INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Annual Report and Accounts

2021 – 2022

Dorset County Hospital NHS Foundation Trust

Annual Report and Accounts 2021 – 2022

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

Contents

Statement from the Chair and Chief Executive

It goes without saying that we, and the NHS as a whole, have faced another exceptionally difficult year.

The impact of the COVID-19 pandemic has continued to be felt across the Trust, with ongoing challenges around managing waiting lists, COVID positive patients and staffing shortages through sickness and isolation.

The financial picture for the future is also challenging. The financial regime for the NHS has changed following two years of pandemic financing - income has been reduced significantly and there is huge pressure on NHS finances.

One thing which didn't change this year was the drive and determination of our staff to continue to provide the very best services and care possible for our patients.

Teams have worked incredibly hard in the most challenging of circumstances for a long time now. People are physically tired and emotionally drained, and yet they continue to do their very best day in, day out.

We can't thank our staff enough for their commitment and we are doing all we can to support them through our wellbeing programme.

The efforts of our staff mean we have plenty of positive developments to report as well as the challenges.

We have made significant progress in tackling the waiting list backlog through the initiatives outlined in this report. We also achieved a breakeven position financially for 2021/22.

This year we have strengthened our focus on ensuring everyone at DCH feels welcome and valued, and on recognising our wider impact on the community we serve. We are going to continue to develop our approach to inclusion and social value.

We have launched a wide-reaching programme of work around inclusion. We will not tolerate discrimination in any form and we are committed to creating a culture with fairness, equity and equality at its heart.

The results of the most recent NHS Staff Survey show that this work is starting to have a positive impact. DCH scored higher than the national average in all nine themes of the survey. It also highlighted that 75% of staff think that the organisation respects individual differences - 8% higher than the national comparator.

This annual report also explores our wider approach to social value – in other words, our contribution to our local community now and into the future.

Social value describes the wider role of an organisation in helping to improve the economic, social and environmental wellbeing of its local communities. We are committed to reducing inequalities and improving the overall wellbeing of the local community we serve. We also play a significant role contributing to the local economy. Our approach will create a lasting, positive social impact for the community we serve.

We were delighted to welcome a group of young people to the Trust as part of the Kickstarter programme this year, and we were really pleased to be able to offer the vast

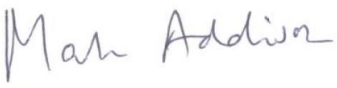
majority of them permanent jobs with us following their placements. Their enthusiasm to learn new skills to launch a career in the NHS was inspiring.

This year and in the years ahead there is much to look forward to, including the major expansion of our Emergency Department and Critical Care Unit, as well as the provision of more coordinated and more convenient services for our patients at South Walks House in Dorchester town centre.

We are also looking forward to working more closely than ever with our partners in the health and care system to further improve and coordinate services through the Dorset Integrated Care System.

Our achievements and success as a hospital is down to our staff, supporters and partners. We would like to take this opportunity to formally thank them for their unfailing commitment and enthusiasm.

Signed



Mark Addison
Trust Chair

Nick Johnson
Interim Chief Executive

Performance Report

Overview of the Trust

Purpose of the Overview

The purpose of the overview is to provide the reader with sufficient information to gain an understanding of Dorset County Hospital NHS Foundation Trust, our purpose, the key risks to the achievement of our objectives and how we have performed during the financial year 2021/22.

About the Trust

Dorset County Hospital NHS Foundation Trust's mission is to provide outstanding care for people in ways which matter to them. Our vision is that Dorset County Hospital, working with our health and social care partners, will be at the heart of improving the wellbeing of our communities.

Dorset County Hospital NHS Foundation Trust ("the Trust") achieved Foundation Trust status on 1 June 2007 under the Health and Social Care (Community Health and Standards Act 2003). The Trust took over the responsibilities, staff and facilities of its predecessor organisation, West Dorset General Hospital NHS Trust.

The Trust is the main provider of acute hospital care to the residents of West Dorset, North Dorset, Weymouth and Portland, a population of approximately 215,000 people. It also provides specialist services to the whole of Dorset and beyond including renal services in Bournemouth and Poole, and South Somerset. It serves an area with a higher than average elderly population and lower than average proportion of school aged children. Dorset continues to experience an increasing total population. The main hospital opened on its current site in 1987 and is situated close to the centre of the county town of Dorchester.

The geographical spread of the community the Trust serves requires it to deliver community based as well as hospital based services. This is achieved through providing services in GP practices, in patient homes through Acute Hospital at Home Discharge to Assess and at community hospitals in West Dorset, including Weymouth Community Hospital, Bridport Community Hospital, the Yeatman Community Hospital in Sherborne and Blandford Community Hospital. The Trust also works closely with other health providers, primary care and social services to ensure integrated services are provided.

As an NHS Foundation Trust, Dorset County Hospital is accountable to Parliament, rather than the Department of Health, and is regulated by NHS Improvement. We are part of the NHS and must meet national standards and targets. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

The Trust provides the following services for patients:

- Full Emergency Department services for major and minor accidents and trauma
- Emergency assessment and treatment services, including critical care (the hospital has trauma unit status)
- Acute and elective (planned) surgery and medical treatments, such as day surgery and endoscopy, outpatient services, services for older people, acute stroke care, cancer services and pharmacy services (not an inclusive list)
- Comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. We have a Special Care Baby Unit

- Children's services including emergency assessment, inpatient and outpatient services
- Diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology
- Renal services to all of Dorset and parts of Somerset
- A wide range of therapy services, including physiotherapy, occupational therapy and dietetics
- An integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

Our business model is based on managing expenditure within the context of agreed contracts with commissioners. The Trust has to manage its costs within the agreed funding envelope to allow us to invest appropriately (staff and infrastructure) in order to provide safe, effective patient care.

The Trust is organised internally as follows. There are two Divisions in the Trust, the Urgent and Integrated Care Division and the Family and Surgical Services Division. Each Division has responsibility for general business: workforce, education, access and flow, space utilisation, and capital and strategic planning. In turn they also have responsibility for governance: safety, clinical effectiveness, safeguarding and patient experience. Each Division is then subdivided into a number of care groups which also hold their own speciality/department meetings.

The Divisions report into the Trust Board Committees on a monthly basis. The committees and their remits are as follows:

- Finance and Performance Committee provides finance and access assurance
- Quality Committee provides quality assurance
- Risk and Audit Committee has a corporate governance responsibility to provide Board Assurance Framework, corporate risks, internal and external audit assurance
- People and Culture Committee oversees the Trust's People Strategy, monitors standard workforce metrics, and recruitment strategies and approaches.

The Board of Directors meets on a bi-monthly basis and is supported by the assurance and performance sub-committees that it has established. The Board and sub committees have formal minutes and the Senior Management Team provides strategic and operational support to the Board of Directors and its sub-committees.

Dorset was one of the first regions to signal the intention to form an Integrated Care System (ICS) in 2018. 'Our Dorset' was formed in 2021 as a new partnership of two local councils, NHS services and the voluntary sector, and is expected to gain final legal standing in July 2022 when the Integrated Care Board (ICB) will begin operation. The Trust is committed to supporting the ICB and aligning its strategy to the emerging ICS Strategy.

Highlights of the Year

The DCH COVID-19 Vaccination Centre closed its doors in April 2021 as a hospital hub in line with the national vaccination programme. Teams throughout the hospital came together to run the centre to vaccinate an incredible 24,000 health and care staff from across Dorset.

The start of construction work on our hospital's multi-storey car park was officially marked with a turf cutting ceremony in April 2021. The car park, due to be completed in summer 2022, is the first phase of the development of the hospital site to free up land for the expansion of clinical facilities, including a larger Emergency Department and Critical Care Unit.

As part of our Social Value Pledge and our commitment to creating employment and training opportunities for young people within our local communities we were delighted to welcome employees through the Government's Kickstart Scheme in a variety of roles across the Trust.

Residents in Weymouth and Portland can benefit from state-of-the-art ultrasound health scan facilities on their doorstep after we joined forces with Dorset HealthCare to provide new equipment and services at Weymouth Community Hospital.

We were absolutely delighted to see our hospital ranked as one of the top 10 in the country for emergency care in September. Patients ranked the hospital highly for involving them in making decisions about their care and treatment, the cleanliness, treating them with respect and dignity and for providing an overall positive experience.

We are so grateful to the Friends of Dorset County Hospital who raised an incredible £20,000 to purchase a new ultrasound machine for the Rheumatology Department. This donation will make such a difference in helping to provide an earlier diagnosis for patients with rheumatoid arthritis.

We were immensely proud to be ranked as the top acute NHS trust in England for the percentage of staff vaccinated against COVID-19. In October, a total of 94.6% of our staff had received both doses of the COVID-19 vaccine - an incredible achievement. This involved a phenomenal effort from staff across the hospital, including our DCH COVID-19 vaccination team.

During the summer, work on refurbishing our Emergency Department (ED) started as part of a drive to upgrade a number of EDs across the country. The aim is to enhance infection prevention and control measures and give us more space to treat patients while we develop longer-term plans to expand our site.

In November we celebrated DCH Thank You Week, an opportunity to shine a light on the incredible workforce we have and everything we do for each other, the Trust and our communities. The week ended with our Going the Extra Mile (GEM) and Long Service Awards evening.

Dorset health organisations were delighted to open the new Outpatient Assessment Centre at South Walks House in Dorchester to patients in November, making great use of a vacant council office building.

Teams at Dorset County Hospital continued to receive praise from patients for their high standards of care. In the latest Children and Young People Patient Experience Survey, parents rated the overnight facilities highly, felt that staff were aware of their child's medical history and explained well how their child's operation or procedure had gone. Parents also praised the level of engagement staff had with their child.

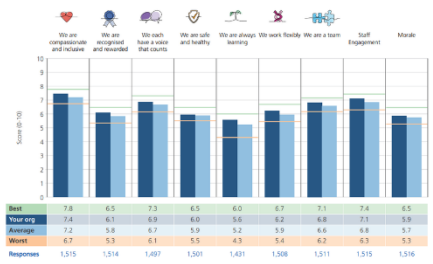
95% of Team DCH received their flu vaccination, ranking us in the top 10 in the South West for uptake in acute trusts and community providers.

We are committed to adding to the biodiversity of the local area and improving the wellbeing of our local communities as part of our site development plans. This forms part of our Social Value Pledge and our new Green Plan. Contractor Willmott Dixon has donated 600 trees to Dorchester Town Council and helped volunteers from local community groups to plant them in the new woodland on Kings Road. Our Chairman, Mark Addison, also popped along to lend a hand.

Our Maternity Unit was recognised as one of the best in the country in the latest national survey results.

We were delighted to welcome members of the Government's New Hospital Programme team to DCH in March to show them our exciting development plans, particularly the new Emergency Department and Critical Care Unit.

In March we celebrated the 90th birthday of our volunteer guide Wendy. Wendy is our longest serving volunteer and has been supporting the Trust for an incredible 25 years! She is a very much loved and valued member of Team DCH and we can't thank her enough for her dedication. She is incredibly well known throughout the Trust for her warm, welcoming and helpful attitude and said she has no intention of stopping her commitment to volunteering with us anytime soon.



It has been a tough two years at Dorset County Hospital and staff remain under immense pressure as we continue to deal with the impact of COVID-19. Our commitment and focus on improving staff experience, health and wellbeing for all staff has never been more important and the positive impact of this work is reflected in the latest NHS National Staff Survey results. (Graph shows that the Trust's Staff Survey scores across the nine themes are better than the national average)

Strategy and Objectives

Strategic Update
After a series of engagement events canvassing the opinion of the workforce, the Trust wide Strategy was refreshed in 2021/22, receiving final Board approval in November 2021. This Strategy covers the next three years to 2025.

As the NHS moves beyond the Covid19 pandemic, elective recovery has become the primary challenge, set against exacerbated workforce and operational pressures. Some other issues have also become more pressing, such as financial sustainability, and the impact of rising demand and the part played by health inequalities in the population.

Development of the Dorset Integrated Care System (ICS) has continued in 2021/22, with the governance plans for Place Based Partnerships and Hospital Collaborations submitted for approval by NHS England. A new ICS Chief Executive has been appointed, and the ICS Board is in the late stages of being recruited, pending formal legislative approval of ICS's nationally expected by July 2022.

The Dorset ICS Strategy is currently in development, and will focus around:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

Dorset County Hospital (DCH) Strategy
The Trust Strategy has been developed to both align to the national NHS Long Term Plan, as well as support DCH long term as the designated planned care and emergency hospital with Accident and Emergency services for the west of the county. The Strategy outlines the Trust's Mission, Vision and Values.

Our mission
Outstanding care for people in ways which matter to them.

Our vision
Dorset County Hospital, working with our health and social care partners, will be at the heart of improving the wellbeing of our communities.

Our values
Our Trust values - **Integrity, Respect, Teamwork, Excellence** - truly reflect what we all feel is most important.

The Trust Strategy has also been developed around three Strategic Goals: People, Place and Partnership.

People
Putting our people first to make DCH a great place to work and receive care.

Place
Building a better and healthier place for our patients and population.

Partnership
Working together to ensure outstanding services, accessible to our patients and population.

People: This goal signals the Trust's intention to truly value its staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, that they belong and they matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.

Partnership: Our vision is to work with our health and social care partners, being at the heart of improving the wellbeing of our communities, demonstrating our continued commitment to collaboration and partnership which will be key to the development of the Dorset ICS.

Place: We recognise that for the NHS to deliver the ambitions identified for Integrated Care Systems it will need to reimagine the way in which it operates and develops services. We aim to move away from services wrapped around institutions to those that are human centred, co-designed with our communities with citizenship at their heart.

Aligned to our Social Value Pledge, we will work hard to deliver on our responsibilities to be a model employer, contributing to the local economy through our income and purchasing power and improving our environmental sustainability plan to meet the NHS net zero targets: becoming the world's first net zero national health service.

Key Issues and Risks
Since January 2022 the Trust has been capturing the risks to implementing the Trust's Strategy and releasing the benefits therein, in the Board Assurance Framework. This outlines and scores the risks and identifies mitigations. The Board Assurance Framework is appraised regularly within the Trust's Governance Framework.

Capacity for Change
The growing financial and operational challenges of the Trust require ensuring short term sustainability, whilst also delivering longer term organisation (and system) wide change. The Trust has to balance the needs of maintaining day to day operational performance, with responding flexibly and quickly to new priorities, whilst ring fencing resource to focus on delivering the long-term strategy.

Hospital Development and New Hospital Program
Dorset County Hospital was named in 2020/21 as one of the 40 'new' hospitals in the Government's New Hospital Programme with Dorset allocated £350m. Dorset County Hospital is expected to receive £80m of this to develop a new Emergency Department, Intensive Care Unit and integrated services, which will provide the opportunity to fundamentally transform the way services are delivered and meet demand for a generation to come. This long-term project will increase the size of the existing departments and bring a range of community services onto site and make these critical services sustainable. Throughout 2021/22 the plans have continued to be developed in close discussion with system partners. Capital funding is not expected until the mid-

2020s, after Dorset County Hospital Project Team have delivered detailed plans to central government.

In addition, the Trust secured £15m funding in Financial Year 2020/21, to be spread over the next two years, to expand the capacity of the existing Emergency Department, to meet current demand for the next five years. The Trust is in the latter stages of delivering the 'ED15 project', with additional treatment bays due to open, as well as a reconfigured department for better patient flow.

Financial Year 2021/22 has also seen the Trust develop and approve the Clinical and People plans which form the backbone of delivering the Trust Strategy. These inform the Operational and Business Plans for its core Divisions and Corporate Services, to ensure key constitutional standards, safety, quality and patient experience are met, and we continue to meet our financial and operational sustainability plans.

The Trust's transformation programmes are the delivery vehicle for Trust wide strategic change and are overseen by the Transformation and Improvement team. A regular meeting of all Trust Executives, senior managers and the Transformation team reviews and agrees the agenda for change, and prioritisation of projects and resources.

Quality Improvement

The Quality Improvement Strategy was approved by the Board in October 2020 with the aim of embedding a culture where everyone in the Trust can make changes to improve things. The strategy aims to build on existing work in the Trust to strengthen the continuous improvement and learning already present and developed over the course of the Covid-19 pandemic. The strategy will be the next step toward the goal of developing an organisational approach and governance to Quality Improvement.

The Transformation and Improvement Office began implementation work in late 2020 but as staffing resources were diverted to support the Covid-19 Vaccination Programme and trials of neutralizing monoclonal antibodies, progress has been paused until recently when both QSIR and QI Lite courses were re-started.

Health Inequalities & Social Value

Health Inequalities

The Dorset County Hospital Health Inequalities (HI) Programme aims to ensure that the Trust takes every opportunity to ensure equity of access and outcomes for all our communities and service users. The programme is now well established and is starting to identify some early priorities and deliverables.

The objective of the early stages of this programme has been to consolidate the understanding of health inequalities, to identify and support existing health inequalities intervention and insight activities and to develop mechanisms for embedding a health inequalities approach into the organisational consciousness and thinking. The programme is now working collaboratively with the Social Value Programme to conceptualise a shared approach to embedding an integrated approach and raise awareness of the value of these new ways of thinking.

Social Value

Dorset County Hospital NHS Foundation Trust commits to maximising the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. You can read more about what we are doing to honour our commitment to delivering social value in the Social Value section of the report.

Going Concern Statement

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

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 going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating surplus in 2020/21 of £0.4 million and is reporting a deficit of £0.1 million for the year ended 31 March 2022, with a cash balance of £26.0 million. The Trust anticipates an operating deficit of £17.0 million in 2022/23 and will need to apply for financial support through interim revenue public dividend capital anticipated to be to the value of £9.0 million.

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.

Performance Overview

Summary of operational performance

The Trust's Emergency Department has seen a decline in performance against the four-hour standard. This has been as a result of increasing demand at the front door and a mismatch between capacity and demand for ongoing care packages that support the safe discharge of patients. This results in patients staying in acute hospital beds when they are medically fit for discharge. The Emergency Department has responded well to these challenges amid the added pressure of building expansion to the department. Patient safety remains the top priority and has been maintained.

The waiting list for planned surgery has reduced in year and the number of patients waiting over 52 weeks has reduced by 1,648 patients. Despite this progress, further work has still to be done, with some patients continuing to wait over 104 weeks for treatment. High bed occupancy rates over a prolonged periods of time and discharge challenges have restricted the Trust's ability to deliver planned activity. Staff shortages, due to the COVID isolation restrictions, resulted in a large amount of outpatient and theatre activity being cancelled. These pressures are expected to ease with the introduction of more relaxed isolation rules and as the Theatre and Outpatient Productivity Improvement Programmes are delivered.

The Trust has performed well against cancer wating time standards compared to previous years. Improvements are still required to achieve the national targets, but performance of the 28 days to diagnosis, two-week wait for first appointment and 62 day to treatment target, have all improved throughout the year. The waiting list size has also reduced, despite an increase in referrals and demand for these services. Whilst performance against the Cancer 62 day treatment standard has fluctuated month on month, with performance figures having been driven to some extent by the relatively small Cancer Department, sustained improvements have been achieved through a rigorous Executively led patient tracking programme and wider system working to address capacity constraints at the beginning of the cancer pathways.

Performance against the six week Diagnostic standard has remained consistent with that of the previous year, although the Trust did not achieve the national target in year. Diagnostic services have seen an increase in demand via the emergency and elective pathways and with planned services resuming activity and returning to full capacity. Staffing issues, due to a national shortage of Radiographers and Covid isolation rules have caused performance challenges and activity fluctuations month by month. New recruitment strategies, including closer working with local education facilities will commence in 2022/23, with the aim of attracting and training more Radiographers within the Dorset system.

The Trust recognises that maintaining and improving performance standards in 2022/23 will present ongoing challenges. Teams remain committed to reducing waiting times for elective pathways and to improving patient flow throughout the hospital. The creation of the Integrated Care System provides further opportunities to explore new ways of collaborative working with system partners and to utilise the capacity and available resources within the Dorset system, to the benefit of local communities and patients.

Financial Performance

In 2021/22, the Trust's financial plan reflected the ongoing impact of the COVID-19 pandemic with two half year plans being set by NHS England/Improvement running 1st March 2021 to 30th September 2021 and 1st October 2021 to 31st March 2022. All Trusts were required to reach a break-even position against the adjusted position in line with accounting guidance over the financial year as a whole.

The Trust delivered a deficit of £0.1 million before technical accounting adjustments, which equates to approximately 0.04% of the Trust's turnover. The position before and after technical adjustments is shown in Table 1 below. The adjusted surplus of £0.1 million takes account of movements linked to donated capital assets of £0.2 million.

