Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust Annual Report and Accounts 1 April 2021 to 31 March 2022

Salisbury NHS Foundation Trust

Annual Report and Accounts

2021 to 2022

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

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PERFORMANCE REPORT

PERFORMANCE OVERVIEW FROM THE CHIEF EXECUTIVE

Overview of Performance

This overview provides a summary of the Trust and its activities. It highlights the Trust's performance against both the NHS national performance standards and the Trust's own corporate and strategic aims. It sets out the primary risks and challenges the Trust has encountered in the delivery of its objectives and how these have impacted on performance.

Chief Executive's Statement

As the hospital community has adapted to the changes in the management of the COVID-19 pandemic, we have adapted our work to meet the challenges of both ongoing and rapid changes in the virus and its impact on our populations. We have been agile in responding to the impact this has had on staff and alert to the wider need to recover our services and meet the current and future needs of the people who use our services.

There has been little respite and 2021-22 has been marked by a significant transition from a national incident management of the pandemic, through to ambitious plans to recover our elective activity whilst still responding to COVID-19. This has included working to return to pre-pandemic levels of productivity, particularly in our planned care services. This has not been an easy transition, notably because the absence rates in our workforce due to COVID infection or isolation plus an increasing turnover rate in colleagues joining or leaving the Trust has put relentless pressure and challenge on an already stretched workforce.

Both the hospital and the wider health system has spent much of the year on the highest operational escalation level (OPEL 4). This has put significant strain on our bed capacity with the requirement to have all escalation beds open throughout much of Q4. There has been a significant increase in the numbers of people delayed in the hospital waiting for ongoing care in the community (nationally described as No Criteria to Reside), which we are committed to resolving with the help of our health and local authority system partners.

The Trust has continued to engage with our partners to address the significant risk that the increase in people with a delayed discharge has posed to both effective flow in the hospital and to those waiting for elective care. Some patients are experiencing longer waiting times in our Emergency Department and our ability to increase elective activity levels to pre-pandemic levels has been impacted by the number of beds available on a day-to-day basis. Nevertheless, I am extremely proud of the teams in the hospital who have not only remained committed to providing outstanding care for our communities but have also continued to deliver our elective recovery plans, significantly reducing the number of patients waiting over 52 weeks for their planned treatment. We have kept pace with other hospitals in respect of both urgent and elective care which is testament to the dedication and efforts of our staff.

As part of our overall recovery from COVID-19, I am delighted that we launched our new Trust strategy 2022-26 in September 2021, which sets out our priorities for the next five years. This is supported by our Improving Together programme, which will help us both meet our strategic priorities of Population, Partnerships and People and is focused on developing a culture and ways of working that promotes continuous improvement across our organisation.

I would like to thank all our staff and partners for their continued efforts and recognise that many of them have been working in a highly pressurised environment on a sustained basis over this last year. I would also like to acknowledge that this environment has meant we have not always been able to provide the level and responsiveness of care and service that we commit to in our vision to provide an outstanding experience. I am confident, however, that the dedication of our teams and support from system partners will enable us to take further positive steps to achieving the best possible health outcomes for our local populations.

Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

Purpose and Activities of the Trust

Introduction to Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust is a statutory body, which became a public benefit corporation on 1 June 2006.

We deliver a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire which includes:

- Emergency and elective inpatient services
- Day Case services
- Outpatient services
- Diagnostic and therapeutic services
- Specialist spinal rehabilitation, plastics and burns

Specialist services, such as burns, plastic surgery, cleft lip and palate, rehabilitation and the Wessex Regional Genetics Laboratory extend to a much wider population of more than three million people. Salisbury District Hospital includes the Duke of Cornwall Spinal Treatment Centre. This is a purpose built, 45 bed unit which specialises in caring for people who have spinal cord injury and serves a population of 11 million covering an area across most of southern England.

Our services are delivered by 4,800 staff who work tirelessly to deliver high quality care to our local population.

Our clinical services are delivered through a divisional management structure which co-ordinates and delivers high quality services. Services are provided through the following Clinical Divisions:

- Medicine
- Surgery
- Clinical Support and Family Services
- Maternity and Newborn

The clinical divisions are supported by a number of corporate functions including estates and facilities, finance, quality, human resources and information technology. Divisions are led by divisional management teams, with a clinical director, supported by a Divisional Director and Divisional Head of Nursing or allied health professional. This means that the hospital's clinically trained staff have direct responsibility for budgets and patient services, within their Division. The Divisions have a clear line to the Board reporting to the Chief Operating Officer who in turn reports to the Chief Executive.

As an NHS Foundation Trust, the Trust has a Council of Governors. The Trust Board is accountable to the Council of Governors. In addition, Governors have a wider role which includes ensuring that the local community and staff have a say in how services are developed and delivered by the Trust.

The Trust has two subsidiary companies, Odstock Medical Ltd and Salisbury Trading Limited. Odstock Medical Ltd (OML) was set up in 2005 to market worldwide its experience and knowledge of functional electrical stimulation and its own pioneering electrical devices for patients who have had a stroke or other neurological disorders. Income generated is used for research and for new initiatives.

Salisbury Trading Limited provides a laundry service to Salisbury District Hospital and other NHS organisations. The Trust also works with other organisations in joint ventures. For instance, we work with our Acute Hospital Alliance partners, the Great Western Hospitals NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust to provide adult community services across Wiltshire through Wiltshire Health and Care. It also works with Sterile Supplies Ltd to provide sterilisation and disinfection services to Salisbury District Hospital and other NHS organisations. Our procurement and payroll services provide support for a number of local NHS organisations.

The Stars Appeal is the official NHS Charity for Salisbury District Hospital. The Stars Appeal has been integral to our pandemic response, funding projects and distributing care packages which bring the hospital and our community together and make a positive impact on the lives of the people we serve and the staff who work at the Trust. The Stars Appeal has also been our primary link to NHS Charities Together throughout the course of the pandemic and we are extremely grateful for the charitable support that has been provided to enhance the care we provide. In 2021-22, we have implemented a wide-ranging governance review of the charity to establish a renewed vision, mission, goals and objectives.

Our Role in the Bath, North East Somerset, Swindon and Wiltshire Partnership (BSW)

We have made strides towards the statutory recognition of BSW as an Integrated Care Board from 1 July 2022. We recognise that we need to balance a system partnership approach with the Trust's priorities and promote relationships (formal and informal), clinical pathways and NHS structural reform which support solutions to our local challenges.

In order to achieve an outstanding experience in our health system, integrating service provision across BSW and locally in Wiltshire offers the best opportunity of addressing the challenges that lie ahead. This transformation approach has continued, and COVID-19 has accelerated an ever-closer collaboration between community services, Wiltshire Council and our local Primary Care Networks. The Trust has a shared vision for improving health and care for the local population.

In 2021-22 we have made significant steps in implementing our Acute Hospital Alliance with Great Western Hospital (Swindon) and Royal United Hospital (Bath) and are benefitting from increasingly collaborative clinical networks across BSW as a result. Our BSW Urgent Care and Elective Care Boards are leading our improvement work to drive recovery of our services from the pressures of COVID-19. Our Wiltshire Integrated Care Alliance is taking formal shape and is leading on work particularly associated with providing outstanding out of hospital care for our communities – or supporting patients who have had a spell in our hospital. As we learn more about how our services need to adapt in a post-pandemic period, our relationships with primary care continue to strengthen and we continue positive developments in our joint working.

Our Strategy 2022-26

Our updated strategy is a key step for the hospital as we set out our future plans and priorities. It articulates the important commitments we are making to our communities over the next five years, and is underpinned by our vision:
To provide an outstanding experience for our patients, their families and the people who work for and with us.
The strategy confirms our three new priorities:

- Improving the health & well-being of the Population we serve
- Working through Partnerships to transform and integrate our services

- Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

These three priorities will guide how we work in the future as part of an integrated care system, along with Bath and Swindon. Publication of the updated strategy is the first step in using these priorities to continuously improve the way we work and focus on the things that are most important to our communities and staff.

As Improving Together, our new way of working, is rolled out across the Trust, we will increasingly prioritise our work through identification of key short- and long-term improvement projects:

Strategic initiatives. These are 'must do, cannot fail' programmes of work that apply Trust-wide, and running for several years. Because they are so important to the successful delivery of the strategy, they have dedicated delivery teams working to ensure they are delivered consistently to every SFT colleague. We have four strategic initiatives of which Improving Together is one, and the other three are:

- Digital Care
- Delivering our People Promise
- Improving Health and reducing health inequalities

12-month break-through objectives. These are operational in nature and where we will focus our improvement. As the name states, they will change every year and those set in 2021-22 are:

- Reducing falls
- Time to first outpatient appointment
- Same Day Emergency Care (SDEC)
- Time between no right to reside (NR2R) and discharge.

This continuous improvement approach applies to every aspect of our strategy, which everyone in the Trust has a role to play in achieving improvement and our priorities.

Corporate Objectives 2021-22

Prior to the roll out of Improving Together, corporate priorities for 21/22 were agreed as part of the annual business planning process. Five themes emerged which our priorities were framed around:

- Improving our patient flow
- Recovery from COVID-19
- Improving our maternity services
- Responding to staff health & wellbeing
- Improving our digital capability

These in turn drove particular projects – as set out in the table below:

Corporate Objective	Area of Focus
Improving patient flow	Frailty Integrated pathway
	Discharge improvement programme, including therapy rehab model
	Integration of Urgent care services
Recovery from COVID-19	Elective recovery programme
	QIA process to support decision making around increased activity and staffing models to support

Improving our maternity services	Review of maternity services
Responding to staff health and wellbeing	Best place to work
	Improving Together
	Staff health and wellbeing
Improving our digital capability	ePMA, Pathology LIMS, shared EPR, SBS (ledger)

Progress against our 2021-22 corporate objectives

Progress against the priorities has varied; the prolonged pandemic and sustained periods of operational pressure have limited ability to progress some of the work identified. Staffing pressures in relation to increased absence due to COVID sickness and isolation, and vacancies is identified as a challenge or risk to achieving almost all of the priorities. As we move in to 2022/23 some of the priorities remain a focus for the Trust and feature as Breakthrough objectives or vision metrics in the Improving Together programme.

Improving Patient Flow

Our front door frailty liaison service (OPAL) has developed Same Day Emergency Care pathways throughout the year and offers this to patients in our Emergency Department, Short Stay Emergency Unit and Acute Medical Unit over 50 hours a week – further hours have been approved and we expect a fully operational service to be in place in 2022-23.

While the hospital has experienced significant patient flow challenges throughout the year, remaining on OPEL 4 escalation for most of Q3 and Q4, we are making progress with improvement work in this area, guided particularly by Same Day Emergency Care and reducing the number of patients with no criteria to reside in hospital being identified as Breakthrough Objectives in Q3 of 2021-22. The work in this area has not been successful in improving performance in this area, and total bed occupancy has increased throughout the year, with escalation areas including Day Surgery and expansion to areas in our Spinal Unit remaining open as inpatient areas throughout Q3 and Q4. The Trust experienced a significant increase in patients with no criteria to reside occupying inpatient areas – in March 2022 this had increased to 20.2% of our available beds.

High levels of bed occupancy made flow through our Emergency Department challenging and unfortunately our patients have regularly experienced long waits for treatment in the department, with increased handover delays between our ambulance services and the department. We are continuing to expand our Same Day Emergency Care services to improve flow through the department (and reduce the number of inpatient admissions made from the Emergency Department) and this will continue to be a priority through 2022-23.

Recovery from COVID-19 – Elective Recovery

We have made good progress in returning elective care to previous levels. Theatre recruitment has continued strongly, with overseas staff now firmly embedded across the theatre's footprint. Additional staffing has supported the opening of two further theatres. These are component parts of a wider 3-year development plan for theatres which has been approved for implementation and is now overseen by a new Head of Theatres. As a consequence, we were able to meet our waiting list management objectives throughout Q3 and Q4. A further review of our waiting list assisted in an improvement against our trajectory in reducing overall waiting list size, which stood at 18,634 cases in March 2022.

Our outpatient activity has remained strong throughout the year, but there is renewed focus to free up capacity in outpatient services by reducing the number of follow up appointments that the Trust offers and undertakes – the national target is a reduction of 25% in 2022-23.

Supporting elective recovery, our diagnostic performance remained consistently strong throughout the year and met the standard in most modalities through Q2 and Q3. Increasing demand towards the end of the year and availability of workforce made this more challenging and performance reduced to 91.3% of patients receiving diagnostics within 6 weeks of referral in March 2022.

The most significant challenge has and continues to be elective bed capacity and escalation into our Day Surgery Unit, at the latter part of Q3 and throughout Q4. This has significantly impacted on the volume of elective activity that has been able to be undertaken, resulting from the consistently high numbers of no criteria to reside patients across the Trust's bed base.

Improving our Maternity Services

The Trust has worked with the Care Quality Commission (CQC) following their inspection of our maternity services on 31 March 2021, and subsequent improvement notice. The requirements set out in this notice were reported to have been met in December 2021. We proudly opened our new entrance and reception area providing improved and integrated access to maternity services including the labour ward, day assessment unit, antenatal clinic and the maternity scanning department (where we approved a business case to expand the service). Recruitment to vacant posts has been prioritised and an international recruitment campaign jointly with Gloucester and Great Western Hospitals has been launched. We have fully embedded our new management and divisional structure in Maternity and Newborn services.

The final report from Ockenden into Shrewsbury and Telford Hospital Trust was published on the 30th March 2022. The review detailed 1,600 clinical incidents and identifies repeated care and governance failures and sets out clear recommendations for all Trusts providing maternity services. The Board have had oversight of our progress against the interim Ockenden recommendations and work will continue with the Maternity and Newborn Division and triumvirate leadership team to respond to the full report. Whilst the focus on the report is on Maternity services there are broader lessons in respect of leadership and governance that the Trust will reflect on.

Responding to Staff Health and Well Being

2021-22 has continued to be very challenging for our staff across all professions – and our workforce has been profoundly affected particularly by absences relating to the Omicron variant of COVID-19. Substantial and ongoing absences have put additional pressures on our teams, our vacancy rates and turnover have increased and this has contributed to a challenging operational environment.

The Trust has been identified as an exemplar/pilot organisation for the implementation of the NHS People Plan and has worked to develop a Trust-level People Plan to support this. This has included a specific focus on supporting staff wellbeing. Our Health and Well Being strategy and plans have been refreshed over the year and we have delivered immediate wellbeing interventions for staff, particularly as part of our winter plan. We have made significant investments, including through the Stars Appeal, in projects to support staff both while they are at work and to give support during breaks and between working times.

Best Place to Work: Over 360 of our staff have benefitted from attending professional development training

National Staff Survey Results 2021

In 2021, 1,881 Trust employees completed the staff survey which was available between September and November. This year the results have been aligned with the NHS People Promise to see how the Trust compares against the seven elements in the Promise, and in comparison, with other acute trusts around the country. 90% of respondents felt that their role makes a difference to patients or service users. We know that the past two years have been difficult and exhausting for all our colleagues. The COVID-19 pandemic has disrupted our work and home lives in ways we could never have imagined, so it is important for us to understand the impact that has had on our experiences at work. It is good to see the positive results in some areas as this gives us the opportunity to learn and improve across the Trust.

However, there are other areas where the results are not as positive as we would like, and it is important that we understand more about that, and what would make SFT a better place to work for everyone. We know that many staff have said they are experiencing 'burnout' and the Trust acknowledges that staffing levels have been, and continue to be, a real challenge. The full survey results are available here:
https://cms.nhsstaffsurveys.com/app/reports/2021/RNZ-benchmark-2021.pdf

Improving our Digital Capability

We have made progress in our plans to transform our electronic prescribing (ePMA), electronic patient records systems (EPR) and pathology laboratory management systems (LIMS), and successfully replaced our financial ledger system using the nationally supported SBS service. We are now able to move forward, with our partners in BSW and the wider health and care system, to implement a shared records service and pathology systems and will continue this work in 2022-23. We have further identified improving Digital Healthcare as a Strategic Initiative for the Trust for the next 5 years, with an initial focus on these projects and improved Business Intelligence and analytics tools (having launched the use of Power BI in 2021). This will be supported by a costed 5-year digital plan.
We continue to improve digital access to our services for both patients and clinicians – our outpatients transformation programmes have included the roll out of a new Advice and Guidance system for our clinical partners and we continue to promote and develop the use of virtual appointments in many of our specialties where appropriate.

Trust Risks, Opportunities and Sustainability

The key emergent risks for the Trust are regularly reviewed as part of the Corporate Risk Register and are reported to Board and Committees through the Board Assurance Framework each quarter. The key risks that we are planning for as we continue recovery from COVID-19, and the plans we have to mitigate them, are summarised below:

Risk	Mitigation strategies
Increased or uncertain demand for COVID-19 related activity and COVID-19 forcing further staff absences.	• Bed modelling undertaken on worse/best/expected scenarios • TIF bid for dedicated elective capacity • Escalation plans adjusted to protect elective areas

IPC and ongoing designation of beds limits flexibility on delivery of elective care	
Uncertainty over future referral patterns and impact on waiting lists	• Increased visibility to Primary Care on waiting times • Implementation of Advice and Guidance platform
Workforce shortages across key clinical areas through inability to recruit, continued increased turnover	• 4 streams of work in People Plan including overhaul of recruitment practices, flexible working policy, rostering and offer to temporary / bank staff
Failure of system-wide plans to address high numbers of patients in hospital with no right to reside	• Creation of protected elective capacity • SDEC and No Criteria to Reside Breakthrough Objectives and resultant plans
Estates risks disrupt delivery of elective activity	• Estates Transformation programme, shared leadership with RUH (Bath) • Targeted Investment Fund bid for ward capacity • Prioritisation of capital programme
Ability of Trust to deliver efficiencies through priority projects	• Further focus on benefits realisation in Breakthrough Objectives • Approved business case evaluation to ensure savings
Inflationary increases beyond planned cost base	• Review procurement opportunities • Continue with implementation of Green Plan to mitigate increases in energy costs

Going Concern

Our Board considered an assessment of the Trust as a going concern at its meeting on 7 April 2022. A number of risks to this position were identified including a planned deficit position for 2022-23 and the uncertainty on material inflation rises throughout the next financial year.

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.

Looking forward to 2022-23

2022-23 will be a transition year in our approach both to planning and delivery as we deploy our new strategy, adjust to an environment increasingly focused on post-pandemic recovery and manage the inequalities to both access to healthcare and health outcomes which have been further exposed across our communities.

Increasingly, our ability to deliver our operational plan is reliant on interdependencies across our health and care system and achieving a consistent and coherent picture across BSW has been a priority to ensure we can align our own plans and ambitions with the support of the wider BSW partnership.

Workforce development is the most important element to enabling the whole NHS to deliver the increases in activity outlined in the guidance. The greatest risk posed to delivery is a general shortage of clinically qualified staff which existed before and has been exacerbated by the pandemic. Layered on top is the sustained pressure and high infection rates which impact retention and absence from work. Without due attention to stabilising and rebuilding the workforce as we emerge out of the pandemic, the national priorities, and our local plans, will not be achievable.

Ultimately, our plan for 2022-23 is based on a series of balances – a commitment to move forward with the Trust strategy and make progress against our priorities of People, Population and Partnerships, renewed drive for improvement through Improving Together, a clear and ambitious national expectation for elective recovery and a recognition that the pandemic has increased our challenges in managing non-elective activity and the inter-relationships between acute hospital care and community and social care services. In managing these balances, we have submitted a plan that does not fully achieve with the national recovery requirements and seeks to manage a significant £18m planned deficit but represents a realistic view of the activity recovery and workforce sustainability that the Trust can achieve in the next 12 months.

PERFORMANCE ANALYSIS

The Trust publishes a monthly Integrated Performance Report (IPR) which provides both the Board and the public with an overview of our performance. The report is structured around the strategic and enabling priorities identified by the Trust, and divided into performance sections of Operational, Quality, Workforce and Resources. The report evolves to reflect new areas of monitoring or national focus.

Our monthly integrated performance reports are available on our website as part of monthly Board papers and can be downloaded via:

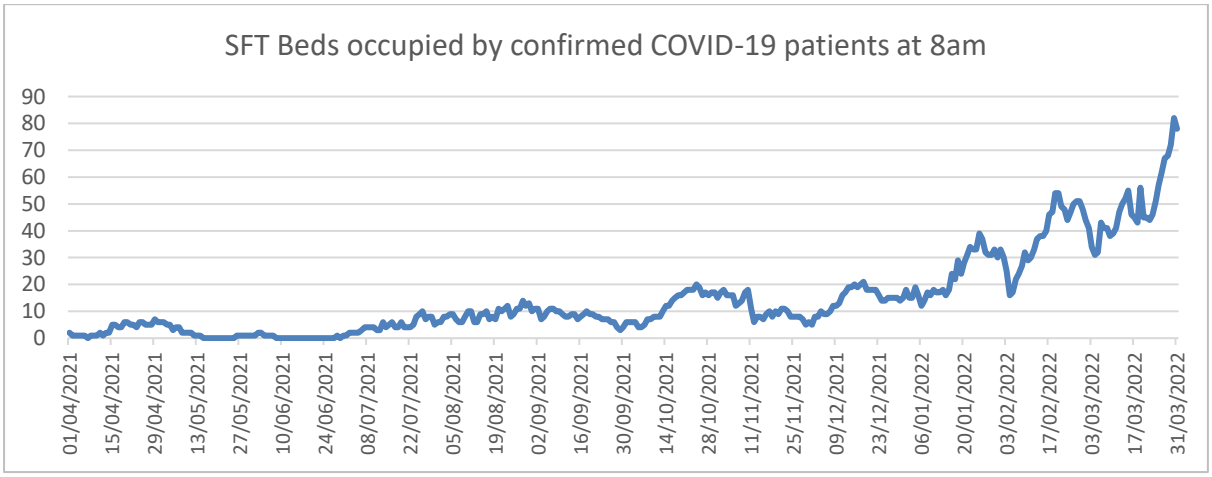
https://www.salisbury.nhs.uk/about-us/the-trust-board/board-papers/

Each of the four performance sections of the IPR are presented at Board Committees, and then brought together into one integrated document for presentation and scrutiny at Trust Board. The statistical process charts allow our Board and Committees to see trend analysis for the previous 24 months, which in an extraordinary year affected by the presence of COVID-19 provides more depth and understanding around our performance.

Performance overview

COVID-19 bed occupancy

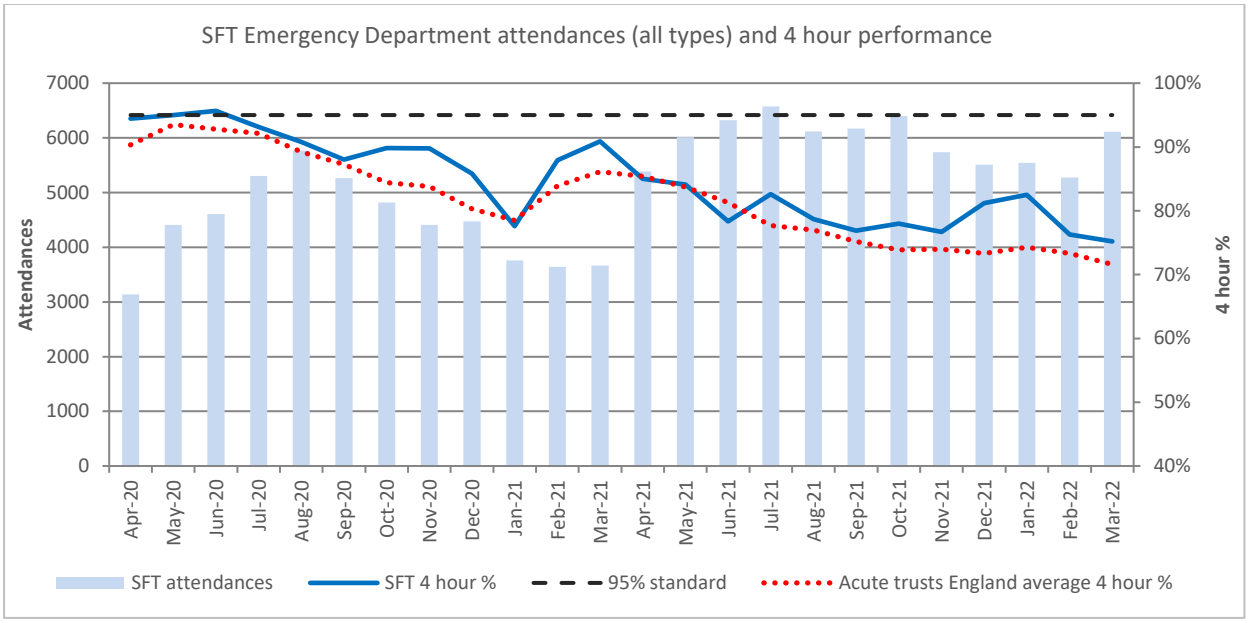
The management of processes around COVID-19 continued to put some additional pressure on the Trust, both in terms of managing patients presenting at the Hospital with COVID-19 symptoms, and the impact from reduced staffing levels as a result of increased sickness due to infection or isolation. There was sustained growth in the number of beds occupied by patients with confirmed COVID-19 throughout the year, peaking at around 82 beds on 31st March 2021, with a small number requiring ITU facilities. In the previous peaks bed occupancy for COVID-19 reached 44 (April 20) and 188 (Jan 21).



