NHS Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust Annual Report and Accounts 1 April 2020 to 31 March 2021

Salisbury NHS Foundation Trust

Annual Report and Accounts 2020 to 2021

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

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PERFORMANCE REPORT

Overview of Performance

This 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. This overview 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

Salisbury District Hospital experienced a year like none other in our history throughout 2020. We finish this year with the national vaccination programme progressing well, delivered locally through our vaccination centre at Salisbury City Hall and also at the hospital where we have vaccinated our staff, partners from across the health and care system and some of the most vulnerable people in our community. We are grateful for the response of our local communities in taking up their vaccinations and for our teams who have worked tirelessly to deliver them.

The demand and rapid changes we had to make to the management of the hospital in early 2020 were unprecedented and tested our planning and management processes and expertise of our staff to the limit. At its first peak in mid-April, we were treating 45 patients who had tested positive for COVID-19, and sadly the hospital had experienced 55 deaths of patients being treated for the virus by June 2020. The period between June and October, however, saw a reduction in hospitalisations and we were able to begin the process of recovery, further improving our new ways of working and implementing the longer term changes required. By October, however, we began to experience again the impact and intense pressure of a rise in community transmission of COVID-19. The volumes of patients who required our care grew very quickly in early 2021 and reached a peak of 188 inpatients on 20 January 2021; nearly half of our available inpatient beds. Very sadly, by the end of March 2021, the hospital had reported 212 COVID-19 related deaths.

For all of us here at this hospital the data is more than statistics, behind every number is a person with a family, friends and neighbours, all of whom were either worried about their loved one or are mourning a life cut short.

Despite the exhausting and relentless nature of the pandemic, the hospital team has amazed me with their professionalism, compassion and flexibility. Not only have we delivered COVID-19 related care in desperately difficult circumstances, we have established a successful vaccination programme in the City Hall and at the hospital for our staff and most vulnerable patients, and we have continued, albeit with significant restrictions, to deliver our normal services including cancer, high priority, emergency and trauma surgery. We have also continued to deliver babies 24 hours a day, 7 days a week.

Alongside our own response, we continue to build our partnerships across Bath, North East Somerset, Swindon and Wiltshire and our growing relationships have been underpinned by the formal identification of our area as an Integrated Care System in November 2020. We are now focussed on how these partnerships will promote the health and well-being of our local communities, and we are particularly keen to play our role in the development of Wiltshire as an Integrated Care Alliance. In 2020-21 we have embarked on a review of our Corporate and Clinical Strategies, ready to embrace the further integrated structures of the NHS and our partner organisations. Subject to further consultation and engagement across our area, we will prioritise:

- Improving the health and well-being of the **population** we serve.
- The **partnerships** that will help us achieve this.
- Investing in the **people** who work for us to ensure they can deliver the best possible care.

These priorities will focus our work for the next five years, and help us design and deliver sustainable and integrated health and care services for our populations in future years. We continue to believe that this gives us the best opportunity to engage with our communities, staff and partners to meet the challenges ahead whilst recovering from this year's pandemic.

I cannot thank the Trust's staff and partners enough for everything they have done over this unprecedented year, whether you are a group or individual who has stood with us for many years, contributed to the Stars Appeal projects which enhance our care or support our staff in their jobs, or whether you are a member of the military who joined our teams in early 2021 to support our response to COVID-19. We have greatly missed having our community of volunteers, supporters and families with us at the hospital during the time we have had to restrict visitors to the site and we are very much looking forward to seeing you all in person again soon.

Stacey Hunter
Chief Executive

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 New born

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 2020-21, we have undertaken a wide-ranging governance review of the charity to establish a renewed vision, mission, goals and objectives.

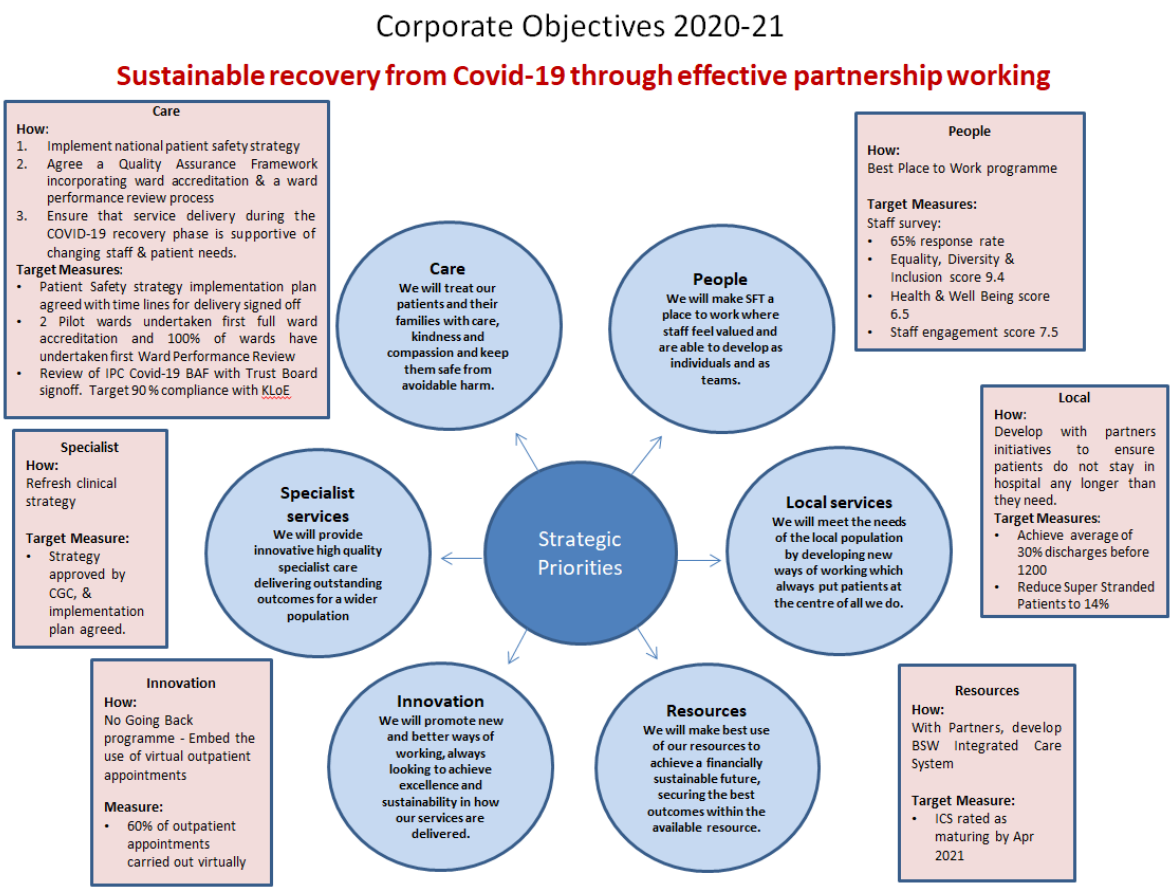
Our Role in the Bath, North East Somerset, Swindon and Wiltshire Integrated Care System (BSW)

BSW was formally recognised as an Integrated Care System in November 2020. Driven by the health and care needs of our local populations, we are committed to developing our role in supporting system partnerships and co-operation across Bath & North East Somerset, Swindon and Wiltshire (BSW). We are working across the geography of both BSW and our local area (which includes parts of Dorset and West Hampshire) to change and improve the way in which health and care is delivered. 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 local challenges.

In order to achieve an outstanding experience for every patient, integrating service provision across 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.

Our Strategic Priorities 2020/21

On 17 March 2020, NHS England and Improvement (NHSEI) published revised guidance on next steps on the NHS Response to COVID-19 which included suspension of normal planning processes. The Board reviewed the draft Trust Operating Plan at its April meeting, accepting that many of the initiatives required suspension. Further guidance on the second phase of the NHS response to COVID-19 was published on 29 April 2020, which included guidance on the restart and recovery of services. In line with this guidance, the Trust commenced recovery activity and this included setting priority actions for the remainder of 2020-21.We identified a small number of priorities that both contributed to the Trust's strategy and assisted in recovering from COVID-19.



Progress against our objectives

Length of Stay in Hospital

During the first wave of COVID-19 guidance was issued by NHSE/I for hospital discharge through the pandemic. This outlined a significant change to the way acute hospitals planned and referred patients for discharge services, with funding in place to support a rapid discharge to assess model. An improvement was seen almost immediately in a reduction in inpatients experiencing the longest spells in hospital. With the refresh of the corporate priorities in June 2020 in the context of recovery from COVID-19, the plan for patients remaining in hospital for more than 21 days was reset to a level of 14% of occupied beds rather than an absolute number. The reason for this being the low occupancy levels in the Trust could artificially show or hide progress

As the impact from the first wave reduced, non-urgent elective work was restarted in the hospital, and non-elective and emergency levels all began to rise with the impact of bed occupancy once again rising. With this, the proportion of super stranded patients began to rise. A second, more intense, wave of COVID-19 in Quarter 4 caused further increases, with many COVID-19 patients requiring long hospital stays.

During the first wave of the pandemic there was an immediate improvement in discharges before midday, but as activity in the hospital increased there has been a fluctuation in the levels, and further COVID-19 waves have slowed the pace of the improvement work. A criteria-led discharge pilot has been undertaken, and work is underway to roll this out across wards.

Transformation of Outpatient Services

29.08% of all outpatient appointments in March 2021 were carried out virtually. Face to Face appointments were heavily restricted in the first wave of the pandemic, with virtual appointments being the default. As face to face services have restarted and outpatient attendances increased, the proportion of appointments that were virtual has decreased, and it has been challenging to increase these. However the actual number of virtual appointments has doubled over the year from 4290 in March 2020 to 10,077 in March 2021. Patient feedback has been promising; with 86% of patients saying their video appointment was better than face to face, and 95% being happy to be seen to by video.

A 'virtual by default' review was started in March 2021, to assess which outpatient services could also move to delivery through virtual means. This is expected to be completed by the end of May and will form part of the 2021/22 project work.

In addition to this, the Trust is hoping to implement a new system providing direct access for General Practitioners to seek advice from our specialty departments, further supporting virtual activity.

Patient Safety Strategy

National guidance was expected for the patient safety strategy but has been delayed. The Trust has good overview systems in place and has implemented weekly safety summits reviewing all risks graded moderate and above. The sign off process for serious incident investigations is being reviewed. These systems provide confidence in the management of patient safety in lieu of the strategy update, which will follow when the national guidance is released.

Ward accreditation

A ward performance review process has been established and 100% of wards have had reviews. A clinical summary dashboard is being developed to support the process; however this has been delayed due to COVID-19. A ward performance review data pack is in place as an interim solution.

Infection, Prevention and Control (IPC) COVID-19 Board Assurance Framework (BAF)

The IPC BAF has been regularly reviewed throughout the year reflecting frequent guidance change. We are over 90% compliant with Key Lines of Enquiry (KLoE), the key areas outstanding are around ventilation in relation to limitation with our physical estate.

National Staff Survey

54.2% of our staff completed the 2020 staff survey. This compares to a response rate for last year's survey of 54.0%. The median response rate was 45.4% and was slightly lower than the 2019 median of 46.9%. The Trust is significantly above the median and increased on the 2019 response rate.

The Trust is benchmarked against 128 acute and community Trusts and has performed above average for five of the ten survey schemes; health and well-being, immediate managers, morale, safe environment (bullying and harassment) and staff engagement. The Trust has scored below average in quality of care, safe environment (violence), safety culture and team working. The Best Place to Work project continues into 2021-22 and is being developed particularly to address the themes raised in the staff survey and in wider engagement and listening to staff views which has taken place this year.

Clinical and Corporate Strategy Review

Development of the Clinical Strategy has taken place alongside the wider strategic review being undertaken by the Trust, as we seek to align and simplify our strategic priorities and direction. Through wide engagement, we have been working to take this work forward under the umbrella of our proposed strategic priorities of **population**, **partnerships** and **people**.

While 'publication' of the new clinical and corporate strategy is only one component of the work, completing this important step will take longer than anticipated due to the pressures of COVID-19 management, Phase 3 planning (in Quarter 2 2020-21) and the wider system development work that the Trust has taken a lead role in. However, the strategic direction is increasingly driving our corporate priorities, relationships with partners and investment in our staff.

The Trust is keen that our future strategic direction is the driver for our work and prioritisation across all areas of the Trust, and we are progressing well through a wide engagement and communication programme, with a view to ensuring that our new strategies are in place as part of our new Corporate Priorities for 2021-22. These priorities link to the specific areas of focus in our clinical strategy – particularly elective recovery, integrated urgent care and frailty services, maternity and mental health service reviews and advancing our digital approaches to care.

Development of our Integrated Care System

Bath and North East Somerset, Swindon and Wiltshire Partnership

Working together for your health and care

BSW achieved designation as an Integrated Care System in November 2020-21 and is fully embracing the next steps on Integrated Care set out in the Government White Paper published in February 2021. The system's planning, prioritisation, performance management and transformation is increasingly moving toward the integrated approach defined by national policy. Our own strategic direction and priorities reflect this ambition. Moving forward into 2021-22, our commitment to work with our partners and deliver services to our communities in an integrated way is further driving our corporate priorities, and we will input further to the development of our ICS, making sure that the benefits of integrating our services with other parts of health and social care are achieved.

Setting our future priorities and strategic direction

The response to the COVID-19 pandemic and the drive for integration has accelerated the Trust's review of its corporate and clinical strategies in 2020-21. We have been developing our strategic priorities as part of an update to our 2018-22 Corporate and Clinical strategies with the expectation that our focus will adjust to three strategic priorities:

- Improving the health and well-being of the population we serve.
- The partnerships that will help us achieve this.
- Investing in the people who work for us to ensure they can deliver the best possible care.

Trust Risks, Opportunities and Sustainability

COVID-19 has presented the primary risk to the delivery of the Trust's broader corporate priorities. The Board Assurance Framework (BAF) is the tool which the Trust uses to assure itself about successful delivery of its priority objectives. High scoring risks in the Corporate Risk Register also have an impact on delivery. In addition to the broader impact and legacy of the 2020 phase of the

COVID-19 pandemic, the key risks being managed by Salisbury NHS Foundation Trust in 2020/21 are set out in the Annual Governance Statement below.

Further integration across BSW provides an opportunity for the Trust to refocus its strategic objectives against those set out in the system Long Term Plan. The Trust is committed to working alongside our partners to progress each of these priorities, along with the wider plans for greater integration of our services which have been accelerated as part of the pandemic response.

Going Concern

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

Looking forward to 2021-22

As we enter 2021-22, we remain focussed on the recovery from the intense COVID-19 related activity experienced by all our staff, local communities and partners throughout 2020. Our corporate priorities for the next year reflect this, and the strategy we are adopting to address the emerging risks we have identified in the Annual Governance Statement below. We look forward to driving forward the transformation of our services and further integration with our partners.

The Trust therefore starts the year focussed on:

- Recovering our planned care programmes and addressing the backlog of care and treatments that has arisen during the management of COVID-19
- The health, wellbeing and recovery of our staff
- Integrating our urgent care services, therapy and rehabilitation services and our care for frail and elderly people
- Further improvements through the Hospital Discharge Programme
- Reviewing our maternity and mental health services
- Strengthening our partnerships to improve the health of our local populations
- Major digital projects in prescribing, patient records, laboratory management and finance
- Publishing our updated corporate and clinical strategies and continuing to make Salisbury NHS Foundation Trust the 'Best Place to Work'.

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. This includes adherence and contribution to the BSW Design Principles (table below), supporting and working with our Primary Care Networks and making our Wiltshire Integrated Care Alliance a success.