Table 1 : Financial Performance against Plan	2021/22 Plan £ millions	2021/22 Actual £ millions	Variance £ millions
Total income	245.1	256.6	11.5
Total expenses	(245.3)	(256.7)	(11.4)
Operating (deficit)/surplus	(0.2)	(0.1)	0.1
Capital donations	(0.2)	(0.2)	0.0
Donated depreciation	0.4	0.4	0.0
Adjusted (deficit)/surplus	0.0	0.1	0.1

Performance Against Plan

Income exceeded the financial plan, leading to a favourable variance of £11.5 million. Of this variance £6.2 million relates to additional employer pension contributions paid by NHS England, £0.6 million for consumables (Personal Protective Equipment) from the Department of Health and Social Care, £1.2 million of NHS commissioner funding to support additional spending, £2.5 million of hosted project funding and £1.0 million of cancer drugs.

Expenditure was £11.4 million above plan, of which £6.2 million relates to the additional employer pension contributions paid by NHS England, £0.6 million of consumables (largely Personal Protective Equipment) from the Department of Health and Social Care, £2.5 million expenditure on hosted projects, £1.0 million of cancer drugs relating to additional income received in year and £1.1 million delivering elective recovery activity pressures.

The impact of donated assets was in line with the original expectations, set out in the financial plan.

Revaluation of Land and Buildings

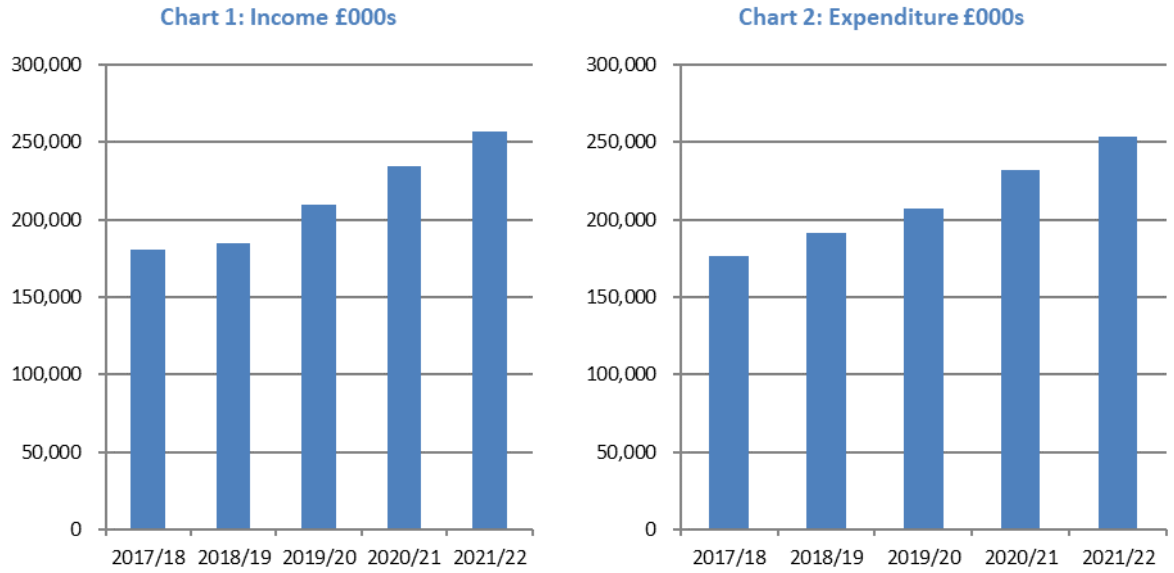
As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of the financial year. This year, these were valued independently by Avison Young, in line with accounting policies.

Overall, there was an increase in valuation of land and buildings of £25.0 million. This included a charge to the Revaluation Reserve of £25.0 million and a charge to other operating expenses in the Consolidated Statement of Comprehensive Income for impairments of £0.3 million and reversals of impairments of £0.3 million.

Trends in Income and Expenditure

The charts below show the trends in income and expenditure over the five-year period from 2017/18 to 2021/22.

Trends in Income and Expenditure (Five Years)



Trends

Chart 1 shows the growth in income over the five-year period from April 2017 to March 2022. This growth in income is at an average rate of 11% per year over the five-year period. From 2019/20, this is primarily the result of the non-recurrent COVID-19 funding during the pandemic and for previous years a result of Provider Sustainability Fund income and additional central funding to cover pay increases such as changes to employers' social security and pension costs.

Chart 2 shows the growth in expenditure over the five-year period. Expenditure has increased at an average rate of 11% per year. This is primarily the result of COVID-19 costs occurred during pandemic and for previous years as a result of growing inflationary costs, including changes to employers' social security and pension costs and additional staff recruited to ensure essential safe staffing levels.

Cash Flow

The Trust ended the year with £26.0 million cash. This was an increase of £8.2 million during the year. The increase in the cash position is because of the timing of capital payments and an improvement in the working capital position.

Charitable Funding

The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2021/22, the Trust received charitable grants for capital projects from the Charity of £0.2 million.

Capital Expenditure

Capital expenditure during 2021/22 was focused on Emergency Department expansion, backlog maintenance, medical equipment, investment in IT projects, design costs for the New Hospital Programme and supporting elective recovery following the pandemic. The Trust's capital plan is set through a risk-based approach to ensure continuity of patient care. The Trust set its capital

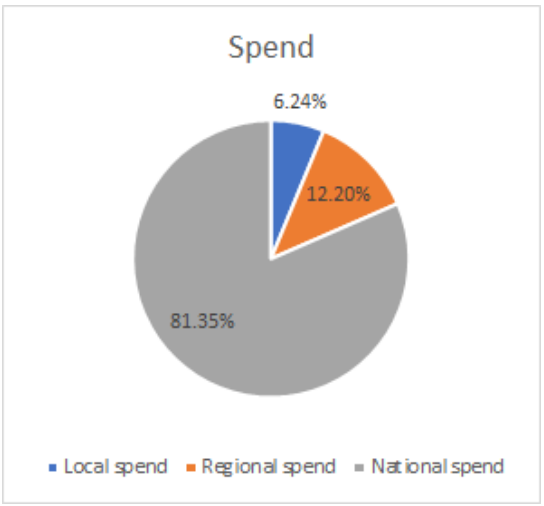
plan at £20.3 million and incurred expenditure of £26.0 million. The overspend was due to additional Public Dividend Capital received relating to elective recovery support following the impact of the pandemic. The largest schemes delivered were improvements to the Emergency Department of £11.4 million and elective recovery support of £6.3 million.

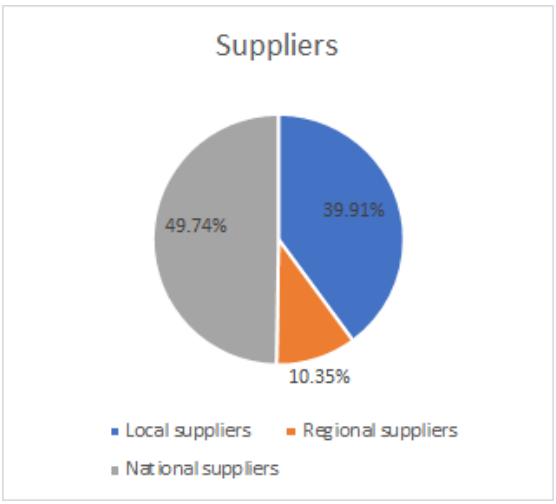
Social Value

The Finance and Procurement teams have been supporting the Trust during the last 12 months in the delivery of short-term objectives linked to its Social Value pledge. These objectives have been addressed as follows:

Short-term Objective	Completed actions
Establish levels of current local spend and set targets going forward	Monthly spend data is analysed to track local, regional and national spend. The spend data for the financial year is shown in the charts below
Develop our website to allow local suppliers to have sight of upcoming projects and be able to contact through the internet	Work is underway to update the Procurement section on the Internet so that a high-level pipeline of opportunities is visible to suppliers, allowing them to “Click here” to contact the Procurement team
Ensure the social value model is embedded in our evaluation of tenders	Although not yet mandatory for non-central government bodies, the Trust has started to include social value in its evaluation criteria on some opportunities
Review spend in catering and estates to identify opportunities for using more local suppliers	The spend data included in the charts below is also tracked monthly by supplier and category.
Request evidence of social value from current suppliers	During the financial year suppliers have been contacted to confirm if they have policies for Equality and Diversity, Sustainability and/or Social Value in place and if not whether they intend to introduce them

The charts below show the breakdown during the financial year between local, regional, and national for the Trust total spend and associated suppliers.





The Finance and Procurement teams will start to deliver a number of long-term objectives to increase local spend with local suppliers, these will be:

- Continuing to cleanse and analyse data by category such as Estates, Catering or IT to determine what scope there is to move more spend to local suppliers. Each member of the procurement team focus on different categories of spend in order to better understand each supplier market and area of spend.
- Further development of the Procurement pages on the Trust internet site to increase visibility and access for local suppliers to contact the Trust based on contract needs.
- Including Social Value scoring criteria in the evaluation in all appropriate tenders and quotes.

The Trust will stay in line with national procurement guidance to ensure a balance is maintained between awarding compliant contracts against national frameworks and buying locally; this will be managed across category headings. Products and service contracts currently in place will not be in scope until they approach expiration.

Performance Analysis

Monitoring Trust Performance

Dorset County Hospital NHS Foundation Trust is committed to the principles of good governance, and this includes a robust approach to performance management and performance improvement. The Board aspires to providing the best services within the resources available, ensuring patient safety and experience are prioritised.

The Board monitors Trust performance against a range of key national and local objectives and targets as agreed with Dorset system partners. The Board Assurance Framework links to key performance indicators and ensures that the Board's focus is on the key risks to delivery of the organisation's principal objectives. This is in turn linked to the Corporate Risk Register to ensure that all necessary mitigations are in place to reduce risk wherever possible.

This process seeks to encompass the achievement of the broader strategic objectives agreed by the Foundation Trust Board and other enabling strategies to ensure a clear line between national requirements, contractual obligations and strategic business priorities of the Trust.

The Trust continued to manage the principal risks related to the COVID-19 pandemic. Isolation requirements, where staff or household members tested positive for COVID-19, led to significant absences. This is turn impacted the Trusts ability to provide consistent levels of activity, impacting waiting lists. Utilising the independent section through insourcing and outsourcing models mitigated some of this, but the independent sector was also impacted by the isolation requirements.

Staffing levels across the Trust continued to be challenged, particularly in specialist areas such as radiology. This is a risk seen throughout the country, which has driven high use of agency and restricted the level of elective activity. The staffing challenges will continue into 2022/23, to mitigate this the Trust has further invested in international recruitment and productivity improvements and pathway redesign initiatives.

Moving into 2022/23, the funding arrangements for the Trust will change, with the national COVID funding arrangements coming to an end. This is an emerging risk and will require much tighter financial controls and a focus on productivity if the Trust is to operate within the required budget. This may have performance implications if productivity improvements are not delivered alongside reduction in spend.

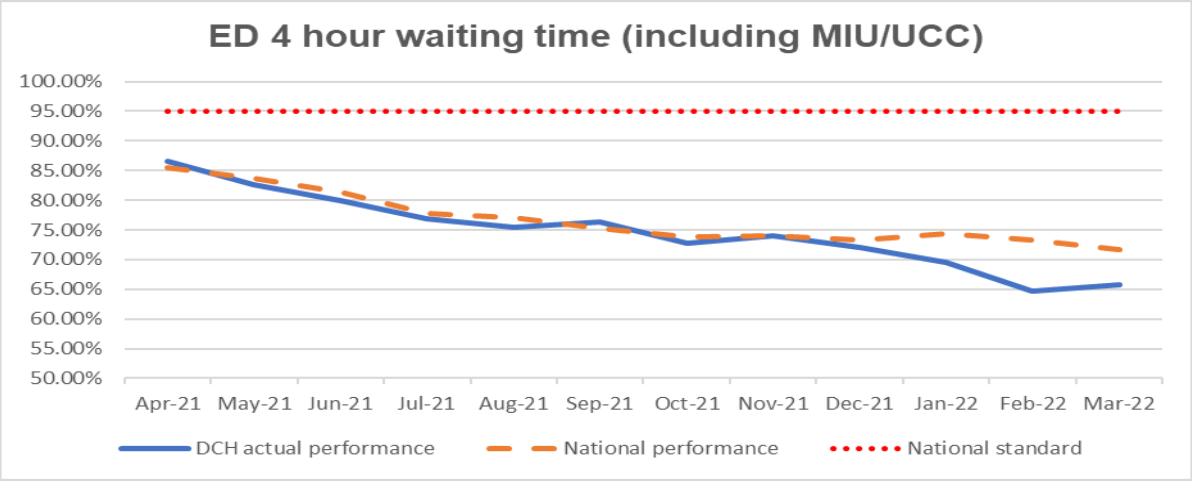
The Trust's performance trajectories were agreed as part of the 2020/21 contracting round and included the following four key performance indicators:

- Emergency Department waiting times,
- Referral to Treatment waiting times,
- Diagnostic waiting times and
- Cancer waiting times.

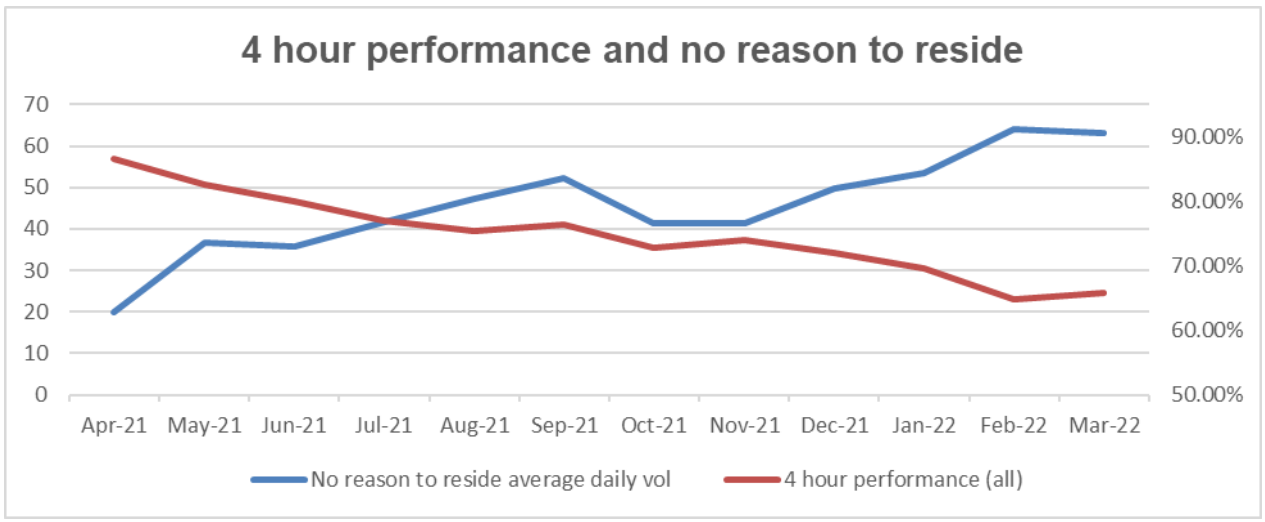
Operational Performance: The Emergency Department

The Emergency Department experienced a significant increase in demand during 2021/22, with 11.42% more attendances than in 2019/20, the pre-covid comparable year. The department also experienced a 3.26% increase in the number of patients admitted to the hospital via the Emergency Department which equated 560 additional patients admitted to wards.

The combined Type 1 and Type 3 performance (Emergency Department and Urgent Care Centre) did not achieve the national standard for the reporting year 2021/22. Performance until December 2021 tracked above, or at the same level as, national performance. This performance was achieved against the backdrop of a demand increases and the operational challenges that Covid continued to present.

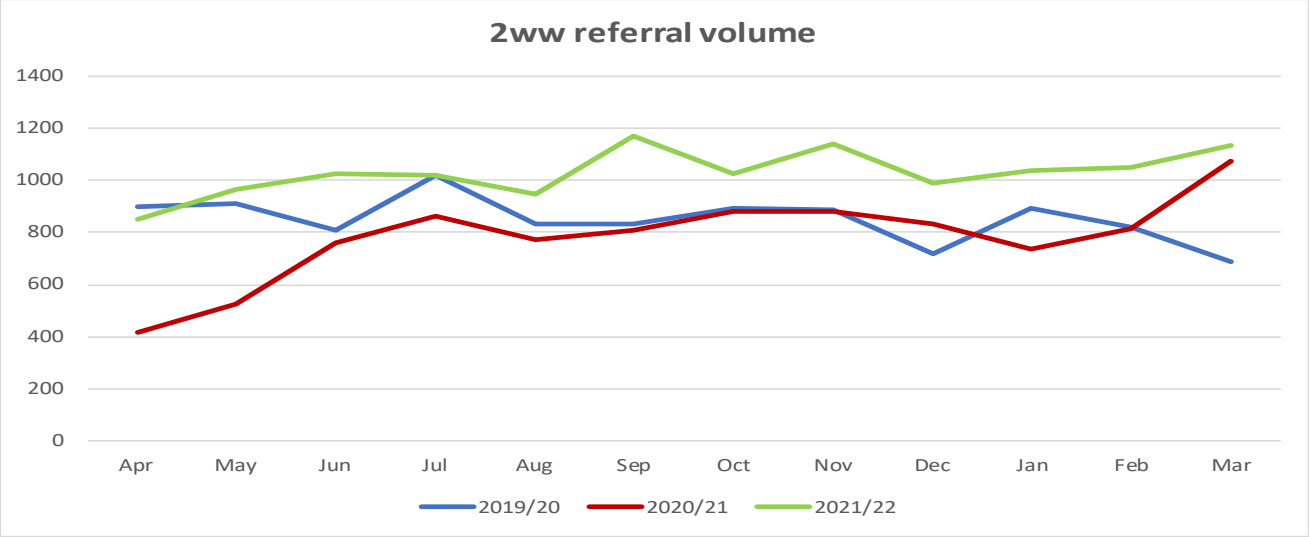


In December 2021, the Trust experienced a significant increase in the number of inpatients with 'no reason to reside'. These are patients that are medically fit for discharge but are waiting on a care package to enable them to go home or return to an out of hospital care setting. High numbers of these patients persisted for the remainder of the year and was a trend reflected nationally due to shortages of care staff, recruitment difficulties, national and care home lockdowns subsequent to several Covid waves. There is a direct correlation between the increased number of inpatients occupying hospital beds with no reason to reside and the four hour Emergency Department waiting time performance as the prolonged high bed occupancy rate, reduced patient flow throughout the hospital.



Operational Performance: Cancer Waiting Times

The Trust has experienced a year of significant increases in the demand for cancer's services. The number of referrals to the two-week referral pathway increased by 21.03% compared to 2019/20, the pre-covid comparable year. This was above the nationally forecast growth rate of 7%.

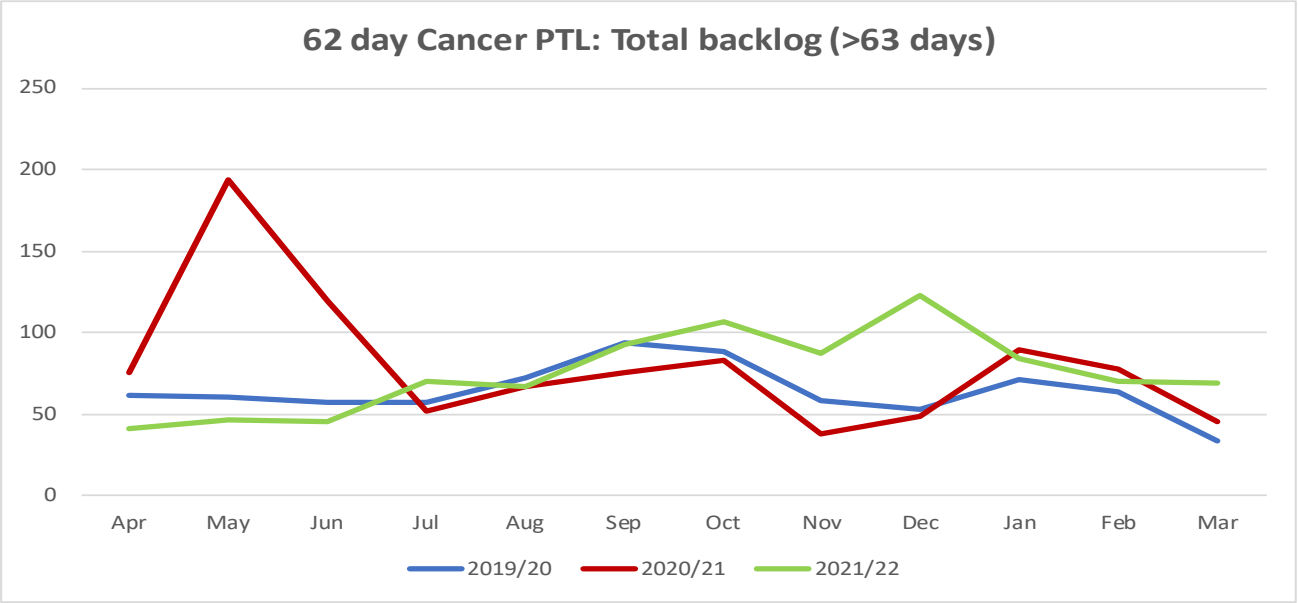


Performance against the cancer waiting time standards was impacted because of the increase in demand. This has resulted in patients waiting longer for assessment and treatment appointments.