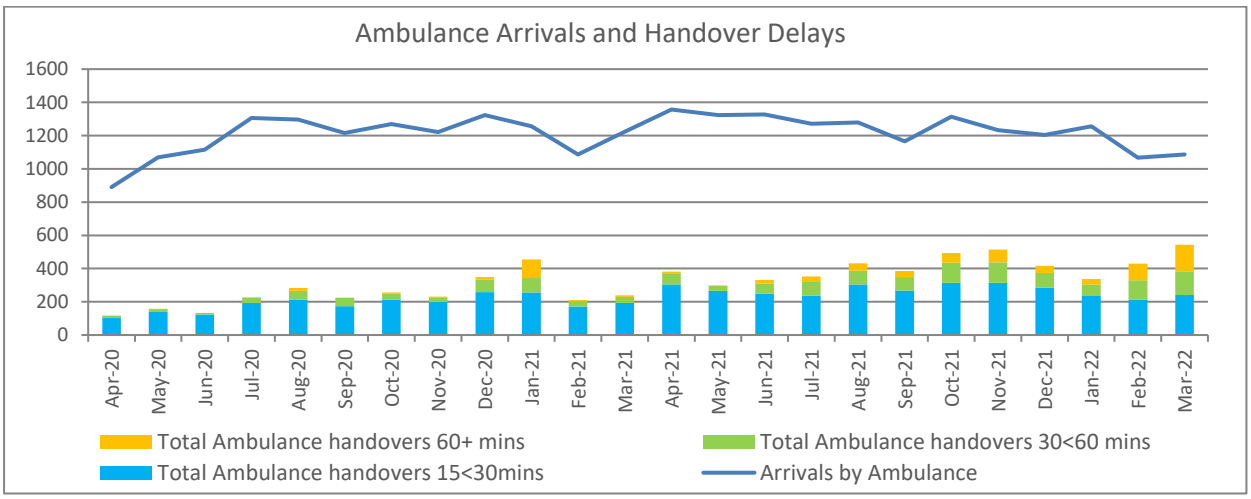
Emergency access

In the first year of the pandemic attendances to the Emergency Department (ED) fell, but across 2021/22 attendances returned to near pre-pandemic levels, with Type 1 (Salisbury Hospital Main Emergency Department) attendances exceeding prior levels in many months. Joint communication strategies with the Walk in Centre (WIC) were trialled which had some success in directing appropriate paediatric patients directly to the Walk in Centre, and the

department increased the number of Same Day Emergency Care pathways they were able to access.



The number of patients who were treated and discharged or admitted within 4 hours from the Emergency Department reduced throughout the year. The Trust did not achieve the 95% national target, however, the performance of our departments compared favourably with the average for acute trusts in England.

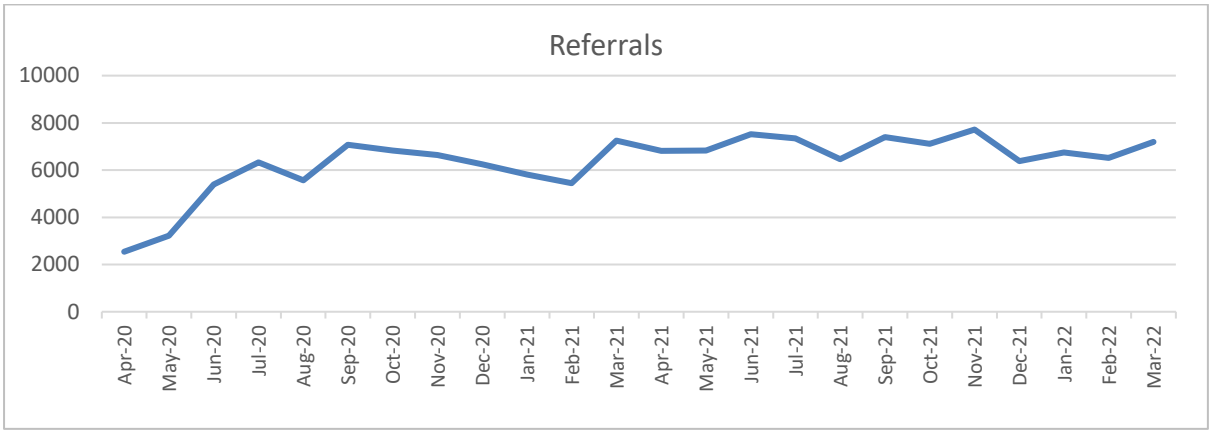


Bed occupancy levels in the Trust remained high throughout the year, with continued impact from COVID-19 and high numbers of inpatients no longer requiring acute care but waiting for alternative care options outside of the hospital. High occupancy levels in the Trust put pressure on flow from the Emergency Department into the hospital for patients requiring admission, and as a result there was an increase in the number of ambulances that were delayed handing over patients into the Emergency Department.

Elective waiting times

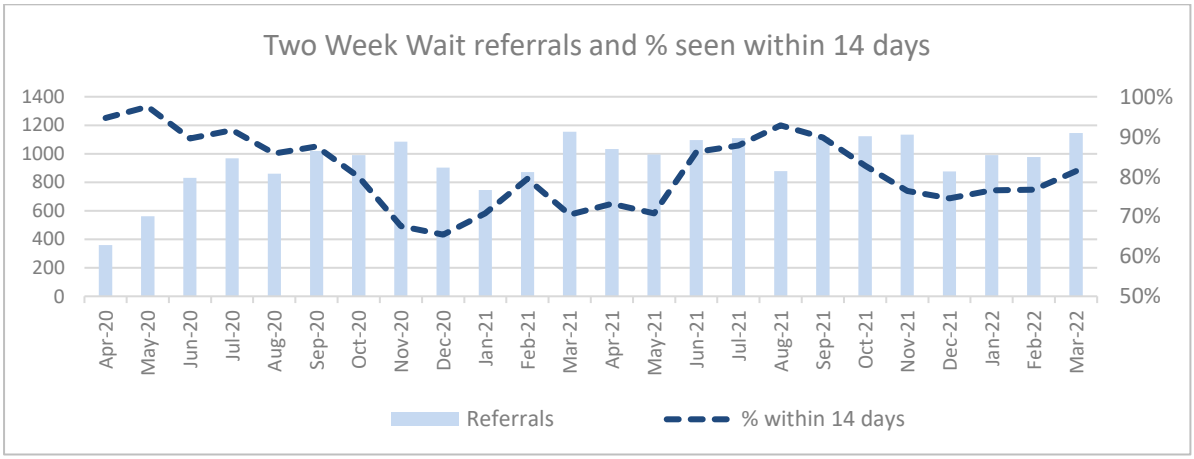
Referrals

A significant reduction in referrals was seen immediately post-pandemic, and although they have continued to rise, they are yet to exceed levels pre-pandemic. The Trust continued to build on its communication and relationships with GP practices to ensure awareness of service availability.



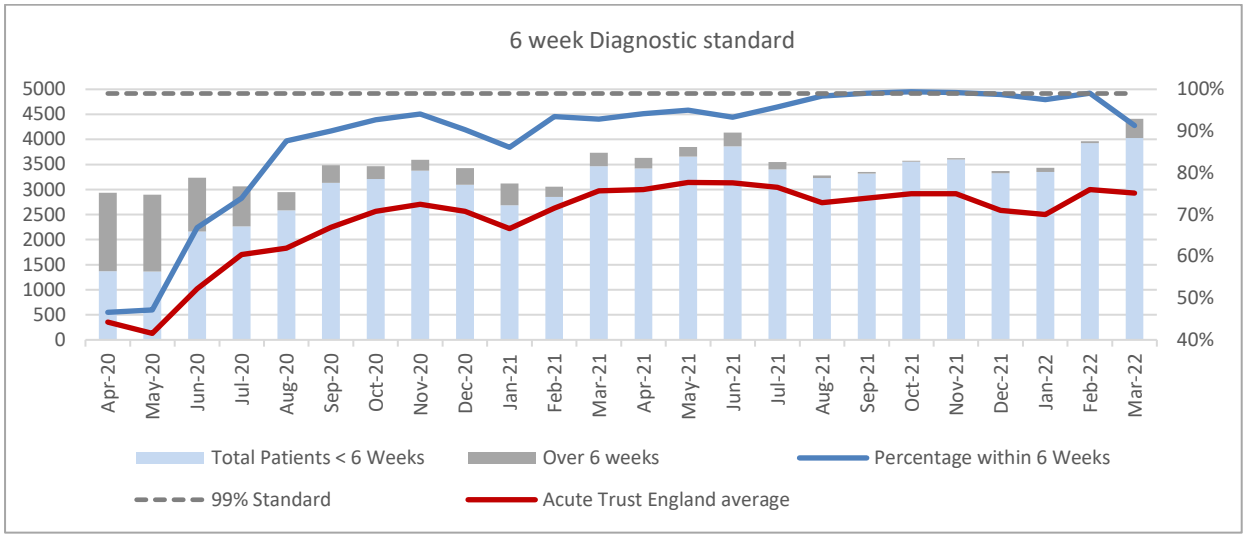
Two Week Wait Suspected Cancer referrals

The volume of cancer referrals received by the Trust has continued to rise following the initial reduction in the first wave of the pandemic, and by the end of the year had recovered to pre-pandemic levels. The 93% two-week standard was not achieved consistently throughout the year, with particular challenges in the Breast tumour site. Average waiting times for Breast two week wait services were around 16-17 days, with minimal impact upon the 31- or 62-day standard for the Breast tumour site. Patient choice continues to be a big factor across all tumour sites, the requirement to isolate and high COVID-19 community prevalence also influenced patients' abilities to be able to attend appointments within 14 days.



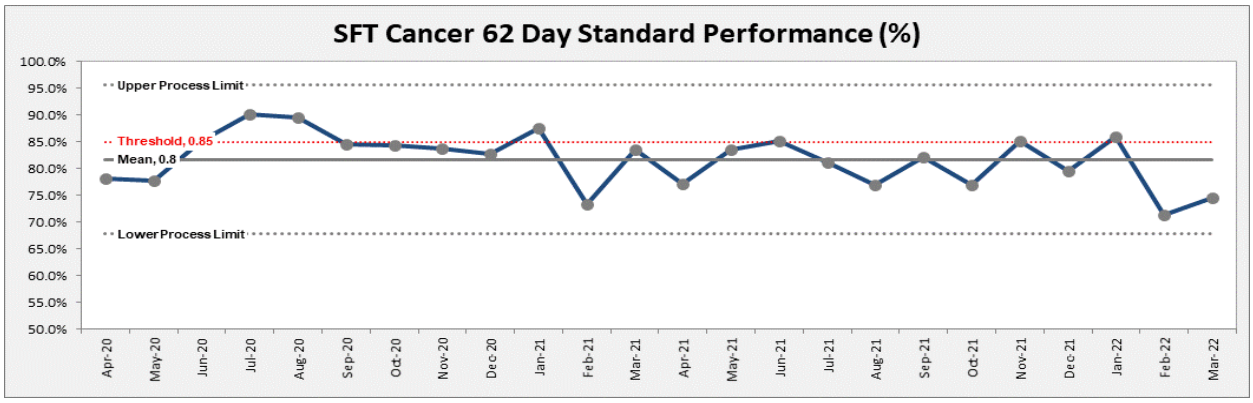
Diagnostics

Good progress has been made in recovery of the 6 week standard, with the Trust significantly ahead in comparison to the acute Trusts in England average. Vulnerabilities in maintaining achievement remain, with small services affected by increased sickness when COVID-19 prevalence increases, performance was affected by this in quarter 4.



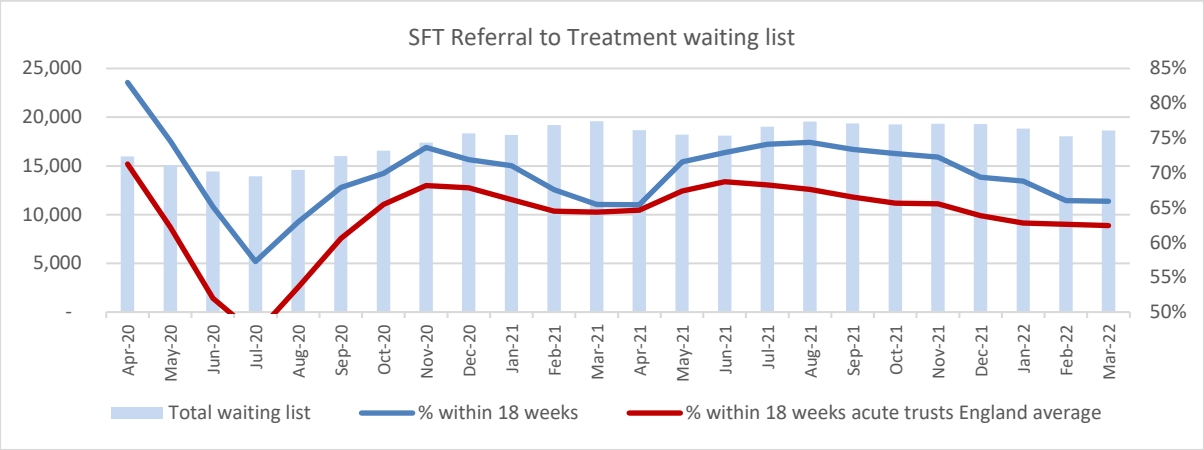
Cancer 62 Day standard – referral to first definitive treatment

Cancer services were protected throughout the pandemic the proportion of patients on a cancer pathway who received their first treatment within 62 Days remained broadly static overall, but not consistently achieving the standard. The trust benchmarks above the acute trusts England average, but continues to strive towards further improvement in cancer waiting times.

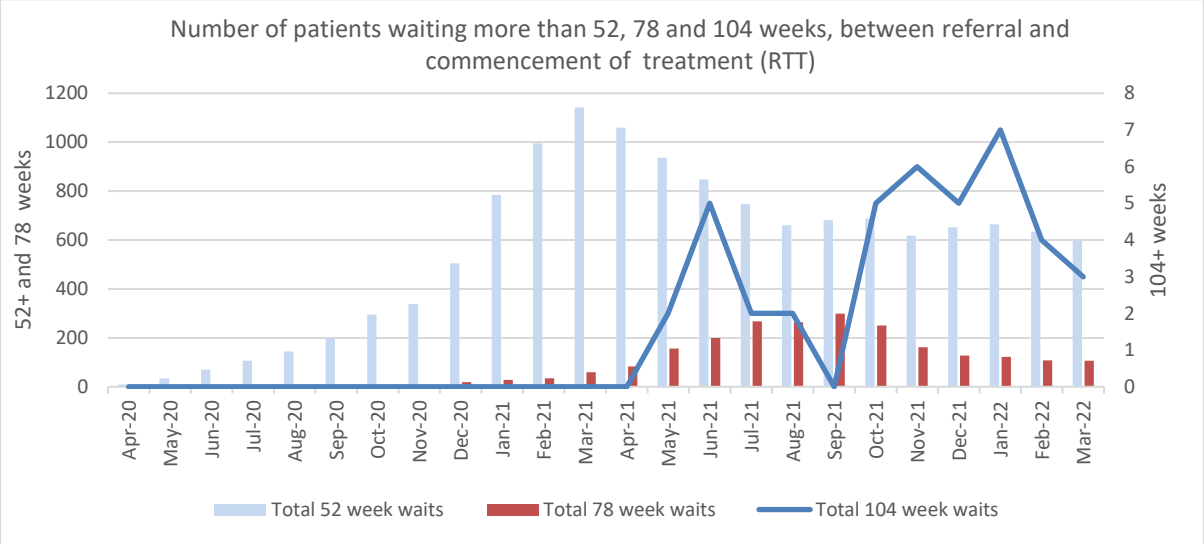


Elective waiting lists (Referral to Treatment)

The Trust has maintained focus on restoring elective activity levels in order to reduce the number, and length of time patients are waiting for elective surgery. A clinical prioritisation framework is used to ensure that clinically urgent patients are identified and treated within appropriate timeframes. The total waiting list size has been maintained despite increasing elective referrals, and challenges in increasing elective activity when the Trust is operating in excess of 95% bed occupancy levels.



The number of patients waiting longer than 52 weeks for a first treatment has reduced from 1059 in Apr 21, to 599 by Mar 22, and the number waiting over 78 weeks peaked at 264, reducing to 107 by Mar 22. There remains a small number of patients waiting over 104 weeks (three by Mar 22) which have been complex cases. Progress has been made in restoring theatre activity which has been complicated by challenges in recruitment and high absence rates for theatre staff.



Tackling Inequalities

Reducing inequalities in access to healthcare and clinical outcomes is a central theme in the NHS recovery plans from the COVID pandemic. Reducing inequalities is one of our 4 strategic initiatives, and a Health Inequalities Group, chaired by the Chief Medical Officer, has been established to oversee work in this area. Our initial focus has been:

- Consideration of how we address inequalities through clinical prioritisation and access to our elective care and maternity services. We are required to compile a system Equalities and Health Inequalities Impact Assessment relating to Elective Recovery plans and this will be completed by 30 June 2022.

- Improved visibility of data relating to inequalities in our population – focused on economic and social deprivation and inequalities for people with protected characteristics
- Addressing how our services cater for people with learning disabilities.
- Continued partnerships to support access to healthcare for our military and veteran populations and their families – including achieving Employee Recognition Scheme Gold status and Veterans Covenant Healthcare Alliance reaccreditation.
- We have continued participation and learning from BSW's participation in Wave 3 of the national Population Health Management programme.

We will report on our plans and progress in addressing Health Inequalities to the Trust Board and re-establish the Non-Executive lead role for Health Inequalities. We are adopting the national CORE20PLUS5 approach to reducing inequalities.

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

The Board of Directors is accountable, through the Chair, to NHS England and NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

Directors of Salisbury NHS Foundation Trust during 2022-22

Dr Nick Marsden	Chairman
Stacey Hunter	Chief Executive
Dr Peter Collins	Chief Medical Officer
Andy Hyett	Chief Operating Officer
Judy Dyos	Chief Nursing Officer
Lisa Thomas	Chief Finance Officer
Melanie Whitfield	Chief People Officer
Susan Young	Interim Director of Organisational Development and People
Lynn Lane	Interim Director of Organisational Development and People
Michael von Bertele CB, OBE	Non-Executive Director
Tania Baker	Non-Executive Director (Senior Independent Director)
Paul Kemp	Non-Executive Director
Paul Miller	Non-Executive Director
Eiri Jones	Non-Executive Director
Rakhee Aggarwal	Non-Executive Director
David Buckle	Non-Executive Director

Register of Directors' Interests

NHS employees are required to be impartial and honest in the conduct of their business. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. There is an annual review of the Register of Interests and compliance with the Fit and Proper Persons Requirements. As a standing agenda item, the Directors declare any interests before each Board and Board Committee meeting which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust Board considers that all its Non-Executive Directors are independent in character and judgement.

The Register of Declared Interests is made available to the public by contacting the Head or of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ. This can also be found on the Trust website following the link below:
https://www.salisbury.nhs.uk/media/314gxu1z/public-register-of-interests-2021_22_web_doc.pdf

NHS Improvement's Well Led Framework

The Trust has considered NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality.

The Care Quality Commission (CQC) undertook an inspection of the well-led question in December 2019 and rated the Trust as 'Good'. The CQC stated that 'There was effective, experienced and skilled leadership, a strong vision for the organisation and embedded values. The leadership had the capacity and capability to deliver high-quality sustainable care. Leaders understood the challenges to quality and sustainability and they were visible and approachable. There was a clear vision for the Trust and strong values.'

During 2021-22, the Trust has focussed on the response to the COVID-19 pandemic and there have also been a number of changes to the Executive Directors. Acknowledging this, there was Trust Board agreement to undertake a self-assessment against the well-led framework in October 2021. An external well-led review will be commissioned in Autumn 2022.

The Annual Governance Statement describes in further detail the Trust's approach to ensuring services are well-led and quality governance. The Quality Account describes quality improvements in more detail.

Other disclosures

Modern Slavery Act 2021-22 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

Cost allocation and charging guidance issued by HM Treasury

Salisbury NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Political Donations

The Trust has made no political donations of its own.

Better Payment Practice Code

The Trust conforms to the principles of the Better Payment Practice Code and aims to pay its bills promptly. Performance against the code can be viewed below. No interest was paid under the late Payment of Commercial Debts (Interest) Act 1998.

Better payment practice code	By Number	By Value £'000
Non-NHS	87.2%	89.5%
NHS	68.4%	69.9%
Total	86.7%	88.3%

Information on fees and charges

Please see table below which provides an aggregate of all schemes that, individually, have cost exceeding £1million.

		2021-22	*2020-21*	*2019-20*
	Expected sign			
Income	+	*14,028*	*13,065*	*14,535*
Full cost	-	*12,787*	*12,103*	*-11,577*
Surplus/Deficit	+/-	***1,241***	***962***	***2,958***

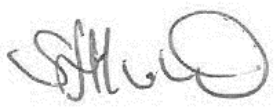
Income Disclosure

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 its income from the provision of goods and services for any other purposes.

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service and makes a contribution towards funding patient care. Services that generate income include payroll services, accommodation, catering, car parking, private patient treatment, pharmacy products and sterile supplies. The total income from all these areas amounted to around £6.3 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £9.6 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £2.2 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

REMUNERATION REPORT

Chairman of the Remuneration Committee's Annual Statement on Remuneration

In accordance with the requirements of NHS England and NHS Improvement, this remuneration report consists of the following parts:

- An Annual Statement on remuneration
- The Senior Manager Remuneration Policy
- The Annual Report on remuneration

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2021-22.

Senior managers have the authority or responsibility for directing and controlling the major activities of the Trust and for Salisbury NHS Foundation Trust this covers the Chairman, the Executive and Non-Executive Directors. It is important to note that the Remuneration Committee of the Board has responsibility for setting the terms and conditions for the Executive Directors, while responsibility for setting the terms and conditions for the Chairman and Non-Executive Directors lies with the Council of Governors, which is advised by the Performance Committee.

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2021-22. Salaries are set in comparison with those given to holders of equivalent posts within the NHS. Advancement within the individual salary scales of Executive Directors is based on successful appraisal outcomes and this is the only performance-related element of the Executive Director's remuneration. The Remuneration Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chairman advises the committee on the performance of the Chief Executive.

2021-22 major decisions on remuneration

During 2021-22, the Remuneration and Nominations Committee did not make any major decisions affecting remuneration for very senior managers. Three Executive Directors have received an uplift in pay in 2021-22 in consideration of national benchmarking and guidance.

The changes to the Trust's Executive team during 2021-22 were:

- Lynn Lane left her post as Interim Director of OD and people on 6 April 2021
- Susan Young left her post as Interim Chief People Officer on 31 August 2021
- Melanie Whitfield started her role as Chief people Officer on 6 September 2021

Nick Marsden
Remuneration Committee Chairman
16/06/2022

Senior Managers' Remuneration Policy

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

The remuneration of the Chief Executive and Executive Directors (with the exception of the Chief Medical Officer*) is determined by the Board of Directors' Remuneration Committee taking into account market levels, key skills, performance and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

*The pay, terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer. The Chief Medical Officer is eligible to apply for discretionary performance-related pay under Medical Terms and Conditions.

The Trust's overarching approach to remuneration is designed to ensure that senior managers' remuneration supports its strategy and business objectives. The approach has been developed to support the provision of high-quality services for patients through its strategic aim of delivering an outstanding experience for every patient, financial stability and improved service performance. The Trust is mindful of a broad range of factors in setting this approach including the equality, diversity and inclusion agenda.

The Trust's remuneration principles are that rewards to senior managers should enable the Trust to:

- Attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients
- Align remuneration with objectives that match the long-term interests of the Trust
- Drive appropriate behaviours in line with the Trust's values
- Focus senior managers on the business aims and appraise them against challenging objectives
- Comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS Constitution and Care Quality Commission and meet the standards set within the Trust Equality, Diversity and Inclusion Policy.

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period

Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: • Improving the health and well-being of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and benchmarked against the NHSI Guidance for pay for very senior managers.	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March.
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short and long term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme

	strategic goals stated in the basic salary component.		
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

The components above apply generally to all Executives and there are no particular arrangements that are specific to an individual Executive Director. The Remuneration Committee adopts the principles of the Agenda for Change framework when considering Executive Director's pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale, even if individual directors meet their annual objectives.

The performance measures were chosen to reflect the Trust's adopted values and its strategic goals form the basis for Directors' objectives. Objectives for each Executive are set at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). These SMART objectives are the performance measures for the individual Executives. The objectives / performance measures are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-Executive Directors does have the authority to decide on whether any pay increase should be awarded each year based on performance.

No Executive Directors have been released to undertake other paid work elsewhere. Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSI guidance for pay for very senior managers.

Remuneration of Non-Executive Directors

Element of pay (Component)	How component supports short and long term strategic objective of the Trust	Operation of the component	Performance metric used and time period
Basic salary	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of:	It is one single pay point based on research of NHS pay for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee

	• Improving the health and well-being of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work.		
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A
Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

*Non-Executive Directors Fees: Responsibility for setting the terms and conditions for the Chairman and Non-Executive Directors lies with the Council of Governors. The policy on remuneration is that the Non-Executive Directors are paid a basic salary (see Salary Scales). No additional duties which require a fee are carried out by the Non-Executive Directors.

Statement of consideration of employment conditions elsewhere in the Trust

While the Trust did not consult with employees on the remuneration policy regarding senior managers, it did take into account the national pay and conditions on NHS employees.

Responsibility for setting the terms and conditions of appointment for Non-Executive Directors rests with the Council of Governors, which is advised by the Performance Committee and takes into account remuneration in other NHS organisations by reviewing available national comparisons in NHS Employers information. This was determined when the Trust was authorised, on the basis of independent advice. Please note that no additional fees are paid to the Chairman and the Non-Executives Directors, other than travel and subsistence costs incurred.

