	(4,398)	-	**(4,398)**	(4,398)
Valuation/gross cost at 31 March 2023	**12,651**	**222**	**12,873**	**11,309**
Provided during the year	1,148	136	**1,284**	1,037
Accumulated depreciation at 31 March 2023	**1,148**	**136**	**1,284**	**1,037**
Net book value at 31 March 2023	**11,503**	**86**	**11,589**	**10,272**
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				10,272

Note 19.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 28 .

Group and Trust	2023/24 £000	2022/23 £000
Carrying value at 1 April	**15,403**	-
IFRS 16 implementation - adjustments for existing operating leases	-	16,657
Lease additions	156	-
Lease liability remeasurements	1,205	-
Interest charge arising in year	144	138
Early terminations	(268)	-
Lease payments (cash outflows)	(1,454)	(1,391)
Carrying value at 31 March	**15,186**	**15,403**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 19.3 Maturity analysis of future lease payments at 31 March 2024

Group and Trust	Total	Of which leased from DHSC group bodies:
	31 March 2024 £000	31 March 2024 £000
Undiscounted future lease payments payable in:		
- not later than one year;	1,353	1,221
- later than one year and not later than five years;	5,002	4,706
- later than five years.	10,378	10,333
Total gross future lease payments	**16,733**	**16,260**
Finance charges allocated to future periods	(1,547)	(1,532)
Net lease liabilities at 31 March 2024	**15,186**	**14,728**
Of which:		
Leased from other NHS providers		4,286
Leased from other DHSC group bodies		10,442

Note 19.4 Maturity analysis of future lease payments at 31 March 2023

Group and Trust	Total	Of which leased from DHSC group bodies:
	31 March 2023 £000	31 March 2023 £000
Undiscounted future lease payments payable in:		
- not later than one year;	1,359	1,159
- later than one year and not later than five years;	4,616	4,277
- later than five years.	11,066	10,901
Total gross future lease payments	**17,041**	**16,337**
Finance charges allocated to future periods	(1,638)	(1,620)
Net finance lease liabilities at 31 March 2023	**15,403**	**14,717**
Of which:		
Leased from other NHS providers		4,324
Leased from other DHSC group bodies		10,393

Note 20 Other investments / financial assets (non-current)

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
Carrying value at 1 April	**2,527**	**2,547**	**22**	**22**
Acquisitions in year	434	306	-	-
Movement in fair value through OCI	84	(215)	-	-
Disposals	(963)	(111)	-	-
Carrying value at 31 March	**2,082**	**2,527**	**22**	**22**

Note 21 Disclosure of interests in other entities

Flourish is a wholly owned subsidiary of the Trust. The accounting date of Flourish is 31 March 2024. In 2023/24 Flourish's income was £2.538m (2022/23: £2.426m) and the expenditure was £2.536m (2022/23: £2.430m). At 31 March 2024 the net assets are £68k (At 31 March 23: £66k) . Flourish trading results are consolidated in the Trust's financial statements.

Note 22 Analysis of charitable fund reserves

The Rotherham Doncaster and South Humber NHS Charitable Fund is a subsidiary of the Trust and the Fund's trading results are consolidated in the Trust's financial statements. The accounting date of the Fund is 31 March 2024.

	31 March 2024	31 March 2023
	£000	£000
Unrestricted funds:		
Unrestricted income funds	1,120	1,691
Restricted funds:		
Other restricted income funds	1,172	1,176
	2,292	**2,867**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the corporate trustee in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the discretion of the corporate trustee only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 23 Inventories

Consumables	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Balance 1 April	505	511	487	493
Additions	1,355	1,533	1,355	1,533
Consumed and recognised in expenditure	(1,240)	(1,539)	(1,240)	(1,539)
Balance 31 March	**620**	**505**	**602**	**487**

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £19k of items purchased by DHSC (2022/23: £129k).