A new target was introduced in year, that set out the requirement that patients would be diagnosed and informed of their cancer, or non-cancer, diagnosis within 28 days of referral. Performance against this standard has improved throughout the year as a result of improved administration pathways and increased capacity in Breast and Dermatology cancer services.

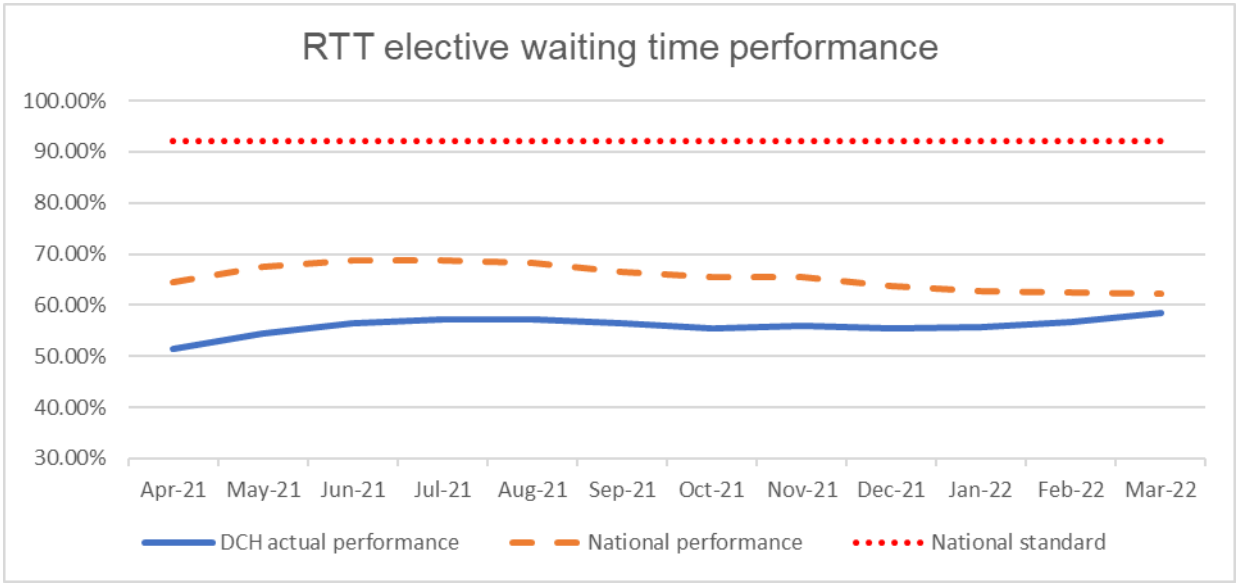
Performance	target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
2ww	93%	69.14%	78.01%	55.96%	55.84%	44.26%	59.69%	38.13%	52.90%	63.79%	52.52%	70.96%	53.63%
Symptomatic	93%	0.00%	3.74%	8.33%	9.38%	9.43%	52.46%	7.02%	52.21%	61.82%	65.15%	88.71%	94.20%
28 day FDS	75%	68.69%	69.39%	71.92%	65.54%	58.04%	62.06%	65.22%	66.03%	67.10%	66.67%	75.03%	71.03%
31 day 1st treatment	96%	96.75%	97.67%	93.75%	97.30%	96.36%	98.46%	92.31%	96.85%	97.89%	97.14%	97.30%	95.69%
31 day Sub (drugs)	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.37%	96.30%	97.50%	100.00%	97.56%
31 day sub (surgery)	94%	100.00%	77.80%	100.00%	100.00%	92.30%	92.31%	100.00%	100.00%	100.00%	100.00%	83.33%	88.89%
62 day RTT - Screening	90%	62.50%	83.33%	57.58%	80.00%	68.75%	70.59%	76.47%	71.43%	77.78%	61.29%	71.43%	85.71%
62 day RTT - 2ww	85%	81.05%	73.96%	74.19%	74.05%	70.50%	72.13%	70.75%	80.82%	63.11%	58.33%	62.03%	81.93%

Despite the challenges arising from the additional demand, the total number of patients waiting over 63 days from referral to treatment tracked inline or below the level seen in the previous two years, except during the Christmas period. The Trust has also continued to maintain a steady waiting list size for the patients with a cancer diagnosis despite an increasing number of referrals.

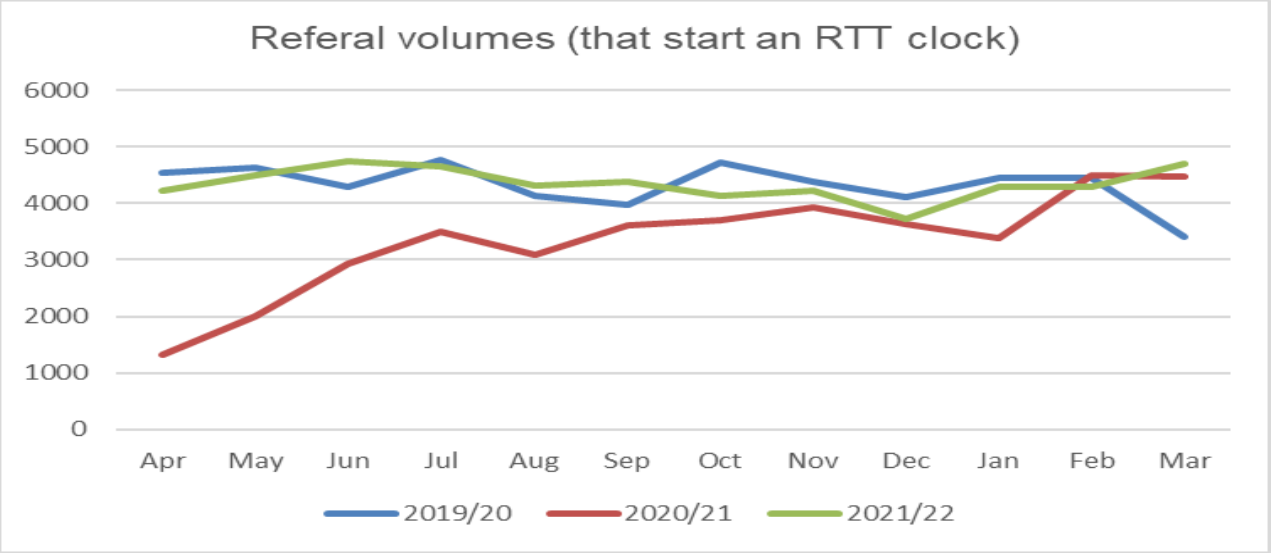


Operational Performance: Referral to Treatment Times

Achievement of the Referral to Treatment (RTT) standard for elective care has been challenging throughout 2021/22 and the Trust did not achieve the national target. Performance has improved steadily, with the number of patients waiting over 52 weeks for treatment reducing by 1,648 patients between March 2020 to April 2021. The total waiting list reached 19,235 in September 2021 but had reduced to 17,196 by April 2021.

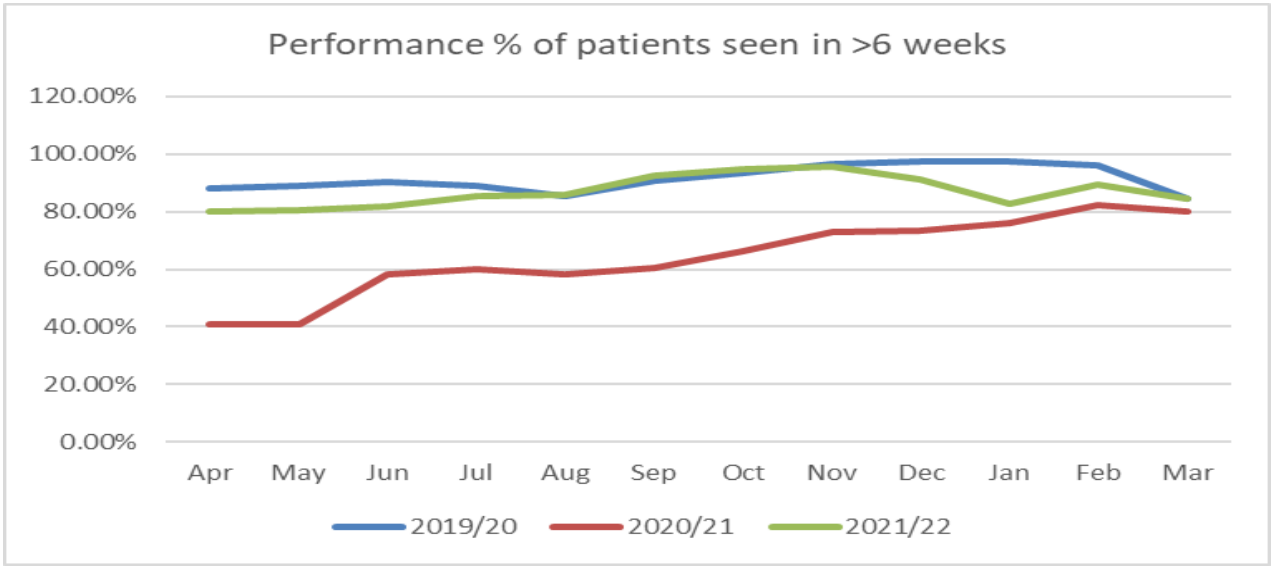


New referrals to elective services reduced in the year following the start of the Covid-19 pandemic. However, in 2021/22, referral rates returned to 100.55% of those in 2019/20. Although this put further pressure on services, the Trust was pleased to see that patients were accessing the care and treatment they needed. The Trust has responded by increasing capacity within the constraints of available resources.

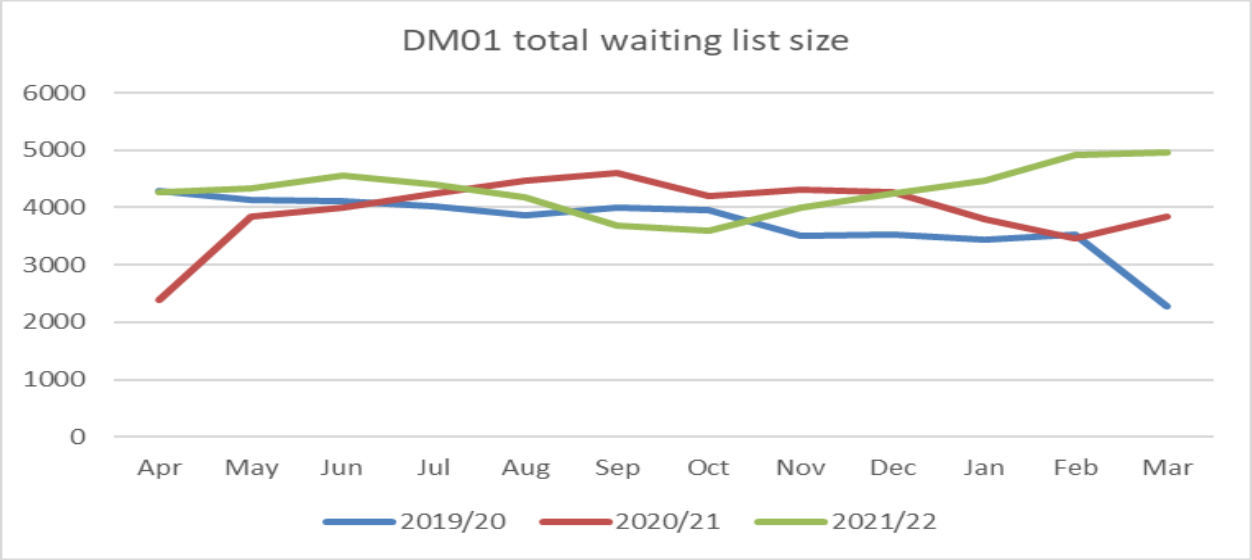


Operational Performance: Diagnostic Waiting Times

Diagnostic performance against the six-week waiting time standard performed well in 2021/22, performing at or above the level of 2019/20, the baseline comparator year. Performance dipped in December as a result of a staff shortages in the Imagining Department due to Covid isolation requirements. This was quickly recovered and by the end of the year, performance was at the same level as 2019/20. Insourcing and outsourcing activity to the independent sector has enabled continued delivery of the same waiting times.



The total waiting list size by December 2021 was larger than that in the previous three years as elective activity returned to pre-Covid levels and emergency and urgent care demand increased.



Despite this, the Trust has maintained performance levels that are comparable to 2019/20 and 2020/21.

Environmental Performance

In October 2020 the NHS committed itself to becoming a net zero carbon organisation by 2045. Previously to this the Trust had already started its journey towards net zero carbon across the Trust. The installation of the Combined Heat and Power Plant and LED lighting, introduction of reusable gowns, and procurement of 100% recycled paper are just some examples of this. In the last year the Trust has taken the next step by recruiting a full time Sustainability Manager and designating a board-level lead for Sustainability.

In January 2022 the Trust published its Green Plan, a three-year strategy towards net zero carbon. The plan contains 29 targets which engage all areas of the Trust in reducing its carbon footprint. Delivery of the plan is overseen by the Sustainability and Travel Working Group which meets every two months. Progress will be formally reported to the Board every year.

The plan aims to further develop the good work already being done across the Trust. For example, the Trust operates a re-homing service whereby old equipment is re-homed elsewhere in the Trust. The Trust is currently managing to rehome 60% of its old equipment; the Green Plan challenges the Trust to reach 75%.

The Trust's commitment to the net zero carbon agenda was further cemented by the publication of the Trust's Sustainable Procurement Policy. The goods and services the Trust buys contribute to over 50% of the Trust's carbon footprint. The policy aims to reduce that, and at the same time ensure social value is delivered.

Another development in 2021-22 has been the creation of the NHS Greener in Dorset Group which comprises the Sustainability Managers from all the Dorset NHS Trusts. This group is working together to realise the collaboration opportunities that the Integrated Care System will bring. Already the group has successfully bid for Greener NHS funding to roll-out an 'App' which will engage and incentivise staff to take part in environmental activities.

Social Community and Human Rights Issues

The Trust takes its responsibilities towards the community it serves very seriously and recognises the responsibility it has to:

- meet the needs of the population it serves as safely, effectively and efficiently as possible
- ensure that services are designed and delivered taking into account the views and opinions of patients
- improving the wider economic, social and environmental well-being of the local population, through its social value commitments as an anchor institution.
- take into account its status as a large employer and that decisions it makes may impact on the local economy and the health and wellbeing not only of staff but their families as well
- take into account the impact it has on the environment. As set out in the sustainability report, the Trust is committed to reducing its environmental impact
- take into account its responsibility to respect human rights and to ensure that actions and decisions do not have an adverse impact on human rights
- ensure that staff feel motivated, empowered and are clear about the difference they are making to patient care and the achievement of the Trust's strategic objectives
- ensure that the Trust is a positive place to work.

Social Value

Dorset County Hospital NHS Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an acute trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community.

Social Value Pledge

The Dorset County Hospital NHSFT Social Value Pledge is available on the hospital's website https://www.dchft.nhs.uk/about-us/social-value/ and presents the Trust's commitments to helping to improve the overall well-being of the community. The Trust is committed to:

Maximising Local Investment
Maximising local investment, recognising the social, economic and environmental benefits of buying locally when procuring goods and services.

Increasing Local Employment
Increasing employment and training opportunities for local people, especially from areas of high deprivation and unemployment.

Being Recognised as a Good Employer
Providing outstanding careers, ensuring that employees have a positive and fulfilling experience - empowering staff to deliver outstanding services, sustainably, everyday.

Championing Equality, Diversity and Inclusion
Championing equality, diversity and inclusion, recognising people from different backgrounds and experience make a valuable contribution to the way in which we work.

Being Greener and Sustainable
Recognising the impact the Trust has on the environment and our responsibility to improve the Trust's sustainability and contributing to better health and well-being of the local community.

Promoting Civic Partnerships
Promoting partnerships between Dorset County Hospital and the civic community, implementing local activities which contribute to reducing inequalities and improving health and well-being for all.

Further details of the work that the Trust is undertaking around apprenticeships, volunteering and young volunteer and work experiences schemes can be found in the Workforce Report section.

Social Value Action Plan

The Trust's Social Value Programme Group has developed Dorset County Hospital Foundation Trust's Social Value Action Plan, aligned to the Trust Strategy. The Social Value Programme Group is focused on embedding delivery of social value, in alignment with the hospital's Health Inequalities programme, across the Trust. This will involve aligning to the new Trust Strategy and enabling plans and embedding social value impact assessment in Trust policies and business planning processes. The group are implementing methodologies for measuring and reporting social value delivered by the Trust. This will form the basis for social value reporting, internally

and externally, including to the Trust Board. Dorset County Hospital's social value delivery is reflected in a range of current activities and longer-term aims including those outlined in the new Dorset County Hospital Green Plan.

Dorset Anchors Network

Dorset County Hospital is a member of the recently formed Dorset Anchors Network. The ambition of the network is outlined in the Dorset Anchors Charter which aims to improve the social, economic and environmental well-being of the communities across Dorset.

Charitable Activities

Dorset County Hospital Charity

The Charity's purpose is to raise funds to enhance patient care and staff welfare at Dorset County Hospital; providing support that is above and beyond the NHS budget. The COVID pandemic has presented significant challenges for fundraising and the charity's income during the year. Dorset County Hospital Charity's new Strategy 2022-25 details new plans and opportunities including a major capital appeal, focused on rebuilding the charity's income, to improve the charity's financial sustainability.

Friends of Dorset County Hospital

The Friends of Dorset County Hospital provide comfort and help to patients. The charity operates a retail shop, manages the volunteer trolley service and fundraises in support of the hospital.

Volunteering and Community involvement

The volunteer service at Dorset County Hospital is part of the Patient and Public Engagement team supporting a positive patient experience. The impact of COVID-19 has seen significant changes to the service and seen the service more in demand than ever before. The volunteer team has been an integral part of the Trust's COVID-19 vaccination centre and engages with voluntary sector partners and the local community on activities to encourage and provide volunteer opportunities.

The Trust's volunteer service also runs a Young Volunteer Programme which is supported by the 'Pears #iWill Fund' and which has developed opportunities for 16 to 24 year olds to volunteer in the hospital. The Trust's volunteer Patient and Public Engagement Action Group - 'Your Voice' has resumed and continues to work on a number of projects to help improve patient experience.

Human Rights

The Human Rights Act is integrated into the Trust's day to day operations and implemented through policies, procedures and strategy. It is essential that staff and service users are aware of the specific requirements of the Act and its application in a human rights based approach to healthcare. The principles of Human Rights are integrated within the Trust training programme and communicated to patients via the Patient Charter.

Anti-Bribery

The Bribery Act 2010 which came into force on 1 July 2011 aims to tackle bribery and corruption in both the public and private sectors.

Bribery can be defined as "giving someone a financial or other advantage to encourage them to perform their functions or activities improperly or reward them for having done so".

Dorset County Hospital NHS Foundation Trust is committed to applying the highest standards of ethical conduct, following good NHS business practice and having robust controls in place to prevent bribery. As an organisation, the Trust cannot afford to be complacent and under no circumstances is the giving, offering, receiving or soliciting of a bribe acceptable. The Trust's zero tolerance approach to bribery and corruption is set out in further detail within the Trust's Anti Bribery Policy and across a range of other Trust policies and procedural documentation.

The Trust is committed to ensuring that all staff are aware of their responsibilities in relation to the prevention of bribery and corruption and that the risk of Trust exposure to acts of bribery is mitigated.

Modern Slavery Act 2015

Dorset County Hospital NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and in supporting victims. In particular, the Trust is committed to ensuring its supply chains and business activities are free from ethical and labour standards abuses. The Trust's Modern Slavery and human trafficking statement can be accessed on the hospital website: https://www.dchft.nhs.uk/about-us/procurement/modern-slavery-statement/

Overseas Operations

The Trust has no overseas operations.

Events After the Reporting Period

There have not been any significant events requiring disclosure after the reporting period to the date of this report.

Signed

Nick Johnson
Interim Chief Executive
20 June 2022

Accountability Report

The Board of Directors, collectively and individually, are required to act with a view to promoting the success of the organisation so as to maximise the benefits for its members and the public. Paragraph 18A of Schedule 7 of the National Health Service Act (NHS Act 2006) (as inserted by the Health and Social Care Act (HSCA) 2012. The Foundation Trust Code states that 'Every Foundation Trust should be headed by an effective Board of Directors. The Board of Directors is collectively responsible for the performance of the Trust'.

Directors' Report

Dorset County Hospital NHS Foundation Trust operates a unitary Board which comprises both Executive and Non-Executive Directors under the leadership of the Chair. In a unitary board, Directors are collectively and corporately accountable for the organisation's performance and benefit from the opportunity to share knowledge and experience gained from a variety of sectors.