Annual Report on Remuneration

Service contracts obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non- Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chairman, Chief Executive and Non-Executive Directors.

There are no specific obligations on Salisbury NHS Foundation Trust that impact on remuneration payments or payments for loss of office that are not disclosed elsewhere within the Remuneration Report.

The Service Contract for Non-Executive Directors is not an employment contract. Non-Executive Directors are appointed for an initial term of up to four years and are eligible for a further term of up to four years. Where a director has served eight years, their appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal. The Council of Governors is responsible for appointing, suspending and dismissing the Chairman and Non-Executive Directors as set out in the Trust's Constitution.

Name	Role	Current term of office	Notice Period
Nick Marsden	Chairman	Commenced December 2021	3 months
Rakhee Aggarwal	Non-Executive Director	Commenced January 2020	3 months
Tania Baker	Non-Executive Director	Commenced May 2022	3 months
Michael von Bertele	Non-Executive Director	Commenced October 2019	3 months
David Buckle	Non-Executive Director	Commenced January 2020	3 months
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2019	3 months
Paul Kemp	Non-Executive Director	Commenced January 2021	3 months
Paul Miller	Non-Executive Director	Commenced March 2021	3 months
Peter Collins	Chief Medical Officer	Commenced October 2020	6 months
Judy Dyos	Chief Nursing Officer	Commenced June 2020	6 months
Stacey Hunter	Chief Executive	Commenced September 2020	6 months
Andy Hyett	Chief Operating Officer	Commenced April 2015	6 months
Lisa Thomas	Chief Finance Officer	Commenced September 2017	6 months
Susan Young	Interim Chief People Officer	Left 31 August 2021	N/A as interim
Lynn Lane	Interim Director of OD and People	Left 6 April 2021	N/A as interim
Melanie Whitfield	Chief People Officer	Commenced September 2021	6 months

The remuneration and expenses for the Trust Chairman and non-executive directors are determined by the Council of Governors, taking account of any National guidance.

Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors. The Trust's Chairman is chair of the Remuneration Committee and all Non-Executive Directors are members of the committee.

The Remuneration Committee reviews the salaries and where relevant, the individual reward packages of the Executive Directors. Most other staff within the NHS have contracts based on Agenda for Change national terms and conditions, which is the single pay system in operation in the NHS. Doctors, dentists, very senior managers and directors have separate terms and conditions. Pay circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change. The Trust follows these nationally set pay polices in negotiating with Trade Unions on areas of local discretion.

Name	Role	Attendance from six meetings
Nick Marsden	Chairman	6/6
Rakhee Aggarwal	Non-Executive Director	3/6
Tania Baker	Non-Executive Director	6/6
Michael von Bertele	Non-Executive Director	6/6
David Buckle	Non-Executive Director	6/6
Margaret (Eiri) Jones	Non-Executive Director	5/6
Paul Kemp	Non-Executive Director	5/6
Paul Miller	Non-Executive Director	6/6

External advice is not routinely provided to the Remuneration Committee. However, the Chief Executive, Chief People Officer and the Director of Integrated Governance attend and provide internal advice to the committee.

Disclosures in accordance with the Health and Social Care Act

Expenses for Senior Managers and Governors

Year	Number of Directors in Office	Number of Directors Reimbursed	Amount Reimbursed to Directors	Number of Elected Governors in Office	Number of Elected Governors Reimbursed	Amount Reimbursed to Elected Governors
2020/2021	18	6	£22,011	22	3	£299
2021/2022	15	5	£13,040	22	1	£133
Expenses incurred during the course of their duties relate to travel, accommodation and subsistence. Directors include those who were in post in an interim capacity during the year						

Salary and Pension Entitlement

Name and Title	Remuneration Year to 31 March 2022					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Nick Marsden - Chairman	45-50	0	0	0	0	45-50
Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20

Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Michael von Bertele OBE - Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret Jones - Non-Executive	10-15	0	0	0	0	10-15
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Stacey Hunter - Chief Executive	170-175	0	0	0	122.5-125	295-300
Lisa Thomas – Chief Finance Officer	135-140	0	0	0	67.5-70	205-210
Peter Collins – Chief Medical Officer	175-180	0	0	0	225-227.5	405-410
Judy Dyos – Chief Nursing Officer	110-115	0	0	0	65-67.5	175-180
Andy Hyett - Chief Operating Officer	125-130	0	0	0	70-72.5	195-200
Susan Young - Interim Chief People Officer	45-50	0	0	0	0	45-50
Lynn Lane - Interim Director of OD and People	50-55	0	0	0	0	50-55
Melanie Whitfield - Chief People Officer	65-70	0	0	0	15-17.5	85-90

This table is subject to audit

The amount shown above for Peter Collins Chief Medical Officer represents his total salary and any remuneration received from his clinical roles. No other member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

Lynn Lane left her position as interim Chief People Officer on 6 April 2021. Her remuneration figure includes a contractual payment in lieu of notice of £44k.

Susan Young left her post as interim Chief People Officer on 31 August 2021 and Melanie Whitfield started as Chief People Officer on 6 September 2021

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

This table is subject to audit

Remuneration 1 April 2020 – 31 March 2021						
	Salary and fees (Bands of £5,000) £000	**Taxable Benefits Rounded to the nearest £100**	**Annual Performance Related Bonus (Bands of £5,000) £000**	**Long term Performance Related Bonus (Bands of £5,000) £000**	**Pension Related Benefits (Bands of £2,500) £000**	**Total (Bands of £5,000) £000**
Cara Charles-Barks Chief Executive	80-85	0	0	0	27.5-30	110-115
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20
Michael von Bertele - Non-Executive	10-15	0	0	0	0	10-15
Christine Blanshard - Medical Director	75-80	0	0	0	30-32.5	105-110
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Peter Collins - Medical Director	95-100	0	0	0	10-12.5	105-110
Rachel Credidio Non-Executive	0-5	0	0	0	0	0-5
Judy Dyos - Director of Nursing	80-85	0	0	0	102.5-105	180-185
Stacey Hunter - Chief Executive	95-100	0	0	0	95-97.5	190-195
Andy Hyett - Chief Operating Officer	115-120	0	0	0	40-42.5	160-165
Margaret Jones - Non-Executive	10-15	0	0	0	0	10-15

Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Lynn Lane - Interim Director of OD & People	135-140	0	0	0	0	135-140
Nick Marsden - Chairman	45-50	0	0	0	0	45-50
Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Lisa Thomas - Director of Finance	130-135	0	0	0	57.5-60	190-195
Lorna Wilkinson Director of Nursing	25-30	0	0	0	55-57.5	85-90

The amount shown above for Christine Blanshard, and Peter Collins Chief Medical Officer, represents their total salary and any remuneration received from their clinical roles. No other member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

Christine Blanshard left her post on 25 August 2020 and Peter Collins started as interim Medical Director on 5 October 2020
Cara Charles-Barks left her post as Chief Executive on 31 August 2020 and Stacey Hunter started as Chief Executive on 1 September 2020
Rachel Credidio left her post as Non-Executive Director on 30 Aril 2020
Lorna Wilkinson left her post as Director of Nursing on 29 June 2020 and Judy Dyos started on 15 June 2020

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

Pension Benefits

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 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 1 April 2021 £000	Employers Contribution to Stakeholder Pension £000
Stacey Hunter - Chief Executive	5-7.5	10-12.5	55-60	105-110	1,001	112	860	0
Peter Collins – Chief Medical Officer	10-12.5	22.5-25	55-60	115-120	1,064	199	835	0
Judy Dyos – Chief Nursing Officer	2.5-5	2.5-5	30-35	65-70	539	52	469	0
Lisa Thomas – Chief Finance Officer	2.5-5	2.5-5	40-45	75-80	629	47	560	0
Andy Hyett - Chief Operating Officer	2.5-5	5-7.5	50-55	105-110	880	63	796	0
Melanie Whitfield – Chief People Officer	0-2.5	0	10-15	0	141	10	105	0
Lynn Lane - Interim Director of OD & People	0	0	0	0	0	0	0	0

This table is subject to audit

Notes to Remuneration and Pension Tables

Susan Young chose not to be covered by the pension arrangements during the reporting year.

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a

senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Pay ratio information

This section is subject to audit

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 of the highest-paid director in the organisation in the financial year 2021-22 was £180,000 (2020-21 £185,000). This is a change between years of -2.7%, which was caused by a higher paid Director leaving the Trust in 2020-21.

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

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £14,000 to £233,000 (2020-21 £14,000 to £213,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 4.9%. Four employees received remuneration in excess of the highest-paid director in 2021-22.

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

2021/2022	25th percentile	Median	75th percentile
Salary component of pay	£ 23,200	£ 33,300	£ 44,900
Total pay and benefits excluding pension benefits	£ 23,200	£ 33,300	£ 44,900
Pay and benefits excluding pension: pay ratio for highest paid director	7.65	5.33	3.95

The banded remuneration of the highest paid director was 5.79 (restated) times the median remuneration of the workforce in 2020-21. The Trust's median remuneration reduced in 2021-2022 compared with the previous year. This resulted from the highest paid director leaving the Trust in 2020-21.

Payments for loss of office

There were no payments made to senior managers for loss of office in 2020-21.

Payments to past senior managers

None to report in 2021-22.

The Remuneration Report has been approved by the Trust Board

Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs (subject to audit)

	Total 2021/22 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	**151,408**	151,408	0
Social security costs	**14,788**	14,788	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	**17,123**	17,123	0
Paid by NHSE on provider's behalf (6.3%)	**7,460**	7,460	0
Pension cost – other	**42**	42	0
Temporary staff/agency contract staff	**7735**	0	7,735
Apprenticeship levy	**737**	737	0
TOTAL STAFF COSTS	**199,293**	191,558	7,735
Less: Costs capitalised as part of assets	**(758)**	(758)	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	**198,535**	190,800	7,735

Analysis of average staff numbers (subject to audit)

	Total 2021/ 2022 number	Permanently employed 2021/ 2022 number	Other 2021/ 2022 number	Total 2020/ 2021 number	Permanently employed 2020/2021 number	Other 2020/ 2021 number
Medical and Dental	459	450	9	444	432	12
Administration and Estates	1,327	1,252	75	1,289	1,214	75
Healthcare assistants and other support staff	673	673	0	668	668	0
Nursing, midwifery & health visiting staff	1,049	1,006	43	1,067	1,061	6
Scientific, therapeutic and technical staff	527	512	15	493	475	180
Total	**4,035**	**3,893**	**142**	**3,961**	**3,851**	**110**

The figure shown under the other column relates to other staff engaged on the objectives of the organisation such as, short term contract staff, agency/temporary staff, locally engaged

staff overseas and inward secondments where the organisation is paying the whole or the majority of their costs.

The comparative numbers have been restated to bring them in line with the occupation codes within the electronic staff record, the NHS human resource and payroll database system.

The number of male and female directors, senior managers and employees at 31 March 2022

Head Count	Female	Male	Total
Directors	7	7	14
***Senior managers**	6	4	10
All other staff	3722	1178	4,900

**Senior managers are defined as members of the Trust Management Committee which provides a forum for the Chief Executive, supported by the Executive Directors and Clinical Directors, to advise on the strategic direction of the Trust and the Trust's involvement in the wider health economy. Senior managers in this context include members of the Trust Management Committee who are not included in the two remaining groups.*

Staff Turnover

Staff turnover information can be found on the NHS Digital website:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Sickness Absence

Year April March	Overall absence days lost	%of total available days	% Short term <28 days	% Long term >28 days	Absence Recorded with No reason given
20/21	27,491	3.75%	2.03%	1.72%	4.36%
21/22	31,218	4.15%	2.11%	2.04%	3.25%
22/23 Forecast	29,738	3.95%	1.95%	2.00%	3.00%

Between April 2021 and March 2022, the Trust has experienced the impact of an Increase in sickness absence levels from 27,491 working days lost in 2020-21, to 31,218 days lost in 2022-23.

It remains our aim to reduce sickness absence to our stretch target of 3%. During 2021 -22 absence rates increased above the previous year's level of 3.75% to 4.15%. Within this figure, 2.11% related to short term absence whilst long term absence accounts for 2.04% in total. We saw significant absence in January to March 2022 due to COVID-19

Overall, COVID-19 has impacted sickness absence rates during this period. The Trust's Occupational Health Department has been following up on cases of COVID-19 for contact tracing and ensuring compliance with the Government regulations of the time regarding isolation and testing. Pro-active support for staff on long term sickness has been a focus

during the year, in particular in quarter 4, where additional support of wellbeing phone calls has been put in place. Clinical Psychology services have also been offering wellbeing interventions to staff as a supportive mechanism of preventing sickness absence.

Managers can view team absence data via ESR Manager Self Service. This tool highlights the number of episodes of sickness absence, enabling managers to identify where additional interventions and support are required. Data is also shared with staff side representatives on a regular basis.

Over a fifth of our workforce absence was due to mental ill health and we are aware that some employees experience personal stress and/or work-related stress. The Trust offers a range of proactive wellbeing initiatives to promote better health and wellbeing for all colleagues. Services include physiotherapy, counselling, support from a mental health nurses' practitioner and a psychologist.

We are also planning a Head of Wellbeing role which will provide greater focus to all these services and promote better health in conjunction with our Occupational Health service. Our aim is to widen the remit of the role to include financial legal and other matters that may be underlying causes of stress.

The Trust has monthly health and wellbeing topics/events, trained mental health first aiders, and health improvement coaches for weight management, alcohol, smoking cessation support, healthy eating, increasing physical activity and building confidence and motivation.

Staff continue to enjoy access to the onsite health and fitness centre, green spaces and walking routes.

A health and wellbeing presentation has been implemented for all new starters as part of their induction. COVID-19 risk assessments are completed for all staff to protect their health and wellbeing at work. Flu and COVID-19 vaccinations continue to be available to all staff.

Policies

This year has seen a number of policies reviewed and also seen the introduction of one new policy and a specific focussed revision of the disciplinary policy. In May 2021 a new Workforce Investigation Policy was ratified by the Trust, and in July 2021 the Trust Disciplinary Policy was updated, in line with national requirements, to reflect the principles of our aim to have a restorative just and learning culture.

During the financial year work has been underway to review the 'Employment of People with Disabilities' Policy and this was approved in May 2021. A working group has been established to renew the Trust's registration for Disability Confident Employer Status. The Trust took part in a national pilot program to achieve Level 3 Disability Confident Leaders status. On the 31st March 2022 after working with the working group and the Shaw Trust Salisbury NHS Foundation Trust completed a Disability Confident self-assessment which achieved Level 2 Disability Confident Employer status.

The Shaw Trust has made a number of recommendations regarding progress to Level 3 and an action plan is being developed. As part of this the Trust is currently re-establishing its Ability Network to provide support for staff with disabilities. This network will also act as a lived experience panel to help the Trust achieve Level 3 Disability Confident Leaders status in the next 12 months.

Regular consultation takes place with staff and staff representatives in relation to policy changes and organisational change policy consultation is also discussed with the Trust's Inclusion Network. The Trust's counter fraud specialists receive all HR policies going for ratification and are consulted on those relating to counter fraud

In January 2022 a comprehensive review of 66 OD & People policies commenced to ensure legal compliance, and that policies are in line with Trust values and the NHS People Promise and the aim for a restorative just and learning culture. This work is scheduled to be completed by the end of quarter 1 2022-23.

The Trust is also in the process of reviewing its recruitment processes in line with the national six-point plan for overhauling recruitment processes across the NHS. This will help us to address some of the issues arising from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports about disparities across our workforce in relation to opportunities and experiences.

Health and Safety

The Health and Safety function is supported by a Health and Safety Committee, which includes representatives from every area of the Trust and staff side representatives. The Committee meets every two months and disseminates policy and information to the wider Trust. There are also sub-committees for specific areas for example Fire Safety, Waste and Radiation Protection. The Health and Safety Committee is responsible for monitoring risk and maintaining appropriate records.

Health and Safety is part of a wider Health and Wellbeing function which encompasses the Occupational Health and the Chaplaincy teams. The regulatory requirements for health and safety are set out through the Trust's Health and Safety Policy that describes the organisation and arrangements for health and safety, and through a series of policies and standards on specific subject areas. Although the ultimate responsibility lies with the Chief Executive Officer, the day-to-day management is delegated through with the Chief People Officer and their Deputy responsible for the monitoring and assurance mechanisms and advice to the Chief Executive Officer.

As a matter of routine, the Health and Safety function provides training at induction for all new starters in the Trust, so that everyone is aware of their responsibilities in respect of protecting their own and colleagues' health and safety. Additionally, the team also provides training and 1:1 support as necessary for managers undertaking risk assessments which can be quite technical and/or complex.

The Health and Safety Department undertakes a programme of inspections to monitor the implementation of the required polices and standards by clinical and non-clinical areas. In addition, monitoring of the outcomes is examined through analysis of accident and incident reports. During the pandemic the department has supported the management of COVID-19 requirements for the Trust.

The Health and Safety Management System is currently under review to ensure there is appropriate interpretation of the legal framework into Trust policies and standards and assurance of their implementation to the Trust Board.

Consultancy Expenditure - Off Payroll Payments

Table 1: Highly paid off-payroll worker engagements as at 31 March 2022 earning £245 per day or greater **For all off-payroll engagements as of 31 March 2022**	
	Number
Number of existing engagements as of 31 March 2022	**124**
Of which:	
Number that have existed for less than one year at the time of reporting	**114**
Number that have existed for between one and two years at the time of reporting	**2**
Number that have existed for between 2 and 3 years at the time of reporting	**3**
Number that have existed for between 3 and 4 years at the time of reporting	**3**
Number that have existed for 4 or more years at the time of reporting	**3**

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater.	
	Number
Number of off-payroll workers engaged during the year ended 31 March 2022	**466**
Of which...	
Not subject to off-payroll legislation	**16**
No. assessed as caught by IR35	**0**
No. assessed as not caught by IR35	**450**
No. of engagements reassessed for consistency / assurance purposes during the year.	**16**

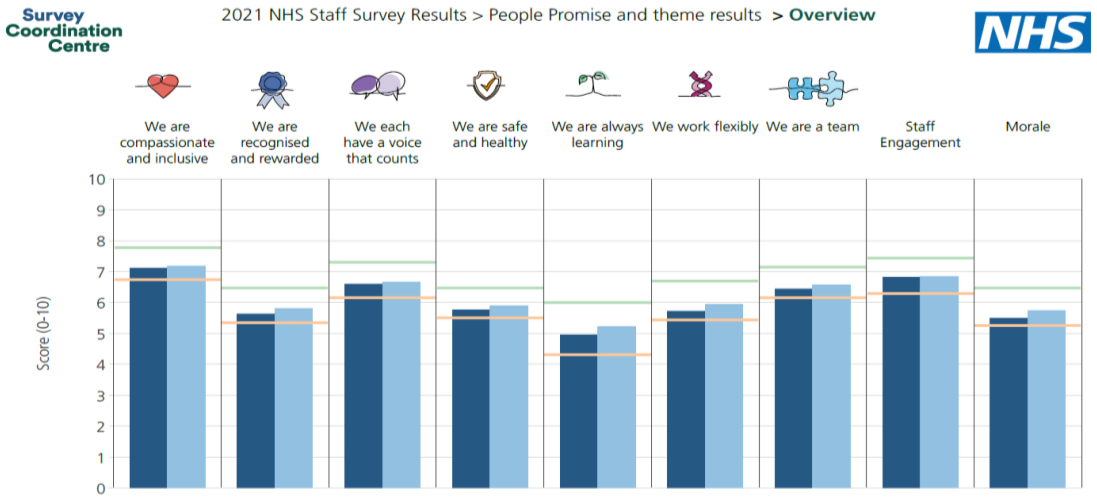
No. of engagements that saw a change to IR35 status following the consistency review	**0**
Table 3: Off-payroll board member/senior official engagements **For any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022**	
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	**0**
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	**18**

Staff Survey

The NHS staff survey is conducted annually. From 2018 to 2020, the results from questions were grouped to give scores in ten indicators. The indicator scores were based on a score out of 10 for certain questions with the indicator score being the average of those. For the first time, in 2021, the questions were aligned with the NHS people promise to track progress against the ambition to make the NHS the workplace we all want it to be by 2024. All staff survey elements nationally are therefore reported against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

The response rate for the 2021-22 survey among trust staff was 48.5% (1881 responses) compared with 54.2% for the 2020 survey (2062) responses. By comparison the median response rate in 2021 for our benchmarking group (acute and acute and community trusts) was 46%.

Scores for each indicator together with the average, best and worst scores in the benchmarking group are presented 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	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.6	6.6	5.8	5.0	5.7	6.4	6.8	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,816	1,851	1,786	1,809	1,744	1,839	1,822	1,858	1,848

Actions are currently being developed to address the key themes arising from the survey which was published on 30 March 2022. These are being aligned with the Trust's 'Improving Together' programme. Last year our action planning was limited by the need to respond to COVID-19. Our actions were therefore prioritised in relation to health and wellbeing of our staff and we will continue to focus on keeping our people safe and healthy. 'Wellbeing walkarounds' enabled managers to take feedback from staff and put actions in place to address concerns raised. Specific focus groups were held with staff to discuss their wellbeing and other actions included a 'take five' campaign to encourage people to take breaks, and the offer of an additional day's 'birthday holiday' for all staff. We have provided a number of relevant wellbeing workshops such as a sleep workshop. We held a 'Thank you' week in September with events in Salisbury for Trust staff and their families. We have reconfigured the staff restaurant to enable its use outside of normal hours and have announced a new Inclusion Network to address the sense of belonging and have given protected time to the network leads.

Following the latest results, we will build on the previous actions and are holding a series of listening events for staff across all of our divisions to encourage them to get involved in further feedback sessions which will generate ideas for improvement. The health and wellbeing of staff continues to be our highest priority, alongside improving morale and developing our leaders across the Trust.

Staff survey action plans will be monitored by the Organisational Development and People Committee on behalf of the Trust Board.

Staff engagement

The Trust is committed to engaging with staff at all levels and through many different media. Whilst COVID-19 has limited our opportunities to come together face to face, we have continued to hold regular briefings and dialogue through MS Team. Our monthly Cascade briefings give the Trust the opportunity to share information and to take views from staff on a wide range of topics. These are well attended and give all staff an opportunity to engage with colleagues at all levels.

Board safety walks give our Board members the opportunity to engage directly with staff. These occur monthly with an Executive Director, Non-Executive Director and divisional management team visiting patient and non-patient facing areas, speaking to staff and listening to their concerns. 'Back to the floor' sessions have also taken place with Executive colleagues shadowing colleagues for half a day on a regular basis to learn from and engage with staff.

Our staff awards were a key part of our engagement activity. In 2021 we presented14 awards to our remarkable staff covering a mix of categories from the Chairman's award, to the COVID-19 Award and Volunteer of the Year to name a few of the categories. It was a great evening and well received by staff. Our Family Fun Day was also well attended by hospital staff, their families, and the local community.

In addition to the annual staff survey, we also run a more regular Pulse Survey to take up to date feedback from staff.

Our staff network groups also play a large part in our staff engagement activity.

Equality, Diversity & Inclusion (ED&I)

During the year we had an audit of our approach to Equality, Diversity and Inclusion (EDI) which made a number of recommendations:

- To formally define an EDI Strategy.

- Revise the EDI action plan including measures of success in response to the newly developed strategy.
- To improve our data analysis capabilities for EDI metrics
- Improve the EDI governance structure and management information in order to successfully track progress
- Further opportunities for embedding EDI
- Review available EDI resource both within the Trust and across the integrated care system.

A draft EDI strategy has been developed for consultation with staff and stakeholders. It is designed to link with the NHS People Plan and People Promise. The EDI networks are key players in this consultation.

Our Workforce Race Equality Standard (WRES) report and Workforce Disability Equality Standard (WDES) report have been reviewed and incorporated into the new strategy which also builds on the evidence form the NHS staff survey, and the gender pay gap (GPG) report as well as the EDI audit. A key part of our 'Improving Together' programme is 'Creating an inclusive culture'.

We will measure our success using data from the Electronic Staff Record (ESR) system, staff survey, WRES and WDES data and GPG data. Future actions will include exploring opportunities to work with our integrated care system (ICS) partners to better understand community demographics.

Our aim is for EDI to be embedded as part of our day-to-day activities. The Board has had EDI development sessions when staff members were invited to come and discuss their experiences with Board members. It was agreed that each Board member will have and EDI objective. Trust Executives sponsor the following staff support networks which have recently been reinvigorated:

- Race Equality Network
- Mental Health First Aiders Network
- Rainbow Shed (LGBTQ+) Network
- Ability Network
- Women's Network.

Protected time of one day per month has been agreed for our staff network leads to facilitate the development of their networks.

The Trust also plays a large part in the development of and support for EDI across the Bath Swindon and Wiltshire (BSW) ICS in the following ways:

- Scoping and engaging with EDI resources/staff across the system
- Identifying active EDI staff networks, best practice, learning and sharing.
- Setting up relevant EDI system networks.
- Collating WRES/WDES (and equivalent data from other system partners) to determine the benefit of BSW system priorities/focus.

In terms of representation of Black Asian or Minority Ethnic (BAME) people the Trust is already more diverse than the local community, for example, 20% of the workforce are from a BAME background as opposed to approximately 4% of the local community. In 2022 we now have 809 staff who declare themselves as BAME compared with 638 in 2020. Staff declaring that they have a disability now number 116 compared with 98 two years ago.