No	Design Principle	Assumptions and Notes
1	**We work as one system** with parity of esteem between social care & wellbeing, mental and physical wellbeing.	• **We operate as one system** to plan and deliver ***high quality, value for money health & social care*** for our population in BSW. • **Operating as one system**, we approach social care & wellbeing, mental and physical health with equal importance, recognising the interdependency between them. • **Subsidiarity, transparency** and **distributed leadership** are embedded in how we work.
2	**Prevention** first, and recognition of the **Wider determinants of health**	• Our professionals focus on health & wellbeing; this starts with prevention • We focus on the **wider determinants of health** in the way that we design and deliver services with partners. • Our approach is asset and strength-based with the capacity and capabilities of individuals, neighbourhoods and communities at the centre of what we do.
3	**Care designed around individuals**.	• Health & Care services are designed ***with and around*** individuals and their needs: ***right*** *approach/* ***service, right place, right time*** based on a personalised approach and 'no decision about me without me'. • Teams strive for continual improvement in model of care. • Only essential staff are based in healthcare facilities
4	**Home is Best**	• Wherever possible people are supported at home including discharge from hospital to home • Assessments at home • Virtual wards
5	**Digital by default**	• Digital by default whilst protecting equality of access • Information will be shared safely and efficiently • Decision-making & direct care will be supported through a population health lens • A digital workforce supported through consistent tools and infrastructure • New care models are supported through digital enablers • Cyber security is a fundamental enabler
6	**Flexible workforce**	• Workforce operates in multidisciplinary teams beyond organisational boundaries • Co-located teams & community hubs • Community and voluntary sector workforce as a vital part of BSW team
7	**7-day provision**	• Hours to be optimised to enable timely decision-making and support.

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. While we have continued to develop these in 2020-21, we have had to focus our attention on the physical changes required to operate the hospital safely during the pandemic including significant improvements to allow social distancing, a reconfiguration of our Emergency Department, dedicated COVID-19 intensive care capacity and an expanded outpatient clinic area.

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

The Trust was required to rapidly reconfigure its services in order to respond to the COVID-19 pandemic. In short timescales the Trust ensured it had sufficient capacity to respond, keeping patients and staff as safe as possible, whilst continuing to deliver high quality care. All staff had to adapt to changes at work, and this was done with remarkable resilience, strength and determination from staff. A dedicated respiratory assessment zone (RAZ) was created in the Emergency Department, allowing better segregation of potentially infectious patients.

Inpatient ward areas were reconfigured to create a dedicated COVID-19 Respiratory Care Unit (RCU) with up to 60 beds. This supported efficient flow of potential COVID-19 patients from the Emergency Department and with a high number of side rooms provided appropriate isolation facilities. In the first wave this was largely enough capacity to manage the demand, however in the second wave the numbers of patients quickly outstripped this area, with substantially more beds required. Further wards were converted to COVID-19 areas as demand grew. At the peak the Trust had 188 COVID-19 positive inpatients.

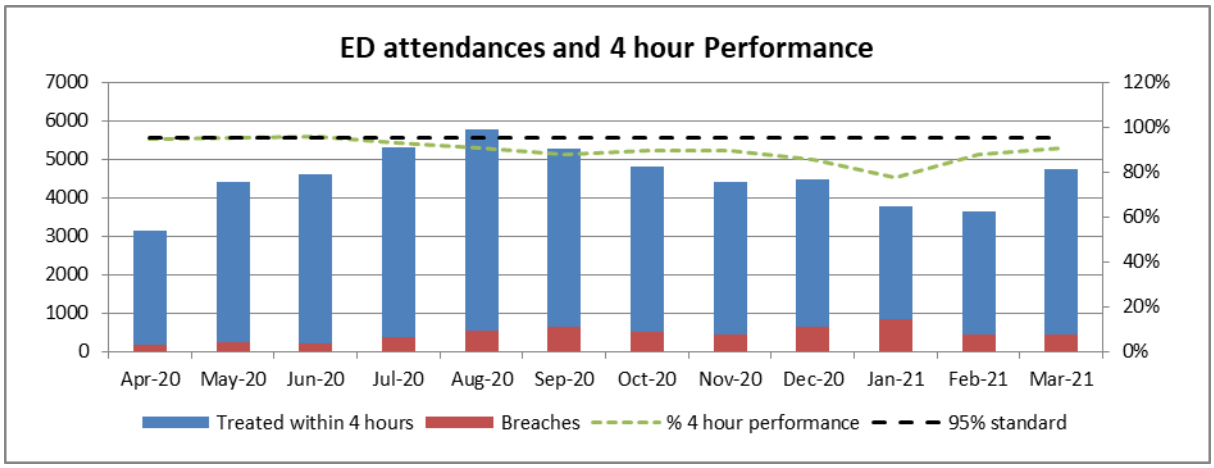
A second intensive care area was opened within our theatre complex to provide an additional, but temporary, critical care unit. Estate work was undertaken throughout Quarter 3 and Quarter 4 to upgrade an area within the Trust to be used as a permanent intensive care area. This opened in March, releasing theatre capacity and providing a long term escalation option for critical care.

Elective surgery continued throughout the second wave, with protected capacity in the Spinal unit preserved for these patients to reduce risk of contact in COVID-19 areas. Outpatient services were rapidly transformed with enhanced advice and guidance services available to GPs through email and telephone services. The use of telephone clinics was expanded, and Attend Anywhere video consultation was widely used. This reduced foot fall on the hospital site, and enabled adequate social distancing in waiting rooms and outpatient areas for those patients required to attend for a face to face appointment.

Emergency Access

As with many acute Trusts the delivery of the Four hour standard for treating 95% of patients attending the Emergency Department has been challenging for the Trust, and the COVID-19

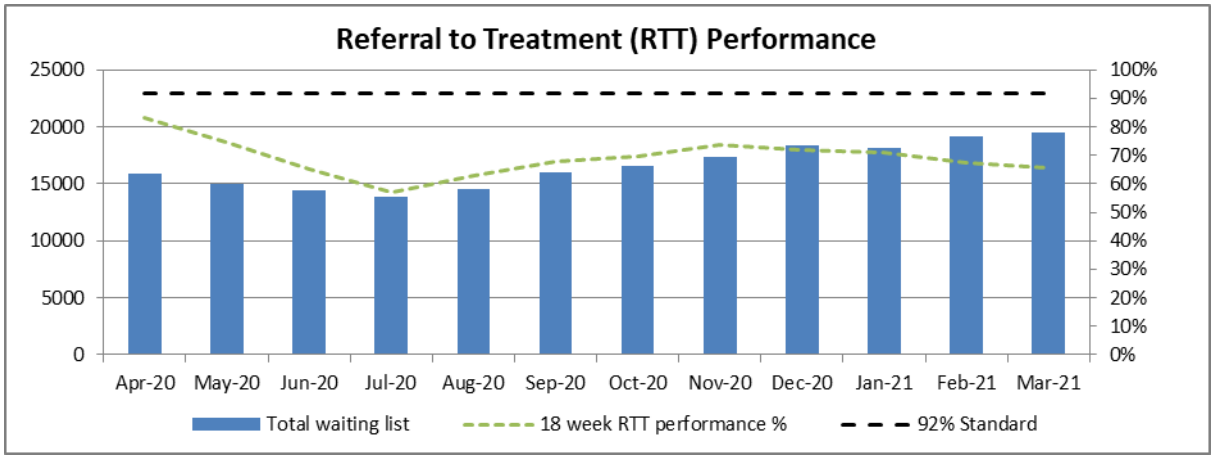
pandemic has added further complexities to the challenge. Attendances over the year have been low, and with an accompanying reduction in the inpatient occupancy levels, performance against the standard significantly improved during the first wave of the pandemic. As attendances increased, and prevalence of COVID-19 in the community began to rise the impact from pandemic was felt most acutely in Quarter 4. The Trust neared 50% of inpatient beds being used to treat COVID-19 patients.



Although ED activity remained lower than previous years the department was under significant pressure managing the flow of acutely unwell patients into the hospital. Despite this pressure the Trust maintained performance above the national average.

Elective care - Referral to Treatment (RTT)

The Trust continues to benchmark favourably against both the national performance and the performance across BSW, although as expected the pandemic has heavily affected the Trust's ability to deliver improved, or even maintained, performance against the 18 week referral to treatment standard.



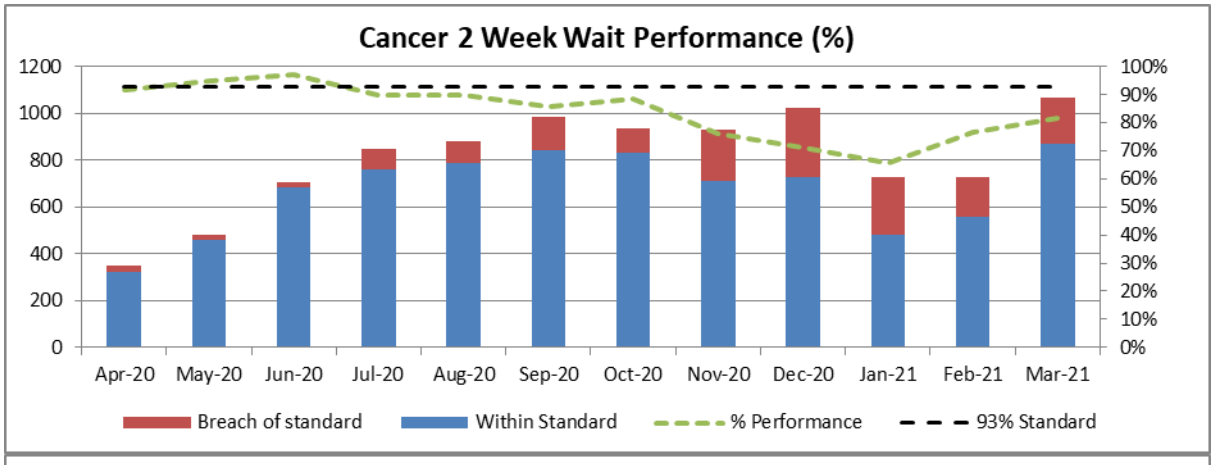
During the first wave of the pandemic all routine elective activity was suspended, however urgent and life threatening surgery was always maintained throughout the year. Routine surgery was restarted following wave 1, but the second, more intense, wave in quarter 4 resulted in routine surgery being further affected. As a result of high numbers of COVID-19 cases in the hospital a second intensive care area was maintained throughout Quarter 4 in the theatre complex, reducing the number of theatres available for elective operating.

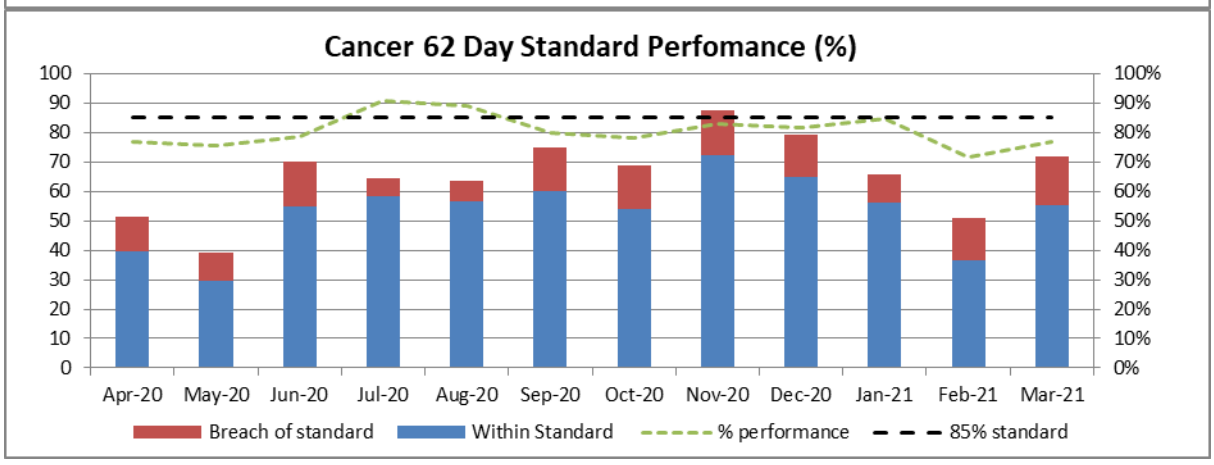
The waiting list volume initially shrank as GP referrals also reduced, but has steadily grown beyond the size at the start of the year, and the Trust was unable to recover performance against the standard. The Trust began to build a backlog of patients waiting longer than 52 weeks for elective treatment. Throughout the year the total waiting list size has increased from 15,958 in April 2020 to 19561 in March 2021. Within this the number over 52 weeks has grown from 10 in April 2020 to 1142 by March 2021. The Trust ended the year with RTT performance of 65.47% in March against the 92% RTT standard.

Some specialties have been more adversely affected than others, with surgical specialties such as Ear, Nose & Throat, Oral Surgery, Gynaecology and Ophthalmology that have a lower proportion of clinically urgent patients receiving reduced levels of access to theatre capacity in order to prioritise providing treatment to the most clinically urgent patients first.
Medical specialties that have been limited by their ability to see patients in a face to face environment have also seen big growth in their waiting lists, in particular Respiratory and General Medicine.

Recovery plans for 2021-22 focus on increasing capacity in specialties close to levels achieved in 2019/20. Increasing theatre staffing, continuing with virtual outpatients and working with our partners across the Integrated Care System will be key to delivering improved and equitable waiting times.

Elective Care - Cancer pathways

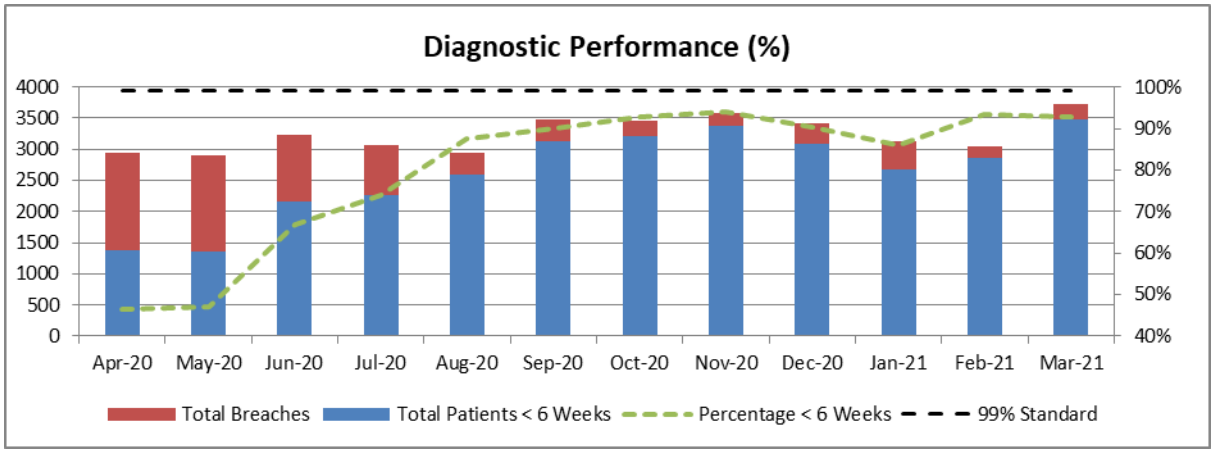




Performance against the cancer waiting times targets has been more challenging in the second half of the year. Throughout the pandemic urgent and emergency treatment was maintained, and initially performance against the cancer standards increased, however this was likely due to referral levels dropping as a result of patients not presenting in primary care for onward referral. Throughout the second half of the year performance against the two week wait standard fell, in

particular for Breast services. Constraints in space to facilitate social distancing measures in outpatient departments led to challenges in utilising capacity effectively.

Elective Care – Diagnostic waits



Performance against the six week diagnostic standard was greatly affected by the ceasing of routine activity during the first wave of the pandemic, and as a result performance fell to less than 50% early in the year. It has steadily improved as the year progressed and despite further peaks in COVID-19 activity in the Trust, performance was recovered close to pre COVID-19 levels by the end of the year. As with other elective measures referral rates remained below pre COVID-19 levels throughout the year, and capacity was reduced by the implementation of social distancing measures.