The unitary Board of Directors comprises:

Voting members

- Mark Addison, Trust Chair
- Sue Atkinson, Senior Independent Director
- Margaret Blankson, Non-Executive Director
- Judy Gillow, Vice Chair
- Eiri Jones, Non-Executive Director (from January 2022)
- Ian Metcalfe, Non-Executive Director (to November 2021)
- Stuart Parsons, Non-Executive Director (from December 2021)
- Stephen Tilton, Non-Executive Director
- David Underwood, Non-Executive Director
- Paul Goddard, Chief Financial Officer
- Dawn Harvey, Chief People Officer (from April 2021)
- Alastair Hutchison, Chief Medical Officer
- Nick Johnson, Interim Chief Executive Officer (from February 2022) (previously Deputy Chief Executive Officer/Director of Strategy, Transformation and Partnerships)
- Nicky Lucey, Chief Nursing Officer and Interim Deputy Chief Executive (from February 2022)
- Patricia Miller, Chief Executive Officer (to January 2022)
- Inese Robotham, Chief Operating Officer (to October 2021)
- Anita Thomas, Chief Operating Officer (from October 2021)

Non voting

- Stephen Slough, Chief Information Officer
- Dhammika Perera, Associate Non-Executive Director (from January 2022)

Dorset County Hospital operates a Fit and Proper Persons Requirement process for all Directors on appointment and operates a code of conduct that builds on the values of the Trust and reflects the high standards of probity and responsibility. The Board has seen the following appointments in year:

- following the appointment as reported in last year's Annual Report, the Chief People Officer commenced in post on 1 April 2021

- the internal appointment of an Interim Chief Executive Officer and Interim Deputy Chief Executive Officer, following the departure from the Trust of the former Chief Executive Officer in January 2022
- the appointment of one Non-Executive Director in November 2021, replacing a Non-Executive Director who left the Trust, plus one additional Non-Executive Director and one Associate Non-Executive Director in January 2022
- the internal appointment of a new Chief Operating Officer following the departure from the Trust of the former Chief Operating Officer in October 2021.

Board of Directors' Register of Interests

Dorset County Hospital NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by Directors which may conflict with their management responsibilities. The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors, Governors and senior members of staff. The Register of Declarations of Interest for our Board members is available on the hospital website https://www.dchft.nhs.uk/about-us/trust-board/ or on request from the Head of Corporate Governance.

HM Treasury Compliance

Dorset County Hospital NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political Donations

Dorset County Hospital NHS Foundation Trust has not made any political donations during 2021/22.

Better Payment Practice Code Compliance

The Trust has adopted the Better Payment Practice Code, which requires it to aim to pay all undisputed invoices by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 29 days for the Trust's trade payables as at 31 March 2022 (2021: 30 days). The Trust incurred interest and compensations charges of £294 during 2021/22 (2020/21 £343) under the Late Payment of Commercial Debt (Interest) Act 1998. The performance of the Trust in complying with the Code were as follows:

	2021/22		2020/21	
	Number	Value £000	Number	Value £000
Trade payables				
Total bills paid in year	**63,065**	**102,044**	55,577	80,502
Total bills paid within target	**58,103**	**94,092**	50,981	73,909
Percentage of bills paid within target	**92%**	**92%**	92%	92%
NHS payables				
Total bills paid in year	**1,168**	**14,039**	1,353	9,508
Total bills paid within target	**1,077**	**13,178**	1,259	8,983
Percentage of bills paid within target	**92%**	**94%**	93%	95%

Income Disclosure

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £982k which represents 0.38% of total Trust income. The Trust's financial planning ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Disclosure relating to NHS Improvement's Well Led Framework

Information relating to the Trust's Well Led inspection can be found in the Corporate Governance Report and the Annual Governance Statement sections of this report.

Remuneration Report

Annual Statement on Remuneration

As Chairman of the Remuneration and Terms of Service Committee, I am pleased to present the Remuneration Report for 2021/22.

The purpose of the Remuneration and Terms of Service Committee is to make recommendations to the Board of Directors in relation to the appointment and remuneration of the Chief Executive Officer and Executive Directors. The committee also reviews and makes recommendations regarding the Board of Directors' skill mix and balance, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise that the Board of Directors requires in order to meet these.

The Remuneration and Terms of Service Committee also ensures adequate succession planning arrangements for the Executive Team are in place. The committee employed the services of an independent search agency when executing its duties in relation to the successful appointment of the Chief Operating Officer. The agent was appointed through the Trust's usual procurement processes on behalf of the committee and the fee for these services was £18,000.

The Remuneration and Terms of Service Committee met on seven occasions and discussed the following:

- a pay award for the executive team in line with national guidance for 2020/21 applied retrospectively and an award to cover inflationary cost increases for 2021/22
- remuneration of the new role of Assistant Chief Executive Officer in 2021
- remuneration for the replacement Chief Operating Officer in 2021
- the arrangements and remuneration for the Interim Chief Executive Officer and the remuneration for the Interim Deputy Chief Executive Officer in 2022.

Mark Addison
Remuneration and Terms of Service Committee Chair

Senior Managers Remuneration Policy

Policy on Remunerations of Senior Managers

The Trust's senior management remuneration policy requires the use of benchmark information and the Trust makes reference to the Foundation Trust Network Annual Salary Comparison Report.

With the exception of Executive Directors, the remuneration of all staff is set nationally in accordance with the NHS Agenda for Change (for non-medical staff) or Pay and Conditions of Service for Doctors and Dentists. Performance Related Pay is not applicable for any Trust staff, including Executive Directors. Future policy on senior manager remuneration will remain in line with national terms and conditions.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with three months' notice, or six months' notice in the case of the Chief Executive. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

The total remuneration for each of the Trust's Executive Directors comprises the following elements:

Salary + Pension and Benefits = Total Remuneration

Future Policy Table

The Trust's remuneration policy in respect of each of the above is outlined in the tables on the next page.

Salary – (Fees and Salary)

Purpose and Link to Strategy

- Helps to recruit, reward and retain
- Reflects competitive market level, role, skills, experience and individual contribution

Operation

Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions.
The Remuneration Committee considers the following parameters when reviewing base salary levels:

- Pay increases for other employees across the Trust
- Economic conditions and governance trends
- The individual's performance, skill and responsibilities through appraisals
- Base Salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust
- Base Salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll
- The Executive Directors do not receive performance related pay.

Opportunity

The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking.

National and Local benchmarking data was reviewed by the Remuneration Committee who reviewed the relative position of each Executive.

Performance Conditions

None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.

Performance Period

Annual Appraisal covers a 12 month period

Pension and Benefits

Purpose and Link to Strategy

- Help to recruit and retain
- NHS Pension scheme arrangements provide a competitive level of retirement income

Operation

Executive Directors are eligible to receive pension and benefits in line with the policy for other employees.

Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme.

Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, he or she retain the benefits accrued from these schemes.

The principal features and benefits of the NHS Pension Scheme are set out in a table in the Remuneration Report.

Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.

Opportunity

The maximum Employers' contribution to NHS Pension Scheme is 20.68% (14.38% paid by the Trust and 6.3% is paid by NHS England) of base salary for all employees including Executive.

Performance Conditions

None

Performance Period

None

Differences in Remuneration for Other Employees

The remuneration approach for Executive Directors is consistent with The UK Corporate Governance Code, NHS Foundation Trust Code of Governance and NHS Policy. This guidance requires that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully.

The structure of the reward package for the wider employee population is based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non-Medical Staff remuneration is in line with the Agenda for Change Framework, which assesses remuneration in line with the framework for Medical and Dental Staff remuneration. All staff are eligible to join and participate in the NHS Pension Scheme.

Where one or more senior managers are paid more than £150,000, the committee is required to ensure this remuneration is reasonable. The Trust has one senior manager paid more than £150,000. The committee is satisfied the salary of the individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

The Trust's policy for Equality, Diversity and Inclusion defines the approach that will be taken to promoting and championing a culture of diversity and equality of opportunity, access, dignity, respect and fairness in the services the Trust provides and in employment practices. The activities and decisions of the Remuneration and Terms of Service Committee are in accordance with the Trusts Equality, Diversity and Inclusion policy.

Policy on Remuneration of Non-Executive Directors

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	The remuneration and expenses for the Trust Chairman and Non-Executives are determined by the Council of Governors.
Appointment		The Council of Governors appoint the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two three year terms. Any term beyond six years is subject to rigorous review, and takes into account the need for progressive refreshing of the board and their independence. This is subject to annual re-appointment approved by the Council of Governors.

Annual Report on Remuneration

The following sections of the Remuneration Report are not subject to audit.

Remuneration and Terms of Service Committee
Remuneration and Terms of Service for the Chief Executive and Executive Directors is considered by a Remuneration and Terms of Service Committee consisting of the Chair and Non-Executive Directors. The Interim Chief Executive Officer and Chief People Officer are invited to attend the committee as and when required.

The committee's attendance record is set out in the table below:

Name	Attendance/Meetings eligible to attend
Mark Addison (Trust Chair) (Chair)	6/7
Sue Atkinson	4/7
Margaret Blankson	5/7
Judy Gillow (Vice Chair)	6/7
Eiri Jones	3/3
Ian Metcalfe	3/3
Stuart Parsons	4/4
Dhammika Perera	3/3
Stephen Tilton	7/7
David Underwood	7/7

Senior Managers Service Contracts

The table below contains contract information on the Trust's Senior Managers for the financial year 2021/22.

Name	Title	Current Tenure	Notice Period
Non- Executive Directors			
Mark Addison	Chair	24/03/2022-23/03/23 (extension to second term)	3 months
Sue Atkinson	NED	01/09/19 – 31/08/22 (second term)	3 months
Margaret Blankson	NED	01/01/21 – 31/12/23	3 months
Judy Gillow	NED, Vice Chair	01/09/19 – 31/08/22 (second term)	3 months
Eiri Jones	NED	01/01/22 – 31/12/24	3 months
Ian Metcalfe	NED	01/11/20 – 31/10/23 (second term) Left the Trust 30/11/21	3 months
Stuart Parsons	NED	01/12/21 – 30/11/24	3 months
Dhammika Perera	Associate NED	01/01/22 – 31/12/22	3 months
David Underwood	NED	01/03/20 – 28/02/23	3 months
Stephen Tilton	NED	01/06/20 – 31/05/23	3 months
Executive Directors			
Patricia Miller	Chief Executive Officer	Commenced 15/09/14 Left the Trust 31/01/22	6 months
Paul Goddard	Chief Financial Officer	Commenced 18/06/18	6 months
Alastair Hutchison	Chief Medical Officer	Commenced 02/07/18	6 months
Nicky Lucey	Chief Nursing Officer	Commenced 01/09/16	6 months
Nick Johnson	Interim Chief Executive Officer (formerly Deputy Chief Executive/Director of Strategy, Transformation and Partnerships)	Commenced Interim Position 01/02/22	6 months
Dawn Harvey	Chief People Officer	Commenced 01/04/21	6 months
Inese Robotham	Chief Operating Officer	Commenced 19/11/18 Left the Trust 01/10/21	6 months
Stephen Slough	Chief Information Officer	Commenced 01/06/19	6 months
Anita Thomas	Chief Operating Officer	Commenced 04/10/21	6 months

Expenses of Governors and Directors

The expenses incurred or reimbursed by the Trust relating to Governors and Directors were:

	2021/22 Number receiving expenses / total	£	2020/21 Number Receiving Expenses / total	£
Governors	**0 / 23**	**0**	**0 / 23**	**0**
Chairman and non-executive directors	**4 / 10**	**1,891**	**2 / 8**	**1,014**
Executive directors	**3 / 8**	**601**	**2 / 7**	**64**
Total expenses		**2,492**		**1,078**

The following sections of the Remuneration Report are subject to audit

The total remuneration of Directors and senior managers for 2021/22 was £1,013,600 (2020/21: £1,018,000).

Remuneration of Directors - 2021/22	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (neares t £100)	Pension related benefits (Bands of £2,500) £ 000s	**2021/22 Total (Bands of £5,000) £ 000s**
Chairman				
Mark Addison	40 – 45	-	-	**40 – 45**
Non-executive Directors				
David Underwood	10 – 15	-	-	**10 – 15**
Judy Gillow	10 – 15	-	-	**10 – 15**
Prof Sue Atkinson	10 – 15	-	-	**10 – 15**
Stuart Parsons[1]	0 – 5	-	-	**0 – 5**
Ian Metcalfe[2]	10 – 15	-	-	**10 – 15**
Stephen Tilton	10 – 15	-	-	**10 – 15**
Margaret Blankson	10 – 15	-	-	**10 – 15**
Dhammika Perera[3]	0 – 5	-	-	**0 – 5**
Eiri Jones[4]	0 – 5	-	-	**0 – 5**
Executive Directors				
Patricia Miller, Chief Executive[5]	145 –150	-	60 – 62.5	**205 –210**
Prof. Alastair Hutchison, Chief Medical Officer	230 –235	-	0 – 2.5	**230 –235**
Nicky Lucey, Chief Nursing Officer	125 –130	-	47.5 – 50	**175 –180**
Paul Goddard, Chief Financial Officer	130 –135	-	47.5 – 50	**180 –185**
Anita Thomas, Chief Operating Officer[6]	50 –55	-	82.5 – 85	**135 –140**
Inese Robotham, Chief Operating Officer[7]	70 –75	-	92.5 – 95	**165 –170**
Dawn Harvey, Chief People Officer[8]	105 –110	-	45 – 47.5	**150 –155**
Nick Johnson, Interim Chief Executive (formerly Deputy Chief Executive/Director of Strategy, Transformation and Partnerships)[9]	135 –140	-	35 – 37.5	**170 –175**

Stephen Slough, Chief Information Officer was appointed on 01/06/2019 and is paid by NHS Dorset CCG and details of remuneration and expenses are included within their Annual Report.

Professor Alastair Hutchison remuneration includes payment of clinical sessions.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement (this is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Remuneration of Directors - 2020/21	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (nearest £100)	Pension related benefits (Bands of £2,500) £ 000s	**2020/21 Total (Bands of £5,000) £ 000s**
Chairman				
Mark Addison	40 – 45	-	-	**40 – 45**
Non-Executive Directors				
David Underwood	10 – 15	-	-	**10 – 15**
Judy Gillow	10 – 15	-	-	**10 – 15**
Prof Sue Atkinson	10 – 15	-	-	**10 – 15**
Victoria Hodges[10]	5 – 10	-	-	**5 – 10**
Matthew Rose[11]	0 – 5	-	-	**0 – 5**
Ian Metcalfe	10 – 15	-	-	**10 – 15**
Stephen Tilton[12]	10 – 15	-	-	**10 – 15**
Margaret Blankson[13]	0 – 5	-	-	**0 – 5**
Executive Directors				
Patricia Miller, Chief Executive[14]	165 –170	-	45 – 47.5	**210 –215**
Prof. Alastair Hutchison, Chief Medical Officer	200 –205	-	0 – 2.5	**200 –205**
Nicky Lucey, Chief Nursing Officer	125 –130	-	7.5 – 10	**130 –135**
Paul Goddard, Chief Financial Officer	125 –130	-	15 – 17.5	**140 –145**
Inese Robotham, Chief Operating Officer	120 –125	-	20 – 22.5	**140 –145**
Mark Warner, Director of Workforce[15] and Organisational Development	190 –195	-	7.5 – 10	**200 –205**
Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships[16]	125 –130	-	25 – 27.5	**150 –155**

1 – Appointed on 01 December 2021
2 – Until on 30 November 2021
3 – Appointed on 01 January 2022
4 – Appointed on 01 January 2022
5 – Until on 31 January 2022
6 – Appointed on 04 October 2021
7 – Until on 01 October 2021
8 – Appointed on 01 April 2021
9 – Appointed Interim 01 February 2022
10 – Until on September 2020
11 – Until on 16 June 2020
12 – Appointed 20 01 June 2020
13 – Appointed on 01 January 2021
14 – Not available between 28 February 2020 to 22 June 2020
15 – Until on 31 October 2020
16 – Acting between 01 March 2020 to 21 June 2020

There have been no annual performance related or long term performance related bonuses paid during the year 2021/22 or 2020/21.

There have been no payments for loss of office during 2021/22 (2020/21: includes a loss of office payment in the fees and salary figure of the Director of Workforce and Organisational Development for redundancy of £47,000).

There have been no payments to past senior managers during 2021/22 or 2020/21.

Fair Pay Multiple Statement

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their Trust against the 25th percentile, median(50th) and 75th percentile of remuneration of the Trust's workforce.

The percentiles of 25%, 50% and 75% remuneration of the workforce is the total remuneration of the staff member lying at these percentiles of the linear distribution of the total staff in the Trust excluding the highest paid Director.

The banded remuneration of the highest-paid director in the Trust in the financial year 2021-22 was £230,001 – £235,000 (2021-22, £200,001 - £205,000). This is a change between years of 14.8%.

The remuneration of the employee at the 25th percentile, median(50th) and 75th percentile is set out in the table below. The pay ratio in the table below shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the Trust's workforce.

2021/22	**25th percentile pay ratio**	**Median (50th percentile) pay ratio**	**75th percentile pay ratio**
Mid-Point of Highest paid Director (X)	£232,501	£232,501	£232,501
Workforce Remuneration (Y)	£19,918	£25,655	£39,027
Pay Ratio (times) [X/Y]:1	**11.67**	**9.06**	**5.96**

2020/21*	**25th percentile pay ratio**	**Median (50th percentile) pay ratio**	**75th percentile pay ratio**
Mid-Point of Highest paid Director (X)	£202,501	£202,501	£202,501
Workforce Remuneration (Y)	£19,737	£27,416	£37,890
Pay Ratio (times) [X/Y]:1	**10.26**	**7.39**	**5.34**

In 2021/22, one (2020/21: 1) employees received remuneration in excess of the highest-paid director in 2021-22. Remuneration was in the banding range of £250,000 to £255,000 (2020/21: £220,000 to £225,000).

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £250,001 - £255,000 to £5,001-£10,000 (2020-21 £200,001 - £205,000 to £10,001 - £15,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 27.9%*.

*The figures for 2020/21 have not been restated for the inclusion of temporary due to missing data.

Pension Arrangements

All Executive Directors of the Trust are eligible to join the NHS Pension Scheme. The Chairman and non-executive directors are not eligible to join the scheme and are not accruing any retirement benefits in respect of their services to the Trust. The Trust did not make any contributions to any other pension arrangements for directors and senior managers during the year.

The principal features and benefits of the NHS Pension Scheme are set out in the table below:

	1995 section	2008 section	2015 section
Member contributions	5% - 13.3% depending on rate of pensionable pay		
Pension	A pension worth 1/80th of final year's pensionable pay per year of membership	A pension worth 1/60th of reckonable pay per year of membership	A pension worth 1/54th of Career Average Re-valued Earnings of pensionable pay per year of membership
Retirement lump sum	3 x pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange part of pension for cash at retirement, up to 25% of capital value. Some members may have a compulsory amount of lump sum	Option to exchange part of pension for a lump sum up to 25% of capital value
Normal retirement age	60	65	Equal to an individuals' State Pension Age or age 65 if that is later
Death in membership lump sum	2 x final years' pensionable pay (actual pensionable pay for part-time workers)	2 x reckonable pay (actual reckonable pay for part-time workers)	The higher of (2 x the relevant earnings in the last 12 months of pensionable service) or (2 x the revalued pensionable earnings for the Scheme year up to 10 years earlier with the highest revalued pensionable earnings
Pensionable pay	Normal pay and certain regular allowances		

The tables on the next page set out details of the retirement benefits that Executive Directors have accrued as members of the NHS Pension Scheme. All the Executive Directors that are accruing benefits under these schemes with their normal retirement age in line with the table above.

	Real Increase in pension at retirement (bands of £2,500) £000	Real Increase in lump sum at retirement (bands of £2,500) £000	Total accrued pension at retirement at 31/03/2022 (bands of £5,000) £000	Related lump sum at retirement at 31/03/2022 (bands of £5,000) £000
Patricia Miller, Chief Executive	2.5 - 5.0	0 - 2.5	50 – 55	90 – 95
Dawn Harvey, Chief People Officer	2.5 – 5.0	0 - 2.5	10 – 15	0 – 5
Inese Robotham Chief Operating Officer	2.5 – 5.0	2.5 – 5.0	35 – 40	66 – 70
Paul Goddard, Chief Financial Officer	2.5 – 5.0	0 – 2.5	60 – 65	130 – 135
Nicky Lucey, Chief Nursing Officer	2.5 – 5.0	0 – 2.5	55 – 60	150 – 155
Anita Thomas, Chief Operating Officer	0 – 2.5	2.5 – 5.0	25 – 30	50 – 55
Nick Johnson Interim Chief Executive (formerly Deputy Chief Executive/Director of Strategy, Transformation and Partnerships)	2.5 – 5.0	0 - 2.5	5 – 10	0 – 5

	Cash Equivalent Transfer Value at 01/04/2021 £000	Cash Equivalent Transfer Value at 31/03/2022 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000s
Patricia Miller, Chief Executive	898	989	51	-
Dawn Harvey, Chief People Officer	150	195	30	-
Inese Robotham, Chief Operating Officer	557	652	40	-
Paul Goddard, Chief Financial Officer	1115	1202	62	-
Nicky Lucey, Chief Nursing Officer	1099	1178	55	-
Anita Thomas, Chief Operating Officer	407	483	30	-
Nick Johnson, Interim Chief Executive (formerly Deputy Chief Executive/Director of Strategy, Transformation and Partnerships)	43	71	8	-

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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETVs are not disclosed for scheme members who have reached their normal retirement date.