There has been a small increase in the number of staff declaring themselves as LGBTQ+ (89 in 2022 compared with 85 in 2020).

The Freedom to Speak Up Service is provided by the Trust to empower staff to raise a concern outside of an individual's management chain should they require it. The service is led by a Freedom to Speak Up Guardian, supported by a team of Ambassadors. The remit of the service is to support the development of a culture that is open and transparent so that raising concerns becomes business as usual for all staff. The Trust's Guardian is responsible for providing confidential advice and support to staff in relation to any concerns about patient safety or any concern that has a detrimental effect on their working conditions. They can also offer advice and support to ensure concerns raised are handled appropriately and result in a clear outcome. The Trust's Freedom to Speak Up Guardian has direct access to all senior leaders including the Chief Executive and all Board members. This year the Trust has shown commitment to Freedom to Speak Up by making online 'Speak Up' Level 1 training mandatory for all staff ensuring every staff member knows how to raise concerns safely. It has also been agreed that the Level 2 Freedom to Speak Up enhanced online training, 'Listen Up' package will apply to all staff with line management responsibilities. This will form part of the Management Training offer which is currently being developed by the Education Department. This approach will enable consistency and quality when concerns are raised.

Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2021-22 89 concerns were raised to the Freedom to Speak Up Guardian. Of these 36 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

	Themes	**Cases Q1 2021-22**	**Cases Q2 2021-22**	**Cases Q3 2021-22**	**Cases Q4 2021-22**
1	Element of Patient Safety and Quality*	8	8	9	11
2	Bullying/Harassment*	7	10	11	10
3	Disadvantageous and/or demeaning treatment*(detriment)	0	2	1	5
4	COVID-19 related concerns	0	1	5	0

**Please note that some cases record more than one theme*

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, business cards are handed to every new member of staff.

Apprenticeships

The government's 2020 vision for creating a highly skilled workforce and addressing the UK's skill shortages and stimulating economic growth across all areas, has resulted in the reform of apprenticeships.

The 2020 NHS People Plan states that we should: *"Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles."* Our Trust and Integrated Care System (ICS) plans support that.

Salisbury NHS Foundation Trust currently pays 0.5% (c. £60k) of its total pay bill into the Apprenticeship Levy per month, with a current total of £1.35 million available for us to access. This is used to pay training providers to provide apprenticeship training which makes up a minimum of 20% of the apprentices' time. Any Levy not utilised within 2 years of

being paid into the fund will expire and be returned. Levy utilisation has improved in the last 12 months.

	2019/2020	2020/2021	2021/2022
Total Number of apprentices	84	128	153
Current Funds	£1,207,780.00	£1,318,012.00	£1,481,729.00
Total Spent to Date	£407,238.17	£832,402.11	£1,265,125.39
Total Spend in Year	£325,294.01 Of which £6,000 (1.8%) was transferred to other organisations	£445,354.91 Of which £12,557 (2.8%) was transferred to other organisations	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations
Annual Expired Levy	£102,815.50	£87,493.45	£112,685.57

The impact of COVID-19 on our apprenticeship programme has not been as significant as anticipated and we have continued to see a small rise in apprentices starting training and a reduction in our expired levy. It has resulted in staff being redeployed into different departments, reduced staffing numbers and significant increases in work pressures across the organisation. Understandably, there has been less capacity to support and train staff on apprenticeships in a way that we would like to. As expected, the focus on training and development has shifted as staff prioritise operational pressures.

There have been challenges regarding procurement of apprenticeships with one Higher Education Institution making last minute cancellation of a degree level apprenticeship that we had recruited to. This affected the credibility of apprenticeship programmes.

The range of apprenticeships being utilised across has increased and we have apprenticeships available at every academic level and across a range of staff groups. See table below

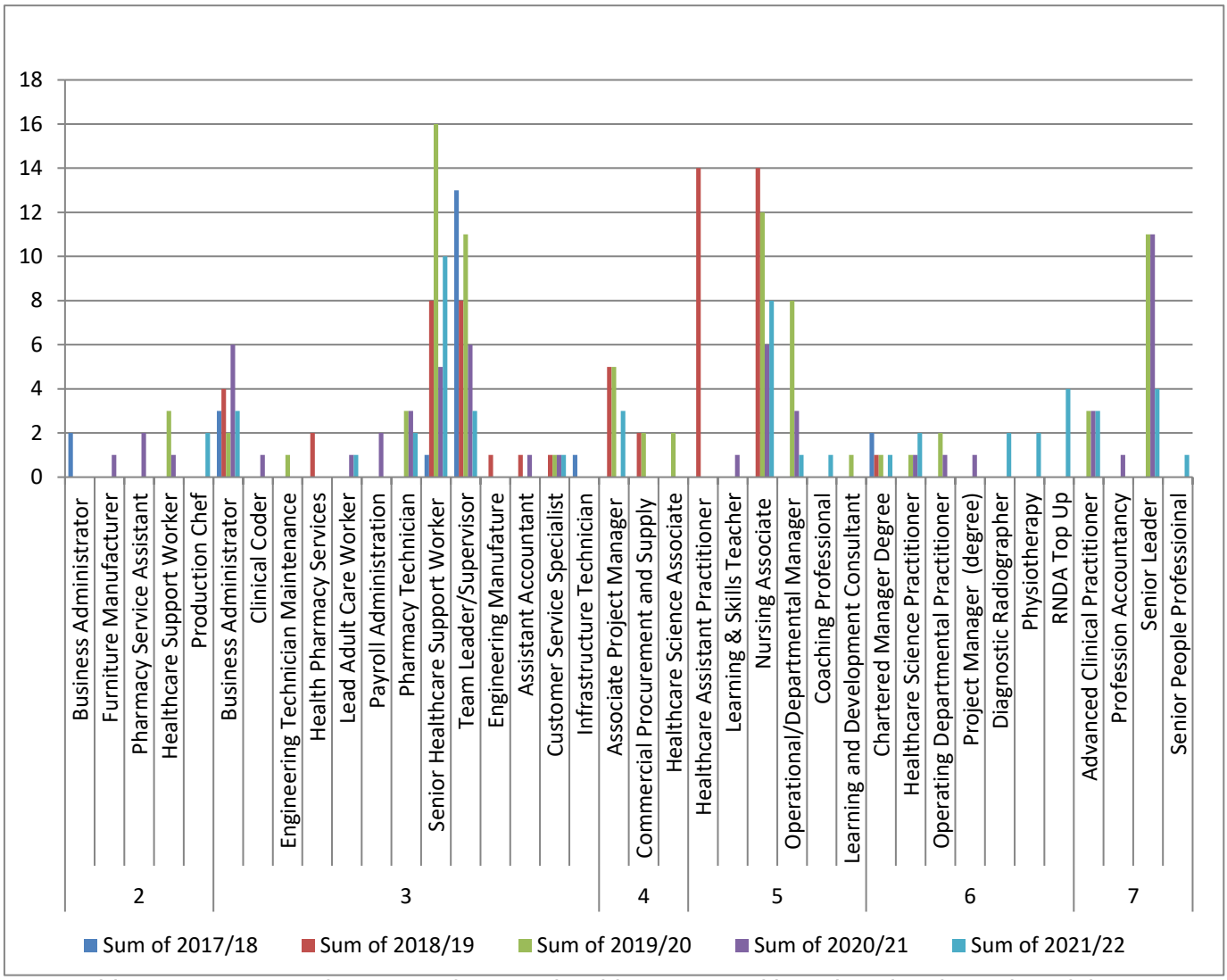


Table: Demonstrates the range of apprenticeships accessed by Educational Level, and the number of apprentices starts each of year on programme.

Levy utilisation has improved in the last 12 months, and we are on track for a decrease over the whole year. Currently a business case for a Registered Nurse Degree Apprenticeship Programme is being considered and if agreed in full will result in additional utilisation of the Levy. This will eliminate any expiry of Levy and support us towards a target 100% utilisation. SFT has already committed to support a further nine apprentices through Levy transfer in 2021-22, with an aim of increasing this further up to 25% of our total levy, to increase accessibility onto apprenticeships for our community.

The target this year, in the current climate, has been to maintain our current apprenticeships and continue to support them through to completion, whilst also responding to any requests for new programme and enrolments.

SFT engaged in regional and system wide procurement of a number of degree level apprenticeships and have internally recruited onto these. This was carried out on a much

larger scale than last year and carried out across the South West instead of just the BSW region.

Across BSW since April 2021, there has been a 15% increase in apprenticeship starts and a 100% increase in Levy transfers, which is testament to the great work that is being achieved in the network and reflects the identified maturity of the learning pillar.

Leadership and Development

During the year a number of key events took place that signalled a requirement to re-evaluate our approach to Leadership & Development for the Trust and re-write our Leadership Strategy to support these shifts, including

- The Launch of a new Trust Strategy.
- Our NHS People Promise – and our Trust's intent on being an 'exemplar site'.
- The launch of our Improving Together Programme and the Leadership behaviour and culture needed to support this endeavour.

Alongside planning these changes, a significant and impactful offer of Leadership content and wider Organisational Development (OD) has continued to be delivered. A large proportion of the Leadership and OD activity has been in response to the previous year's Best Place to Work (BPTW) Diagnosis. This highlighted a number of themes for development such as compassionate leadership, innovation and learning and the development of psychologically safe environments. Development activities have addressed the requirement to support our Leaders in their development of an awareness, capability and belief that the values and behaviours they promoted and used supported the transition from a 'Command and Control' style to a more collaborative and compassionate style of Leadership.

We are pleased that over 4097 Hours of Personal Development have been delivered in the past 12-18 months. Over 937 of these hours have been supporting our staff to become better coaches, and over 3160 hours have been staff attending one of our Leadership development courses. In total, over 360 of our staff have benefited from attending this professional development.

We are developing a new OD & Leadership Strategy, which will support our people to develop themselves to have an awareness, capability and desire to shape the culture we need to deliver our new strategy, our People Promise and the Improving Together programme.

Our Leadership Way identifies three core behavioural foundations of which our strategy and OD & Leadership offer will support, they are:

- **Compassion** – we are inclusive, promote equality and treat people with kindness, compassion and respecting diversity
- **Collaboration** – supporting our people to be the best they can be and grow effective partnership to achieve our goals
- **Curiosity** – We aim for the highest standards and seek to continually improve and harness our ingenuity

In future we will develop a clear 'pathway' for aspiring leaders and current leaders that supports talent management, core Management skills/capabilities, and opportunities for growth in role.

Staff Exit Packages

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2021-22 are included in this table. The 2020-21 figure is in brackets.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Under £10,000	0 (1)	0(9)	0(10)
£10,000 - £25,000	0(0)	1(3)	1(3)
£25,001 – £50,000	0(1)	1(0)	1(1)
£50,001 - £100,000	0(0)	0(1)	0(1)
£100,001 - £150,000	0(0)	0(0)	0(0)
£150,001 - £200,000	0(0)	0(0)	0(0)
Total number of exit packages by type	0(2)	2(13)	2(15)
Total resource cost	£0(£43,000)	£59,000(£164,000)	£59,000(£207,000)

This table is subject to audit.

The other departures shown above relate to contractual payments in lieu of notice.

Trade Union Facility Time Disclosures

Since April 2017, public sector organisations are required to report on trade union facility time.

Table 1 - Relevant Union Officials

Number of employees who were union reps	24
FTE union reps	21.97

Table 2 Percentage of time spent on facility time

Percentage of time	%
0%	10
0-50%	14
51-99%	0
100%	0

Table 3 Percentage of pay bill spent on facility time

Percentage of pay bill on facility time	
Total cost of facility time	£26,937.67
Total pay bill	£198.154m
Percentage facility time	0.1%

Paid Union Activities	
Time spent	0

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

Salisbury NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that for the 2021-22 year the Trust has been fully compliant with the provisions of the Code, with the exception of provision B.6.2 that states “evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years”. An external review was delayed until autumn 2022, given the ongoing executive recruitment and the continued focus on COVID-19 recovery. The Trust Board has undertaken a self-assessment which has highlighted specific areas of focus for improvement, prior to the external review later this year.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this code through the arrangements that it puts in place for our governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Integrated Governance Framework
- Accountability Framework
- Terms of reference for the Board of Directors, the Council of Governors and their committees
- Annual declarations of interest
- Annual Governance Statement

Council of Governors

The Trust’s Governors are the representatives of members, staff, our stakeholders and public interests, and are an integral part of advising us on how best to meet the needs of patients and the wider community. Our Governors have a number of statutory duties but their key role is to hold the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors. Other statutory duties of the Council of Governors’ role include:

- Appointing the Chairman and Non-Executive Directors
- Approving the appointment of the Chief Executive
- Deciding on the remuneration of the Chairman and Non-Executive Directors
- Receiving the Trust’s Annual Accounts, Auditors Report and Annual Report
- Reviewing the Membership and Public Engagement Strategy

The Council has been placed into groups to consider various topics over which they can have an influence. In 2021-22 these covered:

- Membership and Communications Committee

- Performance Committee (Chairman and Non-Executive Directors)
- The Trust's Annual Plan prior to submission to the regulator
- Nominations Committee
- Staff Governors Committee
- Patient Experience Group
- The strategic direction of the Trust
- Volunteers

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. Governors are also party to discussions about elements of the Trust's strategy when items are taken at meetings of the Trust Board and Council of Governors.

The public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election but they may not serve for more than nine years in total.

In addition, some of the organisations we work most closely with nominate stakeholder Governors. An appointed Governor may hold office for three years and can be re-appointed in line with elected Governors.

The representatives of public constituencies must make up at least 51% of the total number of Governors on the Council of Governors.

The Council of Governors hold four meetings a year, in addition to the Annual General Meeting (AGM). The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. It should be noted that constituency meetings have been put on hold due to the COVID-19 pandemic but plans are in place to reintroduce these in 2022-23.

Elected Governors – Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 5 meetings
Kevin Arnold	Salisbury City	June 2020	Three years	3 / 4
Lucinda Herklots	Salisbury City	May 2018	Three years	4 / 4
Joanna Bennett	Salisbury City	June 2020	Three years	4 / 4
Sir Raymond Jack[2]	South Wiltshire Rural	May 2018	Three years	1 / 1
Jennifer Lisle[3]	South Wiltshire Rural	May 2018	Three years	1 / 1
William Holmes[4]	South Wiltshire Rural	May 2018	Three years	1 / 1
Dr James Robertson	South Wiltshire Rural	Sept 2019	Three years	2 / 4
Anthony Pryor-Jones	South Wiltshire Rural	June 2020	Three years	4 / 4
Angela Milne	South Wiltshire Rural	June 2021	Three years	2 / 2
Andrew Rhind-Tutt	South Wiltshire Rural	June 2021	Three years	2 / 2
Peter Russell	South Wiltshire Rural	June 2021	Three years	1 / 2
Michael Glover	South Wiltshire Rural	June 2021	Three years	1 / 2
John Parker	North Dorset	May 2018	Three years	4 / 4
Christine Wynne	North Dorset	May 2018	Three years	4 / 4

John Mangan (Lead)	New Forest	Feb 2018	Three years	4 / 4
Peter Kosminsky[1]	Kennet	June 2020	Three years	1 / 4
Mary Clunie	Rest of England	Feb 2018	Three years	4 / 4

[1] Peter Kosminsky took an agreed leave of absence as agreed by the Chair during 2021/22 and attended whenever possible
[2] Sir Raymond Jack came to the end of his final term of office in May 2021
[3] Dr Jennifer Lisle came to the end of her second term on 31st May 2021 and did not seek re-election
[4] William Holmes came to the end of his first term on 31st May 2021 and did not seek re-election

Elected Governors - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 5 meetings
Paul Russell	Clerical, Administrative and Managerial	June 2020	One year	4 / 4
Pearl James[1]	Volunteers	May 2018	Three years	1 / 1
Jane Podkolinski	Volunteers	June 2021	Three years	2 / 3
Jonathan Cullis[2]	Medical & Dental	May 2018	Three years	0 / 1
Anita Nazeer	Medical & Dental	June 2021	Three years	1 / 3
Lee Phillips[3]	Scientific, Technical & Therapeutic	May 2018	Three years	0 / 1
Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	3 / 3
Jayne Sheppard	Nurses & Midwives	May 2018	Three years	3 / 4

[1] Pearl James' second term ended on the 31st May 2021 and she did not seek re-election
[2] Johnathan Cullis' first term ended on 31st May 2021 and he did not seek re-election
[3] Lee Phillips first term ended on 31st May 2021 and did not seek re-election

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance from 5 meetings
Vacant	Wiltshire Council	N/A	N/A	N/A
Cllr Richard Rogers	Wiltshire Council	9 March 2022	Three Years	N/A
Steve Donald[1]	Wessex Community Action	June 2021	Three years	2 / 3
Vacant	Dorset CCG	N/A	N/A	N/A
Dr Edward Rendell[2]	BaNES, Swindon and Wiltshire (BSW) CCG	June 2020	Three years	2 / 4
James House	West Hampshire CCG	July 2021	Three years	3 / 3
Sarah Walker	Military	July 2021	Three years	3 / 3

[1] Steve Donald stood down from his role as nominated Governor in March 2022
[2] Edward Rendell stood down from his role as nominated Governor in March 2022

During the year the Directors have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chairman and these meetings are attended by the Chief Executive, who presents a performance report and answers questions. This is an opportunity for Governors to express their views and raise any other issues, so that the Chief Executive can respond.

There have been no formal requests for Director attendance at the Council of Governors meetings, but it has been standard practice for the Chief Executive and Director of Nursing to attend. The Chief Operating Officer also attends when operational queries have been raised. Dependent on the agenda, other Executives attend as required.

An informal meeting is normally held between the Governors and the Non-Executive Directors a week after a public board meeting approximately four times a year. However, due to the prevalence of COVID-19 and at the request of our Governors the Trust scheduled an informal briefing with the Non-Executive Directors after every Public Board meeting.

The Trust Board is aware of the work carried out by the Governor committees and information is fed back to the directors.

In 2021-22, the Trust Board met regularly in public and, as part of its commitment to openness, Governors and members are invited by the Chairman to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board.

Public Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.

The Trust Board has invited the lead Governor to attend as an observer at the private meetings of the Board and has also invited Governor observers to attend the meetings of the Board's Finance and Performance Committee, its Clinical Governance Committee and its People and Culture Committee.

Register of Governor Interests

A register of interests is held in the Trust Offices. Information regarding the Governors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting:

Head of Corporate Governance,
Trust Offices,
Salisbury NHS Foundation Trust,
Salisbury
SP2 8BJ

Dispute Resolution

There are a number of mechanisms in place that allow an issue or concern to be discussed and escalated. Informally, there are meetings between the Lead Governor and the Chairman and there are regular meetings between the Governors and the Non-Executive Directors. A formal procedure is in place (see point 51, Dispute Resolution in the Trust's Constitution) should there be a dispute between the Council of Governors and Trust Board.

The Board of Directors

The Board comprises the Chairman, Chief Executive, five other Executive Directors and seven other Non-Executive Directors. There is a clear separation between the roles of the Chairman and the Chief Executive, which has been set out in writing and agreed by the Board. As Chairman, Nick Marsden has responsibility for the running of the Board, setting the agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust. All directors are equally accountable for the proper management of the Trust's affairs.

All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

The Board Committees including the Clinical Governance Committee, Audit Committee, Finance and Performance Committee and People and Culture Committee have completed a self-assessment of committee effectiveness. These reviews concluded that these Committees were meeting the requirements as set out in their terms of reference.

There were no commissioned external reviews of the Board during the reporting year.

The Trust has Board approved Standing Financial Instructions and a Scheme of Delegation and Reservation of Powers, which outline the decisions that must be taken by the Board and the decisions that are delegated to the management of the hospital. These documents include, but are not limited to, instructions on budgetary control, contracts and tendering procedures, capital investment and security of the Trust's property, delegated approval limits, fraud and corruption and payroll.

The Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Trust Board Members

Dr Nick Marsden – Chairman (Independent)

Nick Marsden joined the Trust in January 2014. Before this he was an NHS Non-Executive Director and Vice Chairman at Southampton. He has an engineering Ph.D and also commercial experience having held several senior executive roles at IBM, before becoming Senior Vice President for Service at Danka Europe.

Stacey Hunter – Chief Executive

Stacey is an experienced NHS Board Director with over 34 years' experience working in the NHS and a decade operating in Chief Operating Officer, Divisional Director and Executive System Transformation roles. She has spent time working in large scale teaching hospitals, an integrated acute and community trust and is passionate about reducing the inequalities patients experience in respect of their access to, experience of and outcomes from care.

A nurse by background Stacey spent several years working in clinical leadership roles before expanding her experience in general management. She has invested in her leadership development having undertaken the NHS Leadership Academy Aspiring CEO programme and is keen to continue to support the Trust to develop an inclusive culture that develops clinical and operational leaders to seek to continuously improve their services. Stacey has experience of being a trustee in a number of different charities over the last 20 years most of them related to health and care. Stacey joined the Trust in September 2020.

Rakhee Aggarwal – Non-Executive Director (Independent)

Rakhee Aggarwal joined the Trust in January 2020 on a three-year term. Rakhee has been a mental health nurse since 1999; She has a BSc in Behavioural Studies (Psychology); and a Master's in teaching and Learning for Health Professionals. She has worked for the University of the West of England for the past 15 years as a Senior Lecturer; Associate Head of Nursing and Midwifery - Mental Health and Learning Disability Nursing; Associate Head of Nursing and Midwifery - Adult Nursing; and as Associate Head of Nursing and Midwifery - Continuing Professional Development. Rakhee is leading and developing the CPD Education provision for the NHS and private and voluntary sectors. In addition to her work at the University she has been a Non-Executive Director with the South Western Ambulance Trust since 2017.

Tania Baker - Non-Executive Director (Independent)

Tania Baker joined the Trust in June 2016 for a three-year period. Her term of office was extended for a further two years in February 2019. She was Chief Executive Officer at health analytics company, Dr Foster where she was involved in developing the business nationally and internationally. Before this Tania held senior appointments in private healthcare and was Commercial Director at Aviva Health insurance. Tania is the Senior Independent Director.

Michael von Bertele CB, OBE - Non-Executive Director (Independent)

Michael joined the Trust in November 2016 for a three-year period. His term of office was extended for a further three years in October 2019. As an army junior doctor, he trained in occupational and environmental medicine, and became a consultant in 1992. Michael has served in the UN Protection Force in Croatia, was chief medical planner in the Ministry of Defence and was Director General of the Army Medical Services. He retired in 2012 and worked for Save the Children International until 2015.

Dr David Buckle – Non-Executive Director

Dr David Buckle joined the Trust in January 2020 on a three-year term. He is MB BS, DRCOG and MRCGP qualified and is a Fellow of the Royal College of General Practitioners. He was a practising GP until 2017 whilst latterly working part-time (until May 2018) as the Medical Director for Herts Valley Clinical Commissioning Group, where he was the Director of General Practice development. He has previously held other roles comprising various positions within Berkshire East and Berkshire West Primary Care Trusts and with NHS Berkshire West Primary Care Trust. David currently has a portfolio of Non-Executive appointments, as the President of the Society for Assistance of Medical Families, Non-Executive Director with Berkshire Healthcare NHS Foundation Trust, Non-Executive Director with East and North Hertfordshire NHS Hospitals Trust; and Vice Chair (clinical) of the Stroke Association. David became a voting member of the Board in May 2020.

Mr Peter Collins – Medical Director

Peter trained as a liver specialist and was the clinical lecturer at the Sheila Sherlock Liver Centre at the Royal Free Hospital prior to taking up a consultant post at University Hospitals Bristol Foundation Trust in 2005. He has a research interest in primary liver cancer and alcohol related liver failure and led the regional Primary Liver Cancer Service for the West of England. He has had a number of senior leadership positions in research, education and hospital care.

In 2017 Peter was appointed to the role of Medical Director at Weston Area Health Trust where he played a key role in developing models of integrated care, reconfiguring services across Bristol and North Somerset and readying the organisation for a successful merger with University Hospitals Bristol. Since the merger Peter worked as a Deputy Medical Director for the large organisation focusing on the delivery of safe and effective COVID-19 care and the restoration of non-COVID services for the Trust and the local Healthcare system. Peter joined the Trust as Interim Medical Director in October 2020 and was successfully appointed to the substantive position in March 2021.

Judy Dyos – Director of Nursing

Judy joined the Trust from Isle of Wight NHS Trust where she was formerly Deputy Director of Nursing and was instrumental in the Isle of Wight Trust obtaining a CQC rating of Good in many areas. Prior to this she was the Lead for Clinical Assurance and Quality Governance at University Hospital Southampton. Judy joined the Trust as Interim Director of Nursing in June 2020 and was successfully appointed to the substantive position in March 2021.

Andy Hyett – Chief Operating Officer

Andy Hyett has a wide range of NHS experience. He started his career as a biomedical scientist at Dorset County Hospital in the 1990s and moved into NHS management in Winchester. He continued to progress through senior management positions in Portsmouth and then University Hospital Southampton NHS Foundation Trust where he was Deputy Chief Operating Officer. Andy joined the Trust in 2015.

Eiri Jones – Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019 for a three-year period. Eiri is a registered adult and children's Nurse, has an MA in Professional Development and is a QSIR Practitioner. She has clinical, managerial and executive leadership knowledge and skills gained during a career spanning over 40 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her last UK Executive role was as the Director of Nursing for the United Lincolnshire Hospitals NHS Trust (2012 – 2014). Since then, she has held roles as an interim Quality Manager at NHS Crawley CCG; interim Director of Quality Governance at Barts Health NHS Trust; Implementation Director of GIRFT in the South West of England and most recently as a Quality Programme Director for Cwm Taf Morgannwg Health Board. Eiri is also Non-Executive Director at Homerton University Hospital Foundation Trust and sits on Allocate's Advisory Board.