We continue to assess all of our service performance, clinical policies and processes and change projects through Equality Impact Assessments which guide our services through the potential impact on equality of access and quality of care which could arise either from existing service delivery or proposed changes.

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 2020-21

Dr Nick Marsden	Chairman
Stacey Hunter	Chief Executive (from 1 September 2020)
Cara Charles-Barks	Chief Executive (until 30 August 2020)
Dr Christine Blanshard	Medical Director (until 25 August 2020)
Dr Peter Collins	Interim Medical Director (from 5 October 2020)
Andy Hyett	Chief Operating Officer
Lorna Wilkinson	Director of Nursing (until 29 June 2020)
Judy Dyos	Interim Director of Nursing (from 30 June 2020)
Lisa Thomas	Director of Finance
Lynn Lane	Interim Director of Organisational Development and People
Michael von Bertele CB, OBE	Non-Executive Director
Rachel Credidio	Non-Executive Director (until 30 April 2020)
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 Director 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/5yalae1w/trust-board-register-of-members-interest-2021.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 2020/21, 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 has been Trust Board agreement to undertake a self-assessment against the well-led framework in October 2021 and the commissioning of an external well-led review in May 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 2020-21 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 of 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	86.0%	89.7%
NHS	75.2%	82.2%
Total	85.7%	89.4%

Information on fees and charges

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

		2020-21	***2019-20***
	Expected sign		
Income	+	*13,065*	*14,535*
Full cost	-	*12,103*	*-11,577*
Surplus/Deficit	+/-	***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 of these areas amounted to around £6.9 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £9.3 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £1.7 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.

Stacey Hunter
Chief Executive (Accounting Officer)
18.06.2021 (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's Remuneration Policy
- The Annual Report on remuneration

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2020-21.

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 2020-21. 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.

2020-21 major decisions on remuneration

During 2020-21, the Remuneration and Nominations Committee did not make any major decisions affecting remuneration for very senior managers. In line with recommendation received from NHS England and NHS Improvement in November 2020 regarding an annual cost of living pay increase, the uplift was applied in line with the recommendations.

The changes to the Trust's Executive team during 2020-21 were:

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

Nick Marsden
Remuneration Committee Chairman
18.06.2021

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 Medical Director*) 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 Medical Director 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 Medical Director. The Medical Director 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	Individual pay point is set within a pre designed pay band which has a minimum and maximum	Pay is reviewed annually in relation to individual performance based

	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 outlined in its annual priorities and its long term strategic goals of: Local Services - meeting the needs of the local population by developing new and improved ways of working which always put patients at the centre of all we do Specialist Services - providing innovative, high quality specialist care delivering outstanding outcomes for a wider population Innovation - promoting new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust Care - treating our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm People - making the Trust an outstanding place to work where everyone feels valued, supported and engaged and are able to develop as individuals and as teams Resources - making best use of our resources to achieve a financially sustainable future, securing the best outcomes within available resources	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.	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	(See above)	(see above)

	Executive Directors includes any amount received (See Basic salary on how this component supports short and long term strategic objective/goal of the Trust)		
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 strategic goals stated in the basic salary component.	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme
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 is 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 and long term strategic objectives outlined in its annual priorities and its long term strategic goals of: Local Services - meeting the needs of the local population by developing new and improved ways of working which always put patients at the centre of all we do Specialist Services - providing innovative, high quality specialist care delivering outstanding outcomes for a wider population Innovation - promoting new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust Care - treating our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm People - making the Trust an outstanding place to work where everyone feels valued, supported and engaged and are able to develop as individuals and as teams Resources - making best use of our resources to achieve a financially sustainable future, securing the best outcomes within available resources	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
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, his 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 2016	3 months
Rakhee Aggarwal	Non-Executive Director	Commenced January 2020	3 months
Tania Baker	Non-Executive Director	Commenced June 2016	3 months
Michael von Bertele	Non-Executive Director	Commenced November 2016	3 months
David Buckle	Non-Executive Director	Commenced January 2020	3 months
Rachel Credidio	Non-Executive Director	Commenced March 2018	Left April 2020
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2019	3 months
Paul Kemp	Non-Executive Director	Commenced February 2018	3 months
Paul Miller	Non-Executive Director	Commenced March 2018	3 months
Cara Charles-	Chief Executive	Commenced February 2017	Left August

Barks			2020
Christine Blanshard	Medical Director	Commenced September 2011	Left August 2020
Peter Collins	Interim Medical Director	Commenced October 2020	6 months
Judy Dyos	Director of Nursing	Commenced June 2020	6 months
Stacey Hunter	Chief Executive	Commenced September 2020	6 months
Lynn Lane	Interim Director of OD & People	Commenced October 2019	Left March 2021
Andy Hyett	Chief Operating Officer	Commenced April 2015	6 months
Lisa Thomas	Director of Finance	Commenced September 2017	6 months
Lorna Wilkinson	Director of Nursing	Commenced August 2014	Left June 2020

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 three meetings
Nick Marsden	Chairman	4
Rakhee Aggarwal	Non-Executive Director	4
Tania Baker	Non-Executive Director	4
Michael von Bertele	Non-Executive Director	4
David Buckle	Non-Executive Director	4
Rachel Credidio	Non-Executive Director	0
Margaret (Eiri) Jones	Non-Executive Director	4
Paul Kemp	Non-Executive Director	4
Paul Miller	Non-Executive Director	4

External advice is not routinely provided to the Remuneration Committee. However, the Chief Executive, Director of Organisational Development and People and the Director of Corporate 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
2019/2020	17	10	£12,677	18	6	£2,579
2020/2021	18	6	£22,011	22	3	£299
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 2021					
	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
Rachel Credidio - Non Executive	0-5	0	0	0	0	0-5
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	95-100	0	0	0	95-97.5	190-195
Cara Charles-Barks - Chief Executive	80-85	0	0	0	27.5-30	110-115
Lisa Thomas - Director of Finance	130-135	0	0	0	57.5-60	190-195
Peter Collins - Medical Director	95-100	0	0	0	10-12.5	105-110
Christine	75-80	0	0	0		

Blanshard - Medical Director					30-32.5	105-110
Judy Dyos - Director of Nursing	80-85	0	0	0	102.5-105	180-185
Lorna Wilkinson - Director of Nursing	25-30	0	0	0	55-57.5	85-90
Lynn Lane - Interim Director of Organisational Development & People	135-140	0	0	0	0	135-140
Andy Hyett - Chief Operating Officer	115-120	0	0	0	40-42.5	160-165

This table is subject to audit

The amount shown above for Christine Blanshard, and Peter Collins Medical Director, 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 April 2020

Lorna Wilkinson left her post as Director of Nursing on 29 June 2020 and Judy Dyos started on 30 June 2020

Name and Title	Remuneration Year to 31 March 2020					
	Salary (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Annual Performance Related Bonus (bands of £5000) £000	Long-Term Performance Related Bonus (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Nick Marsden - Chairman	40-45	0	0	0	0	40-45
Paul Kemp - Non Executive	10-15	0	0	0	0	10-15
Tania Baker - Non Executive	15-20	0	0	0	0	15-20
Rachel Credidio - Non Executive	10-15	0	0	0	0	10-15

Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Jane Reid - Non Executive	5-10	0	0	0	0	5-10
Michael von Bertele OBE - Non Executive	10-15	0	0	0	0	10-15
R Aggarwal - Non Executive	0-5	0	0	0	0	0-5
M Jones - Non Executive	5-10	0	0	0	0	5-10
D Buckle - Non Executive	0-5	0	0	0	0	0-5
Stacey Hunter - Chief Executive	0	0	0	0	0	0
Cara Charles-Barks - Chief Executive	185-190	0	0	0	45-47.5	230-235
Lisa Thomas - Director of Finance	125-130	0	0	0	45-47.5	170-175
Peter Collins - Medical Director	0	0	0	0	0	0
Christine Blanshard - Medical Director	175-180	0	0	0	32.5-35	205-210
Judy Dyos - Director of Nursing	0	0	0	0	0	0
Lorna Wilkinson - Director of Nursing	120-125	0	0	0	55-57.5	175-180
Paul Hargreaves - Director of Organisational Development & People	45-50	0	0	0	20-22.5	70-75
Lynn Lane - Interim Director of Organisational Development & People	50-55	0	0	0	0	50-55
Andy Hyett - Chief Operating Officer	115-120	0	0	0	7.5-10	125-130

This table is subject to audit

The amount shown above for Christine Blanshard, Medical Director, represents her total salary and any remuneration received from her clinical role. 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.

The pension related benefits figures for 2019-20 have been restated to include lump sum increases in addition to annual pension rate increases.

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 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 1 April 2020 £000	Employers Contribution to Stakeholder Pension To nearest £100
Cara Charles-Barks - Chief Executive	0-2.5	0-2.5	35-40	50-55	554	20	469	0
Stacey Hunter - Chief Executive	10-12.5	7.5-10	45-50	95-100	860	85	680	0
Christine Blanshard - Medical Director	0-2.5	5-7.5	80-85	230-235	2,061	52	1,874	0
Peter Collins - Medical Director	0-2.5	0	45-50	95-100	835	10	781	0
Lorna Wilkinson - Director of Nursing	0-2.5	5-7.5	50-55	125-130	1,126	55	875	0
Judy Dyos - Director of Nursing	5-7.5	10-12.5	25-30	60-65	469	80	342	0
Lisa Thomas - Director of Finance	2.5-5	2.5-5	35-40	70-75	560	39	495	0
Andy Hyett - Chief Operating Officer	2.5-5	0-2.5	45-50	100-105	796	36	731	0
Lynn Lane - Interim Director of Organisational Development & People	0	0	0	0	0	0	0	1,300

Lynn Lane was not a current member of the NHS pension Scheme and so no additional benefits accrued to her in the year under this scheme.

This table is subject to audit

Notes to Remuneration and Pension Tables

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).

Median Remuneration that Relates to the Workforce (Including Fair Pay Multiple) – these figures are subject to audit

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director in the financial year 2020-21 was £185,000 (£190,000 in 2019-20). This was 7.1 times (7.2 times in 2019-20) the median remuneration of the workforce, which was £25,900 (£26,200 in 2019-20). The Trust's median remuneration reduced in 2020/2021 compared with the previous year. This resulted from the changes to the national Agenda for Change pay scales whereby newly recruited staff within the median pay band serve a number of years before receiving an actual salary increase (increment).

In 2020-21, one employee (three in 2019-20) received remuneration in excess of the highest paid Director. Remuneration ranged from £14,000 to £213,000 (£13,300 to £197,000 in 2019-20). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Payments for loss of office

There were no payments made to senior managers for loss of office in 2020-21 or 2019-20.

Payments to past senior managers

None to report in 2020-21.

The Remuneration Report has been approved by the Trust Board

Stacey Hunter
Chief Executive (Accounting Officer)
18.06.2021 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs (subject to audit)

	Total 2020/2021 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	**140,670**	140,670	0
Social security costs	**14,144**	14,144	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	**16,204**	16,204	0
Paid by NHSE on provider's behalf (6.3%)	**7,073**	7,073	
Pension cost – other	**42**	42	0
Temporary staff/agency contract staff	**5,391**	0	5,391
Apprenticeship levy	**676**	676	0
TOTAL STAFF COSTS	**184,200**	178,809	5,391
Less: Costs capitalised as part of assets	**(854)**	(854)	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	**183,346**	177,955	5,391

Analysis of average staff numbers (subject to audit)

	Total 2020/ 2021 number	Permanently employed 2020/2021 number	Other 2020/ 2021 number	Total 2019/ 2020 number	Permanently employed 2019/2020 number	Other 2019/ 2020 number
Medical and Dental	444	432	12	413	405	8
Administration and Estates	1,289	1,214	75	1,103	1,044	59
Healthcare assistants and other support staff	493	475	17	699	693	6
Nursing, midwifery & health visiting staff	1,067	1,061	6	942	919	23
Scientific, therapeutic and technical staff	668	668	0	441	424	17
Total	**3,961**	**3,851**	**110**	**3,598**	**3,485**	**113**

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 2021

Head Count	Female	Male	Total
Directors	7	7	14
***Senior managers**	4	3	7
All other staff	3,642	1,102	4,744

**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

Between April 2020 and March 2021 the Trust has seen a decrease in sickness absence levels from 27,669 working days lost in 2019/20, to 27,491 in 2020-21.

It is our aim to reduce sickness absence to our stretch target of 3%. During 2020-21 absence rates decreased below the previous year's level of 4.02% to 3.75%. Within this figure, 2.03% related to short term absence whilst long term absence accounts for 1.72% in total; although 28.5% of our staff recorded no sickness absence, we saw significant absence in January 2021 due to COVID-19.

The Trust has procedures in place to manage short term and long term sickness absence. For frequent short term absence a trigger tool is used to help managers set a target for improvement. For long term absences where there is a single underlying cause, staff are referred to Occupational Health and absence is reviewed on a regular basis, providing support and giving due consideration to re-deployment, reasonable adjustments (in the case of disability) and phased return to work.

In addition to the above managers are able to view their sickness absence data by using ESR Manager Self Service. This includes the number of episodes of sickness absence, enabling managers to identify those areas where additional intervention and support is required. Data is also shared with Staff Side organisations on a regular basis.

Ill health can result in impaired productivity if the staff member has remained at work or sickness absence if remaining at work has not been possible. It has been proven that early intervention can have a positive impact on staff in relation to recovery, positive outcomes to their overall wellbeing and/or ability to return to work and their productivity levels. All of which, we know has a positive effect in terms of the individual, team morale and patient outcomes.

Salisbury NHS Foundation Trust offers a range of proactive wellbeing initiatives with the view of promoting health and wellbeing for all staff. This includes an in house full time physiotherapist and

counselling service, monthly health and wellbeing topics/events, trained mental health first aiders, the implementation of a psychological wellbeing practitioner role to promote psychological wellbeing for managers and their teams and the promotion of health improvement coaches for weight management, alcohol, smoking, healthy eating, increasing physical activity and building confidence and motivation. Staff have 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 as a result of the pandemic. A clinical COVID-19 support line dedicated to staff for COVID advice and staff testing has been in place throughout the last 12 months. National and internal health and wellbeing initiatives are frequently advertised to ensure that staff are well informed of the support services required to promote their holistic wellbeing. This is also available in a handy pocket size leaflet. The offer of a Flu and COVID-19 vaccine has been made available to all staff.

Policies

All the Trust policies are time-limited, to comply with the principles of good governance, and require a periodic review to ensure alignment with current employment legislation and best employment practice. The intervals of such review will vary from six months to three years, dependent upon the subject matter and the employment landscape at the time of the review.

All employment policies are subject to consultation with staff side colleagues with regular discussions occurring through the Joint Consultative Committee (JCC) for staff groups covered by Agenda for Change terms and conditions of service, and the Joint Local Negotiating Committee (JLNC) for those staff groups covered by medical terms and conditions.

Policies that are currently in development include the introduction of a new Workforce Investigation policy which is designed to further embed and therefore standardise delivery of high-quality investigations across the Trust, and following positive feedback linked to staff wellbeing initiatives introduced as part of the Trust's COVID-19 response, revision of the Trusts Stress and Wellbeing at Work policy is currently with staff side colleagues for approval.

Other policies that have undergone recent review and update include:

Professional Registration Policy
Secondment Policy
Pre & Post Employment Checks
Trust Associate Specialist
Volunteering Policy
Starting Salaries Policy
Recruitment and Retention Premia (RRP) Policy
Domestic Abuse Policy - Supporting Our Employees
Disclosure and Barring Service Policy
Policy for Use of Bank and Agency
Recruitment and Selection Policy
Personal Contributions for Training and Development Policy

All Trust policies including those linked to counter fraud and corruption, are either ratified by the Trust's Operational Management Board (OMB) or the Trust Management Committee (TMC). Employees are then signposted to approved policies via the Trust's central Microguide system.