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 that 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.

The real increase in CETV represents 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) and uses common market valuation factors for the start and end of the year.

Nick Johnson
Interim Chief Executive
20 June 2022

Staff Report

People Strategy

As a major local employer of 4,000 staff, who fulfil a wide range of professional and multidisciplinary roles, we recognise that our workforce defines who we are and how we are viewed by the patients and we serve. We strive to ensure our staff are highly skilled and well supported in their working environment, in order that they are able to deliver the highest standards of compassionate and safe care. Investment in the recruitment, education, training, support and well-being of our staff remains at the heart of what we do at DCH.

In April 2021 DCH Board approved the Trust Strategy and the focus on three strategic goals: People, Place and Partnership.

The intention of the People pillar is to truly value our staff. Our people are our most important asset, and we want everyone to feel valued, welcomed, respected, that they belong, and they matter. We recognise the link between high levels of staff satisfaction, an inclusive culture and improving patient experience, outcomes and reducing health inequalities. The Trust vision is also about being at the heart of improving the wellbeing of our communities and staff are part of that local community. The People Plan aligns to our Social Value Pledge to be a model employer, contributing to the local economy through employment opportunities and principles of good work.

The People Plan also contributes to DCH's commitment to reducing impact on the environment and supporting better health and wellbeing of our local communities. DCH's People Plan aligns to the NHS People Plan and embeds the elements of the NHS People Promise to support the NHS Long Term Plan. Delivery of the plan will seek to maximise opportunities highlighted by The Future of the NHS HR and OD report.

High level principles for People are defined within DCH Trust Strategy as:

- We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes
- We will create an environment where everyone feels they belong, they matter, and their voice is heard
- We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves
- We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect

Covid 19

In the past year we have continued to see unprecedented challenges within the Heath Service as the Trust faced the second year of the COVID-19 pandemic and placing NHS staff under extreme pressure; staff who were still dealing with the outcomes of the first year of the pandemic. The need for a healthy balance of personal wellbeing and professional commitment remains a key focus and priority for the Trust. The staff at DCH showed extraordinary commitment and resilience during the pandemic and continue to show remarkable collaboration and team working to overcome the daily challenges.

The Trust's vaccination hub closed at the beginning of December having played a central part in the vaccination of Trust staff for first, second and booster vaccinations. The Trust confirmed a

96% vaccination rate for the entire workforce. This is a significant achievement for the Trust and one of the highest vaccination rates in the country.

Recruitment

The past 12 months have seen an increase in the pressures for recruiting to nursing and medical staff posts, with the ongoing challenges of Covid 19. The Trust has implemented several methods to further increase successful recruitment, whilst adjusting to the impact of the pandemic. The People Plan ambitions are driving a review of recruitment and selection practices with a focus on inclusive recruitment to improve the candidate experience.

International nurse recruitment has been the focus to fill clinical vacancies through an external agency recruiting 85 nurses during 2021 across a variety of departments with further recruitment planned for 2022. This complies with the national drive to recruit additional nurses to the NHS and Trust efforts to meet commitments have been recognised by NHS England & Improvement with congratulations received from the Chief Nursing Officer.

The Trust has experienced further challenges with recruiting middle grade doctors and we have continued to see an increase in internationally trained doctors joining the Trust. Supporting all international arrivals is a focus for the Trust as part of the People Plan aims for an inclusive culture

Recruitment for Healthcare Support Workers has been high priority again for 2021 and we have been supported with this by additional funding from NHS England & Improvement to reach zero vacancies and this funding continues into 2022. Recruitment has continued successfully for newly qualified staff joining us on the Trust preceptorship programme to support staff in their first year at work.

Collaboration is a key pillar for the People Plan and the Trust has continued to work closely with other NHS Trust colleagues in the Dorset Integrated Care System to enhance recruitment and selection activity and increase social media presence for Dorset as a place to live and work.

Employment Policies

The Trust has more than 50 employment policies in place which have been designed to provide guidance to our staff and to ensure we meet our legal obligations to them. The effectiveness of each policy is reviewed in conjunction with staff side representatives. During 2021, 21 of our employment policies were reviewed to ensure effectiveness and adherence to legal requirements as well as taking into account necessary amendments dictated by the changing government advice relating to the ongoing coronavirus pandemic.

The Trust is dedicated to developing and sustaining a restorative just and learning culture. One element in the Trust's journey towards this was a review of the Disciplinary policy. Following a lived experience exercise, the Disciplinary policy was rewritten to align with the principles of a just and learning culture

Whilst as a Trust we do not experience a high quantity of formal conduct cases, we have received a positive response from those involved in cases where a just and learning approach has been taken. The line managers involved have been keen to take a different approach now and for any future situations, particularly recognising the impact the pressure and stress a formal process can have on a member of their team. Our intended next step is to review other existing people policies, following the same approach taken with the Disciplinary policy.

Appraisal Process

The ongoing challenges of the pandemic and resulting pressure on staffing levels has continued to contribute to lower than anticipated appraisal completion rates. To counteract this, a focus was put on wellbeing conversations during 21/22 with less focus on the paperwork and an increased focus on the quality of the conversation.

Plans to further simplify the appraisal process are in progress. A new Management Matters programme will be used to equip managers to have appraisal, talent and wellbeing discussions which value every individual.

Staff Gender Analysis (as at 31 March 2021)

A full report on the Trust's gender pay gap statistics was provided to the People and Culture Committee in March 2021, and formal submission was made via the government portal the same month.

The current DCH Gender Pay Gap Report is available to view here:
https://gender-pay-gap.service.gov.uk/Employer/DQEcAlqU/2021

The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages: a mean average and a median average. In simple terms, the mean is the average hourly rate, and the median is the mid-point hourly rate for men and for women in the workforce. The mean figure is the figure most commonly used.

The Trust's overall results across our entire workforce our mean gender pay gap is 26%. This means that the average hourly pay rate for men is 26% higher than for women. This is a 5% increase from 2020/21. Our overall median gender pay gap is 9% - this means that the mid-point hourly rate for men is 9% higher than for women, which is a significant decrease from 22% in 2020/21.

Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2021) are as follows:

- Our mean gender pay gap is 26%
- Our median gender pay gap is 9%
- Our mean bonus gender pay gap is 21%
- Our median bonus gender pay gap is 38%
- Our proportion of males receiving a bonus payment is 6%
- Our proportion of females receiving a bonus payment is 0.5%

For Gender Pay Gap calculations, our bonus payments relate to Clinical Excellence Awards only. These award consultants and academic GPs who perform 'over and above' the standard expected of their role. The only bonus payments paid by the Trust are local and national Clinical Excellence Awards, paid to eligible medical Consultants. It should be noted though that for the 2021 and 2021 CEAs rounds, the national scheme was adapted; the previous application and assessment process was removed, and the total award fund was divided equally to all eligible Consultants; thus all receiving an award of the same value. The CEA scheme is under national review

While men make up only 23% of the workforce, an increase on the previous year, there remains a disproportionate number of males, 33% in the highest paid quartile.

At DCHFT, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff. This is reflected in our overall gender pay gap and, as a trust, we recognise that this is a generational and societal issue. We know, however, that an increasing number of women are choosing to pursue medicine and other previously male-dominated roles as a career.

Our People Plan commits to look after and invest in and develop our workforce. The goal is for DCH to be a highly attractive place to develop a long-term career. This means we will continue to address the barriers for female employees and target the inequalities faced by females belonging to specific groups, based on characteristics such as ethnicity, age and profession. There are clearly fewer female employees in senior medical roles.

Staff Sickness

The Staff sickness information contained in the table below has been calculated and supplied by the Department of Health. The information has been calculated on a calendar year basis.

Figures converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
2,796	26,366	1,020,559	42,771	9.4

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2021

Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Turnover
The Trust's turnover rate for 01 April 2021 – 31 March 2022 was 10.63%. This remains within the Trust's acceptable range of 8% - 12% although has increased from 8.05% last year. The turnover by staff group is detailed in the table below. Turnover data is reported monthly to the Trust's People and Culture Committee.

Staff Group	LTR Headcount %	LTR FTE %
Add Prof Scientific and Technic	16.2963%	14.7495%
Additional Clinical Services	11.8846%	11.8314%
Administrative and Clerical	13.7759%	12.3884%
Allied Health Professionals	10.9005%	11.1341%
Estates and Ancillary	17.5355%	16.0324%
Healthcare Scientists	10.7784%	10.7746%
Medical and Dental	5.6180%	5.1380%
Nursing and Midwifery Registered	6.5021%	6.4269%

Equality Diversity and Inclusion
DCHFT continues to have a firm commitment to equality, diversity and inclusion (ED&I). Progress on ED&I activity is monitored by the Trust's ED&I Steering Group (EDISG) and the Trust's ED&I Inclusion Plan has been refreshed to further enhance the People Plan's objectives of developing an Inclusive Culture across the Trust. An overarching Action Plan joins up all aspects of EDI work.

Whilst drivers include legal requirements (Equality Act 2010, Public Sector Equality Duty, Gender Pay Gap reporting), national standards (Workforce Race and Disability Equality Standards) and contractual obligations (Equality Delivery System), our vision for ED&I at DCH has moved beyond compliance to mainstreaming ED&I so it becomes the 'golden thread' running through everything we do.

We draw our data from a variety of staff engagement routes, including our Staff Networks. Capturing and utilising feedback on staff experience is key to inform future improvements. Five staff networks have been set up to provide peer-led support to staff representing protected characteristics including race, disability and sexuality. All networks are being encouraged to develop communications and engagement plans to inform members about their activities as well as be a critical friend to the trust in terms of reviewing policies.

Recent staff survey results have shown that 75% of staff think that the organisation respects individual differences – this is 8% higher than the national comparator and may be an early indication of the positive impact our inclusion work is having, including the Inclusive Leadership Programme which commenced in June 2021.

Consultation, Partnership Working and Staff Engagement

We have several established mechanisms of communicating information across the Trust, including a weekly email bulletin, a weekly email briefing from the Chief Executive and monthly team briefing sessions; the frequency and content of all adjusted accordingly throughout the pandemic. The Trust also communicates stories of interest via social and local media.

Our established consulting and negotiating bodies, the Partnership Forum (for non-medical staff) and Local Negotiating Committee (for medical staff), continue to make an important contribution to promoting effective staff engagement and partnership working and in ensuring these are underpinned by a commitment to: promoting the success of the organisation; recognising the respective parties' legitimate interests; operating in an honest and transparent manner; focusing on the quality of working life and its benefit to the quality of patient care; maintaining, as far as possible, employment security.

With agreement with respective Staff Side Chairs, we stood down some committee meetings as a direct result of the pandemic and staff capacity however these have now been fully reinstated albeit virtually but this is working successfully.

It has been agreed that the membership of Partnership Forum requires review to ensure there is appropriate representation from the wider workforce, maximise participation and two-way communication with staff; this piece of work has now commenced.

Trade Union Facility Time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	FTE employee number
6	2397

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	-
1-50%	6
51%-99%	-
100%	-

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£3,237
Provide the total pay bill	£166,978,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.002%

Paid trade union activities

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as:	
(total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	87%

Workforce Planning

Workforce planning supports the delivery of operational priorities over the short medium and longer term. We face a range of workforce and resourcing challenges and our updated People Plan aligns with our refreshed Trust strategy providing a framework to help to tackle challenges locally and in collaboration with our ICS, regional and national partners. Our Workforce Business Partners assist leaders in revising and developing workforce plans for each area to inform our recruitment domestic and international recruitment and education plans.

The development of the widening participation team referenced in the Education section aims to exploit new opportunities to attract and grow talent from within our local community providing quality employment, and training opportunities for people starting or changing careers or moving on from voluntary work. We will build further on our successful work with partners including Universities, Colleges, DWP and the Princes Trust to refresh and promote our career and training offer to attract and retain people with the right skills and potential to help us to build sustainable future workforce supply pipelines to meet our recruitment and succession plans.

Workforce plans also introduce new roles and ways of working to support different operating models including Reporting Radiographers, Nurse Consultants, Physician Associates, Advanced Clinical Practitioners, Advanced Critical Care Practitioners. Higher Specialist Scientist roles, Nursing Associates and broadening roles for support staff including responding to digital developments and new technology. Workforce plans are in development to support delivery of a new ED and Critical Care Unit and the development of Integrated Community Services including exploring opportunities for more rotational and system wide approaches to service delivery. Data helps to support evidenced based planning and the Trust is working closely with ICS partners to support the automatic feed of Trust workforce data into the Dorset wide Information and Intelligence Service Dashboard (Diis).

Health and Wellbeing

The health and wellbeing of our staff continues to be a high priority and is imperative for ensuring safe, high-quality care for our patients.

The introduction of a Wellbeing Guardian within the Trust aligns with the current work to implement elements of the NHS Health and Wellbeing Framework. The Wellbeing Guardian role will support further development of a compassionate and inclusive wellbeing culture by independently challenging senior leaders and championing the messaging of the Trust's People Plan.

Evidenced-based approaches to HWB have informed development of a 'wellbeing continuum' and assessment tools to help with self-assessment and triage approaches for more efficient

signposting to appropriate support, which includes both preventative and proactive elements. This approach is underpinned by a programme of internal courses and self-directed learning to help staff manage stress and anxiety. A network of Trust-wide Health & Wellbeing Coaches (HWCs) help signpost staff to appropriate support.

Staff are supported by trauma response network across the Trust. TRiM (Trauma Risk Management) is a peer delivered assessment tool, used to determine by what degree, if any, a colleague has been affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support. The network of trained TRiM practitioners will increase during 22/23, to strengthen our trauma response capacity.

Wellbeing Walkarounds now prioritise 'hot spots' through triangulating data from People Pulse feedback and discussion with leaders within divisions and departments. This allows targeted HWB interventions for individuals and teams.

Staff also have access to Vivup, our Employee Assistance Programme. Vivup are a leading provider of professional counselling, information and advice offering support for issues arising from home or work. The on-site counselling service has received guaranteed funding for the next 12 months, providing an accessible service to staff and forms a valuable element of the staff HWB offer.

We ran our annual flu campaign but with a significant reduction in take up; this was likely to be attributed to the Covid vaccination programme and specifically boosters which coincided. A short survey is being sent to staff to understand their decisions for not taking up the flu vaccine so we can shape our campaign this year.

The Dorset ICS 'Here for Each Other' service complements and enhances the on-site counselling and staff wellbeing support we have in place at DCH. The service has a variety of advice and guidance from trusted sources to help staff manage their own wellbeing. There is a link to this service on the Staff Intranet Wellbeing pages.

Our approach to support staff health and wellbeing throughout 22/23 will be to continue the work already underway to balance preventative and proactive approaches to ensure a robust support package.

Countering Fraud and Corruption

The Trust's Counter Fraud Policy sets out the standards of honesty and propriety expected of staff and encourages employees to report any suspicious activity that might indicate fraud or corruption promptly. The policy links to the Trust's Raising Matters of Concern (Whistleblowing) and Disciplinary policies and various NHS publications on this subject.

The Trust's counter fraud service continues to be provided by TIAA who report directly to the Chief Financial Officer and also report regularly to the Risk and Audit Committee throughout the year. Raising awareness of the need to counter fraud and corruption is taken seriously by the Trust and is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet. TIAA undertake a number of proactive work fraud check streams throughout the year to support the Trust's commitment to this area.

The Trust's Freedom to Speak Up Guardian (FTSUG) is supported by a network of Freedom to Speak Up Champions. The FTSUG has a regular meeting with the Chief People Officer and Senior Independent Officer, to discuss and raise any concerns. A bi-annual Freedom to Speak up report is submitted to the People and Culture committee.

The Trust's Senior Independent Officer (SIO) and Whistleblowing Lead is one of our Non-Executive Board members. This role is in place to ensure there is a direct point of contact on the Board, and to provide Board level visibility of any potential issues.

Staff Experience and Engagement

The Trust recognises the important link between staff engagement and improved patient care. Understanding how staff experience their work environment is critical to the success of any organisation and the NHS National Staff Survey provides an important insight into how our staff experience work at DCHFT. We are proactive in analysing staff experience data monthly through the People Dashboard, but the NSS helps us understand how we compare nationally.

This 'soft' data is one way our people can communicate opinions and views about working here at the Trust. It provides an anonymous forum for staff to give their views on issues which they may not feel comfortable or safe to air via other routes. As the Trust undertakes focused interventions on culture, inclusion, management and leadership, we will expect to see the impact of these in the responses our people give.

At divisional level we will help leadership teams to triangulate the survey data with the monthly people dashboard data and identify and prioritise the elements within the people plan that will assist them to make longer term improvements.

The most critical part of this process is not just about reviewing the results but being clear about where we want to be as an organisation and what needs to be done differently to ensure we are.

NHS Staff Survey

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

The response rate to the 2021/22 survey amongst Trust staff was 47% (2020/21:46%)

2021/22 Results

Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below.

	2021/22	
	Trust	**Benchmark**
We are compassionate & inclusive	7.4	7.2
We are recognised & rewarded	6.1	5.8
We each have a voice that counts	6.9	6.7
We are safe & healthy	6	5.9
We are always learning	5.6	5.2
We work flexibly	6.2	5.9
We are a team	6.8	6.6
Staff engagement	7.1	6.8
Morale	5.9	5.7

2019/20 and 2020/21

Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below.

	2020/21		2019/20	
	Trust	**Benchmarking**	**Trust**	**Benchmarking**
Equality, Diversity & Inclusion	9.2	9.1	9.4	9.1
Health & Wellbeing	6.2	6.1	6.1	5.9
Immediate Managers	7	6.8	7.1	6.9
Morale	6.4	6.2	6.4	6.1
Quality of Care	7.5	7.5	7.4	7.5
Safe environment - Bullying & harassment	8.1	8.1	8.1	8
Safe environment - violence	9.5	9.5	9.5	9.4
Safety culture	6.8	6.8	6.8	6.7
Staff engagement	7.2	7	7.2	7
Team Working	6.6	6.5	6.8	6.6

DCH scored higher than the national average for all 9 key themes in the 2021 results (consisting of 7 People Promise themes plus Morale and Staff Engagement).

Whilst the Trust response rate increased by 1% this year, we want to continue to improve this for the staff survey results to be more meaningful. Our monthly dashboard data and quarterly pulse surveys will combine with the NSS data to allow deeper dives and increased ownership of results at local level. Positive shifts to People Plan elements will arise from enhanced engagement with all of our staff data.
Other staff engagement routes such as the Freedom to Speak Up, People Recovery and Equality, Diversity and Inclusion Steering Groups provide us with data and direction to inform our strategies and interventions. The appointment of a new Inclusion Lead has strengthened the communication with Staff Networks. The Health & Wellbeing (HWB) Lead has launched a network of Health & Wellbeing Coaches (a rebranding and expansion of Wellbeing Champions) which provides another route for staff to feedback on their experiences alongside Wellbeing Walkarounds which are supported by members of the Senior Leadership Group.

Future Priorities and Targets
Our 2022-25 People Plan aligns to the NHS People Plan and embeds the elements of the NHS People Promise to support the NHS Long Term Plan. High level principles for People are defined within DCH Trust Strategy and each People Principle has been broken down into a short number of goals that will be achieved over a period of 1-3 years. Each goal has defined outputs (linked to KPIs) and measures. Progress on the People Plan will be monitored through the People and Culture Committee.

Celebrating Success
Every day, individuals and teams within the Trust go above and beyond the call of duty; and throughout 2021 and the second year of coronavirus pandemic this was again even more evident. In November we held a Thank You Week; an opportunity to send Thank You postcards to colleagues. The week culminated in the GEM Awards and Long Service Awards.

In 2020 we were unable to hold the annual Going the Extra Mile (GEM) Awards, however this year the Trust was able to reinstate the annual event which has become a well-established means of recognising and honouring staff and volunteers for their service and outstanding contribution to the care of patients and running of the hospital. Comprising 10 categories, shortlisted individuals and teams were invited to a formal dinner event with winners announced on the night by members of the executive team. The event incorporated the Long Service Award programme, recognising those staff with 25years of NHS service.

We continue to run our Hospital Heroes Scheme. To help honour our Hospital Heroes, we encourage patients, carers, family member and colleagues to thank both teams and individual members of staff who have provided outstanding care to patients.

To say thank you to staff who have worked tirelessly to deliver compassionate care in the face of unprecedented demand and the ongoing challenge of the COVID-19 pandemic, a special ‘Proud to be part of Team DCH’ pin badge was created to recognise the contributions made by all staff at DCH.