Paul Kemp – Non-Executive Director (Independent)

Paul Kemp joined the Trust in February 2015 for a three-year period having completed 34 years in industry, initially as a development chemist before concentrating on finance, IT and business change leadership. His term of office was extended for a further two years in

November 2020. He has worked for a number of large multinational companies, including British Airways and Cobham plc, the multinational aerospace and defence company. In 2018, Paul was appointed as a Justice of the Peace, sitting on the Dorset bench and in 2019 took up the role of Trustee and Honorary Treasurer for the Magistrate's Association, a charity supporting the magistracy across England and Wales.

Paul Miller – Non-Executive Director (Independent)

Paul Miller joined the Trust in March 2018 for a three-year period. His term of office was extended for a further three years in November 2020. His experience spans 23 years as an executive director in a wide variety of organisations. It includes five years as a Chief Executive in both Wales and England and 16 years as a Director of Finance in specialist regional, mental health and acute organisations. These roles covered finance, strategy, organisational leadership and successful working at a very senior level in a wide variety of health systems.

Lisa Thomas – Director of Finance

Lisa has over 18 years' finance experience in a number of NHS organisations having started her career in 1999 on the Graduate Financial Management Training scheme. She was previously Deputy Director of Finance at Royal United Hospitals Bath NHS Foundation Trust, and prior to that she spent time working in Basingstoke, Winchester and Gloucestershire NHS organisations in senior roles. Lisa joined Salisbury in 2017.

Melanie Whitfield – Chief People Officer

Melanie is an accomplished HR leader and coach with many years' experience leading on significant programmes of change and people strategy in both the private and public sector.

With many years of organisational HR experience, including Board level experience within private equity and public charity sectors, Melanie joined the national team at NHS England and Improvement as one of the founding authors of the People Plan.

Melanie began her career in retail working for some of the best-known brands on the high street including The John Lewis Partnership, Sainsbury's, and Boots. She has continued both her formal academic studies and professional development and has a particular interest in the value and impact of team coaching. On joining the Trust Melanie expressed her wish to support all staff to be the best they could be, by helping create the kind of environment where everyone can thrive and in doing so, provide the best possible care to the community we serve.
Within the Trust's executive team, she is the responsible leader for our Operational HR Services, Resourcing, Organisation design and Development, Education and Communication strategies alongside our Health and Safety and Occupational Health services.

Directors that left the Trust during 2021-2022

Susan Young, Interim Chief People Officer – Susan joined the Trust on 1st March 2021 and left the Trust on 31st August 2021.

Lynn Lane, Interim Chief People Officer – Lynn left the Trust on 6th April 2021.

Board of Directors' Attendance (Member's attendance only)

	Appointment Date		Trust Board (12 meetings)	Audit Committee (6 meetings)	Remuneration Committee (6 meetings)	Finance & Performance (12 meetings)	Clinical Governance Committee (12 meetings)	People and Culture Committee (9 meetings)	Subsidiary Governance Committee (3 meetings)	Council of Governors (4 meetings)
	From	To								
Rakhee Aggarwal Non-Executive	01/01/20	-	9		3			9		1
Tania Baker Non-Executive	01/06/16	-	11	5	6					3
Michael Von Bertele Non-Executive	01/11/16	-	12	5	6			9		2
Dr David Buckle Non-Executive	27/01/20	-	11		6		12			2
Peter Collins Medical Director	05/10/20	-	9				11	9		2
Judy Dyos Director of Nursing	15/06/20	-	11				12	9		4
Andy Hyett Chief Operating Officer	13/04/15	-	11			9	8			0
Stacey Hunter Chief Executive	01/09/20	-	11	3		9	8			4
Eiri Jones Non-Executive	11/11/19	-	12		5	11	12			3
Paul Kemp Non-Executive	01/02/15	-	12	6	5	11			3	1
Nick Marsden Chairman	01/01/14	-	12		6				2	4
Paul Miller Non-Executive	16/04/18	-	12	6	6	12	12		3	2
Lisa Thomas Director of Finance	03/07/17	-	11	6		12			3	0
Melanie Whitfield Chief People Officer	06/09/21		7			4		4	1	0

The Audit Committee

Name	Committee Role	Attendance out of six meetings
Paul Kemp	Chairman	6
Michael von Bertele	Non- Executive Director	5
Tania Baker	Non- Executive Director	5
Paul Miller	Non- Executive Director	6

The Work of the Audit Committee in Discharging its Responsibilities

The Audit Committee is in place to provide the Board with assurance as to the effectiveness of the processes overseen by the Board itself and by the Finance & Performance, People and Culture, and Clinical Governance Committees.

The committee is supported by the Appointed Auditor, Grant Thornton LLP who took office from November 2018. In October 2019 the Council of Governors approved the appointment of Grant Thornton as the Trust's External Auditor for the next four years.

During 2021-22, the internal audit service was provided by PwC UK.

The Committee has an annual work programme as well as dealing with other items that arise during the year. It also agrees annual work programmes with the auditors and the Executive.

The Audit Committee is chaired by Paul Kemp, Non-Executive Director. The Audit Committee is responsible for:

- Monitoring the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them.

- Assisting the Board of Directors with its oversight responsibilities and independently and objectively monitoring, reviewing and reporting to the Board on the adequacy of the processes for governance, assurance, and risk management; where appropriate, facilitates and supports through its independence, the attainment of effective processes.

- Reviews the effectiveness of the Trust's internal audit and external audit function.

- In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.

In addition to its standing items of business, which includes payroll analysis, internal audit recommendation tracker, Internal Audit Reports, External Audit Reports and Counter-Fraud progress reports, the Audit Committee has reviewed risk management systems and processes.

Although the peak of the direct impact of the pandemic on patient numbers occurred during 2020-21, the delta variant in the early part of the current year and the subsequent omicron variant were significant factors in the management of the hospital. Although public restrictions were reduced in the latter part of the year, many of the hospital virus control measures were maintained. There was also a significant, if indirect, impact on the ability to be able to release otherwise fit patients, with the numbers identified as having No Criteria to Reside rising significantly and disrupting patient flows throughout. This latter problem has not yet been resolved and continues to disrupt patient flow. These phenomena are prevalent across the whole of the NHS and are not particularly focused in Salisbury.

The committee reviewed the draft financial statements and governance statements for the 2020-21 annual report and recommended their adoption to the Board. As in the previous year, there were some disruptions to the process and the final signing of the accounts was slightly delayed. However, these issues related to delays in the audit process, rather than

issues with the accounts and did not impact the outcome. The Audit Committee signed off the Annual Accounts on the 18th June 2021, acting on the delegated authority of the Board.

During the financial year 2021-22, PWC carried out reviews in eight areas, agreeing a total of 39 actions with management. Three of the eight reports were rated as "High Risk" overall. On a positive note, the auditors were complimentary about the attention that was being given by management to the closure of agreed actions. Unlike previous years, there were only three actions still open relating to reviews from previous periods, and these were long term actions that were not yet due for completion. Overall, the Head of Internal Audit Opinion remained the same as for the last two years. That is to say that the formal opinion was that the control environment within the Trust was independently judged to be "*Generally satisfactory with some improvements required."*

During the year, the committee continued its practice of inviting management teams to give a detailed presentation on a specific management process or area of concern. The Audit committee has received presentations on the implementation of the new financial ledger system, programme management processes, diagnostic wait time management and improvements in medicine controls in the pharmacy. All the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

During the year the Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter Fraud Functional Standard Return, with the two outstanding red rated items improved to green.

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. The committee reviews the effectiveness of the audit process including verifying compliance with statutory requirements and deadlines, communication with key senior management personnel, satisfactory planning processes, and confirmation that the provision of staff to carry out work for the Trust are those named and qualified.

Grant Thornton has not provided any non-audit services for the Trust in 2021-22.

Membership of the Audit Committee

The Audit Committee is comprised of three of the eight eligible Non-Executive Directors. The other main assurance committees of the Board are the Finance & Performance, People and Culture and Clinical Governance committees.

Financial Audit

The external auditors for the Trust are Grant Thornton. During the 2021-22 period, the Trust has incurred the following costs on external audit:

- Audit services: £85,885 (plus VAT)
- Other services: £12,000 (plus VAT)

As mentioned above, no other remuneration was paid to the auditor and the auditor was not involved in any other work for the Trust that may have compromised their independence.

The Trust has an internal audit function which was delivered under contract by PwC in 2021-22. The work programme is reviewed and approved by the Audit Committee. Senior representatives of PwC report to the audit committee and a working protocol is in place with Grant Thornton, the Trust's appointed auditor. The delivery of the contract with PwC is overseen by the Chief Finance Officer and the internal audit fee for 2021-22 was £95,000.

Revaluation of Property and Land

The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. The five-yearly revaluations are carried out by a professional qualified valuer in accordance with the Royal Institute Chartered of Surveyors (RICS) Appraisal and valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. The last full revaluation was carried out during 2019-20. Fair values are determined as follows:

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

Annual desktop valuations and annual impairment reviews are carried out in all other years where a full revaluation has not taken place.

Recognition of Income

Of the Trust's income, 89% is received from other NHS organisations, with the majority being receivable from NHS Bath and North East Somerset, Swindon and Wiltshire CCG. The Trust participates in the Department of Health and Social Care's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivables balances that arise from Whole Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA receivable and payable balances are appropriately recorded. The Trust's external auditors will review the outcome of the exercise and report their findings to the Audit Committee.

Directors' Responsibilities for Preparing the Annual Report and Accounts

The Directors are aware of their responsibilities for preparing the annual report and accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executive's Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This can be found in the Annual Accounts for Salisbury NHS Foundation Trust. In Summary, the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

NOMINATIONS COMMITTEE

The purpose of the Directors' Nominations Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors).

The Committee membership includes the Trust Chairman, as Chair and all Non-Executive Directors.

In 2021-22 Melanie Whitfield was appointed as Chief People Officer and started at the Trust on 6th September 2021.

FOUNDATION TRUST MEMBERSHIP

The membership of the Trust is made up of local people, patients and staff who have an interest in healthcare and their local hospital. Public members have to be aged 16 and over.

The staff membership has five classes to reflect the following occupational areas:

- Medical and Dental
- Nurses and Midwives
- Scientific, Therapeutic and Technical
- Administrative, Facilities and Managerial
- Voluntary

Public members (including volunteers) can only be a member of one constituency. Staff members can only be a member of the staff constituency. Eligibility requirements for joining different membership constituencies, including the boundaries for public membership, are shown in the Trust's Constitution, which is available on the Trust's website.

During the year the Trust sought to broadly maintain membership numbers. At 31st March 2021 the membership for Salisbury NHS Foundation Trust is as follows:

Public Constituency	Number
Salisbury City	2,524
South Wiltshire Rural	4,664
Kennet	1,214
North Dorset	1,413
East Dorset	582
New Forest	1,033
Rest of England	1,115
Staff Constituency	1,997
Total	**14,567**

Ownership of the Trust's membership strategy rests with the Governors with support from the Trust. A key objective of the strategy is to maintain an engaged membership of Salisbury NHS Foundation Trust which broadly represents the population it serves, taking account of age, ethnicity and diversity in the population of the catchment area.

The Trust's Membership Strategy was revised and approved by the Council of Governors in November 2020, which identified several areas of development that are already in-progress. Currently, the Trust uses its public meetings to highlight the benefits of membership and encourage recruitment. Additionally, members' newsletters are used to encourage existing members to promote membership amongst friends and acquaintances.

During 2021-22 the Trust hoped to widen the scope of the Trust's membership recruitment. However, due to the ongoing impact of COVID-19, reduced public gatherings and footfall in the hospital, recruitment has been challenging. The Memberships and Communications

Committee led by Governors is focusing on different methods of recruitment, including using the Trust's social media platforms. Furthermore, it is hoped that a focused membership page on the Trust's website and the re-introduction of constituency meetings in 2022-23 and other events like 'Medicine for Members' will attract a more representative membership and is a focus for 2022-23.

This year, a digital summary of the Annual Review was distributed to enable a wider reach. This document was published on the Trust website, promoted to our members and provided a succinct and informative summary of the year's events, including our ambitions for the year ahead.

During 2021 Governors continued to join their Committee's and groups virtually due to the COVID-19 pandemic. Towards the end of 2021, due to changing restrictions, Governors started meeting in hybrid settings with some attending in person whilst allowing others to attend meetings virtually. They have been focusing on their statutory duties and have also been involved in the development of the Trust's Annual Plan and Quality Account. A number of other public initiatives that Governors have previously been involved in were put on hold during this time. However, Governors have still been able to participate virtually on Trust-led working groups, such as Food and Nutrition and the Transport Strategy. It is hoped that, with the prevalence of COVID-19 declining, Governors will once again be provided with the other opportunities to be involved in or sample the 'patient experience'.

A dedicated section on the Trust's website and intranet provides details of each Governor, their interests and a means for members to communicate with them. There are also members' newsletters for staff and people in the public constituencies.

Table 1 below sets out the Code of Governance Provisions to be included in the Annual Report and their location.

Table 1: Code of Governance Provisions included in the Annual Report and their location

Relating to	***Code of Governance* reference**	**Summary of requirement**	**Annual Report Location**
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of Governors. This statement should also describe how any disagreements between the council of Governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Code of Governance 'Board of Directors'/ 'Council of Governors'

Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.24 as part of the directors' report.	Code of Governance 'Board of Directors'/ Accountability Report 'Directors Report'
Council of Governors	A.5.3	The annual report should identify the members of the council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead Governor.	Code of Governance 'Council of Governors'
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of Governors and individual attendance by Governors and directors.	Code of Governance 'Council of Governors'/ 'Board of
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Code of Governance 'Board of Directors'
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Code of Governance 'Board of Directors'
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Code of governance 'Board of Directors'/ Remuneration Report

Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Code of Governance 'Nominations Committee'
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A – external consultancy agency used
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of Governors as they arise and included in the next annual report.	Code of Governance 'Board of Directors'
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed Governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Code of Governance 'Council of Governors'

Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a Governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trusts or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Code of Governance 'Council of Governors'. No issues identified in the reporting year.
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Code of Governance 'Board of Directors'
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Code of Governance 'Board of Directors' No commissioned external reviews.
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.97.	See Annual Accounts and Annual Report. 'Directors Responsibilities for preparing the Accounts, the Independent Auditor's Report to the Governors and the Annual Governance Statement'

Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Code of Governance 'Financial Audit'
Audit Committee/ Council of Governors	C.3.5	If the council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of Governors has taken a different position.	No issues identified in the reporting year.
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed. • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Code of Governance 'Audit Committee'

Board/ Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Nil to report for the reporting year
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of Governors and members about the NHS foundation trust, for example through attendance at meetings of the council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Code of Governance 'Foundation Trust Membership' and 'Council of Governors'
Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Code of Governance 'Foundation Trust Membership'
Membership	E.1.4	Contact procedures for members who wish to communicate with Governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Code of Governance 'Foundation Trust Membership'
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership. • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Code of Governance 'Foundation Trust Membership'

Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by Governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of Governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.24 as directors' report requirement.	Accountability Report 'Board of Directors'

NHS OVERSIGHT FRAMEWORK

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. The Trust is currently segmented at 3 and was subject to enforcement undertakings due to the suspected breach of licence from January 2018 for the deteriorating financial position.

This segmentation information is the Trust's position on 31 March 2022. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Statement of the Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities, as the accounting officer of Salisbury NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are

answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Salisbury 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 Salisbury NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

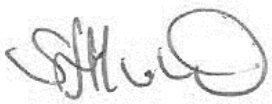
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

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



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

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 Salisbury 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 Salisbury NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As the Chief Executive, I have overall responsibility for risk management within the Trust. The day-to-day oversight has been delegated to an executive lead for risk (the Chief Nursing Officer), who is responsible for reporting to the Trust Board on the development and progress of risk management and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

The Trust's Senior Leadership Team Committee, which I chair, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation. The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit Committee and Board supports the effectiveness of the Trust's systems of internal control.

The Board brings together the corporate, financial, workforce, clinical and operational risk agendas. The Board Assurance Framework (BAF) ensures that there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified. There is a process of escalation to Executive Directors through Executive Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

The Trust has a Risk Management Strategy in place which provides the framework for managing risk across all levels of the organisation. The strategy provides a clear, systematic

approach to the management of risks to ensure that risk assessment is an integral part of all clinical, managerial, and financial processes. Risk management is supported in the following ways: a central risk management team and a Director of Integrated Governance in place. Divisional Governance committees were introduced in 2019 to further strengthen the governance arrangements. The Trust's capacity to handle risk was evidenced through the Care Quality Commission (CQC) Inspection report 1 March 2019 that "The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected". The CQC rated the Trust Good for the Well-led domain which recognised the strong culture of good governance.

The Head of Risk Management supports the Executive Lead and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments and teams directly. The National Patient Safety Strategy that was published in 2019 has revised several of the original strategy timeframes following the disruption arising from the pandemic. New timescales are being initiated to reflect this, which in turn will inform more specific training going forward in line with the Patient Safety Incident Framework that will be replacing the current Serious Incident Framework.

Board members received development sessions in risk management, risk appetite and risk tolerance which includes an overview of the risk systems. The Board is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective.

The Risk and Control Framework

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances will always involve an inherent degree of risk. Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve.

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality-of-care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives. The strategy is updated every three years to ensure that it continues to reflect best practice in risk management methodologies and sets out the key responsibilities and accountabilities and includes a review of the Trust's risk appetite. The Risk Management Strategy sets out the strategic goals towards which the Trust is working with regard to risk management and provides a framework that sets out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk management requires participation, commitment, and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. These risks are documented on risk registers throughout the organisation.

These risks are then analysed to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found, whilst higher scoring risks are managed at progressively higher levels within the organisation.

Risk control measures are identified and implemented to reduce the potential for harm. The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation.

Each Division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments or the division are recorded within the Divisional risk register whilst individual departments/specialties maintain departmental risk registers containing risk to the achievement of individual department's objectives. The escalation process between these risk registers is monitored monthly via the divisional management team with oversight through the Divisional Governance Committees. Deep dives of the Divisional risk registers are undertaken in conjunction with the Chief Nursing Officer and Chief Medical Officer to provide additional scrutiny and oversight. Escalation of Divisional risks to the Corporate Risk Register is via the Executive Performance Reviews.

Risks are identified through third-party inspections, recommendations, comments, and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (including clinical and internal), information from the Patient Advice and Liaison Service (PALS), benchmarking and claims and national survey results. External stakeholders include the Care Quality Commission, NHS England/Improvement, the Health and Safety Executive, NHS Resolution (previously the NHS Litigation Authority), the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

The Audit Committee oversees and monitors the performance of the risk management system, with internal and external auditors working closely with this committee. The internal auditors use a risk-based model to undertake reviews and provide assurances on the systems of internal control operating within the Trust. The results of internal audit reviews are reported to the Audit Committee which oversees that weaknesses in the system are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal Audit recommendations are tracked via reports to the Audit Committee. The Counter Fraud programme is also monitored by the Audit Committee.

The Clinical Effectiveness Steering Group, reporting to the Clinical Management Board consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

The Trust's Board Assurance Framework (BAF) details the principle strategic risks to the achievement of the Trust's corporate objectives. This is received by the Board on a quarterly basis together with the Corporate Risk Register and a report detailing progress against delivery of the objectives. The Finance and Performance Committee, People and Culture Committee and Clinical Governance Committee have oversight of the BAF and Corporate Risk Register on a quarterly basis where the risk profile is reviewed and discussed in detail. The work plan of the Board Committees is linked so that the Board is assured that there is an aligned independent and executive focus on strategic risk and assurance. Referral of issues between committees ensures a respective understanding of risk and assurance concerns.

The management of the coronavirus pandemic has meant the Trust has seen the overall risk profile for 2021-22 dominated with risks associated with the impact of COVID-19, in particular the National requirements for staff testing and isolation. Key risks include:

- Impact on patients, staff and service delivery as a result of COVID-19.

- Staffing availability impacting on service delivery and health and well-being of staff.
- Impact of delayed discharge from hospital including management of an increasing number of No Criteria to Reside patients
- Information technology, clinical systems and technical infrastructure.
- Critical plant and building infrastructure within limited capital funding.

The Trust established controls or implemented actions to manage these risks as summarised below:

- Incident management structure in response to the National Level 4 incident
- System response to address operational and capacity pressures.
- Implementation of National Infection, Prevention and Control measures including vaccination programme.
- Incentive schemes to minimise staffing shortfalls.
- Creative use of volunteers to support ward staff e.g., ward buddies
- Occupational Health and wellbeing support for staff including clinical psychology support
- Implementation of the digital strategy and continued focus development of the infrastructure and controls.
- Robust capital prioritisation processes to ensure resources are deployed effectively.

Major risks 2022/23

As we enter 2022/2023, the Trust is focused on enacting recovery plans following de-escalation from the National Level 4 incident. The focus will be on the delivery of NHS England Operational Planning Priorities 2022/23:

- Supporting the health and wellbeing of staff
- Accelerate the restoration of elective and cancer care and reduce waiting times
- Working with partners to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.
- Ability to achieve financial sustainability

Key risks include:

- Pace of recovery
- Impact of COVID-19 on the health and wellbeing of staff
- Balancing business as usual with recovery plans
- Financial constraints

Within this context, we acknowledge the great opportunity in our closer integration with local partners and will continue to prioritise this and the benefits it provides in the delivery of our wider strategic objectives. We will review these to ensure the Trust is best placed to deliver the NHS and Bath, Swindon and Wiltshire Integrated Care System (BSW ICS) Long Term Plans and we will embrace the priorities of the NHS People Plan with the vision to make the Trust 'the Best Place to Work.'

Our underlying financial position remains a significant challenge. The financial regime for 2021-22 was very different due to the funding arrangements in response to COVID-19, which meant the Trust reported a breakeven position. However, 2022-23 signals a move back to a funding settlement in line with the long-term plan, which would return the Trust to a deficit. As a healthcare system, financial sustainability is also a priority; BSW ICS is

developing plans to address the system deficit where Salisbury will play a significant role. The changes in pathways and services in response to COVID-19 present both a challenge and opportunity to deliver and redesign services ultimately at a lower cost.

The future sustainability of the Trust will also be dependent on our ability to progress the delivery of our Estates masterplan. The operational resilience of areas such as Day Surgery and the Maternity Unit remain regular concerns, alongside managing the risk of high capital expenditure on reactive maintenance in the ageing parts of our Estate.

Quality Governance

The Trust is committed to and expects to provide excellent healthcare services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Management Team have a critical role in leading a culture which promotes the delivery of high-quality services. All efforts are focussed on creating an environment for change and continuous improvement.

The Trust has a robust Quality Governance reporting structure in place through an established Clinical Governance Committee. The Quality Governance arrangements are described in both the Integrated Governance Framework and Accountability Framework. These frameworks are a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Governance Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Quality Account published alongside this Annual Report and Accounts describe quality improvements and quality governance in more detail.

The Chief Executive is the Accountable Officer for quality governance. Each Director is a lead for a number of Board objectives. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.

Improving Together is a new Board approved initiative introduced during 2021, focused on continuous improvement and supported by the development of a coaching culture. Evidence shows that Trusts that have a continuous improvement approach provide better patient care, and colleagues working in these Trusts have greater job satisfaction. Ultimately Improving Together is all about improving the quality-of-care provision, by improving the way that we work and our systems and processes. It covers the following main areas:

- Alignment of priorities – from board to ward focusing on the same priorities, helping achievement of our goals more efficiently.
- Empowerment – Every member of SFT will develop and improve their skills in order to be able to identify and adopt and know that they are empowered to make process changes at a local level.
- Developing our culture – by empowering every member of staff to have a voice and supporting our leaders to adopt compassionate leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to understand and continually improve the services we offer
- Stopping doing things that do not add value

With the simple goal of delivering an outstanding experience for patients, their families and the people who work with us - and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The quality impact assessment process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2021-22 and the quality priorities selected for 2022-23. Progress of the priorities is monitored via the Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators. There is no requirement currently for Foundation Trusts to produce a separate quality report.

The Integrated Performance Report, which comprises of detailed reports on quality, operational performance, finance and workforce, has been received by the Board monthly and is considered in detail.

Dedicated data quality teams pro-actively manage data quality within core systems and provide appropriate training and guidance to service colleagues across the Trust. Independent assurance regarding data quality is provided using SUS dashboards, internal audits which review internal processes and the annual Data Security and Protection Toolkit self-assessment review by internal audit.

Risks to data quality and data security are continually assessed and added to the Trust's risk register and scored appropriately. These are all managed following internal governance processes, overseen at the Information Standards Group and assured through the Information Governance Steering Group. Escalation of issue goes to the Trust Management Committee and the Trust's Finance and Performance Committee where appropriate.

The Trust has a Freedom to Speak Up Guardian (FTSUG) to act in an independent and impartial capacity to support staff who raise concerns and whom has access to the Chief Executive and the Trust's nominated Non-Executive Director for 'Freedom to Speak Up'.

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies underpins the Risk Management Strategy and are available to staff on the intranet. Training and awareness sessions are available to staff across the Trust and via mandatory training. Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and Divisions also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the Coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken. The Trust submits patient safety incident data to the National Reporting Learning System. The Trust works in partnership with our commissioners to share learning and improvement actions. The Trust reviews all incidents graded moderate or severe together with compliance with Duty of Candour on a weekly basis through the Patient Safety Summit.