Health and Safety

The Health and Safety function is supported by a committee, including representatives from every area of the Trust and staff side organisations, which meets regularly and disseminates policy and information to the wider Trust. This committee also has responsibility for other sub-Committees for specific areas for example Fire Safety, Waste and Radiation Protection. The 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 in the Trusts 'Health and Safety Policy.' Although the ultimate responsibility lies with the Chief Executive Officer, the day to day management is with the Director of Organisational Development and People and their Deputy.

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, as part of its responsibility to manage risk, facilitates an annual audit system that is conducted by clinical and non-clinical areas. This covers the full range of Health and Safety topics at a corporate level. The Health and Safety Manager provides a strategic overview of the Trust's position regarding regulatory compliance and ensures that a systematic approach to measuring health and safety and demonstrating assurance is in place. They monitor practicable safe systems of work that are in evidence and complied with throughout the organisation. For the current, and previous, financial year there has been support given for the management of COVID-19 requirements for the Trust.

The Health and Safety governance arrangements are currently under review to strengthen reporting and to ensure there is appropriate escalation to the Trust Board.

Consultancy Expenditure - Off Payroll Payments

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater **For all off-payroll engagements as of 31 March 2021**	
	Number
Number of existing engagements as of 31 March 2021	**11**
Of which:	
Number that have existed for less than one year at the time of reporting	**2**
Number that have existed for between one and two years at the time of reporting	**5**
Number that have existed for between 2 and 3 years at the time of reporting	**1**
Number that have existed for between 3 and 4 years at the time of reporting	**2**
Number that have existed for 4 or more years at the time of reporting	**1**

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater.	
	Number

Number of off-payroll workers engaged during the year ended 31 March 2021	**12**
Of which...	
Not subject to off-payroll legislation	**0**
No. assessed as caught by IR35	**6**
No. assessed as not caught by IR35	**6**
No. of engagements reassessed for consistency / assurance purposes during the year.	**6**
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 2020 and 31 March 2021**	
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

A total of 2,062 or our staff (54.2% of the total) took part in the 2020 NHS Staff Survey. This compares to a response rate for last year's survey of 54.0% (1,954 responses).

For 2020 the survey results were grouped into ten key themes. The Trust score was above average for five of the ten key survey themes, average for one theme (ED & I) and below average for four themes, (Quality of Care, Safe Environment – Violence, Safety Culture, Team Working).

All themes are listed with the Trust Score overleaf:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	6.2	6.9	6.3	7.4	8.2	9.4	6.7	7.2	6.4
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,009	2,022	2,024	1,998	1,792	1,960	2,013	2,009	2,041	2,030

The Trust Score improved compared to last year in two themes, remained the same in three and deteriorated in five. Actions are currently being developed to address key themes arising from the survey and will be aligned with the Trust's 'Best Place to Work' programme as described in the Leadership and Development section below.

Equality, Diversity & Inclusion (ED&I)

The Trust recognises that delivering on equality, diversity and inclusion is a key driver to achieving the Trust's overall strategic aims. It gives a real opportunity to place people at the centre of the work the Trust undertakes, recognising how respecting and valuing the diversity of patients, their relatives, carers, and our people helps to provide high quality care whilst meeting the needs and expectations of the diverse communities we serve.

The Trust is fully committed to engaging and involving all our staff to ensure that they have the appropriate skills to understand some of the causes and employment inequalities of protected groups through ensuring that ED&I training is mandatory for all staff. The close link between EDI and the Freedom To Speak Up Programme has continued. The Head of Diversity & Inclusion and The Freedom To Speak Up Guardian regularly run training sessions together and attend Trust Induction every Monday.

The Trust has continued to meet its legal and contractual duties by engaging with the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap reporting programme. Summaries of the relevant reports for 2020 are included in this report. The original reports are available on the Trust website. For the first time this year the Trust has included the equality data for our 600 volunteers.

During the past 12 months the Trust has reviewed its EDI Policy, introduced a new Equality Impact Assessment process and updated its equality pages on the Trust website.

EDI activity was disrupted by the COVID-19 Pandemic. The pandemic has focussed us on supporting the most vulnerable groups within our workforce and patients. We have engaged

closely with all our people and in particular those who were disproportionally affected (e.g. BAME (Black, Asian and Minority Ethnic) people and people with health conditions.)

The Trust has continued to develop and support a number of staff networks. At the present time the following networks are operating at various stages of development:

- BAME Forum
- Rainbow Shed Network – LGBT+ Network
- Women's Network
- Mental Health First Aiders Network
- #LoveOUREUStaff Network

Work has also started on creating a Disability Network.

The Trust ED&I Committee has been meeting throughout the year and is a link between the Staff Networks and the Organisational Development and People Management Board. The Committee is continuing to align our work programmes to The NHS People Plan and the results of the Best Place to Work programme.

The Trust Head of ED&I now leads a programme of work across the BSW (Bath and North East Somerset, Swindon and Wiltshire) region landscaping the regional ED&I provision and establishing an ED&I network.

Freedom to Speak Up Guardian (FTSUG)

National work

Five years have passed since the publication of the Francis Freedom to Speak Up Review in 2015. The speaking up culture of the health sector in England has changed with a network of over 600 Freedom to Speak Up Guardians in over 400 organisations.

The National Guardian's Office has launched, with Health Education England, training for all workers, and plan training for managers and leaders – with the view that everyone needs to take personal responsibility for their actions.

As the health landscape continues to evolve with the development of Integrated Care Systems (ICS), Regional Integration Plans have been produced to describe actions going forwards and how to measure progress and uptake. The National Guardian's Office is working with primary care organisations to show how this can work at system level. By working in partnership with others we will improve speaking up across patient pathways.

At the start of the first lockdown, the National Guardian's Office launched the first of three pulse surveys to gauge the impact of the pandemic on speaking up. There has been a mixed response; those who had an established culture of speaking up said it made things easier. Others had a less positive response reporting there simply was not enough time to listen to everything workers were raising. The Care Quality Commission (CQC) Chief Inspectors and the National Guardian wrote to all Trust CEO's and Chairs to remind them about how important it was to maintain safe speaking up channels for their workers.

Regional work

The Trust's FTSUG has attended the regional network meetings that have been held virtually during the past 12 months. The main focus has been on peer support during the pandemic. This has been strengthened by regular meetings with the FTSU Guardians from Royal United Hospitals Bath and Great Western Hospital to share experiences, what has worked well and what areas require improvement.

In response to the need to be developing services within the Integrated Care System, recent discussions with Sarum North Primary Care colleagues have taken place and a proposal is being developed for the Trust to provide FTSU services on a consultancy basis commencing early summer 2021.

Local work

During this extraordinary time for the health and care sector, the importance of workers being able to speak up freely is more important than ever. The Trust has responded to this by promoting FTSU in the daily COVID-19 Staff Bulletin and posters have been put up all around the Trust. During the autumn of 2020 the FTSUG recruited five FTSU Ambassadors to support the FTSU programme and support staff networks in promoting Speaking Up and developing an open and honest culture.

Despite the restrictions in place for COVID–19, the numbers of concerns being raised through FTSU has continued to increase in line with the national trajectory. 105 cases were raised during 2020-21, compared to 85 during the same period in 2019-20. Where issues are complex, external investigations commissioned by the Executive Team have taken place.

During this period, the FTSUG has been working full time on site, enabling staff to raise concerns in real time. Induction for new starters has been moved to virtual training, but will move back to face to face when restrictions allow. NHSI/E and Heath Education England (HEE) have developed a three tier on-line training package specifically for FTSU. The first level, Speaking Up in a Healthcare Environment, has been released and is on the Trust's e-learning platform. The Trust Management Committee has agreed that this training for all workers will become mandatory from 1st April 2021.

Apprenticeships

COVID 19 has impacted the uptake of apprenticeships, with a reduction in activity and some programmes pausing. Despite this the Trust has continued to see new starts, albeit in smaller numbers than the Trust would like in order for us to meet our financial and staff development targets.

The more significant impact of COVID-19 has been on the strategic planning and recommendations set out in the 2019-20 Apprenticeship annual report. Whilst some work has been able to continue some has not been started, and nothing is yet completed. The Trust anticipates the start of a number of apprenticeships in the next quarter, including Registered Nurse Degree Apprenticeships (RNDA). This includes a top-up programme from Nursing Associate to Registered Nurse Degree Apprenticeship (RNDA) made available in part due to potential funding from HEE for salary support.

The Trust Wide Training Needs Analysis process that took place at the end of 2020 has identified a number of apprenticeships which could be started as soon as staff are available.

There has been an increase in professional degree apprenticeships available through BSW, South West and National procurement and the Trust will be accessing some of these from September 2021, notably an apprenticeship in Therapy and Radiography. This will support the development of roles which have been identified as hard to fill in the past as well as providing internal development for our people.

Working within BSW the Trust will increase the amount of levy money that can be transferred to other organisations within the system to avoid 'sunsetting'. The term given to money within the apprenticeship levy pot which is not used and then returned to the Treasury. Plans are already in place for a collaborative recruitment programme with a GP surgery to recruit Pharmacy

Technicians, and further support for Trainee Nursing Associates. The Trust is committed to five in 2021.

	April 18- March 19	April 19- March 20	April 20- March 21
Number of apprentices	29	84	125 (plus 7 on pause)
Number of training providers	6	13	19
Current funds	£1,017,848	£1,207,780.00	£1,318,012
Total spent so far	£81,944	£407,238.17	£430357
% of monthly payment spent	19%	48% (based on Feb figures due to error payment in March)	64%
	Apprenticeships in progress		
	Assistant Accountant	Advanced Clinical Practitioner	Accountancy or taxation professional, Level: 7 (Standard)
	Business Administrator	Assistant Accountant	Advanced Clinical Practitioner, Level: 7
	Chartered Manager Degree	Associate Project Manager	Associate project manager, Level: 4
	Healthcare Assistant Practitioner	Business Administrator	Business Administrator, Level: 3
	Infrastructure Technician Level 3	Chartered Manager Degree	Chartered manager degree apprenticeship, Level: 6
	Senior Healthcare Support Worker	Commercial Procurement and Supply	Commercial Procurement and Supply, Level: 4
	Team Leader/Supervisor	Engineering Technician Maintenance	Engineering Manufacture: Engineering Technical Support, Level: 3
		Health Pharmacy Services	Health Pharmacy Services, Level: 3
		Healthcare Assistant Practitioner	Healthcare assistant practitioner, Level: 5
		Healthcare Science Associate	Healthcare science associate, Level: 4
		Healthcare Science Practitioner	Healthcare Science Practitioner, Level: 6
		Healthcare Support Worker	Healthcare support worker, Level: 2
		Maintenance and Operation Engineering Technician	Lead adult care worker, Level: 3
		Nursing Associate	Learning and Skills Teacher, Level: 5
		Operating Departmental Practitioner	Nursing Associate, Level: 5

		Operational/Departmental Manager	Operating Department Practitioner Level: 6
		Senior Healthcare Support Worker	Operations / departmental manager, Level: 5
		Senior Leader	Payroll Administrator, Level: 3
		Team Leader/Supervisor	Pharmacy Services Assistant, Level: 2
			Pharmacy Technician (integrated), Level: 3
			Senior healthcare support worker, Level: 3
			Senior Leader Master's Degree Apprenticeship, Level: 7
			Team leader / supervisor, Level: 3

Leadership and Development

The Trust has continued to develop its leadership offer. In February 2020 the Trust embarked upon a Trust-wide culture change program entitled the 'Best Place to Work' which is based on the evidence-based NHS Improvement (NHSI) 'Culture and Leadership' programme. It is widely acknowledged that:

> "A healthcare organisation's culture – the way we do things around here – shapes the behaviour of everyone in the organisation and directly affects the quality of care they provide. Research shows the most powerful factor influencing culture is leadership" (NHSI).

The programme has three distinct phases. Phase 1 the discovery phase which aimed to establish a baseline for the culture of the organisation is complete. Phase 2, the design phase commenced in February 2021. The purpose of this phase is to design a compassionate inclusive leadership strategy based upon the outputs from Phase 1. This strategy is based upon the Trust's organisational strategy and will describe the leadership needed to nurture an overall culture of compassion and inclusivity, identifying the skills and behaviours needed to achieve strategic goals, and to ensure this style of leadership is developed at all levels across the Trust. Phase 3 is the implementation phase and in order to prepare for this and as part of the initial development of the strategy there is a series of pilot leadership programmes being rolled out across the Trust which include:

- Co-creating compassionate inclusive culture workshops – delivery commencing in mid-May
- Best Place to Work Leadership Development programme – commencing on12th May
- Best Place to Work Clinical Service Leadership Programme, based upon the recommendations from Phase 1
- Midwives Band 7 and 8 development programme

Working with our partners across Bath and North East Somerset, Swindon and Wiltshire (BSW)

The Trust is involved in the establishment of a BSW system academy which will provide a real opportunity to utilise the skills and knowledge available in organisational academies to increase the learning and development opportunities for all, to reduce duplication, create efficiency and increase resilience in delivery of opportunities.

The Trust is already involved in a number of learning and development programmes where one organisation is delivering the programme on behalf of the system, for example:

- Associate Medical Director development programme
- Clinical Lead development programme (in development)

Our plan is to develop this further in programmes such as:

- Leadership apprenticeship training programmes for non-registered staff
- Equality, Diversity and Inclusion leadership programme for senior leaders
- Leading your first team

This is expected to be an area of significant growth as we expand system-wide delivery of care and ensure the learning opportunities and staff development reflects new models of care.

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 2020-21 are included in this table. The 2019-20 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	(4)9	(4)10
£10,000 - £25,000	(0)0	(1)3	(1)3
£25,001 – £50,000	(0)1	(0)	(0)1
£50,001 - £100,000	(0) 0	(0)1	(0)1
£100,001 - £150,000	(0)0	(0)	(0)0
£150,001 - £200,000	(0)0	(0)	(0)0
Total number of exit packages by type	(0) 2	(5)13	(5)15
Total resource cost	(£0)£43,000	(£24000) £164,000	(£24,000) £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	25
FTE union reps	21.59

Table 2
Percentage of time spent on facility time

Percentage of time	
0%	9
0-50%	16
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	£28,574
Total pay bill	£183,050,819
Percentage facility time	0.2%

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 2020-21 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 has been delayed until 2022, given the ongoing executive recruitment and the continued focus on COVID-19 recovery. The Trust Board will undertake a self-assessment later this year which will highlight specific areas of focus for improvement, prior to the external review in 2022.

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 2020-21 these covered:

- Membership and Communications Committee
- Performance Committee (Chairman and Non-Executive Directors)
- The Trust’s Annual Plan prior to submission to the regulator
- 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), and a joint meeting with the Trust Board to review the Annual Plan. 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.

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 / 3
Lucinda Herklots	Salisbury City	May 2018	Three years	5 / 5
Jan Sanders	Salisbury City	May 2017	Three years	1 / 1
Joanna Bennett	Salisbury City	June 2020	Three years	3 / 3
Sir Raymond Jack	South Wiltshire Rural	May 2018	Three years	4 / 5
Dr Alastair Lack	South Wiltshire Rural	May 2017	Three years	1 / 1
Jennifer Lisle	South Wiltshire Rural	May 2018	Three years	5 / 5
William Holmes	South Wiltshire Rural	May 2018	Three years	3 / 5
Dr James Robertson	South Wiltshire Rural	Sept 2019	Three years	3 / 5
Anthony Pryor-Jones	South Wiltshire Rural	June 2020	Three years	3 / 3
John Wigglesworth[1]	South Wiltshire Rural	June 2020	Three years	0 / 0
John Parker	North Dorset	May 2018	Three years	4 / 5
Christine Wynne	North Dorset	May 2018	Three years	4 / 5
John Mangan (Lead)	New Forest	Feb 2018	Three years	5 / 5
Peter Kosminsky	Kennet	June 2020	One year	3 / 3
Nicholas Sherman	East Dorset	Sept 2019	Three years	5 / 5
Mary Clunie	Rest of England	Feb 2018	Three years	5 / 5

[1] John Wigglesworth resigned from his post shortly after the election and therefore attended no Council of Governor meetings.