Leadership Development
Evaluation of our Fundamentals Leadership and Advanced and Clinical Leadership Programmes delivered in recent years have indicated a range of skills gaps exist for our managers. Recent engagement activity to develop the Trust's new People Plan highlighted a need to ensure our managers are competent and confident in people management practices. To ensure all managers at DCH have clarity on the management competence required and be supported to develop appropriate skills and confidence, a new 'Management Matters' Programme will be launched in the Autumn of 2022.

The Inclusive Leadership (IL) Programme has continued to be rolled out to our senior leaders. The initial 4 cohorts completed in December and the second set of 4 cohorts began their sessions last September, generating positive feedback. Participants report they are 'seeing, responding and leading differently' as a result of the programme. Delivery will move to an 'in house' version from Summer 2022 as a sustainable model so we can spread inclusive leadership development to all leaders across DCH.

The NHS Leadership Academy (national and regional) have offered a mixture of virtual events during 2021, many of them 'bite sized' and focused upon virtual facilitation and leadership, resilience & recovery, as well as health & well-being and bitesize coaching sessions for frontline leaders.

Coaching also continued to be accessible via the Our Dorset System's shared Mye-coach platform, with 28 coaching relationships completed either face-to-face, virtually or a combination of the two.

The Dorset ICS piloted the Beyond Difference Programme, aimed at developing aspiring leaders from ethnically diverse backgrounds, with 4 staff from DCH participating. Due to mixed feedback, the programme is being reviewed before consideration is given to any repeat programming.

Organisational Development
The OD work portfolio areas are wide reaching and have significant impact for the organisation: Equality, Diversity & Inclusion, Health & Wellbeing, Leadership & Management Development, Talent Management and Freedom to Speak Up.

Key work programmes evolving from the 2020 Culture Review are the Inclusive Leadership (IL) Programme and Dignity and Respect at Work Programme. These programmes of work are central to driving culture change at the Trust.

Throughout the year the OD Team has supported individuals and teams through coaching, mediation, facilitated conversations and team development sessions. A consultancy approach is taken to team requests and this has led to successful tailored interventions involving a mix of bespoke sessions and existing core resources.

The development of intranet-based OD pages and a weekly OD Bulletin have already raised the profile of OD and increased staff awareness about the portfolio areas. Awareness-raising will continue throughout 22/23 with a roadshow approach, primarily through accessing existing management and team meetings to showcase initiatives and programmes of work.

Education, Learning and Development
The Education, Learning and Development function are committed to supporting the whole workforce to improve their knowledge, skills, and capabilities regardless of role. Our trust strategy and clinical and people plans outline our investment into education and training as an organisation, investing and looking after our staff and developing a multi-professional workforce to deliver and contribute to safe, high quality, evidenced based patient care.

We are constantly developing new and innovative ways of delivering education and as a result of the pandemic we are now fully equipped to run both virtual and simulation training. We are committed to working with our local organisations within the Dorset ICS to streamline, innovate and improve access to education, learning and development for all staff promoting a culture of inclusion and fairness.

Library and Knowledge Services
The service continues to be an important and integral part of the wider education, learning and development function. The library team continue to demonstrate their resilience and flexibility despite the pandemic by providing support to staff and students.

Over the last year we have seen some great innovations and developed different ways of working including the local installation of the NHS Knowledge Hub - a 'one-stop-shop' of all the library's online resources in one place; the launch of the Trust's first Living Library; collaborative working with the Organisational Development and Research teams; team members' involvement with the growing number of staff networks and the setting up of a poetry group.

There has been an increase in the number of enquiries and requests for support from staff with additional learning needs and this has given the library team an opportunity to work with other key departments to meet the learning needs of all staff and improving accessibility. Our people plan outlines our commitment to ensuring that all staff feel they belong, they matter and are heard

Preceptorship
The Preceptorship Programme is a 12-month development program for all non-medical newly qualified health care professionals. We have delivered 7 programs to 132 newly qualified staff over the last year. Despite the challenges of the pandemic all teaching sessions have continued but some dates had to be rescheduled.

International Nurse Education
We continue to be committed to investing in recruitment of international nurses to help us achieve reduction in our nursing workforce gaps. We have welcomed and employed 85 international nurses and supported them with their education through NMC OSCE (Objective Structured Clinical Examination) preparation sessions, mock exams and supervision in clinical practice. The virtual programme developed in 20/21 for our overseas nurses to complete whilst in isolation continued for 21/22.

Access to Healthcare Careers
Apprenticeships
In 21/22 we had 94 staff enrol onto apprenticeship courses across the Trust in numerous subject areas, from entry level 2 to master's level 7. This is an increase of 28% from the previous year. The organisation is currently supporting 176 staff to complete their Apprenticeship programmes. The pandemic has impacted on a number of apprentices, some needing to take breaks in learning, and most have now resumed. The apprenticeship team, work collaboratively with the

Workforce Business Partner's and divisions to promote apprenticeships and ensure they are considered as part of our expansion of services, as well as an alternative to difficult to recruit to posts. For National Apprenticeship Week in February 2022, we promoted our Apprenticeships through our website and internal communications and attended local college events promoting NHS careers contributing to achievement of our people plan.

Kickstart Scheme

In support of our social value pledge, we have been able to offer 35 kickstart placements for local young people at risk of long-term unemployment, across the Trust in clinical and non-clinical roles. We have a dedicated Kickstart Co-ordinator to support managers and Kickstart employees to gain employability skills throughout their 6-month placement, alongside their increased skills, knowledge, and behaviours in their specific work areas. 23 young people completed their placements in 21/22, 21 have been successful in gaining employment in the Trust.

Work Experience, Supported Internships, T Levels and Traineeships

Covid-19 has had a huge impact on our local colleges and schools and our ability to work together to offer placements for widening participation programmes. We are reviewing our directory of possible placements across the Trust for future applicants to select their preferred area for work placements, and we are appointing a new widening participation coordinator to support all routes into NHS careers. As we move to living with Covid-19 we will resume supporting our local young people with accessing careers in the NHS.

The Care Certificate

The Care Certificate is a nationally recognised development program for all new Health Care Support Workers. We continue to achieve excellent rates of achievement and on completion staff can progress to the Level 2 or Level 3 health care apprenticeship if they wish to continue their education. We also offer an abridged version for existing staff who wish to progress their healthcare education. The programme is the foundation for all new Health care support workers to continue their career in the NHS. We have seen an increased number of staff progressing to professional careers in Nursing, Midwifery, Therapies and Medicine.

Non-Medical Undergraduate Education

The organisation continues to face some challenges in supporting non-medical students as a result of the pandemic and we have had to adapt and become more creative with our practice placements. We have introduced the Collaborative Learning in Practice model to additional areas and increased the number of non-ward-based placements. Despite the challenges we have increased our capacity and are now able to support 90 non-medical students each week whilst maintaining capability and quality of learning environments. The organisation remains committed to introducing new workforce models leading to professional registration and we have recruited a further 21 Registered Nurse Degree Apprentices as well as 17 Trainee Nursing Associates. This ensures a future pipeline into our Nursing workforce over the next 5 years. We have also recruited additional staff into the practice education team to ensure we can support the additional numbers of students effectively and provide the necessary guidance and support to our practice supervisors and assessors.

Medical Education

The Medical Education faculty continues to remain committed to the education and training of the medical workforce. We have welcomed and inducted, 55 new Foundation Year 1 and 2 doctors and 70 non-Foundation doctors. For the first time we have also recruited two Physicians Associate as alternatives to traditional Medical and Nursing roles. We have supported 54 medical

students to undertake clinical placements inclusion of elective placements for international medical students. We have also supported overseas medical students.

Our people plan outlines our commitment to investing in long term career plans for international medical recruits. We continue to work on providing named clinical supervisors for all our locally employed doctors (LEDs) and Specialty and Associate Specialty doctors(SAS) before they arrive and ensure they are fully inducted in line with other new starters. The robust supervision of LEDs will allow the development of a better approach for their annual appraisal, and identification earlier of any development needs and training requirements.

As part of a new NHS England initiative to support recruitment and retention of medical posts we appointed 10 Medical Support Workers (MSW). Most candidates are international medical graduates who are resident in the UK and who are working towards GMC registration. They worked as part of the medical team on wards and performed basic clinical and administrative tasks under supervision.

As part of the National COVID recovery plan we received recovery funding from Health Education England to support our junior doctors training and health and wellbeing. This funding has been invested into additional education sessions and wellbeing events for our junior doctors.

Volunteering

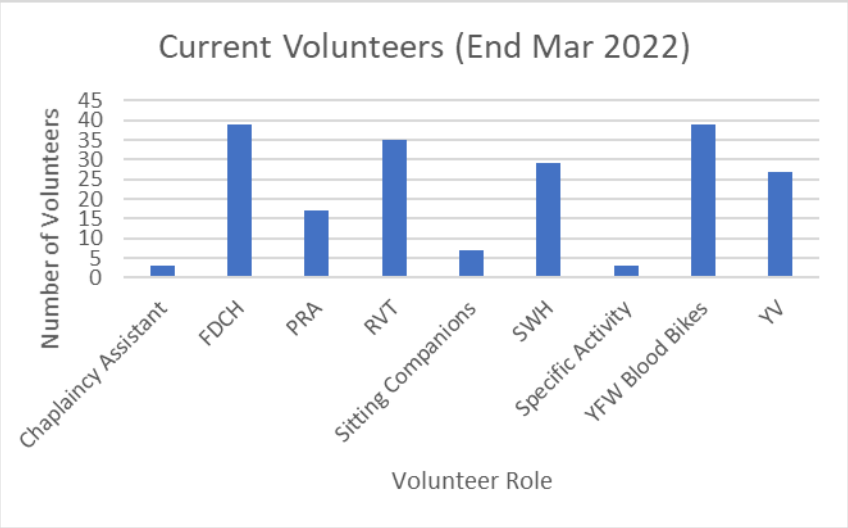
The voluntary service has had a busy year which has remained flexible and responsive to the needs of the Trust and the changing restrictions with COVID regulations. The impact of COVID has seen approximately 80 volunteers, (including Friends of DCH), who were shielding not return but we have continued to recruit new volunteers. Ongoing staffing pressures and demand for service has limited our capacity to support the hospital. Despite this we have made some significant progress with some of our ongoing projects and strived to continue to do as much as we can with the volunteers, who have, as always, been committed and hardworking in the support they continue to provide.

The data below shows the total number of volunteers we have in the Trust with their status, along with current role status. The table below gives a break-down of number of active volunteers currently in each role.

Volunteer Status – Up to 31 March 2022			
Total Active Onsite (including young volunteers)	**Total Currently Active Offsite**	**Total Inactive due to other commitments, shielding or role suspension**	**Total Young Volunteers**
199 (This includes the Yeovil Blood Bike riders and controllers and FDCH)	21 (PRAs and Your Voice)	48 DCH / 40 FDCH	30 (Volunteering weekly, fortnightly or during school holidays)

Volunteer Role Status 31 March 2022	
Active Roles	**Inactive Roles**
• Response • Patient and Public Engagement (Your Voice) • Patient Research Ambassadors • Specific Activity (ICT / Dementia Support) • Friends of DCH • Yeovil Blood Bikes • Chaplaincy Assistant • SWH Outpatient Assessment Centre	• Specific Activity (PAT dogs and music) • Play Assistant

Volunteers In Recruitment / Waiting to start / Return– 31 March 2022	
Direct Roles	**Indirect Roles (FDCH / YFW Blood Bikes)**
19	3 (YFW) 0 (FDCH)



Graph – Active Volunteer Role Numbers

Our focus over the last year has very much been on building our Response volunteer team and that is quantified in part by the increase in requests for volunteers to support on Wards. The role is divided into two key areas:

Healthy Stay: Supporting inpatients on Wards with a number of key tasks, for example hydration rounds, meal-time support and PPE replenishment.

Healthy Visit: Supporting in main entrances and outpatient departments.

Whilst the demand for support on wards from our healthy stay team has been evident through the requests received, the role of the healthy visit team is of equal importance. Alongside ongoing support to the Dialysis Unit and Medical / Surgical Outpatients, the team largely support main entrances, meeting and greeting and directing. They have also increased support where numbers allow in ED Triage and most recently have started to provide regular support one morning per week in the Robert White centre. Along with the healthy stay team they also continue to ensure the daily distribution of surgical masks to departments across the hospital. They largely support areas which are not staffed (i.e., South 1 main entrance) so we do not receive requests for their help. However, when these areas are manned by volunteers supporting patients and visitors coming into the hospital, it makes an enormous difference to patient experience.

Six volunteers in the Response team completed Sitting Companion training in September 2021 with the Palliative Care team. They now 'check in' with the team as part of their shift and provide support for patients at End of Life.

Funding from NHS England in the 2019/20 financial year has also enabled us to plan a project to support patient activity. Planning has continued throughout last year and equipment to deliver this service has now been purchased. We will be carrying out training with volunteers starting in June 2022 to enable them to support staff on wards with patient activity.

We have continued to recruit a steady stream of Young Volunteers over the last 12 months but have struggled to continue to develop the programme in the ways we had planned. This is partly due to ongoing COVID restrictions and partly due to unforeseen demands on the service which has limited our capacity. Despite this, we were able to deliver a Summer Activity Programme in August 2021 which saw Young Volunteers take part in workshops looking at the future Emergency Department plans from a young person's perspective, a research workshop and dementia awareness training. One of our young volunteers was also given the opportunity to volunteer in the Maternity unit during the summer holidays.

We have been able to support Weymouth college Health and Social Care students offering them volunteer placements. They have been able to count their volunteer experience towards meeting the requirements of their college course. We have reengaged with both Blandford Sixth Form and Weymouth College attending their volunteer fairs which they have been able to hold face to face again. We will continue to reengage with local schools and colleges into the 2022/23 year.
After agreement from the Trust Senior Leadership Group, we signed a MOU with St Johns Ambulance (SJA) in September 21 to open a NHS Cadet unit linked to the Trust. This is due to start running in May 2022 following recruitment of cadets and a project lead. The project is funded by NHSEI and run by SJA and gives opportunities for young people aged 14 to 18 to take part in a programme which will see them complete training ranging from learning first aid skills to developing leadership skills. As part of this programme, we will offer those on the foundation programme (14 to 16 years) opportunities to visit the hospital and learn more about different services and careers. The young people on the Advanced programme (16-18) will be offered volunteer placements in the hospital.

We have also re-established discussions with the Dorset Youth Association and hope to collaborate with them and other youth groups in the next 12 months to establish a Youth Voice across Dorset. This will link to the #iWill theme of 'Having your Say' promoting Youth Social Action.

We took on the volunteer service at South Walks House, (SWH) Outpatient Assessment Centre just before it opened in November 2021. We inducted 60 volunteers in the first two weeks of opening enabling the volunteers to support the new centre. This was no easy task and supporting this with no additional resource has meant we have had to reprioritise other projects. This is a new volunteer service operating in a new service for the Trust and has inevitably seen challenges. We are collaborating with the team at SWH to overcome these challenges and with the volunteer team to develop and shape the role. As part of the development plans at SWH, we are also working with the LiveWell / Active Dorset team to develop the Wellbeing Champion branch to the SWH volunteer role.

Volunteer health and wellbeing has been a priority for us over the last year and we continue to monitor closely the health and wellbeing of our volunteers. We make it a priority to be present as a team so they can offload to us when they need too. We are also taking positive steps as a team to make sure we are better equipped to support the health and wellbeing of our volunteers. This has included our volunteer co-ordinator taking part in the first Health and Wellbeing Champion training course at the Trust. The support they provide for one another also continues to grow and the team ethos between themselves and also the growing positive response they receive from staff and patients they help, is helping and providing a more positive atmosphere and volunteer experience.

The last 12 months has also seen us working with a team from the CCG and the voluntary teams at UHD and DHC to deliver the new Better Impact - data base software. The system already used successfully in other NHS trusts will see us migrate volunteer recruitment, training, and management into one system which is designed for volunteers. It has also given us a chance across the three Trusts to align our volunteer processes and share best practice. We are on target now to go live with the recruitment element of the system from June 2022.

The focus over the last 12 months has largely been to continue to respond to changes and work with a small team of volunteers to shape the service we provide. The next 12 months will see us build that team so that we can provide more effectiveness and opportunity both on the main hospital site and at South Walks House. To enable additional capacity to achieve this we will be able to expand the voluntary services team thanks to funding from the NHSEI Voluntary Partnerships Winter funding programme. The new post will be a part time fixed term contract. We will be carefully looking at impact of this post on the service with a view to submitting a business case in the 2022/23 year to make the post permanent in the following financial year so that we can sustain and continue to build the service to meet the need.

Working with the NHSEI voluntary partnerships team, other NHS Voluntary teams and the wider voluntary sector is a key part of ongoing development of the service, and we have continued to contribute to the network and work with them on various projects. This is helping us to look ahead and understand better how volunteering will look in the future. This will be vital in looking at how we develop and recruit into volunteer roles which support the Trust, and which are safe, but which also offer flexibility, meaningfulness, and opportunity to use and develop individual skills and experience.

As we head into another 12 months it will certainly continue to be busy, will see projects we have been working on come to fruition and hopefully offer lots more opportunity to do more.

The following sections of the Staff Report are not subject to audit

Consultancy

The NHS has additional controls for spending on consultancy contracts over the value of £50,000 to ensure value for money. The Trust had one contracts which exceeded the £50,000 limit.

	2021/22 £000s
Finance	25
Human Resources	2
IT/IS Consultancy	4
Property and Construction	19
Strategy	142
Technical	3
Total	**195**

Reporting High Paid Off-payroll Arrangements

The Trust has a policy on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations.

The policy includes controls for highly paid staff including board members and senior officials, individuals under these sections require Accounting Officer approval and should only last longer than six months in exceptional circumstances.

For any off-payroll engagements as at 31 March 2022, for more than £245 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2021	6
Of which, the number that have existed:	
For less than on year at time of reporting	3
For between one and two years at the time of reporting	3

All off-payroll workers engaged at any point during the year ended 31 March 2022, for more than £245 per day	Number of engagements
Number of new engagements during the year ended 31 March 2021	789
Of which…	
Not subject to off-payroll legislation	776
Subject to off-payroll legislation and determined as in-scope of IR35	13
Subject to off-payroll legislation and determined as out-of-scope of IR35	Nil
Number of engagement reassessed for compliance or assurance purposes during the year	Nil
Of which; No of engagements that saw a change to IR35 status following review	Nil

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	18

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2021/22.

The following sections of the Staff Report are subject to audit.

Average number of employees (WTE basis)

	Average for year ended 31 March 2022		
	Total number	Permanent number	Other number
Medical and dental	418	398	20
Administration and estates	499	481	18
Healthcare assistants and other support staff	941	935	6
Nursing, midwifery and health visiting staff	890	808	82
Nursing, midwifery and health visiting learners	32	32	-
Scientific, therapeutic and technical staff	251	248	3
Healthcare science staff	90	87	3
Social care and staff	1	-	1
Other	7	7	-
Total	3,129	2,996	133
Of which: Engaged on capital projects	20	20	-

The average number of employees is calculated on the basis of the number of worked hours reported. This means that the reporting of staff numbers and staff costs incurred are on a more consistent basis.

Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	121,585	120,053	1,532
Social security costs	11,978	11,978	-
Apprenticeship levy	606	606	-
Pension cost – NHS pensions	14,319	14,319	-
Pension cost – Employer contributions paid by NHSE	6,245	6,245	-
Pension cost – other	49	49	-
Termination benefits	110	110	-
Temporary staff – Agency/contract staff	12,086	-	12,086
Total Gross Staff Costs	**166,978**	**153,360**	**13,618**
Included within; costs capitalised as part of assets	1,236	1,236	-

Exit Packages

2021/22 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	28	28
£10,001 - £25,000	-	2	2
Total number of exit packages by type	-	30	30
Total resource cost (£000)	-	110	110

2020/21 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	16	16
£10,001 - £25,000	-	2	2
£100,001 - £150,000	-	1	1
Total number of exit packages by type	-	19	19
Total resource cost (£000)	-	169	169

The payments included in ‘Other departures’ agreed for 2021/22 are twenty-eight in respect of contractual payments made in lieu of notice and two voluntary redundancy (2020/21 nineteen payments for lieu of notice and one payment for voluntary redundancy). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

Corporate Governance Report

NHS Foundation Trust Code of Governance

Dorset County Hospital 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 and aims to promote best governance practices. Whilst the NHS Foundation Trust Code of Governance is a guidance document, it requires that foundation trusts disclose any deviation from it, providing a reason for deviation from the code and explanation as to how alternative arrangements meet the requirement of the code.
The Board of Directors implements the Code of Governance through a number of key governance documents which include:

- The Constitution
- Standing Orders and Standing Financial Instructions
- Scheme of Delegation and Matters Reserved to the Board
- Code of Conduct – Board of Directors and Council of Governors
- Annual Plan
- Board and Committee governance structure

Board of Directors Profiles

Chair

Mark Addison – first term 24/3/2016 – 23/3/2019, second term 24/3/2019 – 23/3/2022, extended to 23/3/2033

Mark has had an executive career in central government, working in senior operational and policy roles in a number of departments. He was the Chief Executive of the Crown Prosecution Service, Director General for Operations in the Department of Environment, Food and Rural Affairs, and was for a short spell the Permanent Secretary of that Department and the Chief Executive of the Rural Payments Agency. Since 2006 he has held non-executive roles, sitting on the boards of The National Archives and the Which? Council. He was the Chair of the Nursing and Midwifery Council.