Salisbury NHS Foundation Trust has taken the following actions to improve the quality of its services and reduce the rate of patient safety incidents that have resulted in severe harm or death by:

- Determining the Trust's quality priorities and monitoring delivery against key objectives. This is reported quarterly to Trust Board and Board Committees together with the Board Assurance Framework.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Service level deep dive reviews through the Clinical Governance Committee receiving assurance on the quality-of-service provision and areas for improvement.
- Reviewing a proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group.
- Review of all COVID related deaths for wave 1 and 2.
- Weekly review of all reported incidents graded moderate and above to agree the appropriate level of investigation.
- Monitoring the identification and timely investigation of incidents and delivery of actions resulting in serious harm through a weekly patient safety summit meeting and executive exit process.
- Ensuring that learning from incidents is maximised and disseminated via Clinical Risk Group, Clinical Management Board and Divisional Governance Committees.
- Weekly oversight of duty of candour to ensure we are transparent with people that use our services if aspects of their care needs.
- Deep dive of Divisional Risk registers with the Chief Nursing and Chief Medical Officers to support risk management.
- Refreshed Clinical and Divisional governance structure and lines of communication to strengthen ward to Board information flows.

The Trust's patient and public involvement and consultation process ensures compliance with relevant legislation, and is described in the Patient and Public Involvement Strategy. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives, where appropriate. The Trust completes an annual patient and public engagement report, which is reported to Trust Board.

When developing plans for significant service changes, the Trust has to show how stakeholders might be affected and to ensure they are consulted and how their views will be taken into consideration in developing proposals for change. Equality impact assessments are part of this process. The Trust works closely with patients and public stakeholders to ensure that the impact of any changes on patients is minimised.

The Trust works with Healthwatch Wiltshire through regular liaison and communication to identify opportunities for the involvement of Healthwatch in Trust activities. Focus groups with people who had completed their complaints journey with the Trust is scheduled this year, in partnership with HealthWatch as an independent facilitator. This is forming part of our internal complaints process review as we continue to align ourselves to the new Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards Framework.

The Trust's Council of Governors engage with the quality agenda through its relevant working groups and a nominated Governor attends the Clinical Governance Committee. There is nominated Governor representation on all Board and Board Committees.

The Maternity Voices Partnership (MVP) is a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families. Working together to share ideas and identify solutions for the design and improvement of maternity care. The function of the MVP is more than simply to listen; it is a way of discussing and overcoming challenges. The group aims to support the development and improvement of maternity care for everyone, regardless of who they are or where they live, so that everyone has access to the same quality of care.
The Trust has assessed compliance with the NHS provider condition 4. The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

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

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via the Finance and Performance Committee. Finance and Performance Committee reviewed the assessment in detail at its meeting on26 April 2022 and confirmed that no material risks had been identified.

The Trust implements key approaches and mechanisms to ensure that the short, medium and long-term workforce strategies and staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective. These include the following:

- Operating a resourcing programme with a strong focus on hard to recruit posts, including registered nurses, consultants, and other professionals.
- Measuring and continually working on reducing our use of bank and agency
- Optimise the use of the Electronic Staff Record (ESR) and the ongoing roll-out of eRoster.
- Plans to implement fuller use of the e-OPAS (Occupational Health) system portal.
- Working more collaboratively between our client areas and workforce informatics through our Organisation Development and People business partners to optimise workforce planning and deployment of staff to ensure safe staffing levels.
- Commissioned an external end-to-end review of our resourcing practices.

Assurance on the above is provided by:

1. Regular board updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. These include care hours per patient day.
2. Formal reports on nurse staffing to Board and Board Committees.
3. Integrated performance reports showing safe staffing levels and bank/agency usage.
4. Executive Performance Review meetings consider staffing issues with escalation of any concerns

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust was last subject to a full CQC inspection, including Use of Resources and Well-Led, in November and December 2018, receiving an improved rating of 'Good'.

CQC unannounced inspection of core services

On 31 March 2021, the Trust had an unannounced inspection of the Spinal and Maternity Services, with the report published in May 2021. The overall rating for the Spinal Services was unchanged from 'Requires Improvement'. The Maternity Services rating changed from 'Good' to 'Requires Improvement' and a Section 29A Notice was served, focused on:

- leadership and culture
- governance and risk management

The Trust worked with the CQC during 2021 to provide evidence of its compliance against the notice. The CQC carried out a short notice, announced inspection in October 2021, focused on the parts of the service that did not meet legal requirements at the last Maternity Services inspection. In the report published December 2021, the CQC judged the requirements of the warning notice had been met, although identified further work was needed to embed the changes and ensure improvements were sustained. The rating of 'Requires Improvement' remained the same.

The teams in both the Spinal and Maternity Services have been committed to making improvements as identified in their respective 'must do' and 'should do' actions following the May 2021 report. In addition, the Maternity Services team have engaged in the NHSE/I Maternity Safety Support Programme. Progress of all work has been overseen by the Divisional Management Teams and reported to the Clinical Governance Committee.
Our engagement with the CQC has continued through scheduled meetings via Teams. These include bi-monthly meetings with designated Executives and the Head of Compliance and bi-monthly meetings with the Head of Risk Management and Head of Compliance to monitor our Clinical Reviews and Serious Incident Investigations. Transitional Monitoring Approach with core services was put on hold in the past year. Learning from our engagement processes and the most recent inspection has been identified and was shared as part of a CQC preparedness report to the Trust Management Committee in January 2022. The Trust's internal peer review programme has been intermittent due the pandemic but there is a plan to review and reintroduce this in a new format.

There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS Improvement and the corporate governance statement.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past 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, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS

programme. 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 Trust regularly reviews the economy, efficiency, and effectiveness of the use of resources through benchmarking, reference costs, regular meetings between directorates and the Executive Directors, and assessing performance against plans. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Audit Committee gives specific consideration to matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's "local counter fraud specialist" and internal audit service.

The Trust continues to actively pursue the opportunities as identified through the model hospital, GIRFT and the right care data, increasingly the Trust is working with system partners to identify how working collaboratively can reduce the cost base. This is reviewed at the Acute Alliance and BSW Directors of Finance meetings.

Arrangements to operate efficiently, economically and effectively are formally reviewed by external audit. Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and through the Trust Transformation programme. This will continue to be taken forward as a key part of financial governance and controls.

The Trust's finances are reviewed by the Finance and Performance Committee at its monthly meetings. Monthly performance, workforce and quality information is scrutinised each month by the Board through the Integrated Performance Report.

Information Governance

The Trust acknowledges the importance patients and staff place on the security, confidentiality, integrity and availability of corporate and personal information. The Trust is committed to proactively managing all its resources through clear leadership and accountability, which is underpinned by the Trusts values and behaviours through awareness and education.

The Chief Medical Officer, Caldicott Guardian and Chief Digital Officer, Senior Information Risk Owner (SIRO), who oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively manages the security and confidentiality of personal information and systems.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) year now runs from the 1st July to the 30th of June. Since July 2021, the Trust reported four security incidents to the Information Commissioners Office and NHS Digital. The incidents related to an undelivered letter, a system issue which resulted in paper documents displaying incorrect information, the publication of information on the Trust website and a system failure. The Information Commissioners Office considered the information provided by the Trust and decided in all instances that no further action was necessary.

Work continued to ensure that a comprehensive and robust evidence-based assurance programme exists to reinforce the work of the DSPT to demonstrate that the organisation

can be trusted to maintain the confidentiality and security of personal information, in an open and transparent manner thereby increasing public confidence.

In line with the NHS Digital guidance, the Trust confirms it will submit the 2021/2022 Data Security and Protection Toolkit assessment on or before the 30th June 2022.

Data Quality and Governance

There is corporate leadership for data quality with the Chief Digital Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees.

The Trust has an up-to-date Data Quality Policy that is reviewed annually and was last refreshed during 2021-22. The policy outlines a strengthened approach to data quality, focussing on the following key areas:

- Raising awareness of the importance of high-quality data.
- Assisting all staff in understanding their role and responsibility in maintaining high quality data.
- Assisting staff in getting data quality 'Right First Time' through supporting staff in putting in working practices and processes which enable high data quality at the first time of input.
- Minimising risks arising from poor data quality.
- Monitoring the quality of data used by the Trust and where needed, to highlight where data is inaccurate and needs to be checked and improved.
- Establishing a framework within which data quality issues can be raised and actioned.

The Trust's Information Standards Group, chaired by the Head of Information, oversees implementation of the Data Quality Policy. This includes the routine assessment of data quality maturity for all metrics used in core external returns and internal monitoring by Trust committees. Where required improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process.

During 2021-22 the Trust has continued its development of a new business intelligence platform underpinned by a new data warehouse. 2021-22 has seen the introduction of Power BI, a modern and intuitive self-service business intelligence platform which will help inform decision making and analysis across the Trust. In addition, a new system to provide notification of data quality issues direct to staff who have entered data has now been rolled out to help improve the response to any data quality issues identified.

The Trust is an active participant in a system wide Business Intelligence Group which seeks to standardise the approach to reporting, ensuring best practice methodologies are followed and build a shared pool of expert resource across the system in the use of tools such as Power BI and demand and capacity. During 2021-22 a system wide Business Intelligence strategy has been developed, part of which sets out a direction towards convergence on cloud-based technology for our underpinning business intelligence infrastructure in the coming years. This will enable improved collaborative working, reduce duplication of reporting and increase the ability to support detailed interpretation and predictive analysis on areas such as population health management.

All data used for quality reporting is derived from operational clinical systems which are well known and reviewed by the staff using them. With regular analysis and use of data coming

from the system comes a degree of assurance about the accuracy of reporting. The weekly division-led Delivery Performance Group regularly reviews performance data, including patient level information especially on elective waiting times.

Waiting list data is updated daily and this feeds into a suite of reports that allow various operational teams to monitor the size and performance of the waiting list. There is a dedicated team that review and validate the waiting list daily, ensuring that records are accurate and up to date as far as possible, and there is close review of the longest waiting patients by the divisional teams, providing the Trust with the greatest possible opportunity to meet waiting list targets and be assured of data accuracy. All key performance related external submissions are reviewed and signed off at Executive level before being submitted. Waiting list size data is included as part of the integrated performance report which is reviewed monthly at Trust Board. This is supported by the use of Statistical Process Control (SPC) charts to allow close monitoring of specialty level performance over time, highlighting any deteriorating or improving trends or outliers.

Data Quality features within the roles and responsibilities of key staff members who are inputting data into systems, and those who review and assess data accuracy.

One of the Data Quality Policy's activities is to improve the education of staff in the role they play in meeting the high standards of data quality the Trust aspires to; and data quality champions have been introduced across the Trust during 2021-22. The work the data quality champions undertake will be built upon during 2022-23.

A Data Quality Improvement Group reviews key data quality issues and oversees data quality improvement across the following headings:

- Training – design and delivery of targeted training to support high quality data.
- Awareness – using existing forums (e.g. ward clerk meetings) to communicate data quality issues.
- Process change – use of structured Standard Operating Procedures to meet operational and reporting requirements.
- Information systems – regular checks to ensure data being used is compliant and accurate.
- Data quality monitoring – reviewing nationally and locally developed data quality reports, use of spot checks (e.g., monthly review of waiting list data) and software such as coding software to check data quality.
    - Data Quality Standards - agree and approve different DQ standards within the Trust e.g., Identifying an Admitting Consultant. This is created as a document (which is reviewed annually) and published to the Intranet.

The Improvement Group also feeds up any persistent DQ issues to the Data Quality Champion Group which meets bi-monthly, this is an opportunity to reflect current performance to operational staff.

The Trust receives both internal audit and external audit reviews to check processes and compliance with regards to data quality.

Review of Effectiveness

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

maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly which covers the key national priority and regulatory indicators and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supported by a number of more granular reports reviewed by Board committees and regular Executive performance review meetings with the Divisions.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. There is a full programme of clinical audit in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2021-22 remains unchanged from the opinion given for the year 2020-21. The opinion on the adequacy and effectiveness of governance, risk management and control is that this is "Generally satisfactory with some improvement noted". This demonstrates the continued commitment to robust governance including the improvement in timely closure of recommendations.

During 2021-22, Internal Audit conducted eight internal audits. The finalised reports have resulted in the identification of four high, 24 medium and 11 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness.

A summary of the four high risk findings were taken into account in forming the opinion as to the adequacy and effectiveness of the Trust's framework of governance, risk management and control is set out below:

- Capacity Management and Discharge: Inconsistency between decision recorded on the Criteria to Reside checklists and patient notes. Action deadline is 30/06/2022.
- Key Financial Systems: Expenditure transactions and payments were not being approved in line with the Trust's Standing Financial Instructions (SFIs) and bank mandate. Since the review, the audit sponsor has confirmed that action has been taken to correct the authorisation levels within the ledger and the payment authorisation controls.
- IT Disaster Recovery (ITDR): Absence of robust and monitored ITDR action plans. Action deadline is 30/06/2022.
- Workforce Planning: Lack of a strategic workforce plan. Action deadline is 31/03/2023.

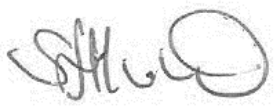
A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, with the results of audit work reported to the Audit Committee. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. Where Internal Audit issued a limited assurance report, the relevant audit executive lead attended the Audit Committee to discuss the report and actions taken. A process was implemented that any extension to action deadlines requires collective executive approval and is presented by the executive Sponsor for the audit.

The Trust is focused on action plans to address the identified risks reported in 2021-22 which have been approved by the Trust Audit Committee. The Trust implemented an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. The success of this is demonstrated by the closure of 58 of the 61 actions generated from the previous year findings.

Conclusion

The Trust Board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. Any serious incidents or incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action. This is to ensure that patients, service users and staff and stakeholders can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

Overall, there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. The risks the Trust has faced, together with the actions taken to address each of these areas are detailed within this annual governance statement. My review confirms that Salisbury NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts and no significant internal control issues have been identified.



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2022

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2022 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:

Stacey Hunter - Chief Executive

Date: 16 June 2022

Independent auditor's report to the Council of Governors of Salisbury NHS Foundation Trust

Report on the Audit of the Financial Statements

Qualified opinion on financial statements

We have audited the financial statements of Salisbury NHS Foundation Trust (the 'Trust') and its subsidiaries, associates and joint ventures (the 'group') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, the Consolidated Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, except for the possible effects on the corresponding figures of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Trust Statement of Financial Position of £5.892 million and the Group Statement of Financial Position of £7.514 million. Consequently, we were unable to determine whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Our audit opinion on the financial statements for the year ended 31 March 2021 was modified accordingly. Our opinion on the current year's financial statements is also modified because of the possible effect of this matter on the comparability of the current year's figures and the corresponding figures.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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 Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

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 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.

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.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

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

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the Trust inventory quantities of £5.892 million and the group inventory quantities of £7.514 million held as at 31 March 2020, and whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2021/22 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider 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 this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2021/22, 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 Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the group and Trust's financial reporting process.

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

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

•We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).

•We enquired of management and the Audit Committee, concerning the group and Trust's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

•We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

•We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the risk of inappropriate revenue and expendiuture recognition. We determined that the principal risks were in relation to:

- High risk and unusual journals, management estimates including land buildings and dwellings valuations, private finance initiative liability (PFI) and depreciation and transactions outside the course of business;
- fraudulent recognition of revenue:we rebutted income received under block contract arrangements, where income received could be verified to agreements with third parties and where income received was immaterial. For variable income streams, we did not consider that we were able to rebut the presumption of fraud;

•Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- sample testing of revenue transactions where income was not received under block contract arrangements;
- due to the implementation of a new financial ledger, we undertook testing on journal entries made in both the old and new systems. Our journal entry testing, was focussed on high risk and unusual journals including those posted by staff with elevated access privileges, journals posted by senior officers, journals with related parties,material post year end manual journals, unusual account combinations from revenue and expenditure, journals posted by unauthorised users; journals with blank descriptions and journals posted by officers who had left the organisation.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land, buildings and dwellings valuations and the PFI liability;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

•These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we

•The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land, buildings and dwellings valuations and the PFI liability.

•Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the group and Trust operates
- understanding of the legal and regulatory requirements specific to the group and Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

•In assessing the potential risks of material misstatement, we obtained an understanding of:

- The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in

Report on other legal and regulatory requirements – Certificate

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

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Signature:

Barrie Morris

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
Date: 20 June 2022

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2022

		Group		Trust	
		2021/22	2020/21	**2021/22**	2020/21
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**278,480**	243,623	**278,480**	243,623
Other operating revenue	5	**39,252**	51,672	**26,887**	40,274
Operating expenses	7	**(311,781)**	(289,341)	**(299,976)**	(277,623)
OPERATING SURPLUS		**5,951**	5,954	**5,391**	6,274
FINANCE COSTS					
Finance income	12	**309**	287	**233**	170
Finance expense	13	**(2,002)**	(2,122)	**(2,002)**	(2,122)
PDC Dividends payable		**(4,073)**	(3,322)	**(4,073)**	(3,322)
NET FINANCE COSTS		**(5,766)**	(5,157)	**(5,842)**	(5,274)
Losses on disposal of assets	17	**(249)**	(156)	**(249)**	(156)
Share of profit of associates/ joint ventures	33	**65**	93	**65**	93
Movement in fair value of other investments	18	**438**	1,417	**-**	-
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**439**	2,151	**(635)**	937
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations		**10,261**	4,601	**10,042**	4,549
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**10,700**	6,752	**9,407**	5,486
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**27**	3	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**412**	2,148	**(635)**	937
TOTAL		**439**	2,151	**(635)**	937
(b) Total comprehensive income/ (expense) for the year attributable to:					
(i) Minority interest, and		**27**	3	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**10,673**	6,749	**9,407**	5,486
TOTAL		**10,700**	6,752	**9,407**	5,486

The notes on pages 5 to 52 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2022

	Note	Group		Trust	
		31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
		£000	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	16	**9,896**	10,952	**9,896**	10,952
Property, plant and equipment	17	**162,419**	149,210	**158,532**	146,956
Investments in subsidiaries	32	**-**	-	**-**	5
Investments in joint ventures	33	**246**	181	**246**	181
Investments	18	**8,225**	7,893	**-**	-
Other financial assets	19	**2,497**	2,395	**4,006**	4,551
Receivables	21	**656**	762	**656**	762
Total non-current assets		**183,939**	171,393	**173,336**	163,407
CURRENT ASSETS					
Inventories	20	**7,939**	7,634	**6,311**	6,050
Receivables	21	**14,211**	12,077	**13,103**	11,783
Investments	18	**337**	113	**-**	-
Other financial assets	19	**-**	-	**1,940**	1,027
Cash and cash equivalents	22	**39,306**	31,169	**30,819**	22,309
Total current assets		**61,793**	50,993	**52,173**	41,169
Total assets		**245,732**	222,386	**225,509**	204,576
CURRENT LIABILITIES					
Trade and other payables	23	**(46,071)**	(36,727)	**(44,755)**	(35,364)
Borrowings	24	**(1,714)**	(1,608)	**(1,546)**	(1,608)
Provisions	25	**(1,234)**	(971)	**(1,234)**	(971)
TOTAL CURRENT LIABILITIES		**(49,019)**	(39,306)	**(47,535)**	(37,943)
TOTAL ASSETS LESS CURRENT LIABILITIES		**196,713**	183,080	**177,974**	166,633
NON-CURRENT LIABILITIES					
Borrowings	24	**(18,145)**	(18,680)	**(17,146)**	(18,680)
Provisions	25	**(895)**	(1,256)	**(895)**	(1,256)
TOTAL NON CURRENT LIABILITIES		**(19,040)**	(19,936)	**(18,041)**	(19,936)
TOTAL ASSETS EMPLOYED		**177,673**	163,144	**159,933**	146,697
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		**80**	53	**-**	-
Public dividend capital	34	**94,826**	90,997	**94,826**	90,997
Revaluation reserve		**75,780**	65,738	**75,780**	65,738
Income and expenditure reserve		**(9,239)**	(8,896)	**(10,673)**	(10,038)
Charitable fund reserves	35	**16,226**	15,252	**-**	-
TOTAL TAXPAYERS EQUITY		**177,673**	163,144	**159,933**	146,697

The notes on pages 5 to 52 form an integral part of these financial statements.
The financial statements on pages 1 to 52 were approved by the Board on 16 June 2022 and signed on its behalf by:

Signed:

Stacey Hunter - Chief Executive

CONSOLIDATED STATEMENTS OF CHANGES IN TAXPAYERS EQUITY

	Trust				Subsidiary		Charitable Fund	Group
	Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Trust Reserves	Profit & Loss Reserves	Minority interest	Charitable Funds reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2020	58,650	(10,979)	61,193	108,864	1,200	50	13,931	124,045
Changes in taxpayers' equity for 2020/21								
Retained surplus/(deficit) for the year	-	937	-	937	(58)	3	1,269	2,151
Other recognised gains and losses	-	-	-	-	-	-	-	-
Impairment of property plant and equipment	-	4	(4)	-	-	-	-	-
Net gain/(loss) on revaluation of property plant and equipment	-	-	4,549	4,549	-	-	-	4,549
Transfers between reserves	-	-	-	-	-	-	-	-
Revaluations and impairments - charitable fund assets	-	-	-	-	-	-	52	52
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-	-
Public dividend capital received in year	32,419	-	-	32,419	-	-	-	32,419
Public dividend capital repaid in year	(72)	-	-	(72)	-	-	-	(72)
Balance at 31 March 2021	**90,997**	**(10,038)**	**65,738**	**146,697**	**1,142**	**53**	**15,252**	**163,144**
Changes in taxpayers' equity for 2021/22								
Retained surplus/(deficit) for the year	-	(635)	-	**(635)**	292	27	755	**439**
Other recognised gains and losses	-	-	-	**-**	-	-	-	**-**
Impairment of property plant and equipment	-	-	-	**-**	-	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	10,042	**10,042**	-	-	-	**10,042**
Transfers between reserves	-	-	-	**-**	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	**-**	-	-	219	**219**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	-	-	**-**	**-**
Other reserve movements	-			**-**	-	-	**-**	**-**
Public dividend capital received in year	4,112	-	-	**4,112**	-	-	**-**	**4,112**
Public dividend capital repaid in year	(283)	-	-	**(283)**	-	-	**-**	**(283)**
Balance at 31 March 2022	**94,826**	**(10,673)**	**75,780**	**159,933**	**1,434**	**80**	**16,226**	**177,673**

The notes on pages 5 to 52 form an integral part of these financial statements

CONSOLIDATED STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2022

	Note	Group 2022 £000	Group 2021 £000	Trust 2022 £000	Trust 2021 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus		**5,951**	5,954	**5,391**	6,274
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	7	**13,682**	12,370	**13,481**	12,084
Impairments	7	**474**	318	**474**	318
Non-cash donations credited to income		**(685)**	(1,253)	**(685)**	(1,253)
(Increase)/ decrease in trade and other receivables	21	**(2,036)**	3,311	**(1,229)**	1,910
(Increase)/ decrease in inventories	20	**(305)**	(120)	**(261)**	(158)
Increase/ (decrease) in trade and other payables	23	**4,608**	5,905	**4,665**	5,955
Increase/ (decrease) in provisions	25	**(96)**	775	**(96)**	775
NHS charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**(17)**	7	**-**	-
Net cash inflow from operating activities		**21,576**	27,267	**21,740**	25,905
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**32**	-	**115**	74
Purchase of financial assets		**-**	-	**-**	-
Payments to acquire property, plant and equipment	17	**(7,839)**	(12,309)	**(7,390)**	(12,269)
Receipts from sale of property, plant and equipment		**50**	57	**50**	57
Payments to acquire intangible assets	16	**(1,922)**	(4,379)	**(1,922)**	(4,379)
NHS charitable funds - net cash flows from investing activities		**57**	54	**-**	-
Net cash (outflow) from investing activities		**(9,622)**	(16,577)	**(9,147)**	(16,517)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	**4,112**	32,419	**4,112**	32,419
Public dividend capital repaid	34	**(283)**	(72)	**(283)**	(72)
Loans received		**-**	-	**40**	-
Loan to subsidiary		**-**	-	**(306)**	(500)
Loan to joint venture	19	**-**	-	**-**	-
Loan repayment received		**-**	-	**-**	-
Movement in loans from the Department of Health and Social Care		**(631)**	(21,713)	**(631)**	(21,713)
Capital element of finance lease rental payments		**(435)**	(434)	**(435)**	(434)
Capital element of Private Finance Initiative obligations	29	**(525)**	(479)	**(525)**	(479)
Interest paid		**(44)**	(190)	**(44)**	(190)
Interest element of finance lease rental payments		**(20)**	(24)	**(20)**	(24)
Interest element of Private Finance Initiative obligations	29	**(1,944)**	(1,939)	**(1,944)**	(1,939)
PDC dividend paid		**(4,047)**	(3,234)	**(4,047)**	(3,234)
Net cash inflow/ (outflow) from financing		**(3,817)**	4,334	**(4,083)**	3,834
Increase/ (decrease) in cash and cash equivalents		**8,137**	15,024	**8,510**	13,222
Cash and cash equivalents at the beginning of the financial year		**31,169**	16,145	**22,309**	9,087
Cash and cash equivalents at the end of the financial year	22	**39,306**	31,169	**30,819**	22,309

The notes on pages 5 to 52 form an integral part of these financial statements.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

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

1.1 Accounting convention

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

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.

After making enquiries, the directors have a reasonable expectation that the services provided by the 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.

1.3 Critical accounting estimates and judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts.

Critical accounting judgements employed in the year are outlined in note 36.