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	2 / 3
Pearl James	Volunteers	May 2018	Three years	5 / 5
Vacant	Hotel & Property Services	N/A	N/A	N/A
Jonathan Cullis	Medical & Dental	May 2018	Three years	3 / 5
Lee Phillips	Scientific, Technical & Therapeutic	May 2018	Three years	3 / 5
Jayne Sheppard	Nurses & Midwives	May 2018	Three years	4 / 5

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance from 5 meetings
Vacant	Wiltshire Council	June 2018	Three years	0 / 5
Vacant	Wessex Community Action	April 2017	Three years	4 / 5
Vacant	Dorset CCG	N/A	N/A	N/A
Dr Edward Rendell	BaNES, Swindon and Wiltshire (BSW) CCG	June 2020	Three years	3 / 5
Rachel King	West Hampshire CCG	January 2020	Three years	1 / 5
Vacant	Military	N/A	N/A	N/A

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. Executive and Non-Executive Directors also attend some of the Governor committees.

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

In 2020-21, 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:

Director 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 and Finance and Performance 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. The People and Culture Committee did not undertake a self-assessment as the Internal Audit of Board Governance and Compliance in November 2019 had identified improvements required. This has now been supported with the introduction of the OD and People Management Board.

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 , experience and outcomes of 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 Masters 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.

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.

Directors that left the Trust during 2020/2021

Cara Charles–Barks – Chief Executive

Cara Charles-Barks has a wide range of clinical and management experience in both the NHS and Australian healthcare systems. She qualified as a registered nurse in Australia in 1991 and, having worked in London for three years, moved back to Australia where she became a nurse consultant, then clinical practice manager and subsequently Nursing Director. Cara was then Deputy Chief Operating Officer in Peterborough in the UK and, before coming to Salisbury, she was Deputy Chief Executive Officer and Chief Operating Officer at Hinchingbrooke Health Care NHS Trust. Cara left the Trust in August 2020.

Dr Christine Blanshard – Medical Director

Christine Blanshard graduated in Medicine from Cambridge University in 1986 and has over 25 years NHS experience. She trained in East Anglia and London, and became a consultant gastroenterologist and general physician in 1998. She has undertaken a variety of managerial roles alongside her clinical work and before joining the Trust was Director of Strategy and Associate Medical Director at Homerton University Hospital NHS Foundation Trust. Christine left the Trust in August 2020.

Rachel Credidio – Non Executive Director (Independent)

Rachel Credidio joined the Trust in March 2018 for a one year period. This term of office was extended for a further two years from March 2019. She started her career in housing in 1998 and has worked for the Aster Group since 2005. Rachel's current role is Group People and Transformation Director, where her role includes people, IT and communications. Prior to this she was Group Strategic Change Director. She has been sponsor for the group's major change projects. Previous roles at Aster included Sales and Development Director. Rachel left the Trust in April 2020.

Lynn Lane – Director of Organisational Development and People

Lynn joined the Trust in October 2019 with over 20 years' generalist HR experience working at Executive Director level with both the BBC, and the NHS. Lynn lives in Oxfordshire and works primarily covering interim director roles across London, the South East and the South West of the UK in both the acute and non-acute sectors. Lynn left the Trust in March 2021.

Lorna Wilkinson – Director of Nursing

Lorna qualified as a registered nurse at the Royal Free Hospital, London in 1989 and has over 30 years NHS experience. She progressed through a number of nursing roles in London before moving into quality improvement and clinical governance. She was Deputy Director of Nursing, firstly in Salisbury and then in Portsmouth, before returning to the Trust in August 2014 as Director of Nursing. Lorna left the Trust in May 2020.

Board of Directors' Attendance (Members attendance only)

	Appointment Date		Trust Board (12 meetings)	Audit Committee (5 meetings)	Remuneration Committee (4 meetings)	Finance & Performance (12 meetings)	Clinical Governance Committee (10 meetings)	People and Culture Committee (8 meetings)	Subsidiary Governance Committee (3 meetings)	Council of Governors (4 meetings)
	From	To								
Rakhee Aggarwal Non-Executive	01/01/20	-	12		4			7		2
Tania Baker Non-Executive	01/06/16	-	12	4	4					1
Michael Von Bertele Non-Executive	01/11/16	-	11	4	4			7		1
Christine Blanshard [1] Medical Director	05/09/11	25/08/20	5				3	2		0
Dr David Buckle Non-Executive	27/01/20	-	12		4		3			3
Cara Charles-Barks [2] Chief Executive	09/01/17	31/08/20	5	1		4	4			2
Peter Collins [3] Medical Director	05/10/20	-	4				6	3		1
Rachel Credidio [4] Non-Executive	11/03/18	30/04/20	0		0					0
Judy Dyos [5] Director of Nursing	15/06/20	-	9				9	6		3
Andy Hyett Chief Operating Officer	13/04/15	-	10			10	8			0
Stacey Hunter [6] Chief Executive	01/09/20	-	6	3		7	5			2
Eiri Jones Non-Executive	11/11/19	-	12		4	12	10			2
Paul Kemp Non-Executive	01/2/15	-	12	5	4	12			3	1
Lynn Lane Director of OD & People	07/10/19	30/03/21	12			9		7	0	0
Nick Marsden [7] Chairman	01/01/14	-	12		4		6	1[7]	2	5
Paul Miller Non-Executive	16/04/18	-	12	5	4	12	10		3	2

Lisa Thomas Director of Finance	03/07/17	-	**12**	**5**		**12**			**3**	**0**
Lorna Wilkinson [8] Director of Nursing	04/08/14	29/06/20	**1**				**1**			**1**

[1] Christine Blanshard left the Trust in August 2020
[2] Cara Charles-Barks left the Trust in August 2020
[3] Peter Collins joined the Trust in October 2020
[4] Rachel Credidio left the Trust in April 2020
[5] Judy Dyos joined the Trust in June 2020
[6] Stacey Hunter joined the Trust in September 2020
[7] Nick Marsden acted as Chair for the March 2021 People and Culture Committee in Michael Von Bertele's absence. Although a regular attendee, Nick is not a member of People and Culture Committee.
[8] Lorna Wilkinson left the Trust in June 2020

The Audit Committee

Name	Committee Role	Attendance out of five meetings
Paul Kemp	Chairman	5/5
Michael von Bertele	Non- Executive Director	4/5
Tania Baker	Non- Executive Director	4/5
Paul Miller	Non- Executive Director	5/5

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 2020-21, 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.

During 2020-21 there was a distinct adjustment in priorities within the executive team due to COVID-19 which did have an impact on delivery of some actions. It is acknowledged that whilst delivery of some actions has been delayed, there are no indicators of any failures in the main control systems of the Trust.

The Committee reviewed the draft financial statements and governance statements for the 2019/20 Annual Report. The Trust and the auditors were required to make some late adjustments to the planned process of completing and reviewing the accounts, principally related to the necessity of adopting remote working. Overall, within the constraints of the circumstances, the process and outcomes were satisfactory.

Over the financial year 2020/21 PwC carried out reviews of six areas, agreeing a total of 22 actions with management, of which three were rated high risk findings. Of the 22 management actions 16 were agreed to be completed by year-end and 13 met this target. Additionally, there were six management actions from an audit undertaken in 2019-20 which remained incomplete at the end of 2020-21. Overall, the Head of Internal Audit issued a formal opinion of “generally satisfactory with some improvements required” as was reported the previous year. The opinion also noted seven specific examples of good practice within the Trust.

The Committee has continued to invite management teams to give detailed presentations on specific management processes or areas of concern. In 2020-21 the Committee received presentations on capital management processes, management of outsourced service contracts, programme management processes and management of cancer waiting lists. All of the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

The Committee also received regular updates from the Local Counter Fraud Officer (LCFO) who continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority.

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 2020-21.

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 2020-21 period, the Trust has incurred the following costs on external audit:

- Audit services: £77,735 (including VAT)
- Other services: None

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 2020-21. 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 Director of Finance and the internal audit fee for 2020-21 was £96,151**.**

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, 88% 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 2020-21 Judy Dyos was appointed as Interim Director of Nursing and Peter Collins was appointed as Interim Medical Director. Following a recruitment process for the substantive posts, both Judy Dyos and Peter Collins were successfully appointed to the Chief Nursing Officer and Chief Medical Officer roles respectively. Stacey Hunter was appointed as Chief Executive Officer and started at the Trust in September 2020.

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.

Until February 2021 the staff membership had six classes to reflect the following occupational areas:

- Medical and Dental
- Nurses and Midwives
- Scientific, Therapeutic and Technical
- Hotel and Property Services
- Clerical, Administrative and Managerial
- Voluntary

The Hotel and Property Services staff class had not been successfully filled for a number of years and therefore it was decided to merge this with the Clerical, Administrative and Managerial class. This staff class has been renamed Administrative, Facilities and Managerial. The constitutional change for this constituency was approved in January 2021 and February 2021 by the Trust Board and Council of Governors respectively.

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. However, in 2020-21 the Trust procured an externally managed database. A thorough data cleanse was undertaken and membership numbers have decreased since 2019/20 but remain at an expected level for the size of the organisation. At 31 March 2021 the membership for Salisbury NHS Foundation Trust was as follows:

Public Constituency	Number
Salisbury City	2,584
South Wiltshire Rural	5,235
Kennet	1,253
North Dorset	1,466
East Dorset	592
New Forest	1,058
Rest of England	1,126
Staff Constituency	1,707
Total	**15,068**

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 2020-21 the Trust hoped to widen the scope of the Trust's membership recruitment. However, due to COVID-19 and the impact on public gatherings and footfall in the hospital, recruitment has been challenging. It is hoped that the newly implemented membership database will help recruit members as it provides enhanced digital capability which the Trust did not have previously; e.g. people interested in Trust membership can now sign up online via the website. Furthermore, it is hoped that a focused membership page on the Trust's website and the re-introduction of constituency meetings and other events like 'Medicine for Members' will attract a more representative membership and is a focus for 2021-22.

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 this year Governors have been joining their Committee's and groups virtually due to the COVID-19 pandemic. 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 as well as formal constituency meetings where governors can gather the views of their members.

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 trust's 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 as at 31 March 2021. 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)
18.06.2021 (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 2021 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, 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 operational management, 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 Corporate Governance in place. Directorate 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 in 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.

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. A review of the Trust's risk appetite statement is taking place in 2021 and will inform the review of the Trust Risk management Strategy.

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 in order 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 as a whole 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 which were introduced in 2019 to strengthen the

governance arrangements. 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 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 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 three times per year 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 bi-monthly 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 2020-21 dominated with risks associated with the management of COVID-19. Whilst we have focussed on ensuring our staff and patients remain safe and effectively treated during the COVID-19 pandemic we have also sought to mitigate the effects of risk of the delayed diagnosis or treatment for non-COVID-19 related conditions. Key risks include:

- Information technology, clinical systems and technical infrastructure.
- Critical plant and building infrastructure within limited capital funding.
- Managing the cancer pathway and the consistent tracking of patients.
- Impact on patients, staff and service delivery as a result of COVID-19.
- Management of COVID-19 associated infection outbreaks.
- Health and well-being of staff during and following the pandemic.
- Maternity leadership capacity and culture
- Compliance with access standards

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

- Maximising the use of remote access to consultations
- Developing robust processes for tracking patient with known or suspected cancer and investigating any harm caused by delays
- Ensuring robust processes for prioritising elective surgery

- Working with our system partners to maximise elective diagnostic and treatment activity across all available providers
- Incident management structure in response to the National Level 4 incident
- COVID-19 risk assessment for all staff.
- Vaccination programme.
- Creative use of volunteers to support ward staff e.g. ward buddies
- Occupational Health and wellbeing support for staff including clinical psychology support
- Introduction of mental health first aiders
- Enhanced cleaning services
- Redeployment programme
- Implementation of the digital strategy and continued focus development of the infrastructure and controls.
- Thematic analysis of maternity serious incidents. Intensive support to the service management team. Development of a quality improvement plan following a commissioned external review of the maternity service.
- Robust capital prioritisation processes to ensure resources are deployed effectively.
- Continuation of the development of a health and care campus.
- Controls in place for oversight and monitoring of access and performance information.

Major risks 2021/2022

As we enter 2021/2022, 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 2021/22:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming 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.

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 2020-21 was very different due to the funding arrangements in response to COVID-19; which meant all NHS organisations reported a breakeven position. However 2021-22 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 Report, 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.

The Board approved ‘Our Strategy for Improvement’ and Quality Improvement (QI) Plan in May 2019.

The implementation of full spectrum of the plan initiatives was restricted by the pandemic. Developing a continuous QI culture across the organisation will be given a greater priority as part of the Trust operational excellence programme. Delivery of this will take pace during 2021/22.

During 20/21 quarter 1 areas of focus and that was taken forward were:

- Delivery of a very successful Dragons Den initiative
- Commencement of a ward level accreditation programme
- Development of QI coaches and associated training
- Delivery of some QI training/workshops
- Inclusion within Trust wide induction programme

The future QI development programme will form part of our proposed Operational Excellence Programme and be integrated into our wider cultural change programme work. It is intended to build our Trust capability and capacity thorough the proposed development of internal “coach house” team to work alongside our clinical teams and service departments.

Our QI approach will be tailored to the findings collected from the Best Place to Work survey and development of our service transformation approach within our Service Divisions and clinical teams

The Trust has maintained 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. This is then presented at the Quality Review Panel, where the Medical Director and Director of Nursing make the final approval decision. The Trust's overall processes for monitoring quality and triangulating information provide a framework within which to monitor the impact of schemes.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality report which sets out the progress made against our quality priorities in 2020-21 and the quality priorities selected for 2021-22. Progress of the priorities is monitored via the Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators.

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. Through 2020-21, there was a continued focus on this report

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 annual external audits of key national performance indicators, as reported in the annual Quality Account, various internal and external audits carried out throughout the year, and the annual Data Security and Protection Toolkit self-assessment review by internal audit and external auditors.

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 underpin 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 Directorates 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 compliance with Duty of Candour on a monthly basis.

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

- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these to Board via the Integrated Performance Report
- Investigating incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Executive Directorate Performance Review meetings and ward performance review meetings.
- Reviewing a proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group
- Monitoring the identification and timely investigation of incidents resulting in serious harm through a weekly patient safety 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
- Monitoring the completion of recommendations from incident reviews at the Clinical Management Board and Clinical Governance Committee.
- Improved oversight of duty of candour to ensure we are transparent with people that use our services if aspects of their care needs to be reviewed
- Introduction of a Ward performance review and ward accreditation programme to ensure ward leaders are fully sighted on their red flag risks.
- Refreshing the Clinical and Divisional governance structure and lines of communication to strengthen ward to Board information flows.

The Trust is working with partners within the BSW ICS and with KPMG to embed a transparent just culture, learning from our mistakes and our successes and driving quality improvement in all aspects of care.

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 to enable regular liaison and communication, to identify opportunities for the involvement of Healthwatch in Trust activities. A planned focus group with people who had raised a complaint had to be cancelled due to the pandemic but HealthWatch spoke with all those who had wanted to attend and their feedback has been incorporated into Trust guidance on writing a response letter. HealthWatch members are active members in a number of engagement groups in the Trust (for example the Carers Group and Outpatient Transformation Group).