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

Note 24 Receivables

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Current				
Contract receivables	1,963	1,844	1,947	1,837
Contract receivables not yet invoiced	2,996	10,673	3,350	10,673
Allowance for impaired contract receivables	(120)	(113)	(114)	(113)
Prepayments (non-PFI)	1,388	730	1,388	730
VAT receivable	96	320	96	320
NHS charitable funds receivables	16	16	-	-
Total current receivables	**6,339**	**13,470**	**6,667**	**13,447**
Non-current				
Clinician pension tax provision reimbursement funding from NHSE	98	129	98	129
Total non-current receivables	**98**	**129**	**98**	**129**
Total receivables	**6,437**	**13,599**	**6,765**	**13,576**
Of which receivable from NHS and DHSC group bodies:				
Current	1,906	9,079	1,906	9,079
Non-current	98	129	98	129

Note 25 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**40,295**	**48,429**	**39,590**	**47,652**
Net change in year	(5,884)	(8,134)	(6,143)	(8,062)
At 31 March	**34,411**	**40,295**	**33,447**	**39,590**
Broken down into:				
Cash at commercial banks and in hand	1,153	855	189	150
Cash with the Government Banking Service	33,258	39,440	33,258	39,440
Total cash and cash equivalents as in SoFP	**34,411**	**40,295**	**33,447**	**39,590**
Total cash and cash equivalents as in SoCF	**34,411**	**40,295**	**33,447**	**39,590**

Note 25.1 Third party assets held by the trust

Rotherham Doncaster and South Humber NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2024	31 March 2023
	£000	£000
Bank balances	97	201
Monies on deposit	302	221
Total third party assets	**399**	**422**

Note 26 Trade and other payables

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Current				
Trade payables	4,433	2,995	4,178	2,693
Capital payables	836	557	836	557
Accruals	4,877	12,913	4,877	12,913
Social security costs	1,658	1,638	1,658	1,638
Other taxes payable	1,430	1,257	1,430	1,257
PDC dividend payable	347	396	347	396
Pension contributions payable	2,193	1,994	2,193	1,994
Other payables	234	561	225	569
NHS charitable funds: trade and other payables	2	48	-	-
Total current trade and other payables	**16,010**	**22,359**	**15,744**	**22,017**
Non-current				
Other payables	-	-	-	-
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Total trade and other payables	**16,010**	**22,359**	**15,744**	**22,017**
Of which payables from NHS and DHSC group bodies:				
Current	2,028	2,412	2,028	2,412

Note 27 Other liabilities

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	403	1,385	291	1,385
Total other current liabilities	**403**	**1,385**	**291**	**1,385**

Note 28 Borrowings

Group and Trust	31 March 2024	31 March 2023
	£000	£000
Current		
Loans from DHSC	370	373
Lease liabilities	1,213	1,222
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,185	590
Total current borrowings	**2,768**	**2,185**
Non-current		
Loans from DHSC	3,478	3,841
Lease liabilities	13,973	14,181
Obligations under PFI, LIFT or other service concession contracts	12,137	7,220
Total non-current borrowings	**29,588**	**25,242**

Note 28.1 Reconciliation of liabilities arising from financing activities

Group and Trust - 2023/24	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**4,214**	**15,404**	**7,810**	**27,428**
Cash movements:				
Financing cash flows - payments and receipts of principal	(363)	(1,311)	(1,647)	**(3,321)**
Financing cash flows - payments of interest	(158)	(144)	(661)	**(963)**
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023			6,600	**6,600**
Additions	-	156	-	**156**
Lease liability remeasurements	-	1,205	-	**1,205**
Application of effective interest rate	155	144	661	**960**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	559	**559**
Early terminations	-	(268)	-	**(268)**
Carrying value at 31 March 2024	**3,848**	**15,186**	**13,322**	**32,356**

Group and Trust - 2022/23	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	**4,577**	**-**	**8,350**	**12,927**
Cash movements:				
Financing cash flows - payments and receipts of principal	(363)	(1,253)	(539)	**(2,155)**
Financing cash flows - payments of interest	(171)	(138)	(711)	**(1,020)**
Non-cash movements:				
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	16,658	-	**16,658**
Application of effective interest rate	171	138	710	**1,019**
Carrying value at 31 March 2023	**4,214**	**15,404**	**7,810**	**27,428**

Note 29 Provisions for liabilities and charges analysis

Group and Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Dilapidations	Clinicians' pension reimbursement	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2023	**115**	**237**	**81**	**-**	**669**	129	**1,231**
Change in the discount rate	30	(106)	-	-	16	(15)	**(75)**
Arising during the year	0	3	51	74	2	-	**130**
Utilised during the year	(13)	(6)	(57)	-	-	-	**(76)**
Reversed unused	-	-	(28)	-	(222)	(16)	**(266)**
At 31 March 2024	**132**	**128**	**47**	**74**	**465**	**98**	**944**
Expected timing of cash flows:							
- not later than one year;	19	6	47	15	-	-	**87**
- later than one year and not later than five years;	69	21	-	-	240	-	**330**
- later than five years.	44	101	-	59	225	98	**527**
Total	**132**	**128**	**47**	**74**	**465**	**98**	**944**

Pension provisions are calculated using the criteria provided by the Government Actuary department. Payments are made over the lifetime of the member and on his/her death a reduced sum is paid to the survivor.