Chief Executive Officer

Patricia Miller OBE – appointed substantive Chief Executive Officer from 15 September 2014 to 31 January 2022

Patricia has worked for the NHS for 30 years and holds a Masters degree in Health Care Management. She is a graduate of the East of England Aspiring Directors Programme, the 'Breaking Through' Leadership Programme, the Athena Leadership Programme for Executive Women and more recently the Collaborative Leadership Programme at the Kings Fund. Patricia joined Dorset County Hospital NHS Foundation Trust as Chief Operating Officer in 2011 and after leading a successful turnaround programme, Patricia was appointed as Chief Executive in September 2014. Whilst working in the NHS Patricia has remained passionate about improving the lives of patients and staff in ways that matter to them. She has led a range of innovative and successful initiatives to improve patient safety and quality. Patricia, together with two CEO colleagues of neighbouring Trusts, was successful in an application for the Acute Care Collaboration Vanguard and is currently a key partner in the Our Dorset system, a wave one Integrated Care System. Patricia has a strong focus on equality, diversity, inclusion and health inequalities and is currently co-chair of the provider Chairs and CEOs network, a member of the

NHS England's Health Inequalities Oversight Group and is a member of the newly created NHS Race and Health Observatory Board. Patricia is a member by distinction of the Faculty of Public Health and has been a member of the NHS Assembly since its inception. Patricia is also one of only 8 CEOs in the NHS hospital sector from the ethnic minority community. Patricia was named as one of 25 Rising Stars of the NHS in 2013, one of the top 50 CEOs in 2019, and was amongst the top 50 figures who will exercise the most power and/or influence in the NHS and health policy 2020.

Interim Chief Executive Officer

Nick Johnson – appointed Interim Chief Executive Officer 1 February 2022 (Director of Strategy, Transformation and Partnerships from 1 February 2016)

Nick joined DCHFT in 2016 from University Hospital Southampton NHS Foundation Trust where he was responsible for strategy and commercial development projects, including establishing an innovative commercial development joint venture, for which he was a Board Member.

Nick became the Trust's Deputy Chief Executive in 2020 and since joining the Trust Nick's portfolio has expanded to include strategy and corporate planning, corporate governance, transformation, communications, commercial, the DCH Charity and strategic estates developments, including the New Hospital Programme. Nick is also the executive lead for health inequalities and one of the Dorset Integrated Care System board member representatives for the Wessex Academic Health Science Network, as well as executive lead for the Trust's Subsidiary Company and Dorset Estates Partnership.

Prior to that he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider focussing on strategic public private partnerships. Nick has also worked in a number of local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has a MSc from Warwick Business School and started his career on the National Graduate Management Scheme for Local Government.

Non-Executive Directors

Prof. Sue Atkinson - first term 01/09/16 – 31/8/19, second term 01/09/2019 – 31/08/22, Senior Independent Director from 01/10/20

Sue has considerable experience in Public Health, clinical medicine, commissioning, as a chief executive, executive director and non-executive director in the NHS and Department of Health. She was Regional Director of Public Health (RDPH) for London and developed the role as Health Advisor to the Mayor and Greater London Authority. She was previously RDPH and Medical Director of South Thames, South West Region and Wessex. Her work includes health strategy, inequalities and partnership working, including with national and local government and the third sector. Sue holds a number of non-executive and academic posts, including founding Director and Chair of PHAST (Public Health Action Support Team – a not for profit social enterprise). She is a Board Member of the Faculty of Public Health, Visiting Professor at UCL, Co-Chairs the Climate and Health Council and was a board member of the Food Standards Agency.

Margaret Blankson – first term 01/01/21 – 31/12/23

Promoting issues of diversity and inclusion have been core tenets throughout Margaret's personal life and professional career. Following a career in local government, Margaret established her own consultancy providing strategic advice on transformation, regeneration and Corporate Social Responsibility programmes, with a focus on embedding issues of diversity inclusion into

mainstream delivery. Margaret's clients extend across all three sectors and have included Nike UK, Unilever, Lloyds Banking and the Football Association. Margaret spent several years involved in training Metropolitan Police Service officers in diversity and inclusion.

She has held a number of advisory roles including Chair for the charity IMPACT and advisory Board member for Choice FM Radio. Margaret is currently a Trustee of Over the Wall, a charity providing breaks for children facing serious health challenges and is the founder of the Foodbank DoorSteppers, an organisation she established in response to COVID 19. Margaret is currently undertaking an MA in Consulting and Leadership in Psychodynamic and Systemic Approaches at the Tavistock Institute, London.

Judy Gillow MBE – first term 01/9/16 – 31/8/19, second term 1/09/2019 – 31/08/22, Vice Chair from 02/09/19

Judy has had an extensive and successful career in the NHS in clinical, operational management, educational and Executive Director roles. She was awarded an MBE in 2010 for her work on improving hospital infection rates and in 2016 she was awarded an honorary doctorate by Southampton University for her work on developing clinical academic careers for nurses and health professionals. Her most recent post was Director of Nursing at University Hospital Southampton where she led the quality improvement agenda. She has undertaken the role of Senior Nurse Advisor for Health Education England, and is currently a Non-Executive Director with Southampton, Hampshire and Isle of White Clinical Commissioning Group. In addition, she is a Specialist Advisor for Care Quality Commission Inspections.

Eiri Jones – first term 01/01/22 – 31/12/24

Eiri Jones joined the Trust in January 2022. Eiri is a Registered Adult and Children's Nurse; has an MA in Professional Development; and is a QI practitioner supporting several Trusts with improvement work. Eiri has clinical, managerial and executive leadership knowledge and skills gained during a career spanning over 45 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 most recent full time role was as the Regional Director for Getting it Right First Time (GIRFT) in the South West region. She is a Clinical Non-Executive Director in Salisbury Foundation Trust and has recently moved to Dorset.

Ian Metcalfe - first term 01/11/17 – 31/10/20, second term 01/11/20 to 30/11/21

Ian is an experienced Finance Director and a qualified management accountant who started his career in the commercial sector, but for the past twenty years has worked as an executive and non-executive director in the not-for-profit, charity and health sectors, and more recently in arts organisations. Ian has served on a number of Boards, including eight years as a non-executive director with Royal Bournemouth Hospital, where he was Chair of a number of committees, including the project board which led the re-build of Christchurch Hospital as a health and care community. He is currently a Trustee of Lighthouse, Poole's centre for the arts, and has re-joined the Board of Activate, an arts enabling organisation based in Dorchester.

Stuart Parsons – first term 01/12/21 – 30/11/24

Stuart is a fellow of the Association of Chartered Certified Accountants, having qualified whilst working at Eldridge, Pope Brewery in the centre of Dorchester. He has more than 30 years of experience in commercial finance and has held senior positions in a number of sectors including telecoms, logistics, equipment rental, asset management and engineering services. Before retirement he held the position of Group Commercial and Finance Director for Briggs Equipment UK Limited based in Staffordshire. His roles have included international businesses across

Northern Europe and Russia. His experience demonstrates a strong collaborative approach, whilst improving governance and control, along with the critical challenge to improve performance and efficiency. He has a keen love of sport and music and is returning to Dorset after moving to the Midlands more than 23 years ago.

Dhammika Perera - Associate Non-Executive Director from 01/01/22 to 31/12/22
Dhammika is the Global Medical Director at MSI Reproductive Choices. He is a public health professional with over 22 years' experience as a physician and over a decade's experience in health service management at the global level. He holds a medical degree from the University of Colombo, a masters' degree in evidence based public health from the University of Manchester, a PhD in population health from Walden University, Minnesota and a fellowship from the UK Faculty of Public Health.

He has work experience in the field of healthcare in multiple continents and has provided design, monitoring, quality improvement and clinical governance support to reproductive health service programmes in over 40 countries. Prior to joining MSI Reproductive Choices, Dhammika was the senior adviser for reproductive health at the International Rescue Committee in New York. He has also worked in multiple countries with Doctors Without Borders for over seven years. He is a strong believer in health equity, clinical governance, and patient centered care.

Stephen Tilton – first term 01/06/20 to 31/05/23
Stephen qualified as a Chartered Accountant with Price Waterhouse and is a Fellow of the ICAEW. He has held a series of senior executive roles in the financial services sector specialising in regulation, risk and governance, including over 10 years as director of legal and compliance at a global private equity firm. He joined DCH having spent nearly four years as a Non-Executive Director at Worcestershire Health and Care NHS Trust where he chaired the Audit and Charitable Funds committees and was a member of the Quality and Safety committee. Stephen is also an accomplished musician, and for 10 years was Master of Music at the Chapels Royal, HM Tower of London, having been a choral scholar at King's College, Cambridge from where he graduated with a degree in Classics.

David Underwood – first term 1/03/20 – 28/02/23
Dave is an experienced senior leader having worked first at the Civil Aviation Authority as an Air Traffic Control Scientist and Research Manager before joining the Met Office, in 1998, to lead their Civil Aviation Business. Over 20 years with the Met Office Dave undertook a range of senior executive roles including Group Head of Public Sector Business, Deputy Director of Technology and Information Systems and latterly Deputy Director of High Performance Computing. In addition to his executive roles Dave has more than 10 years non-executive leadership experience gained in the fields of Environmental Business, Further Education (serving on the Board of Exeter College) and most recently as a Non-Executive Independent Advisor to the Royal Devon & Exeter NHS Foundation Trust with regard to their MyCare Technology enabled Transformation Programme. Dave is passionate about delivering effective leadership of change and promoting the benefits of careers in science, technology, engineering, mathematics and medicine.

Executive Directors

Chief Financial Officer: Paul Goddard – appointed 18 June 2018

Paul is a fellow of the Association of Chartered Certified Accountants and has over 30 years' experience in NHS finance. He joined the Trust in June 2018 from University Hospital Southampton FT where he spent over 10 years rising from Assistant Director of Finance to the role of Director of Finance which included a directorship of one of the wholly owned subsidiaries. He has worked extensively across the NHS sector at a senior level within both provider and commissioning organisations and also gained valuable experience working in a commercial role within a large US owned facilities management company.

Chief People Officer: Dawn Harvey – appointed 1 April 2021

Dawn joined DCH in April 2021 from Birmingham Women's and Children's Foundation Trust. She is a Fellow of the Chartered Institute of Personnel and Development and is passionate about steering the people agenda and inclusive culture development to create environments where everyone can perform at their best and deliver the best patient care.

After graduating from the University of Kent she has enjoyed a 30 year career spanning the private and public sector. She has held senior leadership in sales and operations as well as HR and Learning and Organisation Development. Dawn joined the NHS in 2011. Since then she has led a range of award winning staff experience improvements and major change and transformation including the people elements of the merger between Birmingham Children's and Birmingham Women's Hospitals. She is a graduate of the NHS Aspiring Director of Workforce programme. Dawn is an executive coach and mentor and has two grown up children.

Chief Medical Officer: Professor Alastair Hutchison – appointed 1 July 2018

Alastair joined DCH in July 2018 from Manchester Royal Infirmary, where he was Clinical Head of Division for Specialist Medicine and Clinical Professor of Kidney Medicine (University of Manchester). He has worked in clinical leadership roles in Manchester for over 15 years, including being Clinical Director for Renal Medicine, the Royal College Tutor in Medicine, Associate Clinical Head of the Division of Medicine, and most recently the Clinical Head for Specialist Medicine. He has clinically supervised the development and introduction of new IT systems as well as having a major interest in infection control. Alastair has wide-ranging experience in managing complex clinical services, and is actively involved in research into acute and chronic kidney disease with around 100 publications in peer-reviewed journal and books. He has written chapters for both the Oxford Textbook of Medicine and the Oxford Textbook of Clinical Nephrology.

Chief Nursing Officer: Nicky Lucey – appointed 1 September 2016. Interim Deputy Chief Executive from 21 February 2022

Nicky joined DCHFT from Kent Community Health NHS Foundation Trust where she was Director of Nursing and Quality. During her career Nicky has held a number of senior roles, including Director of Clinical Standards at Portsmouth Hospitals NHS Trust. Her wealth of experience includes having successfully led many initiatives, such as workforce redesign involving education and career development, as well as patient care improvements. Nicky, who trained at Uxbridge, Middlesex, also has an MBA from Solent University. She has a professional background in cardiothoracic and critical care.

Chief Operating Officer: Inese Robotham – from 19 November 2018 to 1 October 2021
Inese joined the Trust in November 2018 from Worcestershire Acute Hospitals NHS Trust where she held a variety of roles, the last one being Acting Chief Operating Officer. She has worked for the NHS for over 18 years in both highly performing and challenged organisations and has led a number of complex service redesign and improvement initiatives. Inese is passionate about improving the quality of patient care and experience and holds a Masters Degree in Leadership for Healthcare Improvement from the University of Birmingham. She is also a Leadership Fellow with the Health Foundation.

Chief Information Officer: Stephen Slough – appointed 1 June 2019 (non-voting)
Stephen joined DCHFT as the first Chief Information Officer on the Trust Board. He is a Chartered Fellow of the British Computer Society and a Leading Practitioner for the newly launched national FED-IP digital healthcare leadership framework, and brings experience from a variety of national, European and global leadership roles he held for Siemens over a 20 plus year career in the private sector, before joining the NHS in Dorset in 2016. Since joining the NHS he has led the creation of the digital transformation portfolio for the Dorset ICS, driving forward the digital agenda for the county with an ambition to provide sustainable digital services to the staff and public alike. Living close to Dorchester with his family he is a Scout Leader and a volunteer with Dorset Search and Rescue in his spare time.

Chief Operating Officer: Anita Thomas – appointed 4 October 2021
Anita joined DCHFT in 2000 as an Administration Manager. Since then she has worked in a variety of roles across the Trust including Head of Health Records, Transport and Waste, Head of Access and Administration, Associate Director for Cancer and Access Services, Deputy Chief Operating Officer, Head of Transformation and Performance Improvement and Divisional Manager for Urgent and Integrated Care.

Anita has a degree in History (Warwick), Masters in Developing and Leading Services (School of Health and Social Care, Bournemouth University), completed the 2015 NHS Leadership Academy Nye Bevan Programme - NHS Leadership Academy Award in Executive Healthcare Leadership as well as Quality Improvement and Service Redesign (NHSI QSIR Programme) and has been a Teaching Faculty Member Associate since 2017. She has a passion for quality improvement led by staff and patient/carer co-design, use of data, user experience and intelligence to drive improvement and support teams to deliver high quality care for all.

Board of Directors

The Board of Directors is responsible for establishing the strategy of the Trust and for the operation of the Trust's business, ensuring compliance with the Trust's Constitution, NHS Provider License, statutory requirements and contractual obligations. Details of the composition of the Board can be found in the Directors' Report above. Terms of Office and remuneration details are contained within the Remuneration Report.

Individual members of the Board of Directors undertake annual appraisal in order to establish performance objectives for the coming year. The process includes self-assessment, peer review and feedback from Governors and external stakeholders. The Trust Chair's appraisal is undertaken by the Senior Independent Director and submitted to NHS Improvement. The Board has considered the skills, expertise and experience needed to ensure appropriate balance and completeness to meet the ongoing requirements of the Trust and has reflected these requirements in the appropriateness of appointments made to the Board of Directors during the year.

Attendance at Trust Board Meetings 2021/22

P1 = Public P2 = Private D = Development	28 Apr 21 P2	28 Apr 21 D	26 May 21 P1	26 May 21 P2	30 June 21 D	28 July 21 P1	28 July 21 P2	25 Aug 21 D	29 Sept 21 P1	29Sept 21 P2	10 Nov 21 D	24 Nov 21 P1	24 Nov 21 P2	15 Dec 21 D	26 Jan 22 P1	26 Jan 22 P2	03 Mar 22 D	30 Mar 22 P1	30 Mar 22 P2
Non Executives																			
Mark Addison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Atkinson	✓	✓	A	A	✓	✓	✓	A	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Margaret Blankson	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Judy Gillow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eiri Jones (from 01 01 22)															✓	✓	✓	✓	✓
Ian Metcalfe (to 30 11 21)	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓	✓						
Stuart Parsons (from 01 12 21)														✓	✓	✓	✓	✓	✓
Dhammika Perera (from 01 01 22)															✓	✓	✓	✓	✓
Stephen Tilton	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dave Underwood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executives																			
Patricia Miller (to 31 01 22)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓	A	A			
Paul Goddard	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓
Dawn Harvey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alastair Hutchison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nick Johnson	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicky Lucey	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inese Robotham (to 01 10 21)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									
Stephen Slough	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Anita Thomas (from 04 10 21)											✓	✓	✓	✓	✓	✓	✓	✓	✓

During the ongoing pandemic, the Board revised the format and focus of Board and committee meetings in order to maintain focus on the delivery of actions required to maintain safe services, focus on the mitigation of key risks and to support the wellbeing of staff. Further details are contained within the Well Led section of this report.

Risk and Audit Committee

The Risk and Audit Committee comprised a Non-Executive Chair with accounting experience and at least two other Non-Executive Directors, Chief Medical Officer or the Chief Nursing Officer and the Chief Operating Officer, Interim Chief Executive and the Chief Finance Officer. The committee is supported by Internal and External Auditors and representation from the Counter Fraud Authority. The work of the committee is regularly observed by members of the Council of Governors.

The purpose of the committee is to maintain oversight of the Trust's systems of internal control, governance and quality safety on behalf of the Board of Directors, seeking assurances from Non-Executive committee chairs, supported by Executive Directors. The committee approves and monitors the Internal Audit Work Programme and receives regular reports and assurances on the adequacy of controls in place. The Audit Programme facilitates and informs the Head of Internal Audit Opinion that is included within the Trust's Annual Report each year.

External Auditors review the plan of work, risks and mitigations and provide conclusions. They undertake a formal audit of the Trust's Accounts and Annual Report each year which includes scrutiny of: Management Override of Controls, Valuation of Land and Buildings, Fraudulent recognition of Revenue and Fraudulent recognition of non-pay expenditure.

The committee considered the Annual Report and Audited Accounts for 2021-22 at a meeting held on 24 May 2022 and concluded that there were no significant risks requiring action pursuant to the Corporate Governance Code.

Non-Executive Director Members Attendance at the Risk and Audit Committee 2021-22

Name	Attendance/Meetings eligible to attend*
Sue Atkinson	4/6
Judy Gillow	4/6
Ian Metcalfe (Committee Chair to end November 2021)	4/4
Stuart Parsons (Committee Chair from end November 2021)	3/3
Stephen Tilton	5/6
Dave Underwood	6/6

* Meetings of the Risk and Audit Committee took place in May, July, September, November, January and March.

Remuneration and Terms of Service Committee

Information about this committee and its activities can be found in the Remuneration Report.

Effectiveness Evaluation

The Board of Directors has a programme of Staff and Patient Stories at each formal Board meeting and this has been maintained throughout the year. These stories provide direct feedback from staff, patients and their carers.

The Board has undertaken a comprehensive review of its subcommittee performance in order to extract learning from changes made during the pandemic and in order to review cross committee communication and escalation of matters to the Board. Whilst the format of meetings has been intermittently amended according to service and operational demand pressures, the committees have remained focussed on key issues and risk mitigation. A review of strategic risks contained within the Board Assurance Framework (BAF) was undertaken during the year following the refresh of the Trust's strategy and Board subcommittees have reviewed the respective risks, mitigations and controls.

Well Led Review

NHS Foundation Trusts are required to undertake an independent external review against the Care Quality Commission's Well Led Framework every three to five years. Dorset County Hospital NHS Foundation Trust commissioned PriceWaterHouseCoopers (PWC) to undertake this review which commenced in the autumn 2021 and involved documentary review of the Board and subcommittee operation, interviews with members of the Board of Directors, senior managers, Council of Governors and external stakeholders. PWC also observed a number of committee and board meetings as part of their review and produced a final report in quarter 4.

Whilst the Trust was well led overall, the report noted the pandemic context and the need for the Trust to refocus on its financial position and contribution to addressing the system underlying deficit position and to improve the timeliness for publication of papers in support of board and committee meetings. The report noted the need to strengthen governance and escalation processes at care group level and commented on the exceptional circumstances and changed financial regime in operation nationally. A plan to address these recommendations is scheduled to be presented to the Board of Directors in May 2022 for approval.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008.

The Trusts current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2021- 2022.
The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC suspended scheduled onsite inspections during the Covid-19 pandemic. A Monitoring Approach was implemented and risk based inspections were to be undertaken where appropriate. No risks have been identified in the reporting period and no actions required against DCHFT. The Trust engages with all developments of the regulatory approach and supports the CQC's future developments.