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 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 on 27 April 2021 and confirmed that no material risks had been identified.

In October 2018, the *Developing Workforce Safeguards Framework* was launched. Building on existing National Quality Board (NQB) guidance, the framework provides a set of recommendations on workforce safeguards to strengthen the delivery of safe, high quality care across all staff groups and includes new recommendations for governance processes and formal reporting from ward to board.

The Trust has a number of key 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:

- Resourcing programme with a strong focus on hard to recruit posts, including registered nurses, consultants and other professionals.
- Optimisation programme for the use of the Electronic Staff Record (ESR) which will have close links with the roll-out of eRoster and implementation of e-OPAS (Occupational Health) systems.
- Workforce planning and deployment of staff to ensure safe staffing levels.
- Twice daily nurse staffing meetings.
- The Board receives regular updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. These include care hours per patient day.
- Use of evidence-based tools to support planning and rostering of permanent and temporary staff.
- Formal reports on nurse staffing to Board and Board Committees.
- Integrated performance reports showing safe staffing levels and bank/agency usage.
- 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). There was an unannounced visit from the CQC on 30th March 2021 to the Maternity and Spinal Units. The Trust has received the draft report.

The CQC has not been routinely inspecting services during the COVID-19 pandemic period and recovery phase, although they have still been carrying out some focused inspections. They have been maintaining contact with providers through their usual engagement calls, with an agenda focused around COVID-19 arrangements. The Trust has continued to discuss key risks and our main quality concerns. Our local CQC engagement team have felt assured about progress and mitigation and appropriate reports and evidence have been/continue to be shared as agreed. All core services have had direct engagement with the CQC since our last inspection in November/December 2018, either face-to-face or via Microsoft Teams during the pandemic.

In July 2020, the Trusts engagement call specifically centred around the completion of CQCs' Emergency Support Framework, a document focusing on infection prevention and control arrangements. There were no concerns raised as a result of the conversation and the summary record of this process provided by the CQC stated that the assessment outcome indicated the Trust is assured and that the Trust is managing and have managed well through the COVID-19 pandemic. Completion of the NHSE Infection Prevention and Control Board Assurance Framework has been discussed during the engagement calls and a copy of our completed framework was shared with the CQC. Furthermore, the CQC have been carrying out a series of rapid reviews of

how providers are working collaboratively in local areas to help health and social care services learn from the experience of responding to COVID-19. Participation in the reviews is not mandatory and findings of reviews do not affect providers' ratings. The Trust has participated in two reviews; provision of services within urgent and emergency care settings and provision of cancer services. No immediate concerns have been brought to the Trusts attention as a result of these reviews.

In August 2020 the Trust received positive feedback from our local CQC engagement team. We were thanked for really good engagement during the COVID-19 pandemic, described as open, honest and timely. The team were very appreciative of the opportunity to have continued engagement with the core services virtually; something which has not been seen in all organisations.

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

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 Director of Transformation Senior Information Risk Owner (SIRO), 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. During the 2020/2021 Data Security and Protection Toolkit (DSPT) year, the Trust self-reported one security incident to the Information Commissioners Office and NHS Digital. The incident related to video footage taken on site. The Information Commissioners Office considered the information provided by the Trust, and decided that no further action by the ICO is necessary on this occasion.

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, increasing public confidence that the NHS and partner organisations can be trusted with personal data.

The Trust prepared for the UK's exit from the European Union and the implementation of the UKs General Data Protection, Network and Information System Regulations within the organisation. Asset Owners and Information Asset Administrators evidence is internally audited and updated on a regular basis. The Trust has also committed time and resources to continually review policies, procedures and guidance to ensure changes in regulatory, legislative and best practice are incorporated.

In line with the NHS Digital guidance, the Trust confirms it will not be submitting a Data Security and Protection Toolkit assessment until 30th June 2021.

Whilst, the Trust recognises the DSPT submission deadline has being amended, we remain resolved in our commitment to maintaining and continually look for ways to proactively improve the security and confidentiality of personal information entrusted to us.

Data Quality and Governance

There is corporate leadership for data quality with the Director of Transformation (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 2020-21. 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 introduced a data quality maturity assessment for core reports in 2019-20. This has been extended from key performance indicators used in key Trust Committees to include all reports used for core external returns. Where required improvements have been highlighted a full analysis of the impact on reporting is completed to ensure there is a robust change control process. The maturity assessment is overseen at the Trust's Information Standards Group.

During 2020-21 the Trust has continued its development of a new business intelligence platform underpinned by a new data warehouse. This project will continue into 2021-22 and will be complimented by the introduction of Power BI in 2021-22. Power BI will provide a modern and intuitive self-service business intelligence platform to help inform decision making and analysis cross the Trust. A system wide information group is reviewing standardising of key reports and best practice. This is likely to expand in 2021-22 to include the standardised development of Power BI and potential move to cloud based business intelligence for true mobile business intelligence provision.

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 directorate-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 directorate team, providing the Trust with the greatest possible opportunity to meet waiting list targets. All key performance related external submissions are reviewed and signed off at Executive level before being submitted. 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.

The Trust will be further educating staff in the role they play in meeting the high standards of data quality the Trust aspires to; and data quality champions are being introduced across the Trust during 2021-22.

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.

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 Directorates.

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 remains unchanged from the opinion given for the year 2019-20 for 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.

During 2020-21, Internal Audit conducted six internal audits. The finalised reports have resulted in the identification of three high, 14 medium and five low risk findings to improve weaknesses in the design of controls and/or operating effectiveness.

A summary of the three 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:

- Staff risk assessments were not completed in line with NHSE/I deadlines as part of the COVID-19 response. Since the review, the audit sponsor confirmed that the key actions identified in relation to this finding (completing all staff risk assessments, and implementing risk assessments as part of the on-boarding process for new joiners) have been completed.

- A number of key processes within Pharmacy were not supported by relevant Standard Operating Procedures (SOPs). Since the review, the audit sponsor confirmed that relevant documentation has been created and/or updated, and is available to relevant staff.
- Stock takes within Pharmacy were not performed daily, and the independent review of stock takes and investigation of discrepancies was inconsistent.

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 provide 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.

The Trust is focused on action plans to address the identified risks reported in 2020-21 which have been approved by the Trust Audit Committee. The Trust is in the process of implementing an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. This will be fully implemented early 2021-22.

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.

Stacey Hunter
Chief Executive (Accounting Officer)
18.06.2021 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2021

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2021 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: 18 June 2021

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 2021, 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 accounts, 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 2020 to 2021.

In our opinion, except for the possible effects 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 the Trust as at 31 March 2021 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 2020 to 2021; 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 any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on drugs and supplies and services for the year ended 31 March 2021.

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 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 2020 to 2021 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 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

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £5.892 million held by the Trust and £7.514 million held by the Group as at 31 March 2020, and related balances. 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 2020/21 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 set out on pages 63 to 64, 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 2020/21, 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 statements.

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

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 2020 to 2021).

- 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 2020 to 2021).

- 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 fraudulent revenue and expenditure recognition. We determined that the principal risks were in respect of the Trust and in relation to:
  - journals with risk characteristics that we determined as elevated or high risk
  - management estimates in particular those relating to land, buildings and dwellings valuations:
  - fraudulent recognition of revenue streams that are not derived from contracts that are agreed in advance at a fixed price or from central allocations from government :
  - fraudulent expenditure recognition, and specifically the completeness of expenditure.

- Our audit procedures involved, which related to the Trust only:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - selected journal entry testing, with a focus on journals with risk characteristics that we determined as elevated or high risk, such as large journals, journals posted by staff with elevated access privileges, inter group and related party transactions**;** post year end transactions and journals posted by senior management.
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land, buildings and dwellings valuations and the PFI liability;
  - evaluation of the Trust's income recognition policies and agreeing a sample of income transactions to supporting documentation; and
  - assessing the completeness of operating expenditure with a particular focus on the adequacy of year end accruals and testing a sample of transactions recorded close to and after the year end to ensure they were recorded in the correct financial period.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from 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 would become aware of it.

- 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 Trust's PFI liability.

- 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 Improvement'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 year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 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 document 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 consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Salisbury NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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.

Barrie Morris

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

22 June 2021

STATEMENT OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2021

		Group		Trust	
		2020/21	2019/20	**2020/21**	2019/20
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**243,623**	222,621	**243,623**	222,621
Other operating revenue	5	**51,672**	38,106	**40,274**	24,918
Operating expenses	7	**(289,341)**	(263,885)	**(277,623)**	(252,570)
OPERATING SURPLUS/ (DEFICIT)		**5,954**	(3,158)	**6,274**	(5,031)
FINANCE COSTS					
Finance income	12	**287**	454	**170**	265
Finance expense	13	**(2,122)**	(2,592)	**(2,122)**	(2,592)
PDC Dividends payable		**(3,322)**	(3,037)	**(3,322)**	(3,037)
NET FINANCE COSTS		**(5,157)**	(5,175)	**(5,274)**	(5,364)
Losses on disposal of assets	17	**(156)**	(72)	**(156)**	(72)
Share of profit/ (loss) of associates/ joint ventures	33	**93**	(15)	**93**	(15)
Movement in fair value of other investments	18	**1,417**	(986)	-	-
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**2,151**	(9,406)	**937**	(10,482)
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations		**4,601**	(441)	**4,549**	(444)
Items that may be reclassified to income and expenditure					
Fair Value gains/ (losses) on Available-for-sale financial investments	18	**-**	-	-	-
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**6,752**	(9,847)	**5,486**	(10,926)
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**3**	8	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**2,148**	(9,414)	**937**	(10,482)
TOTAL		**2,151**	(9,406)	**937**	(10,482)
(b) Total comprehensive income/ (expense) for the year attributable to:					
(i) Minority interest, and		**3**	8	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**6,749**	(9,855)	**5,486**	(10,926)
TOTAL		**6,752**	(9,847)	**5,486**	(10,926)

The notes on pages 5 to 50 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION
31 MARCH 2021

	Note	Group		Trust	
		31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
		£000	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	16	**10,952**	8,828	**10,952**	8,828
Property, plant and equipment	17	**149,210**	140,083	**146,956**	137,635
Investments in subsidiaries	32	**-**	-	**5**	5
Investments in joint ventures	33	**181**	88	**181**	88
Investments	18	**7,893**	6,319	**-**	-
Other financial assets	19	**2,395**	2,299	**4,551**	4,982
Receivables	21	**762**	649	**762**	649
Total non-current assets		**171,393**	158,266	**163,407**	152,187
CURRENT ASSETS					
Inventories	20	**7,634**	7,514	**6,050**	5,892
Receivables	21	**12,077**	15,575	**11,783**	13,894
Investments	18	**113**	133	**-**	-
Other financial assets	19	**-**	-	**1,027**	-
Cash and cash equivalents	22	**31,169**	16,145	**22,309**	9,087
Total current assets		**50,993**	39,367	**41,169**	28,873
Total assets		**222,386**	197,633	**204,576**	181,060
CURRENT LIABILITIES					
Trade and other payables	23	**(36,727)**	(29,191)	**(35,364)**	(27,799)
Borrowings	24	**(1,608)**	(22,784)	**(1,608)**	(22,784)
Provisions	25	**(971)**	(198)	**(971)**	(198)
TOTAL CURRENT LIABILITIES		**(39,306)**	(52,173)	**(37,943)**	(50,781)
TOTAL ASSETS LESS CURRENT LIABILITIES		**183,080**	145,460	**166,633**	130,279
NON-CURRENT LIABILITIES					
Borrowings	24	**(18,680)**	(20,271)	**(18,680)**	(20,271)
Provisions	25	**(1,256)**	(1,144)	**(1,256)**	(1,144)
TOTAL NON CURRENT LIABILITIES		**(19,936)**	(21,415)	**(19,936)**	(21,415)
TOTAL ASSETS EMPLOYED		**163,144**	124,045	**146,697**	108,864
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		**53**	50	**-**	-
Public dividend capital	34	**90,997**	58,650	**90,997**	58,650
Revaluation reserve		**65,738**	61,193	**65,738**	61,193
Income and expenditure reserve		**(8,896)**	(9,779)	**(10,038)**	(10,979)
Charitable fund reserves	35	**15,252**	13,931	**-**	-
TOTAL TAXPAYERS EQUITY		**163,144**	124,045	**146,697**	108,864

The notes on pages 5 to 50 form an integral part of these financial statements.
The financial statements on pages 1 to 50 were approved by the Board on 18 June 2021 and signed on its behalf by:

Signed:

Stacey Hunter - Chief Executive

CONSOLIDATED STATEMENT 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 2019	**57,297**	**(687)**	**61,827**	**118,437**	**1,032**	**42**	**13,028**	**132,539**
Changes in taxpayers' equity for 2019/20								
Retained surplus/(deficit) for the year	-	(10,482)	-	**(10,482)**	168	8	900	**(9,406)**
Other recognised gains and losses	-	-	-	**-**	-	-	-	**-**
Impairment of property plant and equipment	-	13	(13)	**-**	-	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	(444)	**(444)**	-	-	-	**(444)**
Transfers between reserves	-	-	-	**-**	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	**-**	-	-	3	**3**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	-	-	**-**	**-**
Other reserve movements	-	177	(177)	**-**	-	-	**-**	**-**
Public dividend capital received in year	1,353	-	-	**1,353**	-	-	**-**	**1,353**
Balance at 31 March 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**

The notes on pages 5 to 50 form an integral part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2021

	Note	Group 2021 £000	Group 2020 £000	Trust 2021 £000	Trust 2020 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus/ (deficit)		**5,954**	(3,158)	**6,274**	(5,031)
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	7	**12,370**	11,204	**12,084**	10,982
Impairments	7	**318**	19	**318**	19
Non-cash donations credited to income		**(1,253)**	(606)	**(1,253)**	(606)
(Increase)/ decrease in trade and other receivables	21	**3,311**	7,776	**1,910**	9,012
(Increase)/ decrease in inventories	20	**(120)**	(744)	**(158)**	(1,052)
Increase/ (decrease) in trade and other payables	23	**5,905**	4,092	**5,955**	4,090
Increase/ (decrease) in provisions	25	**775**	353	**775**	(295)
NHS charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**7**	(400)	**-**	-
Net cash inflow from operating activities		**27,267**	18,536	**25,905**	17,119
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**-**	113	**74**	108
Payments to acquire property, plant and equipment	17	**(12,309)**	(6,683)	**(12,269)**	(6,449)
Receipts from sale of property, plant and equipment		**57**	-	**57**	-
Payments to acquire intangible assets	16	**(4,379)**	(2,436)	**(4,379)**	(2,436)
NHS charitable funds - net cash flows from investing activities		**54**	68	**-**	-
Net cash (outflow) from investing activities		**(16,577)**	(8,938)	**(16,517)**	(8,777)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	**32,419**	1,353	**32,419**	1,353
Public dividend capital repaid	34	**(72)**	**-**	**(72)**	**-**
Loan to subsidiary		**-**	-	**(500)**	(700)
Loan repayment received		**-**	-	**-**	115
Movement in loans from the Department of Health and Social Care		**(21,713)**	(631)	**(21,713)**	(631)
Capital element of finance lease rental payments		**(434)**	(434)	**(434)**	(434)
Capital element of Private Finance Initiative obligations	29	**(479)**	(468)	**(479)**	(468)
Interest paid		**(190)**	(643)	**(190)**	(643)
Interest element of finance lease rental payments		**(24)**	(24)	**(24)**	(24)
Interest element of Private Finance Initiative obligations	29	**(1,939)**	(1,928)	**(1,939)**	(1,928)
PDC dividend paid		**(3,234)**	(3,194)	**(3,234)**	(3,194)
Net cash inflow/ (outflow) from financing		**4,334**	(5,969)	**3,834**	(6,554)
Increase/ (decrease) in cash and cash equivalents		**15,024**	3,629	**13,222**	1,788
Cash and cash equivalents at the beginning of the financial year		**16,145**	12,516	**9,087**	7,299
Cash and cash equivalents at the end of the financial year	22	**31,169**	16,145	**22,309**	9,087

The notes on pages 5 to 50 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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Charitable donations and assets are maintained and administered separately and distinctly from those of the Trust by Charitable Trustees. By virtue of the fact that the patients and staff of Salisbury District Hospital are the beneficiaries of the charity's fundraising activities HM Treasury has mandated that the Trust must consolidate the charity's financial data to comply with International Financial Reporting Standards.