Critical accounting estimates made in the year are outlined in note 37.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Basis of Consolidation

1.4.1 NHS Charitable Fund

The Trust is the Corporate Trustee to Salisbury District Hospital 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 has the ability to affect those returns and other benefits through its power over the fund.

The consolidation is for reporting purposes only and does not affect the charity's legal and regulatory independence and day to day operations.

The charitable fund's statutory accounts are prepared to 31 March 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.

1.4.2 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to 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 capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the previous year together with draft figures for the current year.

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.

Unless otherwise stated the notes to the accounts refer to the Group and not the Trust. Where the Trust's balances are materially different, these are stated separately.

1.4.3 Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the Trust from the associate.

1.4.4 Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

Joint ventures are accounted for using the equity method.

1.4.5 Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement.

The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition

1.5.1 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.

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.

Revenue from NHS contracts

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

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

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

Education and training
Income for training and education is received from Health Education England. The Trust recognises the income when the conditions of the contract have been met.

1.5.2 Other forms of income

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

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

Income received by the Charity
Charitable incoming resources are recognised once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability.

Legacy income is accounted for within the charity as incoming resources, either upon receipt, or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made, or property transferred, and once all conditions attached to the legacy have been fulfilled.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Expenditure on employee benefits

1.6.1 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.

1.6.2 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.

National Employment Savings Trust (NEST)
Employees that are not entitled to enrol on the NHS Pension Scheme are auto-enrolled into the Government NEST defined contribution workplace pension scheme.

Under the terms of the NEST scheme employees retain the right to opt-out after having been auto-enrolled.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Subsidiary pension scheme
The subsidiary companies operate defined contribution schemes for employees who have contracts of employment directly with the companies. Employer's pension costs are charged to operating expenses as and when they become due.

These schemes comply with legislative requirements.

1.7 Expenditure on 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.8 Intangible assets

1.8.1 Recognition

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

Internally generated intangible assets

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

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

Software

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

1.8.2 Measurement

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

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost (DRC) and the value in use where the asset is income generating. The Trust uses historic cost less depreciation as an approximation of DRC. Revaluation 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.

Amortisation

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

Useful lives of intangible assets

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

Software 1 - 7 Years

1.9 Property, plant and equipment

1.9.1 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

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.

1.9.2 Measurement

Valuation

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

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

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

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

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

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

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

Property, plant and equipment which have 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.

Useful lives of property, plant and equipment
Items of property, plant and equipment are depreciated over their remaining useful lives, as follows:

Buildings (excluding dwellings)	5 - 70 years
Dwellings	8 - 59 years
Plant and Machinery	1 - 15 years
Transport equipment	3 - 10 years
Information Technology	1 - 10 years
Furniture and Fittings	5 - 15 years

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

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

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

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

1.9.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds, less costs associated with the sale, and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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.

1.9.4 Donated, government grant and other grant funded assets

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

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

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

1.9.5 Private Finance Initiative (PFI) transactions

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

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

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

Services received

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

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

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

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

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

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

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

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

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.10 Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

Investments in quoted stocks, shares, gilts and alternative investments are included in the Statement of Financial Position at mid-market price, ex-dividend.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and 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 opening market value (or value at purchase date if later).

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured on the First In, First Out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life (except for Towels and Scrub Suits which have a two year life), in determining an approximation of net realisable value.

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

1.13 Cash and cash equivalents

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

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

1.14 Financial assets and financial liabilities

1.14.1 Recognition

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

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

1.14.2 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14.3 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 and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.14.4 Impairment of financial assets

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

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

The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

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

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

1.14.5 De-recognition

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases

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

1.15.1 The Trust as lessee

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

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

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

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

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

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

1.15.2 The Trust as lessor

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

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

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.

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Provisions (Continued)

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2022:

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.3% in real terms (prior year: minus 0.95%)

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

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

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 entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

A Contingent liability is disclosed 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.

1.18 Public dividend capital

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

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

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Public dividend capital (continued)

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 in the PDC dividend policy issued 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.

1.19 Value Added Tax

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

1.20 Corporation Tax

The Trust does not have a corporation tax liability for the year 2021/22 (2020/21 £nil). Tax may be payable by the Trust on activities described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private Healthcare falls under this legislation and is not therefore taxable.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- Annual profits from the activity must exceed £50,000

The Trust's subsidiary companies have made a modest profit leading to a corporation tax liability of £37k (2020/21: £30k).

1.21 Climate change levy

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

1.22 Foreign exchange

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

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

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

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

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

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 31) to the accounts in accordance with the requirements of HM Treasury’s FReM.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.24 Losses and Special Payments

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

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

1.25 Gifts

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

1.26 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted (continued)

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	Group £'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	2,419
Additional lease obligations recognised for existing operating leases	(2,265)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**154**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,149)
Additional finance costs on lease liabilities	(28)
Lease rentals no longer charged to operating expenditure	1,040
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(137)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,818**

	Trust £'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	1,026
Additional lease obligations recognised for existing operating leases	(847)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**179**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(700)
Additional finance costs on lease liabilities	(28)
Lease rentals no longer charged to operating expenditure	583
Other impact on income / expenditure	
Estimated impact on surplus / deficit in 2022/23	**(145)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,818**

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

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise five key operating areas where costs are closely monitored during the year. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board review and make decisions on activity and performance of the Trust as a whole entity, not for its separate business activities. The activities of the subsidiary companies, Odstock Medical Limited and Salisbury Trading Limited, and of the charity, Salisbury District Hospital Charitable Fund, are not considered sufficiently material to require separate disclosure.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities

3.1 Revenue by Nature

	Group and Trust	
	2022	2021
	£000	£000
Block contract / system envelope income	**233,471**	207,419
High cost drugs income from commissioners	**20,952**	18,645
Other NHS clinical income	**2,882**	2,602
Total revenue at full tariff	**257,305**	228,666
Private patient revenue	**2,416**	1,759
Elective recovery fund	**3,440**	-
Additional pension contribution central funding*	**7,460**	7,073
Other clinical income	**7,859**	6,125
Total income from patient care activities	**278,480**	243,623

Other types of activity revenue above includes amounts due for specialist services (e.g. spinal, burns, genetics, cleft lip and palate), direct access, intensive care, community and hospice services.

*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.

3.2 Revenue by Source

	Group and Trust	
	2022	2021
	£000	£000
NHS England	**59,779**	53,483
Clinical commissioning groups	**206,667**	181,501
Department of Health and Social Care	**7**	42
Other NHS providers	**3,853**	2,787
NHS other	**553**	152
Local authorities	**1,553**	1,554
Non NHS:		
- Private patients	**2,416**	1,759
- Overseas patients (chargeable to patient)	**93**	107
- NHS Injury cost recovery scheme	**640**	725
- Other	**2,919**	1,513
	278,480	243,623

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 23.76% (2021: 22.43%) to reflect expected rates of collection. The doubtful debt provision is included in the allowance for impaired contract receivables included in note 21.3.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities (continued)

3.3 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:

	Group and Trust	
	2022	2021
	£000	£000
Income from services designated as commissioner requested services	**259,382**	227,289
Income from services not designated as commissioner requested services	**19,098**	16,334
	278,480	243,623

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

	Group and Trust	
	2022	2021
	£000	£000
Income recognised this year	**93**	107
Cash payments received in-year	**90**	113
Amounts added to provision for impairment of receivables	**-**	-
Amounts written off in-year	**2**	24

4. Private patient revenue

The Health & Social Care Act 2012 removed the restriction on the amount a Foundation Trust could earn from private patient income as a percentage of total income, provided a ceiling of 49% is not exceeded for non-NHS income.

Salisbury NHS Foundation Trust private patient income in 2021/22 (and 2020/21) was substantially below the revised level permitted.

NOTES TO THE ACCOUNTS

5. Other operating revenue

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Reimbursement and top up funding	**3,050**	15,644	**3,050**	15,644
Research and development	**916**	842	**916**	842
Education and training	**10,142**	9,022	**10,142**	9,022
Non-patient care services to other bodies	**3,980**	2,383	**3,980**	2,383
Received from DHSC group bodies for COVID response- donated assets	**-**	869	**-**	869
Received from NHS charities - donated assets	**-**	-	**685**	384
Contributions to expenditure - equipment donated from DHSC group bodies for COVID response below capitalisation threshold	**-**	2	**-**	2
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**883**	3,640	**883**	3,640
Salisbury Trading Limited	**9,593**	9,324	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**1,820**	1,228	**-**	-
Odstock Medical Limited	**2,151**	1,686	**-**	-
Accommodation	**1,259**	1,268	**1,259**	1,268
Administrative services provided to Sterile Supplies Limited	**229**	311	**229**	311
Car Parking	**198**	256	**198**	256
Catering	**500**	413	**500**	413
Payroll services provided to other organisations	**1,961**	1,676	**1,961**	1,676
Other	**2,570**	3,108	**3,084**	3,564
	39,252	51,672	**26,887**	40,274

Included within 'Other' revenue above are: Royalty Income £890k (2021: £nil), procurement framework income re: apprenticeships £433k (2021: £346k), Leisure Centre income £121k (2021: £10k), income from the rent and hire of rooms £166k (2021: £105k), Vat recoveries £nil (2021: £210k), Central funding in respect of annual leave and overtime £nil (2021: £1,129k), cancer transformation £432k (2021: £nil) and overseas recruitment £23k (2021: £133k).

6. Operating lease income

6.1 As lessor

The Trust has entered into short term commercial leases on buildings, which primarily relate to the rental of an area within the hospital main entrance to a high street retailer and properties rented to subsidiary companies

6.2 Receipts recognised as income

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**166**	177	**413**	425

6.3 Total future minimum lease income

	Group		Trust	
	2022	2021	**2022**	2021
Receivable:	**£000**	£000	**£000**	£000
Within 1 year	**93**	175	**257**	423
Between 1 and 5 years	**361**	408	**568**	893
After 5 years	**323**	462	**323**	511
Total	**777**	1,045	**1,148**	1,827

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**3,871**	3,469	**3,871**	3,469
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,097**	2,991	**3,097**	2,991
Staff and executive directors costs	**198,535**	183,346	**191,336**	176,803
Non-executive directors	**166**	168	**166**	168
Supplies and services – clinical (excluding drugs costs)	**25,943**	24,612	**25,127**	24,030
Supplies and services - general	**4,861**	5,897	**3,684**	4,392
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**25,213**	22,516	**25,213**	22,516
Inventories written down	**99**	64	**99**	64
Consultancy costs	**680**	2,016	**680**	2,016
Establishment	**3,065**	2,059	**3,065**	1,505
Premises	**16,838**	13,707	**15,649**	12,427
Transport	**1,660**	1,541	**1,056**	1,541
Depreciation on property, plant and equipment	**10,714**	10,090	**10,513**	9,815
Amortisation on intangible assets	**2,968**	2,280	**2,968**	2,280
Impairments net of (reversals)	**474**	318	**474**	318
Movement in credit loss allowance: contract receivables / contract assets	**15**	-	**15**	-
Provisions arising /(released) in year	**(43)**	79	**(43)**	79
Change in provisions discount rate(s)	**4**	6	**4**	6
Operating lease expenditure (net)	**94**	108	**136**	150
Audit fees payable to the external auditor				
audit services- statutory audit	**117**	104	**117**	94
Internal audit costs	**111**	82	**111**	82
Clinical negligence	**8,190**	7,041	**8,190**	7,041
Legal fees	**67**	504	**67**	504
Insurance	**292**	361	**292**	361
Research and development	**46**	40	**46**	40
Education and training	**1,465**	906	**1,465**	906
Charges to operating expenditure for on-SoFP PFI scheme	**1,114**	1,110	**1,114**	1,110
Other	**2,125**	3,926	**1,464**	2,915
	311,781	289,341	**299,976**	277,623

The total employer's pension contributions are disclosed in note 9.1.

Redundancy payments totalling £nil (2021: £43k) are included in staff costs.

There is a limitation on the Auditor's liability of £2.0m (2021: £2.0m). The fees payable to auditors for the statutory audit and additional services above are quoted gross of VAT at 20%, reflecting the Trust's inability to reclaim VAT on this type of expenditure.

Other expenses include professional fees associated with the hospital site development £0.3m (2021: £0.9m), a contractual dispute with a supplier £nil (2021: £0.5m), home testing kits £0.2m (2021: £0.3m) as well as costs attributable to Salisbury Trading Limited £0.1m (2021: £0.3m) and charitable fund expenses of £0.6m (2021: £0.7m).

NOTES TO THE ACCOUNTS

8. Operating leases expenditure

8.1 As lessee

The Group has entered into commercial leases on certain items of property, motor vehicles and equipment. The principal arrangements are in respect of motor vehicles. For these, rentals are for an agreed mileage over a three year term. Excess mileage is charged at a price per mile determined at the inception of the lease.

8.2 Payments recognised as expense

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Minimum lease payments	**94**	108	**136**	150

8.3 Total future minimum lease payments

	Group		Trust	
	2022	2021	**2022**	2021
Payable:	**£000**	£000	**£000**	£000
Within 1 year	**28**	52	**42**	87
Between 1 and 5 years	**27**	26	**27**	40
After 5 years	**-**	-		-
Total	**55**	78	**69**	127

9. Employee benefits

9.1 Staff costs

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Salaries and wages	**151,408**	140,670	**145,387**	135,398
Social security costs	**14,788**	14,144	**14,788**	14,144
Apprenticeship levy	**737**	676	**737**	676
Employer's contributions to NHS pensions	**24,583**	23,277	**24,489**	23,208
Pension cost - other	**42**	42	**42**	41
Temporary staff (including agency)	**7,735**	5,391	**6,651**	4,190
Total gross staff costs	**199,293**	184,200	**192,094**	177,657
Of which				
Costs capitalised as part of assets	**758**	854	**758**	854

NOTES TO THE ACCOUNTS

9. Employee benefits (continued)

9.2 Directors' remuneration

	Group and Trust	
	2022	2021
	£000	£000
Salaries and wages	**1,040**	991
Social Security Costs	**127**	108
Employer contributions to Pension Schemes	**161**	141
	1,328	1,240

The total number of Directors accruing benefits under pension schemes is 6 (2021: 6). The Directors Remuneration only relates to the Group.

10 Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution schemes for Odstock Medical Limited and Salisbury Trading Limited was £17.1m (2021: £16.2m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf (6.3%), as at 31 March 2022 (and 2021), contributions of £2.53m (2021: £2.29m) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

10.1 NHS Pension Schemes

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

NOTES TO THE ACCOUNTS

10 Pension costs (continued)

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 that set out the technical detail of how the costs of remedy are included in the 2016 valuation process.
The directions are available here:
Amending Directions 2021

Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at:
https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

11. Retirements due to ill-health

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

During the year to 31 March 2022 there was 5 (2021: 1) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £474k (2021: £56k). The cost of the 2022 ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

NOTES TO THE ACCOUNTS

12. Finance income

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Interest receivable	**309**	287	**102**	96
Other loans and receivables	**-**	-	**131**	74
	309	287	**233**	170

13. Finance costs

Group and Trust

	2022	2021
	£000	£000
Interest on capital loans from the Department of Health and Social Care (DHSC)	**40**	49
Revenue support / working capital loans from DHSC	**-**	-
Interest on obligations under finance leases	**20**	24
Finance costs on obligations under Private Finance Initiatives	**1,098**	1,130
Contingent finance costs - PFI	**846**	809
Total finance expense - financial liabilities	**2,004**	2,012
Other finance costs - unwinding of discounts on provisions	**(2)**	110
Total	**2,002**	2,122

14. The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts payable arising from claims made by businesses under this legislation (2021: £Nil).

15. Losses and special payments

	Group and Trust			
	2022		2021	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Cash losses	**-**	**-**	-	-
Fruitless payments and constructive losses	**1**	**-**	-	-
Bad debts and claims abandoned	**445**	**308**	470	181
Stores losses	**5**	**100**	2	2
	451	**408**	472	183
Special payments				
Compensation payments	**-**	**-**	-	-
Extra-contractual payments	**-**	**-**	-	-
Ex-gratia payments	**23**	**247**	20	17
Special severance payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
	23	**247**	20	17
Total losses and special payments	**474**	**655**	492	200

There were no case payments that exceeded £0.1m.

NOTES TO THE ACCOUNTS

16. Intangible Assets

16.1 Intangible assets at the balance sheet date comprise the following elements:

Group and Trust

	Assets under Construction £000	Software Licences £000	Total £000
Cost or valuation			
At 1 April 2021	2,143	19,077	21,220
Additions - purchased	1,922	-	1,922
Additions - donated	-	-	-
Impairments charged to operating expenses	-	-	-
Reclassifications	(759)	759	-
Disposals	-	(1,967)	(1,967)
At 31 March 2022	**3,306**	**17,869**	**21,175**
Amortisation			
At 1 April 2021	-	10,268	10,268
Provided during the period	-	2,968	2,968
Impairments charged to operating expenses	-	-	-
Disposals	-	(1,957)	(1,957)
Amortisation at 31 March 2022	**-**	**11,279**	**11,279**
Net book value at 31 March 2022			
- Purchased at 31 March 2022	3,306	6,579	9,885
- Donated at 31 March 2022	-	11	11
Total at 31 March 2022	**3,306**	**6,590**	**9,896**

Cost or valuation			
At 1 April 2020	1,637	15,179	16,816
Additions - purchased	4,379	-	4,379
Additions - donated	-	30	30
Impairments charged to operating expenses	(5)	-	(5)
Reclassifications	(3,868)	3,868	-
Disposals	-	-	-
At 31 March 2021	**2,143**	**19,077**	**21,220**
Amortisation			
At 1 April 2020	-	7,988	7,988
Provided during the period	-	2,280	2,280
Impairments charged to operating expenses	-	-	-
Disposals	-	-	-
Amortisation at 31 March 2021	**-**	**10,268**	**10,268**
Net book value at 31 March 2021			
- Purchased at 31 March 2021	2,143	8,760	10,903
- Donated at 31 March 2021	-	49	49
Total at 31 March 2021	**2,143**	**8,809**	**10,952**

NOTES TO THE ACCOUNTS

17. Property, plant and equipment

Group

17.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,813	106,610	7,587	6,082	50,207	251	14,432	3,708	190,690
Additions - purchased	-	-	-	12,574	1,166	-	-	-	13,740
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,649)	5,209	33	1,877	157	-
Revaluation	588	4,831	351	-	-	-	-	-	5,770
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(8,323)	(174)	(2,965)	(534)	(11,996)
At 31 March 2022	**2,401**	**116,709**	**7,938**	**6,007**	**48,530**	**110**	**13,351**	**3,369**	**198,415**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	29,190	202	9,495	2,593	41,480
Provided during the period	-	4,362	219	-	4,077	11	1,762	282	10,713
Revaluation	-	(4,271)	(219)	-	-	-	-	-	(4,490)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(8,040)	(174)	(2,965)	(528)	(11,707)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**25,098**	**39**	**8,292**	**2,347**	**35,996**
Net book value at 31 March 2021									
Owned	1,813	85,874	7,587	6,082	20,005	49	3,869	1,115	126,394
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On balance sheet PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	-	-	-	869	-	-	-	869
Total at 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**21,017**	**49**	**4,937**	**1,115**	**149,210**
Net book value at 31 March 2022									
Owned	2,401	94,593	7,938	6,007	21,592	71	4,379	1,022	138,003
Finance leased	-	-	-	-	1,286	-	680	-	1,966
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	-	-	-	554	-	-	-	554
Total at 31 March 2022	**2,401**	**116,489**	**7,938**	**6,007**	**23,432**	**71**	**5,059**	**1,022**	**162,419**

On 31 March 2022 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Group

17.2 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2020	1,715	103,528	7,793	3,441	70,514	361	12,995	3,882	204,229
Additions - purchased	-	-	-	13,879	40	-	-	-	13,919
Additions - donated	-	-	-	-	1,193	-	15	15	1,223
Impairments	-	(244)	-	(69)	-	-	-	-	(313)
Reclassifications	-	2,658	2	(11,169)	6,881	25	1,565	38	-
Revaluation	98	668	(208)	-	-	-	-	-	558
Disposals	-	-	-	-	(28,421)	(135)	(143)	(227)	(28,926)
At 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**50,207**	**251**	**14,432**	**3,708**	**190,690**
Accumulated depreciation									
At 1 April 2020	-	-	-	-	53,305	332	8,033	2,476	64,146
Provided during the period	-	3,823	220	-	4,104	5	1,605	333	10,090
Revaluation	-	(3,823)	(220)	-	-	-	-	-	(4,043)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28,219)	(135)	(143)	(216)	(28,713)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**29,190**	**202**	**9,495**	**2,593**	**41,480**
Net book value at 31 March 2020									
Owned	1,715	82,906	7,793	3,441	17,044	29	3,505	1,406	117,839
Finance leased	-	-	-	-	165	-	1,457	-	1,622
On-SoFP PFI	-	20,622	-	-	-	-	-	-	20,622
Donated	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**1,715**	**103,528**	**7,793**	**3,441**	**17,209**	**29**	**4,962**	**1,406**	**140,083**
Net book value at 31 March 2021									
Owned	1,813	85,874	7,587	6,082	20,874	49	3,869	1,115	127,263
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**21,017**	**49**	**4,937**	**1,115**	**149,210**

On 31 March 2021 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Trust

17.3 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,010	106,610	6,647	6,082	46,732	251	14,432	3,708	185,472
Additions - purchased	-	-	-	12,125	-	-	-	-	12,125
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,200)	4,760	33	1,877	157	-
Revaluation	450	4,831	294	-	-	-	-	-	5,575
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(7,076)	(174)	(2,965)	(534)	(10,749)
At 31 March 2022	**1,460**	**116,709**	**6,941**	**6,007**	**44,687**	**110**	**13,351**	**3,369**	**192,634**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	26,236	202	9,495	2,593	38,526
Provided during the period	-	4,362	196	-	3,900	11	1,762	282	10,513
Revaluation	-	(4,271)	(196)	-	-	-	-	-	(4,467)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(6,803)	(174)	(2,965)	(528)	(10,470)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**23,204**	**39**	**8,292**	**2,347**	**34,102**
Net book value at 31 March 2021									
Owned	1,010	80,588	6,647	6,082	17,245	49	3,851	868	116,340
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On balance sheet PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	5,286	-	-	3,118	-	18	247	8,669
Total at 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**20,506**	**49**	**4,937**	**1,115**	**146,956**
Net book value at 31 March 2022									
Owned	1,460	89,049	6,941	6,007	18,792	71	4,358	804	127,482
Finance leased	-	-	-	-	120	-	680	-	800
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	5,544	-	-	2,571	-	21	218	8,354
Total at 31 March 2022	**1,460**	**116,489**	**6,941**	**6,007**	**21,483**	**71**	**5,059**	**1,022**	**158,532**

On 31 March 2022 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Trust

17.4 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2020	940	103,528	6,853	3,441	67,079	339	12,995	3,882	199,057
Additions - purchased	-	-	-	13,879	-	-	-	-	13,879
Additions - donated	-	-	-	-	1,193	-	15	15	1,223
Impairments	-	(244)	-	(69)	-	-	-	-	(313)
Reclassifications	-	2,658	2	(11,169)	6,881	25	1,565	38	-
Revaluation	70	668	(208)	-	-	-	-	-	530
Disposals	-	-	-	-	(28,411)	(113)	(143)	(227)	(28,894)
At 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**46,742**	**251**	**14,432**	**3,708**	**185,482**
Accumulated depreciation									
At 1 April 2020	-	-	-	-	50,603	310	8,033	2,476	61,422
Provided during the period	-	3,823	196	-	3,852	5	1,605	333	9,814
Revaluation	-	(3,823)	(196)	-	-	-	-	-	(4,019)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28,219)	(113)	(143)	(216)	(28,691)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**26,236**	**202**	**9,495**	**2,593**	**38,526**
Net book value at 31 March 2020									
Owned	940	77,636	6,853	3,441	13,814	29	3,493	1,098	107,304
Finance leased	-	-	-	-	165	-	1,457	-	1,622
On-SoFP PFI	-	20,622	-	-	-	-	-	-	20,622
Donated	-	5,270	-	-	2,497	-	12	308	8,087
Total at 31 March 2020	**940**	**103,528**	**6,853**	**3,441**	**16,476**	**29**	**4,962**	**1,406**	**137,635**
Net book value at 31 March 2021									
Owned	1,010	76,417	6,647	6,082	17,245	49	3,851	868	112,169
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	9,457	-	-	3,118	-	18	247	12,840
Total at 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**20,506**	**49**	**4,937**	**1,115**	**146,956**

On 31 March 2021 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

17.5 Net Book Value of Assets Held Under Finance Leases

Group

	Plant & Machinery £000	Information technology £000	On-SoFP PFI £000	Total £000
Cost or valuation				
At 1 April 2021	228	1,943	20,736	22,907
Additions - Purchased	1,166	-	440	1,606
Revaluations	-	-	720	720
Disposals	-	-	-	-
At 31 March 2022	**1,394**	**1,943**	**21,896**	**25,233**
Accumulated depreciation				
At 1 April 2021	86	875	-	961
Provided during the period	23	388	594	1,005
Revaluation	-	-	(594)	(594)
Disposals	-	-	-	-
Accumulated depreciation at 31 March 2022	**109**	**1,263**	**-**	**1,372**
Net book value at 31 March 2022				
- Purchased	1,285	680	21,896	23,861
Total at 31 March 2022	**1,285**	**680**	**21,896**	**23,861**
Cost or valuation				
At 1 April 2020	844	1,943	20,622	23,409
Additions - purchased	-	-	449	449
Revaluation	-	-	(396)	(396)
Disposals	(616)	-	-	(616)
At 31 March 2021	**228**	**1,943**	**20,675**	**22,846**
Accumulated depreciation				
At 1 April 2020	679	486	-	1,165
Provided during the period	23	389	573	985
Revaluation	-	-	(573)	(573)
Disposals	(616)	-	-	(616)
Accumulated depreciation at 31 March 2021	**86**	**875**	**-**	**961**
Net book value at 31 March 2021				
- Purchased	142	1,068	20,675	21,885
Total at 31 March 2021	**142**	**1,068**	**20,675**	**21,885**

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

17.5 Net Book Value of Assets Held Under Finance Leases (continued)

Trust only

	Plant & Machinery £000	Information technology £000	On-SoFP PFI £000	Total £000
Cost or valuation				
At 1 April 2021	228	1,943	20,736	22,907
Additions - Purchased	-	-	440	440
Revaluations	-	-	720	720
Disposals	-	-	-	-
At 31 March 2022	**228**	**1,943**	**21,896**	**24,067**
Accumulated depreciation				
At 1 April 2021	86	875	-	961
Provided during the period	23	388	594	1,005
Revaluation	-	-	(594)	(594)
Disposals	-	-	-	-
Accumulated depreciation at 31 March 2022	**109**	**1,263**	**-**	**1,372**
Net book value at 31 March 2022				
- Purchased	119	680	21,896	22,695
Total at 31 March 2022	**119**	**680**	**21,896**	**22,695**
Cost or valuation				
At 1 April 2020	844	1,943	20,622	23,409
Additions - purchased	-	-	449	449
Revaluation	-	-	(396)	(396)
Disposals	(616)	-	-	(616)
At 31 March 2021	**228**	**1,943**	**20,675**	**22,846**
Accumulated depreciation				
At 1 April 2020	679	486	-	1,165
Provided during the period	23	389	573	985
Revaluation	-	-	(573)	(573)
Disposals	(616)	-	-	(616)
Accumulated depreciation at 31 March 2021	**86**	**875**	**-**	**961**
Net book value at 31 March 2021				
- Purchased	142	1,068	20,675	21,885
Total at 31 March 2021	**142**	**1,068**	**20,675**	**21,885**

18. Investments

Non-current	**Group**		**Trust**	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Carrying value at 1 April	**7,893**	6,319	-	-
Additions	**7,415**	4,961	-	-
Fair value (losses)/ gains taken to I & E	**438**	1,417	-	-
Fair value movements taken to OCI	**-**	-	-	-
Disposals	**(7,521)**	(4,804)	-	-
Carrying value at 31 March	**8,225**	7,893	-	-
Current				
Financial assets designated at amortised cost	**337**	113	**-**	-

Non-current investments represents an investment portfolio managed by HSBC Private Bank (UK) Limited on behalf of the charitable fund.