The personal injury allowance is in respect of one ex employee. The provision is calculated using information as to gender, life expectancy and amount of allowance payable.

The legal claim provision is in respect of personal injury claims and is calculated using information provided by NHS Resolution as to probability of outcome and cost.

The redundancy provision relates to the introduction of new models for the provision of services.

The dilapidation provision relates to the 'dilapidation' costs for expired building leases.

The clinicians' pension provision is in respect of liabilities arising from the 2019/20 clinicians' pension compensation scheme.

The exact timing of cash-flows is uncertain; the expected timing is shown above.

Note 29.1 Clinical negligence liabilities

At 31 March 2024, £2.609m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2023: £2.713m).

Note 30 Contingent assets and liabilities

Group and Trust	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
NHS Resolution legal claims	20	33
Gross value of contingent liabilities	**20**	**33**
Amounts recoverable against liabilities		
Net value of contingent liabilities	**20**	**33**

Contingent liabilities relate to employer and public personal injury claims

Note 31 Contractual capital commitments

Group and Trust	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	217	200
Total	**217**	**200**

Note 32 Defined benefit pension schemes

Note 32.1 Actuarial assumptions

The main actuarial assumptions used at the date of the Statement of Financial Position in measuring the present value of the defined benefit scheme liabilities are:

	31 March 2024	31 March 2023
Rate of increase in pensions (CPI)	2.80%	3.00%
Rate of increase in salaries	3.40%	3.60%
Discount rate	4.80%	4.75%

Duration information at the end of the accounting year

As at the date of the most recent valuation, the duration of the Employer's funded obligations is 15 years.

The financial actuarial assumptions used for IAS19 calculations at the 31 March year ends depends on the market yields at that date. These yields vary from employer to employer depending on the duration of their pension liabilities. For accounting purposes, the duration is assessed as at the date of the latest formal actuarial valuation of the Fund (or the date of admission to the fund if later).

Note 32.2 Sensitivity analysis

The sensitivities regarding the principal assumptions used to measure the scheme obligations are set out below:

Change in assumptions at 31 March 2024	Approximate % increase in Defined Benefit Obligation	Approximate monetary amount (£000)
0.1% decrease in Real Discount Rate	1%	73
1 year increase in member life expectancy	4%	196
0.1% increase in Salary Increase Rate	0%	6
0.1% increase in the Pension Increase Rate (CPI)	1%	68

Note 32.3 Detailed asset breakdown as at 31 March 2024

	31 March 2024	31 March 2023
	£000's	£000's
Equities	4,446	4,150
Government bonds	1,322	1,404
Property	519	520
Cash/liquidity	89	58
Total	**6,376**	**6,132**

The plan assets are invested in a wide range of categories of investments and therefore the Trust is not exposed to any plan specific risks.

Note 32.4 Changes in the defined benefit obligation and fair value of plan assets during the year

Group and Trust	2023/24	2022/23
	£000	£000
Present value of the defined benefit obligation at 1 April	**(4,862)**	**(6,708)**
Current service cost	(34)	(64)
Interest cost	(228)	(180)
Contribution by plan participants	(8)	(10)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial gains/(losses)	79	1,935
Benefits paid	230	165
Past service costs	(69)	-
Present value of the defined benefit obligation at 31 March	**(4,892)**	**(4,862)**
Plan assets at fair value at 1 April	**5,332**	**6,321**
Interest income	248	168
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	180	-
- Actuarial gain	-	(202)
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	(503)	(800)
Contributions by the plan participants	8	10
Benefits paid	(230)	(165)
Plan assets at fair value at 31 March	**5,035**	**5,332**
Plan surplus/(deficit) at 31 March	**143**	**470**