The key accounting policies of the charitable funds are included below in the relevant sections to which they relate.

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

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level.

The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

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

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

Comparative period (2019/20)

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

At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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

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

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

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.

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. In line with National Guidance resulting from the Covid 19 pandemic, employees are entitled to carry forward accrued leave arising in the year, but untaken at 31 March 2021, for a period of up to two years.

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 employer, 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 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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.

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. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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.

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

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.

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. All other assets are being depreciated as follows:

Buildings (excluding dwellings) 3 - 67 years
Dwellings 9 - 60 years
Plant and Machinery 1 - 15 years
Transport equipment 3 - 10 years
Information Technology 3 - 10 years
Furniture and Fittings 5 - 15 years

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

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.

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

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.

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

1.9.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/ or intangible assets as appropriate.

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

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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, 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 or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

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 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. 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.

Contingent liabilities are not recognised 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 2020/21 (2019/20 £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 £30k (2019/20: £77k).

1.21 Foreign exchange

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

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.

1.22 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)

1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that 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.

1.24 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.

1.25 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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

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

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	
		Restated
	2021	2020
	£000	£000
Block contract / system envelope income*	**207,419**	184,319
High cost drugs income from commissioners	**18,645**	18,515
Other types of activity revenue	**2,602**	2,326
Total revenue at full tariff	**228,666**	205,160
Private patient revenue	**1,759**	2,118
Additional pension contribution central funding**	**7,073**	6,436
Other clinical income	**6,125**	8,907
Total income from patient care activities	**243,623**	222,621

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

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	
	2021	2020
	£000	£000
NHS England	**53,483**	49,762
Clinical commissioning groups	**181,501**	160,927
Department of Health and Social Care	**42**	19
Other NHS providers	**2,787**	4,646
NHS other	**152**	609
Local authorities	**1,554**	1,546
Non NHS:		
- Private patients	**1,759**	2,118
- Overseas patients (chargeable to patient)	**107**	158
- NHS Injury cost rcovery scheme	**725**	1,345
- Other	**1,513**	1,491
	243,623	222,621

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 22.43% (2020: 21.79%) 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	
	2021	2020
	£000	£000
Income from services designated as commissioner requested services	**227,289**	197,618
Income from services not designated as commissioner requested services	**16,334**	25,003
	243,623	222,621

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

	Group and Trust	
	2021	2020
	£000	£000
Income recognised this year	**107**	158
Cash payments received in-year	**113**	143
Amounts written off in-year	**24**	2

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 2020/21 (and 2019/20) was substantially below the revised level permitted.

NOTES TO THE ACCOUNTS

5.1 Other operating revenue

	Group		Trust	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET) (2019/20 only)	**-**	4,626	**-**	4,626
Reimbursement and top up funding	**15,644**	-	**15,644**	-
Research and development	**842**	926	**842**	926
Education and training	**9,022**	8,392	**9,022**	8,392
Non-patient care services to other bodies	**2,383**	2,483	**2,383**	2,483
Received from DHSC group bodies for COVID response- donated assets	**869**	-	**869**	-
Received from NHS charities - donated assets	**-**	-	**384**	606
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	**3,640**	-	**3,640**	-
Salisbury Trading Limited	**9,324**	8,513	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**1,228**	3,736	**-**	-
Odstock Medical Limited	**1,686**	1,996	**-**	-
Accommodation	**1,268**	1,380	**1,268**	1,380
Administrative services provided to Sterile Supplies Limited	**311**	365	**311**	365
Car Parking	**256**	1,815	**256**	1,815
Catering	**413**	1,027	**413**	1,027
Payroll services provided to other organisations	**1,676**	1,488	**1,676**	1,488
Other	**3,108**	1,359	**3,564**	1,810
	51,672	38,106	**40,274**	24,918

Included within 'Other' revenue above are: Central funding in respect of annual leave and overtime £1,129k (2020: £nil) and overseas recruitment £133k (2020: £nil), procurement framework income re: apprenticeships £346k (2020: £nil), Leisure Centre income £10k (2020: £221k), income from the rent and hire of rooms £105k (2020: £191k), Vat recoveries £210k (2020: £149k) and Hospice at Home service £nil (2020: £134k).

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	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**177**	181	**425**	427

6.3 Total future minimum lease income

	Group		Trust	
	2021	2020	**2021**	2020
Receivable:	**£000**	£000	**£000**	£000
Within 1 year	**175**	75	**423**	240
Between 1 and 5 years	**408**	71	**893**	670
After 5 years	**462**	-	**511**	100
Total	**1,045**	146	**1,827**	1,010

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**3,469**	3,684	**3,469**	3,684
Purchase of healthcare from non-NHS and non-DHSC bodies	**2,991**	3,493	**2,991**	3,493
Staff and executive directors costs	**183,346**	167,996	**176,803**	161,751
Non-executive directors	**168**	142	**168**	142
Supplies and services – clinical (excluding drugs costs)	**24,612**	22,869	**24,030**	22,714
Supplies and services - general	**5,897**	4,824	**4,392**	3,511
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**22,516**	21,222	**22,516**	21,222
Inventories written down	**64**	-	**64**	-
Consultancy costs	**2,016**	322	**2,016**	322
Establishment	**2,059**	2,762	**1,505**	2,762
Premises	**13,707**	10,773	**12,427**	9,973
Transport	**1,541**	2,171	**1,541**	1,587
Depreciation on property, plant and equipment	**10,090**	9,151	**9,815**	8,868
Amortisation on intangible assets	**2,280**	2,053	**2,280**	2,053
Impairments net of (reversals)	**318**	19	**318**	19
Movement in credit loss allowance: contract receivables / contract assets	**-**	32	**-**	32
Provisions arising /(released) in year	**79**	(37)	**79**	(37)
Change in provisions discount rate(s)	**6**	12	**6**	12
Operating lease expenditure (net)	**108**	92	**150**	134
Audit fees payable to the external auditor				
audit services- statutory audit	**104**	92	**94**	82
other auditor remuneration (external auditor only)	**-**	-	**-**	-
Internal audit costs	**82**	120	**82**	120
Clinical negligence	**7,041**	6,435	**7,041**	6,435
Legal fees	**504**	100	**504**	100
Insurance	**361**	298	**361**	298
Research and development	**40**	50	**40**	50
Education and training	**906**	822	**906**	822
Charges to operating expenditure for on-SoFP PFI scheme	**1,110**	1,074	**1,110**	1,074
Other	**3,926**	3,314	**2,915**	1,347
	289,341	263,885	**277,623**	252,570

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

Redundancy payments totalling £43k (2020: £nil) are included in staff costs.

There is a limitation on the Auditor's liability of £2.0m (2020: £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 £0.9m (2020: £nil), a contractual dispute with a supplier £0.5m (2020: £nil), home testing kits £292k (2020: £199k) as well as costs attributable to the Trust's subsidiary companies and Charity, Odstock Medical Limited £nil (2020: £nil), Salisbury Trading Limited £0.3m (2020: £0.9m) and charitable fund expenses of £0.7m (2020: £1.0m).

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	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Minimum lease payments	**108**	92	**150**	134

8.3 Total future minimum lease payments

	Group		Trust	
	2021	2020	**2021**	2020
Payable:	**£000**	£000	**£000**	£000
Within 1 year	**52**	56	**87**	97
Between 1 and 5 years	**26**	68	**40**	116
After 5 years	**-**	-	**-**	-
Total	**78**	124	**127**	213

HM Treasury has delayed the implementation of IFRS 16 Leases until 2022-23, see Accounting Policy note 1.26.

9. Employee benefits

9.1 Staff costs

	Group		Trust	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Salaries and wages	140,670	127,620	**135,398**	122,799
Social security costs	14,144	12,149	**14,144**	12,149
Apprenticeship levy	676	619	**676**	619
Employer's contributions to NHS pensions	23,277	21,296	**23,208**	21,254
Pension cost - other	42	37	**41**	35
Temporary staff (including agency)	5,391	6,635	**4,190**	5,235
Total gross staff costs	**184,200**	168,356	**177,657**	162,091
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**184,200**	168,356	**177,657**	162,091
Of which				
Costs capitalised as part of assets	854	360	854	360

NOTES TO THE ACCOUNTS

9. Employee benefits (continued)

9.2 Directors' remuneration

	Group and Trust	
	2021	2020
	£000	£000
Salaries and wages	**991**	965
Social Security Costs	**108**	118
Employer contributions to Pension Schemes	**141**	155
	1,240	1,238

The total number of Directors accruing benefits under pension schemes is 6 (2020: 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 £16.2m (2020: £14.86m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf (6.3%), as at 31 March 2021, contributions of £2.29m (2020: £2.16m) 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

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 2021 there was 1 (2020: 2) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £56k (2020: £114k). The cost of the 2021 ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

NOTES TO THE ACCOUNTS

12. Finance income

	Group		Trust	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Interest receivable	**287**	454	**96**	208
Other loans and receivables	**-**	-	**74**	57
	287	454	**170**	265

13. Finance costs

Group and Trust

	2021	2020
	£000	£000
Interest on capital loans from the Department of Health and Social Care (DHSC)	**49**	61
Revenue support / working capital loans from DHSC	**-**	578
Interest on obligations under finance leases	**24**	24
Finance costs on obligations under Private Finance Initiatives	**1,130**	1,161
Contingent finance costs - PFI	**809**	767
Total finance expense - financial liabilities	**2,012**	2,591
Other finance costs - unwinding of discounts on provisions	**110**	1
Total	**2,122**	2,592

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

There were no amounts payable arising from claims made by businesses under this legislation (2020: £Nil).

15. Losses and special payments

	Group and Trust			
	2021		2020	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Cash losses	**-**	**-**	-	-
Fruitless payments and constructive losses	**-**	**-**	-	-
Bad debts and claims abandoned	**470**	**181**	501	18
Stores losses	**2**	**2**	1	43
	472	**183**	502	61
Special payments				
Compensation payments	**-**	**-**	1	-
Extra-contractual payments	**-**	**-**	-	-
Ex-gratia payments	**20**	**17**	38	47
Special severence payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
	20	**17**	39	47
Total losses and special payments	**492**	**200**	541	108

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 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**

Cost or valuation			
At 1 April 2019	201	14,124	14,325
Additions - purchased	2,436	-	2,436
Additions - donated	-	55	55
Impairments charged to operating expenses	-	-	-
Reclassifications	(1,000)	1,000	-
Disposals	-	-	-
At 31 March 2020	**1,637**	**15,179**	**16,816**
Amortisation			
At 1 April 2019	-	5,935	5,935
Provided during the period	-	2,053	2,053
Impairments charged to operating expenses	-	-	-
Disposals	-	-	-
Amortisation at 31 March 2020	**-**	**7,988**	**7,988**
Net book value at 31 March 2020			
- Purchased at 31 March 2020	1,637	7,137	8,774
- Donated at 31 March 2020	-	54	54
Total at 31 March 2020	**1,637**	**7,191**	**8,828**

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 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
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
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 balance sheet 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 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. (see note 17.5 Valuation Report)

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 2019	1,170	106,121	8,520	138	68,836	361	12,337	3,769	201,252
Additions - purchased	-	421	-	6,487	57	-	-	-	6,965
Additions - donated	-	-	-	-	467	-	-	84	551
Impairments	-	-	-	(19)	-	-	-	-	(19)
Reclassifications	-	379	206	(3,165)	1,888	-	658	34	-
Revaluation	545	(3,393)	(933)	-	-	-	-	-	(3,781)
Disposals	-	-	-	-	(734)	-	-	(5)	(739)
At 31 March 2020	**1,715**	**103,528**	**7,793**	**3,441**	**70,514**	**361**	**12,995**	**3,882**	**204,229**
Accumulated depreciation									
At 1 April 2019	-	-	-	-	50,042	320	6,468	2,172	59,002
Provided during the period	-	3,102	238	-	3,927	12	1,565	307	9,151
Revaluation	-	(3,102)	(238)	-	-	-	-	-	(3,340)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(664)	-	-	(3)	(667)
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**53,305**	**332**	**8,033**	**2,476**	**64,146**
Net book value at 31 March 2019									
Owned	1,170	85,762	8,520	138	16,084	41	4,011	1,309	117,035
Finance leased	-	-	-	-	188	-	1,845	-	2,033
On-SoFP PFI	-	19,269	-	-	-	-	-	-	19,269
Donated	-	1,090	-	-	2,522	-	13	288	3,913
Total at 31 March 2019	**1,170**	**106,121**	**8,520**	**138**	**18,794**	**41**	**5,869**	**1,597**	**142,250**
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**

On 31 March 2020 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 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
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
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 balance sheet 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	80,588	6,647	6,082	17,245	49	3,851	868	116,340
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP 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**

On 31 March 2021 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. (see Note 17.5 Valuation Report)

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	Restated Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2019	390	106,121	7,555	138	65,458	339	12,337	3,769	196,107
Additions - purchased	-	421	-	6,487	-	-	-	-	6,908
Additions - donated	-	-	-	-	467	-	-	84	551
Impairments	-	-	-	(19)	-	-	-	-	(19)
Reclassifications	-	379	206	(3,165)	1,888	-	658	34	-
Revaluation	550	(3,393)	(908)	-	-	-	-	-	(3,751)
Disposals	-	-	-	-	(734)	-	-	(5)	(739)
At 31 March 2020	**940**	**103,528**	**6,853**	**3,441**	**67,079**	**339**	**12,995**	**3,882**	**199,057**
Accumulated depreciation									
At 1 April 2019	-	-	-	-	47,586	302	6,468	2,172	56,528
Provided during the period	-	3,102	205	-	3,681	8	1,565	307	8,868
Revaluation	-	(3,102)	(205)	-	-	-	-	-	(3,307)
Disposals	-	-	-	-	(664)	-	-	(3)	(667)
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**50,603**	**310**	**8,033**	**2,476**	**61,422**
Net book value at 31 March 2019									
Owned	390	85,762	7,555	138	15,162	37	4,011	1,309	114,364
Finance leased	-	-	-	-	188	-	1,845	-	2,033
On-SoFP PFI	-	19,269	-	-	-	-	-	-	19,269
Donated	-	1,090	-	-	2,522	-	13	288	3,913
Total at 31 March 2019	**390**	**106,121**	**7,555**	**138**	**17,872**	**37**	**5,869**	**1,597**	**139,579**
Net book value at 31 March 2020									
Owned	940	73,465	6,853	3,441	13,814	29	3,493	1,098	103,133
Finance leased	-	-	-	-	165	-	1,457	-	1,622
On-SoFP PFI	-	20,622	-	-	-	-	-	-	20,622
Donated	-	9,441	-	-	2,497	-	12	308	12,258
Total at 31 March 2020	**940**	**103,528**	**6,853**	**3,441**	**16,476**	**29**	**4,962**	**1,406**	**137,635**

On 31 March 2020 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 Valuation Report

In the prior year Gerald Eve LLP performed the estate valuation exercise between February and April 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 (Red Book), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is due to the impact of markets caused by the outbreak of Novel Coronavirus (Covid 19). The values in the report have been used to inform the measurement of property assets at 31 March 2020.
In the current year valuation at 31 March 2021 no material valuation uncertainty ws declared by Gerald Eve.