Current asset investments are the cash balances held by HSBC Private Bank (UK) Limited on behalf of the charitable fund and represents dividend income, interest income and the proceeds of fixed asset investment disposals which have not yet been reinvested.

NOTES TO THE ACCOUNTS

18. Investments (continued)

Fair value measurement of investments
Financial assets and financial liabilities measured at fair value in the Statement of Financial Position are grouped into three levels of a fair value hierarchy. The three levels are defined based on the observability of significant inputs to the measurement, as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets or liabilities
Level 2: inputs other than quoted prices included in level 1 that are observable for the asset or liability, either directly or indirectly
Level 3: unobservable inputs for the asset or liability

The investments in the group financial statements are all level 1 investments and are measured at quoted prices at the date of the Statement of Financial Position.

19. Other financial assets

Non-current	**Group**		**Trust**	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,395**	2,299	**4,551**	4,982
Loans provided in year	**-**	-	**306**	500
Transfer (to)/ from current assets	**-**	-	**(913)**	(1,027)
Amortisation at the effective interest rate	**102**	96	**102**	96
Repayments in year	**-**	-	**(40)**	-
Carrying value at 31 March	**2,497**	2,395	**4,006**	4,551
Current				
Carrying value at 1 April	**-**	-	**1,027**	-
Transfer from/ (to) non-current assets	**-**	-	**913**	1,027
Loans	**-**	-	**-**	-
Carrying value at 31 March	**-**	-	**1,940**	1,027

Current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due in less than one year; and
b) Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.
c) Odstock Medical Limited to assist with working capital requirements

Non-current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due after more than one year: and
b) Sterile Supplies Limited to re-develop a new production facility with a third party.
c) Odstock Medical Limited to assist with working capital requirements

Details of the loans to Salisbury Trading Limited are as follows:
1. £1.3m to purchase the laundry stock.
2. £2.0m to purchase the laundry equipment.
3. £0.5m to purchase laundry stocks.
4. £0.7m to purchase laundry stock.
5. £0.5m to purchase laundry stock to assist with the Covid 19 pandemic.

NOTES TO THE ACCOUNTS

19. Other financial assets (continued)

The first four of the loans with an outstanding balance of £2.682m at 31 March 2022 were amalgamated into one loan during the year. This loan will be repaid over the next five years culminating in the final repayment on 1 April 2026.

The remaining fifth loan of £0.5m at 31 March 2022 is subject to ongoing discussions with regard to also amalgamating this into the above agreement.

Details of the loan to Sterile Supplies Limited is as follows:
In March 2016 the Trust made a loan to its then wholly owned subsidiary company, Sterile Supplies Limited. The intention was for this sum to be used to help finance a joint venture arrangement with a third party, which will deliver cost savings into the future. Until the joint venture agreement was finalised and formal agreement signed, the loan remained repayable on demand.

During 2016-17 Sterile Supplies Limited became the joint venture vehicle between the Trust and a third party, Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). As part of the joint venture agreement the Trust ceded control of Sterile Supplies Limited and the loan agreement was formalised as long term.

The long term loan of £2.0m is to assist the development of a new production facility. Loan repayments will commence when the building becomes operational. Interest is payable at 4% above the Bank of England base rate and is capitalised and added to the principal sum.

Details of the loan to Odstock Medical Limited is as follows:
During 2021-22 the Trust made a loan to its wholly owned subsidiary company, Odstock Medical Limited, to assist with its working capital requirements. The loan repayments commenced in November 2021. Interest is payable at 3.5% above the Bank of England base rate and is capitalised and added to the principal sum.

20. Inventories

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Drugs	**1,395**	1,329	**1,395**	1,329
Consumables	**4,554**	4,275	**4,554**	4,275
Laundry	**1,628**	1,405	**-**	-
Other	**362**	625	**362**	446
	7,939	7,634	**6,311**	6,050
Inventories recognised as an expense in the period	**54,095**	45,963	**52,697**	44,726

In response to the Covid pandemic, The Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During the year the Trust received £883k (2020-21: £3,640k) items free of charge.

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.

NOTES TO THE ACCOUNTS

21. Receivables

21.1 Amounts falling due after more than one year:

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Clinician pension tax provision reimbursement funding from NHSE	**656**	762	**656**	762
	656	762	**656**	762
Of which receivables from NHS and DHSC group	**656**	762	**656**	762

21.2 Amounts falling due within one year:

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Contract receivables	**11,079**	9,445	**9,900**	9,124
Allowance for impaired contract receivables / assets	**(954)**	(1,351)	**(954)**	(1,351)
Prepayments (non-PFI)	**2,930**	3,262	**2,930**	3,262
PDC dividend receivable	**31**	57	**31**	57
VAT receivable	**950**	627	**950**	627
Clinician pension tax provision reimbursement funding from NHSE	**9**	-	**9**	-
Other receivables	**166**	37	**237**	64
	14,211	12,077	**13,103**	11,783
Of which receivables from NHS and DHSC group	**3,464**	2,179	**3,464**	2,179

The majority of transactions are with Clinical Commissioning Groups (CCGs) or NHS England's Specialist Commissioners, as commissioners for NHS patient care services. As CCGs and Specialist Commissioners are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

The average credit period taken on sale of goods is 17 days (2021: 14.4 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2022		31 March 2021	
	receivables and contract assets £000	**All other receivables £000**	receivables and contract assets £000	All other receivables £000
Allowance for credit losses at 1 April - brought forward	**1,351**	**-**	1,569	-
New allowances arising	**15**	**-**	-	-
Utilisation of allowances (write offs)	**(412)**	**-**	(218)	-
Balance at 31 March	**954**	**-**	1,351	-

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

NOTES TO THE ACCOUNTS

22. Cash and cash equivalents

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Balance at beginning of year	**31,169**	16,145	**22,309**	9,087
Net change in year	**8,137**	15,024	**8,510**	13,222
Balance at end of year	**39,306**	31,169	**30,819**	22,309
Made up of:				
Cash with Government Banking Service	**30,791**	22,201	**30,791**	22,201
Cash at commercial banks and in hand	**8,515**	8,968	**28**	108
Cash and cash equivalents as in balance sheet	**39,306**	31,169	**30,819**	22,309
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**39,306**	31,169	**30,819**	22,309

23. Trade and other payables

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Amounts falling due within one year:				
Trade payables	**18,942**	11,522	**17,614**	10,200
Capital payable	**9,289**	4,554	**9,289**	4,554
Accruals and deferred income	**2,514**	1,693	**2,514**	1,693
Receipts in advance	**2,140**	3,057	**2,140**	3,057
Social security and other taxes payable	**4,115**	3,754	**4,115**	3,754
Pay and pensions related	**5,449**	5,648	**5,449**	5,648
Other	**3,622**	6,499	**3,634**	6,458
	46,071	36,727	**44,755**	35,364
Of which payables from NHS and DHSC group bodies:	**2,845**	3,076	**2,845**	3,076

Included in 'Other' payables is £1.2m (2021: £0.9m) potential exposure following change in Vat guidance, £0.9m (2021: £0.9m) funds due as an agent on an education training contract, £0.3m (2021: £nil) Public Dividend capital repayable.

All Trade and other payables are current liabilities.

NOTES TO THE ACCOUNTS

24. Borrowings

Group	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Obligations under finance leases	**458**	434	**999**	292
Amounts due under PFI (note 30)	**612**	526	**15,564**	16,175
Capital loans from Department of Health and Social Care (DHSC)	**644**	648	**1,582**	2,213
Revenue support / working capital loans from DHSC	**-**	-	**-**	-
	1,714	1,608	**18,145**	18,680

Trust	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Obligations under finance leases	**290**	434	**-**	292
Amounts due under PFI (note 30)	**612**	526	**15,564**	16,175
Capital loans from Department of Health and Social Care (DHSC)	**644**	648	**1,582**	2,213
Revenue support / working capital loans from DHSC	**-**	-	**-**	-
	1,546	1,608	**17,146**	18,680

The Trust finance leases relate to the purchase of medical equipment and hardware infrastructure. Both are for a term of 5 years. For the year ended 31 March 2022 the effective borrowing rates were 3.4% and 5.1% respectively. Interest rates are fixed at the contract date.

The additional lease liabilities at a Group level are due to a finance lease agreement for new laundry equipment for Salisbury Trading Limited.

The capital loan from the Department of Health and Social Care is unsecured and for a 10 year period, repayable in equal instalments commencing on 18 May 2016. Interest is payable on the loan at a rate of 1.64% pa.

Department of Health and Social Care revenue support/ working capital loans taken out during 2017-18 and 2018-19 were repayable at the end of three year periods from the inception date of each loan; interest accruing at 1.5% - 3.5% per annum and payable twice yearly. However, on 1 April 2020 DHSC, NHSE and NHSI implemented reforms to the NHS cash regime. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Amounts payable under finance leases:

Group	Minimum lease payments		Present value of minimum lease payments	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Within one year	**502**	459	**458**	434
Between one and five years	**1,172**	306	**999**	292
After five years	**-**	-	**-**	-
	1,674	765	**1,457**	726
Less finance charges allocated to future periods	**(217)**	(39)		
	1,457	726		
Included within:				
Current borrowings			**458**	434
Non-current borrowings			**999**	292
			1,457	726

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

Trust	Minimum lease payments		Present value of minimum lease payments	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Within one year	**306**	459	**291**	434
Between one and five years	**-**	306	**-**	292
After five years	**-**	-	**-**	-
	306	765	**291**	726
Less finance charges allocated to future periods	**(15)**	(39)		
	291	726		
Included within:				
Current borrowings			**291**	434
Non-current borrowings			**-**	292
			291	726

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Pensions - early departure costs	**13**	19	**25**	13
Pensions - injury benefits	**24**	23	**214**	236
Legal claims	**973**	453	**-**	-
Clinician pension tax reimbursement	**9**	-	**656**	762
Other	**215**	476	**-**	245
	1,234	971	**895**	1,256

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2021	32	259	453	762	721	**2,227**
Change in the discount rate	-	4	-	-	-	**4**
Arising during the year	20	1	528	-	-	**549**
Utilised during the year	(14)	(24)	(8)	-	-	**(46)**
Reversed unused	-	-	-	(97)	(506)	**(603)**
Unwinding of discount	-	(2)	-	-	-	**(2)**
At 31 March 2022	**38**	**238**	**973**	**665**	**215**	**2,129**
Expected timing of cash flows:						
Within 1 year	13	24	973	9	215	**1,234**
1 - 5 years	5	96	-	6	-	**107**
5-10 years	20	118	-	650	-	**788**
	38	**238**	**973**	**665**	**215**	**2,129**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury and employee claims. These are based on valuation reports provided by the Trust's legal advisers.

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges (continued)

Clinician pension tax reimbursement provision arises in respect of clinicians who are members of the NHS Pension Scheme, and wh as a result of work undertaken, face a tax charge in respect of the growth of their NHS pension benefits above their pension saving annual allowance threshold. Government policy is that the Trust will reimburse the NHS Pension Scheme on the retirement of th clinician in exchange for the Scheme paying the additional tax due.

Other provisions relate to the early termination of a supplier contract, a contractual dispute with a supplier and additional tax liabilite following revised guidance by HMRC.

£122.9m is included in the provisions of NHS Resolution at 31 March 2022 in respect of clinical negligence liabilities of the Trust (202 £79.4m).

26. Capital and other commitments

Capital commitments - Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £1.68m (2021: £2.77m).

27. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £0.5m

28. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health and Social Care is regarded as a related party. During the year ended 31 March 2022 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities include Clinical Commissioning Groups, NHS England, Health Education England, NHS Resolution and other Trusts and Foundation Trusts.

Salisbury NHS Foundation Trust also has transactions with its subsidiary companies, joint ventures and charitable funds (for which it is the Corporate Trustee) These are listed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Year ending 31 March 2022				
Salisbury Trading Limited	**261**	**817**	**239**	**59**
Odstock Medical Limited	**214**	**-**	**78**	**1**
Salisbury District Hospital Charitable Fund	**724**	**42**	**543**	**-**
Sterile Supplies Limited	**1,178**	**1,988**	**243**	**199**
Wiltshire Health and Care LLP	**616**	**269**	**64**	**21**
Year ending 31 March 2021				
Salisbury Trading Limited	200	787	258	65
Odstock Medical Limited	215	-	380	-
Salisbury District Hospital Charitable Fund	423	42	586	-
Sterile Supplies Limited	1,066	1,949	177	198
Wiltshire Health and Care LLP	697	380	-	72

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI)

29.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services
At the end of the contract term the hospital buildings revert back to the Trust
There were no changes to the terms and conditions of the PFI agreement

Terms of the Arrangement - the unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a service fee which is subject to indexation based upon 'the Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

29.2 PFI scheme - Charge to operating expense in Statement of Comprehensive Income

	Group and Trust	
	2022	2021
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**1,114**	1,110
Depreciation of PFI asset	**594**	573
Net charge to operating expenses	**1,708**	1,683

29.3 PFI scheme - Analysis of amounts payable to service concession operator

	Group and Trust	
	2022	2021
	£000	£000
Interest	**1,098**	1,130
Repayment of finance lease liability	**526**	479
Service element	**1,114**	1,110
Capital lifecycle maintenance	**440**	449
Contingent rent	**846**	809
Unitary payment payable to service concession operator	**4,024**	3,977

29.4 Annual commitments under Private Finance Transactions - On Statement of Financial Position

The Trust is committed to make the following service payments on the PFI:	**2022**	2021
	£000	£000
Due within one year	**1,166**	1,114
Due within 2 to 5 years	**4,794**	4,500
Due after 5 years	**11,190**	11,845
	17,150	17,459

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

Imputed finance lease obligations comprise:	**Minimum lease payments**		**Present value of minimum lease payments**	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Rentals due within one year	**1,673**	1,624	**612**	526
Rentals due within 2 to 5 years	**6,936**	6,868	**3,159**	2,895
Rentals due thereafter	**16,761**	18,501	**12,405**	13,280
	25,370	26,993	**16,176**	16,701
Less: interest element	**(9,194)**	(10,292)		
Total	**16,176**	16,701		

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI) (continued)

29.5 Total future payments committed in respect of PFI

	2022	2021
	£000	£000
Total	**70,510**	71,223
of which due:		
Within one year	**4,329**	4,025
Within 2 to 5 years	**18,424**	17,130
Due thereafter	**47,757**	50,068
Total	**70,510**	71,223

30. Financial instruments

IFRS 7 and IFRS 9 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

30.1 Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations although the charity holds a small number of investments denominated in United States dollars and Euros, these are immaterial and, as a result, the Group has low exposure to currency fluctuations.

30.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

30.3 Interest-rate risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

30.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2022

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	**3.4 - 5.1**	**16**	**33**	**453**	**195**	**586**	**391**	**(217)**	**1,457**
PFI obligations	**6.5**	**139**	**278**	**1,256**	**1,718**	**5,218**	**16,761**	**(9,194)**	**16,176**
DHSC capital loan	**1.64**	**-**	**334**	**331**	**655**	**966**	**-**	**(73)**	**2,213**
Floating rate									
Trade and other payables	**-**	**30,745**	**-**	**-**	**-**	**-**	**-**	**-**	**30,745**

As at 31 March 2021

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	3.4 - 5.1	-	-	459	306	-	-	(39)	726
PFI obligations	6.5	135	270	1,219	1,673	5,195	18,501	(10,292)	16,701
DHSC capital loan	1.64	-	339	336	665	1,621	-	(117)	2,844
Floating rate									
Trade and other payables	-	17,769	-	-	-	-	-	-	17,769

NOTES TO THE ACCOUNTS

30. Financial instruments (continued)

30.5 Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2022 are in receivables from customers, as disclosed in note 21.

30.6 Carrying values of financial assets

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	**10,557**	**-**	-	**10,557**
Other investments / financial assets	**2,497**	**-**	-	**2,497**
Cash and cash equivalents	**33,448**	**-**	-	**33,448**
Consolidated NHS Charitable fund financial assets	**6,197**	**8,225**	**-**	**14,422**
Total at 31 March 2022	**52,699**	**8,225**	**-**	**60,924**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	8,512	-	-	8,512
Other investments / financial assets	2,395	-	-	2,395
Cash and cash equivalents	25,415	-	-	25,415
Consolidated NHS Charitable fund financial assets	6,248	7,893	-	14,141
Total at 31 March 2021	42,570	7,893	-	50,463

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	**9,848**	-	-	**9,848**
Other investments / financial assets	**6,192**	-	-	**6,192**
Cash and cash equivalents	**30,819**	-	-	**30,819**
Total at 31 March 2022	**46,859**	**-**	**-**	**46,859**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	8,599	-	-	8,599
Other investments / financial assets	4,737	-	-	4,737
Cash and cash equivalents	22,309	-	-	22,309
Total at 31 March 2021	35,645	-	-	35,645

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

30.7 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	**2,226**	**-**	**2,226**
Obligations under finance leases	**1,457**	**-**	**1,457**
Obligations under PFI, LIFT and other service concession contracts	**16,176**	**-**	**16,176**
Trade and other payables excluding non financial liabilities	**39,486**	**-**	**39,486**
Provisions under contract	**1,820**	**-**	**1,820**
Total at 31 March 2022	**61,165**	**-**	**61,165**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	2,861	-	2,861
Obligations under finance leases	726	-	726
Obligations under PFI, LIFT and other service concession contracts	16,701	-	16,701
Trade and other payables excluding non financial liabilities	28,464	-	28,464
Provisions under contract	2,227	-	2,227
Total at 31 March 2021	50,979	-	50,979

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	**2,226**	**-**	**2,226**
Obligations under finance leases	**291**	**-**	**291**
Obligations under PFI, LIFT and other service concession contracts	**16,176**	**-**	**16,176**
Trade and other payables excluding non financial liabilities	**38,217**	**-**	**38,217**
Provisions under contract	**1,820**	**-**	**1,820**
Total at 31 March 2022	**58,730**	**-**	**58,730**

Unless otherwise stated above, carrying value is considered to be a reasonable approximation of fair value.

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	2,861	-	2,861
Obligations under finance leases	726	-	726
Obligations under PFI, LIFT and other service concession contracts	16,701	-	16,701
Trade and other payables excluding non financial liabilities	27,147	-	27,147
Provisions under contract	2,227	-	2,227
Total at 31 March 2021	49,662	-	49,662

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
In one year or less	**43,251**	33,599	**42,262**	32,282
In more than one year but not more than five years	**9,836**	9,567	**9,836**	9,567
In more than five years	**17,549**	19,649	**17,549**	19,649
Total	**70,636**	62,815	**69,647**	61,498

31. Third Party Assets

The Trust held £0.5k cash at bank and in hand at 31 March 2022 (2021: £0.1k) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Investment in subsidiary

32.1 Odstock Medical Limited

Salisbury NHS Foundation Trust established, following Department of Health approval, a subsidiary company, Odstock Medical Limited (registered in England), to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 70% of Odstock Medical Limited.

	Trust 2022 £'000	Trust 2021 £'000
Shares at cost		
At 31 March	**-**	**5**

The Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

In the year the Trust charged the goodwill on the purchase of shares from former employees of the subsidiary to expenditure.

The Trust's charity, Salisbury District Hospital Charitable Fund, owns a further 18% of Odstock Medical Limited.

NOTES TO THE ACCOUNTS

32. Investment in subsidiary (continued)

32.2 Salisbury Trading Limited

Salisbury NHS Foundation Trust established a subsidiary company, Salisbury Trading Limited (registered in England), to market and deliver laundry and linen services. The company commenced trading on 1 October 2013. Salisbury NHS Foundation Trust owns 100% of Salisbury Trading Limited. The company has experienced steady growth since commencing to trade by winning new linen contracts. It has increased operational capacity through arrangements involving the management of another NHS laundry facility, which will provide an additional base for future expansion.

	Trust
Shares at cost	£
At 31 March 2022 and 31 March 2021	**1**

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

33. Investment in Joint Ventures

33.1 Sterile Supplies Limited

Salisbury NHS Foundation Trust owns 50% of the issued share capital of Sterile Supplies Limited, the remaining 50% is owned by Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). The Board structure and voting rights are such that the Trust is not able to exert overall control of Sterile Supplies Limited, the Trust therefore recognises the company as a joint venture. The joint venture is re-developing a new production facility, from which it will market and deliver sterilisation services. The Joint Venture currently trades from the Trust's existing sterilisation and Disinfection Unit.

Group and Trust	**2022**	2021
	£000	£000
Carrying value of investment at 1 April	**68**	88
Share of profit/ (loss) in the period	**18**	(20)
Carrying value of investment at 31 March	**86**	**68**

33.2 Wiltshire Health and Care

The Trust is a one third partner in Wiltshire Health and Care LLP. The other equal partners being Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. Wiltshire Health and Care is focused solely on delivering improved community services in Wiltshire and enabling people to live independent and fulfilling lives for as long as possible.

Salisbury NHS Foundation Trust has not invested any capital sum in this partnership.

Group and Trust	**2022**	2021
	£000	£000
Carrying value of investment at 1 April	**113**	-
Share of surplus in the period	**47**	113
Carrying value of investment at 31 March	**160**	**113**

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	2022 £000	2021 £000
Public Dividend Capital at 1 April	**90,997**	58,650
New public dividend capital received	**4,112**	32,419
Public dividend capital repaid	**(283)**	(72)
Public Dividend Capital at 31 March	**94,826**	90,997

The new public dividend capital received in the year relates to the conversion of revenue loans to PDC £nil (2021: £21,082k) and the net receipt of additional funding to purchase capital items of £3,829k (2021: £11,337k).

35. Charitable fund balances

Group only	2022 £000	2021 £000
Restricted funds	**6,217**	8,408
Unrestricted funds	**10,000**	6,835
Endowment funds	**9**	9
	16,226	15,252

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

Endowment funds are funds which the trustees are required to invest or to keep and use for the Charity's purposes.

36. Critical accounting judgements

The Trust has made no critical judgements in the application of the accounting policies set out on pages 5 to 21.

37. Critical accounting estimates

In the application of the Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- The valuation of the Trust's estate of land and buildings was carried out on 31 March 2022 by Gerald Eve, Chartered Surveyors. Gerald Eve valued the land and buildings (including dwellings) at £125.1m, of which £116.7m relates to specialised assets valued on a depreciated replacement cost basis."

  It is the rebuilding cost values determined by the valuer using industry standard rates that gives rise to the uncertainty in the valuation.

  A 10% change in the valuation would have £11.7m impact on the statement of financial position with a £409,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements."

NOTES TO THE ACCOUNTS

38. 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 the 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 and Social Care as the public dividend capital dividend..

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

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

Minority interest
Minority interest relates to the ownership stake in the subsidiary companies which is under 50% of the total shares in terms of voting rights and hence doesn't exercise control of the company.