Note 32.5 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

Group and Trust

	31 March 2024	31 March 2023
	£000	£000
Present value of the defined benefit obligation	(4,892)	(4,862)
Plan assets at fair value	5,035	5,332
Net defined benefit (obligation) / asset recognised in the SoFP	**143**	**470**
Fair value of any reimbursement right		
Net asset/(liability) after the impact of reimbursement rights	**143**	**470**

Note 32.6 Amounts recognised in the SoCI

Group and Trust

	2023/24	2022/23
	£000	£000
Current service cost	(34)	(64)
Interest expense / income	20	(12)
Past service cost	(69)	-
Total net (charge) / gain recognised in SOCI	**(83)**	**(76)**

Note 33 On-SoFP PFI

The PFI provides services accommodation for Mental Health services for Older People and for Mental Health Rehabilitation services. The PFI buildings are on the St Catherine's site and Bentley in Doncaster.

The PFI agreement is with Albion Healthcare Ltd who have a contract with HBG (Facilities Management) Ltd to provide the hard facilities management services to the buildings. The PFI arrangement is for 27 years commencing in 2005 and ending in 2032. There are no renewal or termination options in the agreement.

The service element of the lease was bought out in 2017/18 and payments now relate solely to the lease of the property. The annual payment in 2023/24 was £2.308m. The re-pricing of the annual charge is yearly on 1 April in line with the movement in the Retail Price Index.

The scheme has not resulted in any guarantees, commitments or other rights or obligations.

Note 33.1 On-SoFP PFI obligations

The following obligations in respect of the PFI are recognised in the statement of financial position:

Group and Trust	31 March 2024	31 March 2023
	£000	£000
Gross PFI liabilities	**18,640**	**11,354**
Of which liabilities are due		
- not later than one year;	2,306	1,250
- later than one year and not later than five years;	9,224	5,000
- later than five years.	7,110	5,104
Finance charges allocated to future periods	(5,318)	(3,544)
Net PFI obligation	**13,322**	**7,810**
- not later than one year;	1,185	590
- later than one year and not later than five years;	5,926	2,943
- later than five years.	6,211	4,277

Note 33.2 Total on-SoFP PFI commitments

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

Group and Trust	31 March 2024	As originally stated 31 March 2023	Adjustment 31 March 2023	As restated 31 March 2023
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**18,640**	**11,354**	**9,593**	**20,947**
Of which payments are due:				
- not later than one year;	2,306	1,250	1,056	2,306
- later than one year and not later than five years;	9,224	5,000	4,225	9,225
- later than five years.	7,110	5,104	4,312	9,416

Prior Period Adjustment

During the year, the DHSC GAM clarified that the disclosure of total future payments committed in respect of the PFI should be contractual commitments at current prices at the balance sheet date (i.e. it should include actual inflation to date but no assumptions for future inflation). The prior year disclosure (as set out above) excluded the impact of inflation and has therefore been restated.

Note 33.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust 2023/24	2022/23
	£000	£000
Unitary payment payable to service concession operator	**2,308**	**2,064**
Consisting of:		
- Interest charge	661	710
- Repayment of balance sheet obligation	1,647	540
- Contingent rent	-	814
Total amount paid to service concession operator	**2,308**	**2,064**

Note 34 Financial instruments

Note 34.1 Financial risk management

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the ICBs and local authorities and the way in which these bodies 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 that would be typical of listed companies, to which the financial reporting standard mainly applies. 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. The Trust's treasury activity is subject to review by internal audit.

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.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has little exposure to credit risk. The maximum exposures at 31 March 2024 are in receivables from other customers, as disclosed in Trade and other receivables, note 24.

Liquidity risk

The Trust's operating costs are incurred under annual service agreements with ICBs and local authorities, which are financed from resources voted annually by Parliament. The Trust is not, therefore exposed to significant liquidity risk.

Interest rate risk

The Trust is not exposed to any interest rate risk. The only loan that the Trust has is with the Department of Health and Social Care and this is at a fixed interest rate.