Group and Trust

17.6 Net Book Value of Assets Held Under Finance Leases	Plant & Machinery £000	Information technology £000	On-SoFP PFI £000	Total £000
Cost or valuation				
At 1 April 2020	844	1,943	20,622	23,409
Additions - Purchased	-	-	449	449
Revaluations	-	-	(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**
Cost or valuation				
At 1 April 2019	844	1,943	19,269	22,056
Additions - purchased	-	-	421	421
Revaluation	-	-	932	932
At 31 March 2020	**844**	**1,943**	**20,622**	**23,409**
Accumulated depreciation				
At 1 April 2019	656	97	-	753
Provided during the period	23	389	468	880
Revaluation	-	-	(468)	(468)
Accumulated depreciation at 31 March 2020	**679**	**486**	**-**	**1,165**
Net book value at 31 March 2020				
- Purchased	165	1,457	20,622	22,244
Total at 31 March 2020	**165**	**1,457**	**20,622**	**22,244**

18. Investments

Non-current	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Carrying value at 1 April	**6,319**	7,059	-	-
Additions	**4,961**	3,949	-	-
Fair value (losses)/ gains taken to I & E	**1,417**	(986)	-	-
Fair value movements taken to OCI	**-**	-	-	-
Disposals	**(4,804)**	(3,703)	-	-
Carrying value at 31 March	**7,893**	6,319	-	-
Current				
Financial assets designated at amortised cost	**113**	133	**-**	-

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 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,299**	2,204	**4,982**	3,340
Loans provided in year	**-**	-	**500**	700
Transfer (to)/ from current assets	**-**	-	**(1,027)**	962
Amortisation at the effective interest rate	**96**	95	**96**	95
Repayments in year	**-**	-	**-**	(115)
Carrying value at 31 March	**2,395**	2,299	**4,551**	4,982
Current				
Carrying value at 1 April	**-**	-	**-**	962
Transfer from/ (to) non-current assets	**-**	-	**1,027**	(962)
Loans	**-**	-	**-**	-
Carrying value at 31 March	**-**	-	**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.

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.

Details of the loans to Salisbury Trading Limited are as follows:
1. £1.3m to purchase the laundry stock is repayable over a 5 year term and attracts interest at 2% above the Bank of England base rate. Repayments commenced on 1 July 2015 but were deferred for two years from 1 July 2019. They are due to commence again on 1 July 2021, with no change to the original term of the loan.

2. £2.0m to purchase the laundry equipment is repayable over a 10 year term and attracts interest at 2% above the Bank of England base rate . Repayments commenced on 1 July 2015 but were deferred for two years from 1 July 2019. They are due to commence again on 1 July 2021, with no change to the original term of the loan.

NOTES TO THE ACCOUNTS

19. Other financial assets (continued)

3. £0.5m to purchase laundry stocks is repayable in full on 1st November 2021 and attracts interest at 3% above the Bank of England base rate.

4. £0.7m to purchase laundry stock is repayable over a 5 year term commencing on 1 July 2021 and attracts interest at 3.5% above the Bank of England base rate.

5. £0.5m to purchase laundry stock to assist with the Covid 19 pandemic. The loan is repayable on a 5 year term commencing on 1 September 2021 and attracts interest at 3.5% above the base Bank of England base rate.

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.

20. Inventories

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Drugs	**1,329**	1,656	**1,329**	1,656
Consumables	**4,275**	4,081	**4,275**	4,081
Laundry	**1,405**	1,454	**-**	-
Other	**625**	323	**446**	155
	7,634	7,514	**6,050**	5,892
Inventories recognised as an expense in the period	**45,963**	46,179	**44,726**	45,027

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 2020/21 the Trust received £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.

21. Receivables

21.1 Amounts falling due after more than one year:

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Clinician pension tax provision reimbursement funding from NHSE	**762**	649	**762**	649
	762	649	**762**	649
Of which receivables from NHS and DHSC group bodies:	**762**	649	**762**	649

NOTES TO THE ACCOUNTS

21. Trade and other receivables (continued)

21.2 Amounts falling due within one year:

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Contract receivables	**9,445**	12,849	**9,124**	11,603
Allowance for impaired contract receivables / assets	**(1,351)**	(1,569)	**(1,351)**	(1,569)
Prepayments (non-PFI)	**3,262**	3,358	**3,262**	3,290
PDC dividend receivable	**57**	145	**57**	145
VAT receivable	**627**	219	**627**	219
Other receivables	**37**	573	**64**	206
	12,077	15,575	**11,783**	13,894
Of which receivables from NHS and DHSC group	**2,179**	5,161	**2,179**	5,161

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 14.4 days (2020: 21.7 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2021		31 March 2020	
	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	**1,569**	**-**	1,547	-
New allowances arising	**-**	**-**	32	-
Utilisation of allowances (write offs)	**(218)**	**-**	(10)	-
Balance at 31 March	**1,351**	**-**	1,569	-

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 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Balance at beginning of year	**16,145**	12,516	**9,087**	7,476
Net change in year	**15,024**	3,629	**13,222**	1,611
Balance at end of year	**31,169**	16,145	**22,309**	9,087
Made up of:				
Cash with Government Banking Service	**22,201**	8,969	**22,201**	8,969
Cash at commercial banks and in hand	**8,968**	7,176	**108**	118
Cash and cash equivalents as in balance sheet	**31,169**	16,145	**22,309**	9,087
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**31,169**	16,145	**22,309**	9,087

23. Trade and other payables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Amounts falling due within one year:				
Trade payables	**11,522**	12,470	**10,200**	11,070
Capital payable	**4,554**	2,944	**4,554**	2,944
Accruals and deferred income	**1,693**	770	**1,693**	770
Receipts in advance	**3,057**	1,802	**3,057**	1,802
Social security and other taxes payable	**3,754**	3,182	**3,754**	3,182
Pay and pensions related	**5,648**	4,494	**5,648**	4,494
Other	**6,499**	3,529	**6,458**	3,537
	36,727	29,191	**35,364**	27,799
Of which payables from NHS and DHSC group bodies:	**3,076**	3,702	**3,076**	3,702

Included in 'Other' payables is £0.8m (2020: £0.6m) drugs accrual, £0.3m (2020: £0.4m) PFI accrual, £0.5m (2020: £nil) professional fees associated with the hospital site development, £0.9m (2020: £0.8m) potential exposure following change in Vat guidance, £0.9m (2020: £nil) funds due as an agent on an education training contract.

All Trade and other payables are current liabilities.

NOTES TO THE ACCOUNTS

24. Borrowings

Group and Trust	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Obligations under finance leases	**434**	434	**292**	726
Amounts due under PFI (note 30)	**526**	479	**16,175**	16,701
Capital loans from Department of Health and Social Care (DHSC)	**648**	652	**2,213**	2,844
Revenue support / working capital loans from DHSC	**-**	21,219	**-**	-
	1,608	22,784	**18,680**	20,271

The 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 2021 the effective borrowing rates were 3.4% and 5.1% respectively. Interest rates are fixed at the contract date.

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 2021 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:	**Minimum lease payments**		**Present value of minimum lease payments**	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Within one year	**459**	459	**434**	434
Between one and five years	**306**	765	**292**	726
After five years	**-**	-	**-**	-
	765	1,224	**726**	1,160
Less finance charges allocated to future periods	**(39)**	(64)		
	726	1,160		
Included within:				
Current borrowings			**434**	434
Non-current borrowings			**292**	726
			726	1,160

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Pensions - early departure costs	19	24	**13**	-
Pensions - injury benefits	23	23	**236**	250
Legal claims	453	151	**-**	-
Clinician pension tax reimbursement	-	-	**762**	649
Other	476	-	**245**	245
	971	198	**1,256**	1,144

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2020	24	273	151	649	245	**1,342**
Change in the discount rate	-	6	-	-	-	**6**
Arising during the year	29	4	350	-	476	**859**
Utilised during the year	(19)	(23)	(14)	-	-	**(56)**
Reversed unused	-	-	(34)	-	-	**(34)**
Unwinding of discount	(2)	(1)	-	113	-	**110**
At 31 March 2021	**32**	**259**	**453**	**762**	**721**	**2,227**
Expected timing of cash flows:						
Within 1 year	19	23	453	-	476	**971**
1 - 5 years	13	95	-	-	-	**108**
5-10 years	-	141	-	762	245	**1,148**
	32	**259**	**453**	**762**	**721**	**2,227**

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.

Clinician pension tax reimbursement provision arises in respect of clinicians who are members of the NHS Pension Scheme, and who as a result of work undertaken, face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. Government policy is that the Trust will reimburse the NHS Pension Scheme on the retirement of the 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 liabilites following revised guidance by HMRC.

£79.4m is included in the provisions of NHS Resolution (previously the NHS Litigation Authority) at 31 March 2021 in respect of clinical negligence liabilities of the Trust (2020: £76.2m).

NOTES TO THE ACCOUNTS

26. Capital and other commitments

Capital commitments - Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £2.77m (2020: £3.46m).

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 2021 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 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
Year ending 31 March 2020				
Salisbury Trading Limited	200	825	264	81
Odstock Medical Limited	212	-	176	-
Salisbury District Hospital Charitable Fund	645	42	304	-
Sterile Supplies Limited	1,066	1,907	179	192
Wiltshire Health and Care LLP	713	371	56	93

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.

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 covering a number of specialties including: Burns, Plastics,
At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration.
There were no changes to the terms and conditions of the PFI agreement during the year.

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.

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI) (continued)

29.2 PFI scheme - Charge to operating expense in Statement of Comprehensive Income

	Group and Trust	
	2021	2020
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**1,110**	1,074
Depreciation of PFI asset	**573**	468
Net charge to operating expenses	**1,683**	1,542

29.3 PFI scheme - Analysis of amounts payable to service concession operator

	Group and Trust	
	2021	2020
	£000	£000
Interest	1,130	1,161
Repayment of finance lease liability	479	468
Service element	1,110	1,074
Capital lifecycle maintenance	449	420
Contingent rent	809	767
Unitary payment payable to service concession operator	**3,977**	3,890

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:	**2021**	2020
	£000	£000
Due within one year	**1,114**	1,110
Due within 2 to 5 years	**4,500**	4,520
Due after 5 years	**11,845**	13,163
	17,459	18,793

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**	
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
Rentals due within one year	**1,624**	1,609	**526**	479
Rentals due within 2 to 5 years	**6,868**	6,751	**2,895**	2,601
Rentals due thereafter	**18,501**	20,242	**13,280**	14,100
	26,993	28,602	**16,701**	17,180
Less: interest element	**(10,292)**	(11,422)		
Total	**16,701**	17,180		

29.5 Total future payments committed in respect of PFI

	2021	2020
	£000	£000
Total	**71,223**	76,114
of which due:		
Within one year	**4,025**	3,977
Within 2 to 5 years	**17,130**	16,927
Due thereafter	**50,068**	55,210
Total	**71,223**	76,114

NOTES TO THE ACCOUNTS

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 2021

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £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**
DHSC revenue support loans	1.5 - 3.5	-	-	-	-	-	-	-	**-**
Floating rate									
Trade and other payables	-	17,769	-	-	-	-	-	-	**17,769**

As at 31 March 2020

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Fixed rate									
Finance lease obligations	3.4 - 5.1	-	-	459	765	-	-	(64)	**1,160**
PFI obligations	6.5	250	250	1,109	1,896	4,855	20,242	(11,422)	**17,180**
DHSC capital loan	1.64	-	344	342	615	2,285	-	(111)	**3,475**
DHSC revenue support loans	1.5 - 3.5	-	-	21,219	-	-	-	-	**21,219**
Floating rate									
Trade and other payables	-	16,184	-	-	-	-	-	-	**16,184**

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 2021 are in receivables from customers, as disclosed in note 21.

NOTES TO THE ACCOUNTS

30. Financial instruments (continued)

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 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**

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 2020				
Trade and other receivables excluding non financial assets	12,119	-	-	12,119
Other investments / financial assets	2,299	-	-	2,299
Cash and cash equivalents	10,420	-	-	10,420
Consolidated NHS Charitable fund financial assets	6,225	6,319	-	12,544
Total at 31 March 2020	**31,063**	**6,319**	**-**	**37,382**

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**

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 2020				
Trade and other receivables excluding non financial assets	10,889	-	-	10,889
Other investments / financial assets	5,075	-	-	5,075
Cash and cash equivalents	9,087	-	-	9,087
Total at 31 March 2020	**25,051**	**-**	**-**	**25,051**

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

30.7 Carrying values of finacial 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 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**

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 2020			
Loans from the Department of Health and Social Care	24,715	-	**24,715**
Obligations under finance leases	1,160	-	**1,160**
Obligations under PFI, LIFT and other service concession contracts	17,180	-	**17,180**
Trade and other payables excluding non financial liabilities	24,182	-	**24,182**
Provisions under contract	1,342	-	**1,342**
Total at 31 March 2020	**68,579**	**-**	**68,579**

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**

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 2020			
Loans from the Department of Health and Social Care	24,715	-	**24,715**
Obligations under finance leases	1,160	-	**1,160**
Obligations under PFI, LIFT and other service concession contracts	17,180	-	**17,180**
Trade and other payables excluding non financial liabilities	22,815	-	**22,815**
Provisions under contract	1,342	-	**1,342**
Total at 31 March 2020	**67,212**	**-**	**67,212**

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
In one year or less	**33,599**	48,308	**32,282**	46,942
In more than one year but not more than five years	**9,567**	5,852	**9,567**	5,852
In more than five years	**19,649**	14,419	**19,649**	14,419
Total	**62,815**	68,579	**61,498**	67,213

31. Third Party Assets

The Trust held £0.1k cash at bank and in hand at 31 March 2021 (2020: £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.

Shares at cost	Trust £
At 31 March 2021 and 31 March 2020	**5,034**

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.

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 2021 and 31 March 2020	**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.

32.3 Replica 3DM Limited

Salisbury NHS Foundation Trust initially purchased one third of the shares at cost in a start up company, Replica 3DM Limited (registered in England), which produces three dimensional models from scans and is marketing this capability to other NHS organisations. The company commenced trading in September 2012, but results from that date to 31 March 2020 are deemed to be immaterial and have not been incorporated into these consolidated financial statements. During the year to 31 March 2017 the Trust acquired the remaining share capital in the company for a nominal sum of 1 pence per issued share. The company has now ceased trading.

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 Sterlisation and Disinfection Unit.

Group and Trust	**2021**	2020
	£000	£000
Shares at cost	250	250
Brought forward share of profit/ (loss)	(162)	(147)
Share of profit/ (loss) in the period	(20)	(15)
Carrying value of investment at 31 March	**68**	**88**

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	**2021**	2020
	£000	£000
Share of surplus in the period	113	-
Carrying value of investment at 31 March	**113**	**0**

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	2021 £000	2020 £000
Public Dividend Capital at 1 April	**58,650**	57,297
New public dividend capital received	**32,419**	1,353
Public dividend capital repaid	**(72)**	-
Public Dividend Capital at 31 March	**90,997**	58,650

The new public dividend capital received in the year relates to the conversion of revenue loans to PDC £21,082k and the receipt of additional funding to purchase capital items of £11,337k.

35. Charitable fund balances

Group only	2021 £000	Restated 2020 £000
Restricted funds	**8,408**	9,027
Unrestricted funds	**6,835**	4,895
Endowment funds	**9**	9
	15,252	13,931

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 2021 by Gerald Eve, Chartered Surveyors. Gerald Eve valued the land and buildings (including dwellings) at £114.3m, of which £113.3m 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 £11.3m impact on the statement of financial position with a £396,000 impact on the PDC dividend due to be paid next year and accrued in these finacial 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 revalaution 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.

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

In our auditor's report issued on 22 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021, issued on 22 June 2021, we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2021 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 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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 year ended 31 March 2021.

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 April 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 arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Salisbury NHS Foundation Trust for the year ended 31 March 2021 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.

Barrie Morris

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

Bristol

22 July 2021