Note 35 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

Note 35.1 Impact of change in accounting policy on the allocation of unitary payment

	IFRS 16 basis (new basis) 2023/24 £000	IAS 17 basis (old basis) 2023/24 £000	Impact of change 2023/24 £000
Unitary payment payable to service concession operator	**2,308**	**2,308**	**-**
Consisting of:			
- Interest charge	661	500	**161**
- Repayment of balance sheet obligation	1,647	436	**1,211**
- Contingent rent	-	1,372	**(1,372)**

Note 35.2 Impact of change in accounting policy on primary statements

Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:	**£000**
Increase in PFI / LIFT and other service concession liabilities	(5,948)
Decrease in PDC dividend payable / increase in PDC dividend receivable	220
Impact on net assets as at 31 March 2024	**(5,728)**

Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:	**£000**
PFI liability remeasurement charged to finance costs	(559)
Increase in interest arising on PFI liability	(161)
Reduction in contingent rent	1,372
Reduction in PDC dividend charge	220
Net impact on (deficit)	**872**

Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:	**£000**
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(6,600)
Net impact on 2023/24 surplus / deficit	872
Impact on equity as at 31 March 2024	**(5,728)**

Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:	**£000**
Increase in cash outflows for capital element of PFI / LIFT	(1,211)
Decrease in cash outflows for financing element of PFI / LIFT	1,211
Net impact on cash flows from financing activities	**-**

Note 36 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	4,839	-	**4,839**
Cash and cash equivalents	33,859	-	**33,859**
Consolidated NHS Charitable fund financial assets	568	2,082	**2,650**
Total at 31 March 2024	**39,266**	**2,082**	**41,348**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	12,296	-	**12,296**
Cash and cash equivalents	39,923	-	**39,923**
Consolidated NHS Charitable fund financial assets	388	2,527	**2,915**
Total at 31 March 2023	**52,607**	**2,527**	**55,134**

Note 36.1 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	5,182	-	**5,182**
Cash and cash equivalents	33,447	-	**33,447**
Total at 31 March 2024	**38,629**	-	**38,629**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	12,289	-	**12,289**
Other investments / financial assets	22	-	**22**
Cash and cash equivalents	39,590	-	**39,590**
Total at 31 March 2023	**51,901**	-	**51,901**

Note 36.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,848	**3,848**
Obligations under leases	15,186	**15,186**
Obligations under PFI, LIFT and other service concessions	13,322	**13,322**
Trade and other payables excluding non financial liabilities	11,945	**11,945**
Consolidated NHS charitable fund financial liabilities	2	**2**
Total at 31 March 2024	**44,303**	**44,303**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,214	**4,214**
Obligations under leases	15,403	**15,403**
Obligations under PFI, LIFT and other service concessions	7,810	**7,810**
Trade and other payables excluding non financial liabilities	17,026	**17,026**
Consolidated NHS charitable fund financial liabilities	48	**48**
Total at 31 March 2023	**44,501**	**44,501**

Note 36.4 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,848	**3,848**
Obligations under leases	15,186	**15,186**
Obligations under PFI, LIFT and other service concessions	13,322	**13,322**
Trade and other payables excluding non financial liabilities	11,681	**11,681**
Total at 31 March 2024	**44,037**	**44,037**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,214	**4,214**
Obligations under leases	15,403	**15,403**
Obligations under PFI, LIFT and other service concessions	7,810	**7,810**
Trade and other payables excluding non financial liabilities	16,723	**16,723**
Total at 31 March 2023	**44,150**	**44,150**

Note 36.5 Fair values of financial assets and liabilities

The book value of the Trust's assets and liabilities at 31 March 2024 is a reasonable approximation of fair value.

Note 36.6 Maturity of financial liabilities

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

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
In one year or less	15,977	20,057	15,711	19,706
In more than one year but not more than five years	16,041	11,430	16,041	11,430
In more than five years	19,153	18,200	19,153	18,200
Total	**51,171**	**49,687**	**50,905**	**49,336**

Note 37 Losses and special payments

	2023/24		2022/23	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	9	1	4	-
Bad debts and claims abandoned	1	1	24	62
Stores losses and damage to property	1	0	1	-
Total losses	**11**	**2**	**29**	**62**
Special payments				
Compensation under court order or legally binding arbitration award	2	5	2	21
Ex-gratia payments	18	3	14	187
Special severance payments	1	14	-	-
Total special payments	**21**	**22**	**16**	**208**
Total losses and special payments	**32**	**24**	**45**	**270**

Note 38 Related parties

The Trust is a body corporate established by order of the Secretary of State.

The Department of Health is regarded as the ultimate controlling party. During the year the Trust had a number of material transactions with the Department and with other entities for which the Department is regarded as the parent. The Trust also had a number of material transactions with other Government departments and other central and local government bodies. These entities are listed below.

- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities

Note 39 Events after the reporting date

There are no events after the reporting date.