The Trust is currently rated 'Good' overall by the CQC following inspection in July –September 2018. The Trust continues to engage in quarterly meetings with the local and regional CQC inspection team.
The ratings grid below, as published by the CQC on its website, shows the ratings given to the core services and five domains at the time of their inspection (please note some areas were not

re-inspected in 2018 following the 2016 inspection, therefore the 2016 rating stands for those services until the CQC re-inspect and rate accordingly):

Ratings for Dorset County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good ↑ Oct 2018	Good ↑ Oct 2018
Medical care (including older people's care)	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good ↑ Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good ↑↑ Oct 2018	Good ↑ Oct 2018
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018
Diagnostic imaging	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Requires improvement →← Oct 2018	Good ↑ Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Good ↑ Oct 2018	Good →← Oct 2018

Compliance with the Code

Dorset County Hospital NHS Foundation Trust has remained compliant with the Code of Governance throughout the year. The Board of Directors has maintained effective leadership and maintained focus on key decision making and risks, whilst facilitating flexibility to release operational capacity to manage operational pressures and demand.

Information Governance

Significant work has continued in year to strengthen Information Governance arrangements across the Trust and to ensure improved compliance with the Data Protection and Security Toolkit requirements, achieving a compliant submission in year.

Council of Governors

The Council of Governors represent the interests of the populations and communities served by the Trust and partner organisations. The Council has a duty to hold Non-Executive Directors to account individually and collectively for the performance of the Board of Directors, providing feedback on the Trust's performance to stakeholder organisations and members. The Chair of the Council of Governors is also the Chair of the Board of Directors and is responsible for the performance of Non-Executive Directors.

The Council of Governors received the Annual Report and Accounts and has responsibility for conducting an Annual Members' Meeting, which is held jointly each year with the Annual General Meeting.

Members of the Council of Governors and the constituencies they represent are outlined below.

Governor contact details are available on the Trust's website www.dchft.nhs.uk or correspondence can be sent to the Head of Corporate Governance, Dorset County Hospital NHS Foundation Trust, Trust Headquarters, Williams Avenue, Dorchester, DT1 2JY.

Governors and Terms of Office and Attendance at Council of Governors' meetings 2021-22

ELECTED GOVERNORS

Name	Constituency	Current Tenure	Attendance at Council of Governors meetings/Meetings eligible to attend*
Simon Bishop	East Dorset	01/10/20 – 30/09/23 (second term)	3/6
Maurice Perks	North Dorset	09/07/21 – 08/07/24 (second term)	3/6
Lynn Taylor	North Dorset	09/07/21 – 08/07/24 (first term)	5/5
Judy Crabb	West Dorset	09/07/21 – 08/07/24 (first term)	5/5
Sarah Carney	West Dorset	09/07/21 – 08/07/24 (second term)	3/6
David Cove (Lead Governor)	West Dorset	01/10/20 – 30/09/23 (third term)	6/6
Kathryn Harrison	West Dorset	01/10/20 – 30/09/23 (first term)	6/6
Steve Hussey	West Dorset	09/07/21 – 08/07/24 (first term)	4/5
David Tett	West Dorset	09/07/21 – 08/07/24 (third term)	2/6
Margaret Alsop	Weymouth and Portland	01/10/20 – 30/09/23 (second term)	0/6
Mike Byatt	Weymouth and Portland	01/10/20 – 30/09/23 (first term)	4/6
Stephen Mason	Weymouth and Portland	09/07/21 – 08/07/24 (second term)	5/6
David Richardson	Weymouth and Portland	09/07/21 – 08/07/24 (first term)	1/5
Dave Stebbing	Weymouth and Portland	09/07/21 – 08/07/24 (second term – non-consecutive)	3/6
Kathryn Cockerell	Staff	09/07/21 – 08/07/24 (first term)	1/5
Tracy Glen	Staff	01/10/20 – 30/09/23 (third term – non-consecutive)	5/6
Tony Petrou	Staff	09/07/21 – 08/07/24 (first term)	3/5

VACANCIES			
1 VACANCY	East Dorset	-	-
1 VACANCY	South Somerset and Rest of England	-	-
1 VACANCY	Staff	-	-

APPOINTED GOVERNORS

Name	Organisation	Current Term Ends	Attendance at Council of Governors meetings/Meetings eligible to attend*
David Thorp	Age UK	31/12/2024 (first term)	0/6
Tony Alford	Dorset Council	04/07/22 (first term)	4/6
Annette Kent/Barbara Purnell	Friends of DCH	04/10/2022 (second term)	1/6
Davina Smith	Weldmar Hospice Care Trust	23/10/2024 (third term)	3/6

GOVERNORS WHO LEFT DURING THE YEAR

Name	Constituency/Organisation	Leaving Date	Attendance at Council of Governors meetings/Meetings eligible to attend*
Christine McGee	North Dorset	08/07/21	1/1
Wally Gundry	West Dorset	08/07/21	1/1
Naomi Patterson	West Dorset	08/07/21	0/1
Marion Levick	Weymouth and Portland	07/05/21	0/0
Sharon Waight	Weymouth and Portland	08/07/21	1/1

* The Council of Governors met on the following dates in 2021/22: 10 May, 13 September, 18 October (extraordinary), 8 November, 13 December (extraordinary) and 14 February.

Governor Activities

In line with guidance from NHS England/Improvement and NHS Providers, social distancing and lockdown rules, and the Trust's governance arrangements during the pandemic, Governor activities continued to be somewhat reduced in 2021/22. However, a number of governor committees were reconvened during the year and governors were active in non-executive recruitment, the refresh of the Trust strategy and the reinvigoration of the Membership Development Committee, following a period of abeyance due to the pandemic.

Throughout the year governors have continued to meet virtually via videoconferencing. In addition to the quarterly Council of Governors' meetings, two extraordinary meetings of the Council were held in October and December 2021 to approve Non-Executive Director recruitment (details below) and the arrangements following the departure of the Chief Executive Officer. Each regular meeting of the Council of Governors was attended by two Non-Executive Directors who provided updates on key topics for the Governors, as well as updates from the Chief Executive Officer, the Chief Finance Officer, and periodic updates from the Strategic Estates Team. In

September 2021 the Governors received the Annual Report and Accounts and a presentation on the external auditors opinion from the Trust's external auditors.

In addition to the Council of Governors' meetings, the Governors also meet on a more informal basis four times a year at the Governors' Working Group. These meetings are chaired by the Trust Chair and attended by two Non-Executive Directors on a rotational basis. The summer Governors' Working Group session was replaced by an induction session for new Governors with presentations from the Chair, Head of Corporate Governance and members of the non-executive team, which all Governors were invited to attend. In addition to the regular Governor meetings, the Trust hosted sessions for Governors on the new health and care system and hosted an engagement workshop for Governors.

Following on from the active engagement with Governors on the review of the Trust's strategy during 2020/21, two strategic planning workshops were held for Governors during 2021/22 to discuss the Trust Strategy, developments in the Integrated Care System and the Trust's Social Value pledge. So that all Governors could participate in this important work, the invitation to attend these sessions with the Deputy CEO/Director of Strategy, Transformation and Partnerships was extended to all Governors, not just members of the governors' Strategic Plan Committee.

Governors were pleased to re-establish the Membership Development Committee following a break during the pandemic. The committee, chaired by public governor Kathryn Harrison, met six times during 2021/22 and made much progress in defining the membership priorities, overhauling the membership literature, and starting to make plans for increased engagement with the membership and governors' local communities.

Details of the activity of the Governors' Nominations and Remunerations Committee are given below.

Nomination and Remuneration Committee (Council of Governors' sub-committee)

The Nomination and Remuneration Committee is a subcommittee of the Council of Governors and is responsible for the appointment of Non-Executive Directors and determining the rate of remuneration for Non-Executive Directors.

The committee met on five occasions to consider the appointment of two Non-Executive Director vacancies. Members of the committee were involved at all stages of the recruitment process which was extended this year to incorporate stakeholder engagement events. The committee recommended the appointment of two Non-Executive Directors and the appointment of an Associate Non-Executive Director in order to strengthen the Board's skill mix and support future succession planning.

The committee also made a recommendation to the Council of Governors to extend the term of office for the Trust Chair for up to twelve months following the end of his second term in office. This recommendation was approved by the Council of Governors which noted the exceptional circumstances and that the extension would support senior leadership stability across the Dorset system.

Attendance at Nomination and Remuneration Committee 2021-22

Name	Title	Attendance/ Meetings invited to or required to attend
Mark Addison (Chair)	Trust Chair	2/2
Judy Gillow	Vice Chair	3/3
Simon Bishop	Public Governor	4/4
David Cove	Lead Governor	4/5
Kathryn Harrison	Public Governor	4/4
Steve Hussey	Public Governor	3/4
Wally Gundry	Public Governor	0/1
Christine McGee	Public Governor	1/1
Stephen Mason	Public Governor	5/5
Davina Smith	Appointed Governor	4/5
Dave Stebbing	Public Governor	2/4
David Tett	Public Governor	2/5

How the Board and Governors Work Together

Despite Governor meetings continuing to be held virtually, there are a number of mechanisms in place to enable the Board and governors to work together. The Board and Governors maintain contact via Governor observers at Board sub-committee meetings, Executive and Non-Executive attendance at Council of Governor meetings, Executive and senior colleague attendance at a range of Governor meetings including the Strategic Plan Committee workshops and the Governor Engagement Workshop, and an open invitation for Governor attendance at Part One Board virtual meetings. Governors have also had contact with the non-executive team through the 2021 induction session which, although run for the newly elected Governors, were open to all Governors.

This year the Trust has extended its Governor Observer Programme at Board sub-committees to include bi-annual meetings between the Governor observers and committee Chairs, as part of the Trust's ongoing commitment to support the Governors in their statutory role of holding the Non-Executive Directors to account for the performance of the Board.

Governors have continued to be able to ask questions of the Board via the Governor Matters item at Council of Governors' meetings, at Part One Board meetings and via the Corporate Governance team as required.

In the event of a disagreement between the Council of Governors and the Board of Directors, the Dispute Resolution process referred to in the Trust's Constitution (Annex 8) will be invoked.

Director Attendance at Public Council of Governor Meetings during 2021-22

Date of Public Council of Governors' Meeting	Executive Attendance*	Non-Executive Attendance**
10 May 2021	Chief Executive Officer Chief Financial Officer Chief Information Officer	Mark Addison (Chair) Ian Metcalfe Stephen Tilton Dave Underwood
13 September 2021	Deputy Chief Executive Officer Chief Financial Officer	Mark Addison (Chair) Ian Metcalfe Stephen Tilton
8 November 2021	Chief Executive Officer Deputy Director of Finance	Mark Addison (Chair) Margaret Blankson Judy Gillow
14 February 2022	Interim Chief Executive Officer Chief Financial Officer	Mark Addison (Chair) Eiri Jones Dhammika Perera

* Executives attend the Council of Governors as requested to present relevant reports. Governors also have the right to request members of the executive team attend the meetings, but the Council of Governors has not exercised this right during 2021/22.

** In addition to the Chair's attendance, Non-Executive Directors are invited to attend Part One Council of Governor meetings on a rota basis.

Governor Elections

In 2021/22 the Trust held Governor elections in North Dorset, West Dorset, Weymouth and Portland, and the Staff constituency. There were elections for contested seats in West Dorset and Weymouth and Portland, with Governors in North Dorset and the Staff constituency being elected unopposed. The election turnout was 29% in West Dorset and also 26% in Weymouth and Portland. The following results were announced on 8 July 2021.

North Dorset

Maurice Perks (re-elected)
Lynn Taylor (elected)

West Dorset

Sarah Carney (re-elected)
David Tett (re-elected)
Steven Hussey (elected)
Judy Crabb (elected)

Weymouth and Portland

Stephen Mason (re-elected)
David Richardson (elected)
Dave Stebbing (re-elected, non-consecutive terms)

Staff Governors

Kathryn Cockerell (elected)
Tony Petrou (elected)

The following governors left the Council of Governors at the end of the election process:

Naomi Patterson – West Dorset (did not stand)
Wally Gundry – West Dorset (did not stand)
Christine McGee – North Dorset (end of final term)
Sharon Waight – Weymouth and Portland (did not stand)

Membership

Foundation Trusts have a responsibility to engage with the communities that they service and listen to community views when planning services.

The Trust has two types of membership: public and staff. The Trust encourages people who live within its constituency boundaries to register as public members. Being a member demonstrates support for the hospital and the services it provides and gives the opportunity to share views with the Trust to help it best meet patient needs.

Membership is open to people ages 16+ years who are resident in England. Registration as a member can be via a membership application form, online at www.dchft.nhs.uk, via email to foundation@dchft.nhs.uk, or by phoning 01305 255419.

The Council of Governors has established a Membership Development Committee which meets on a quarterly basis to keep the Membership Development Strategy under review and to oversee membership communications, events and recruitment. The Trust has maintained a fairly steady level of membership throughout 2021/22. In line with guidance from NHS England / Improvement and NHS Providers, the engagement work of the Governors' Membership Development Committee has been curtailed during 2021/22. However, the Trust has continued to keep in contact with its members via the Trust's website, social media and the publication of the DCH Way newsletter. The Governors have also launched their bi-annual Governor Bulletin; an e-newsletter to enable to Governors to communicate directly with the membership. Members have also started receiving regular Your Future Hospital newsletters by email from the Trust.

Constituency	2021/22	2020/21
East Dorset	222	224
North Dorset	224	237
South Somerset and the Rest of England	86	90
West Dorset	1,152	1,184
Weymouth and Portland	674	703
Total Public Members	2,358	2,438
Staff Members	4,235	4,097
Total	6,593	6,535

NHS Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability

Based on information from these theses, providers are segmented from 1 to 4, where "4" reflects providers receiving the most support, and "1" reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHS Improvement has placed the Trust in Segment 3 at 31 March 2022. Segment 3 is Providers requires significant support needs against one or more of the five themes and in actual or suspected breach of the licence. The Trust was placed into this segment because of its waiting time performance for elective care. Rather than additional meetings or enforcement action, NHS England joined the Dorset systems elective performance groups and the Elective Care Oversight Group. The Trust has made good process in the reduction of the waiting list, which has been recognised by reduced meeting frequency and oversight.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website: NHS England » NHS system oversight framework segmentation

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County Hospital 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 Dorset County Hospital 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 Dorset County Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

Nicholas Johnson
Interim Chief Executive
20 June 2022

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.*

Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dorset County Hospital 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 Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

The trust has maintained a robust system of internal control throughout the COVID-19 pandemic incident; revising how it both responded to the operational crisis and ensured that the Board and Council of Governors remained fully briefed on the operational response whilst maintaining oversight of the risks to delivery of strategic priorities and progress in key areas of programmed work where this has been possible.

Capacity to Handle Risk

During the pandemic, the Board revised how best to conduct Board and subcommittee business in line with national guidance 'reducing the burden'. Meetings of the Board and its committees were conducted via video conferencing and agendas were reduced to focus on key risks and issues and essential decision making; releasing operational capacity to address the crisis and support recovery of elective activity. The frequency of Board and sub-committee meetings remained unchanged in order that the board could continue to make essential decisions in a timely manner and short Non-Executive Director (NED) briefing meetings were continued in order that NEDs could be apprised of the emergent situation and provide support to executive colleagues.

The Board continued to receive regular reports against key quality metrics and performance; being benchmarked with other regional partners on metrics for urgent care, cancer and diagnostic services and waiting times. The opportunity to receive patient and staff feedback was considerably reduced during the year, although patient and staff stories were positively received by the Board when circumstances intermittently permitted in year.

The Chief Nursing Officer is the executive lead for risk management and is supported in this by the Head of Risk Management and Quality Assurance. The Trust has a Safety Group, which reviews risks, incidents and Health and Safety matters. It reports by exception to the Quality Committee. The Risk Management Framework sets out the Board's requirement that a

systematic approach to identify and manage risks is adopted across the Trust and that systems are in place to mitigate those risks where possible. The Framework also stipulates that it is essential that all Trust staff are made aware and have an understanding of the procedures in place to identify, report, assess, monitor and reduce or mitigate risk as far as possible.

The Trust's approach to risk management is pro-active and does not differentiate the processes applied to clinical and non-clinical issues. Common systems for the reporting, identification, assessment, evaluation and monitoring of risk have been developed within the Trust and apply to all risk issues, regardless of type. The risk management approach involves:

- identifying sources of potential risk and proactively assessing risk situations, and mitigating those risks as far as possible;
- identifying risk issues through the reporting of serious untoward incidents, adverse incidents, near misses, complaints and claims, and internal and external review reports;
- investigating and analysing the root causes of incidents;
- undertaking aggregated root cause analysis (RCA) which includes consideration of incidents, complaints, claims and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) data;
- taking action to eliminate or minimise harmful risks;
- monitoring the delivery and effectiveness of actions taken to control risk;
- learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the organisation;
- Continuation of a 'Learning from Incidents' Panel, which is chaired by the Chief Medical Officer and the Chief Nursing Officer, which provides a positive challenge on root causation, learning and meaningful actions and helps to identify notable practice. Learning is shared by being cascaded through respective divisions through their local governance and risk groups.

Effective implementation of the strategy facilitates the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk. To achieve this, the trust:

- ensures all staff and stakeholders have access to a copy of the Risk Management Framework;
- produces a register of risks across the Trust which is subject to regular review at Divisional level, by the Senior Management Team, Safety Group, Board sub-committees and the Board;
- communicates to staff any action to be taken in respect of risk issues;
- has developed policies, procedures and guidelines based on the results of assessments and identified risks;
- ensures that training programmes raise and sustain awareness throughout the Trust of the importance of individual responsibility in identifying and managing risk;

- ensures that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with the strategy; and

- monitors and reviews the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

- Corporate risks are linked to the Board Assurance Framework, and they are also linked to any supporting information to evidence where and how the risk has arisen and how the risk score has been determined.

The Trust has well developed business continuity plans in place and established an Incident Management Centre in order to respond to the COVID-19 crisis and respond to pressures arising from increasing urgent and emergency care demands. The trust has had sufficient protective and other essential equipment and retained capacity to deal with cases, swabbing and vaccination requirements throughout although increased staff absence during the Omicron wave placed significant pressures on the Trust's capacity.

The Board and Risk and Audit Committee review the Corporate Risk Register and the Board Assurance Framework every two months. Following a review of the Trust's strategy in year and subsequent review of the Board Assurance Framework, the Board sub-committees will provide greater scrutiny of the to controls and litigations in place in support of the Board Assurance Framework on a quarterly basis.

Risk training forms part of the Trust Induction programme for clinical and non-clinical staff. Risk training is also included in preceptorship and junior doctor training. Specific training in Root Cause Analysis, statement writing and investigations is provided on a bi-monthly basis by the Risk Management team.

The Risk and Control Framework

The Trust acknowledges that effective risk management is a key enabler to ensuring continuous improvement in the quality of care delivered and that all members of staff have an important role to play in identifying, assessing and managing risk. This is achieved, through proactive risk assessment, or reactively, through review of risk events, complaints inquests and legal claims. To support staff in this role, the Trust provides a fair, consistent environment that encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report when things have, or could have, gone wrong. At the heart of the Trust's Risk Management Framework is the desire to learn from incidents and near misses, complaints inquests and claims, in order to continuously improve management processes and clinical practice.

The Trust has in place clear policies and systems for identifying, evaluating and monitoring risk. These include:

- The Risk Framework

- Trust policies and procedures

- Service, Care Group, Divisional and Corporate Risk Registers that contain both clinical and non-clinical risks together with the Board Assurance Framework

- Designated appointments to support the Board and staff in the management of risk including the Executive Nurse, Head of Risk and Quality Assurance, Health, Safety and Security Manager, Emergency Planning lead and identified Divisional leads.

Trust-wide risk profiling is an on-going process and managers are required to ensure that risk assessment and audit is undertaken within their areas of responsibility and is recorded within the trust's incident and risk assessment system and that findings are acted upon and adequately monitored. Audit of the centralised system ensures that managers review assessments as required.

The Trust's Risk Event Reporting Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) being managed at a local level and the highest (red) managed at executive level with reports made to the Board and statutory external agencies. Risk learning is shared across system partners through Clinical Commissioning Group chaired meetings and through the Patient Safety Specialists.

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greater appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Risk appetite can be defined as the amount of risk an organisation is prepared to accept in pursuit of its strategic objectives and defines the level of risk an organisation is prepared to tolerate or be exposed to at any point in time. Outlining the strategic risk appetite provides clear leadership direction about the level of acceptable risk and assists in the identification further mitigating actions.

The Trust has regularly referred to the risk appetite statement in discussion by the Board and sub-committees and in decision making throughout the year. The Trust has a clear statement as to the level of risk it is willing to tolerate in the following areas;

- Quality and safety
- Compliance and regulation
- Innovation and transformation
- Finance
- Commercial
- Reputation and
- Workforce

Inclusion of the risk appetite in Board and Committee cover sheets has raised the profile and awareness of the Trusts appetite amongst senior managers and decision makers.

Quality

The Chief Nursing Officer is the executive lead for quality and safety governance, supported by the Chief Medical Officer and the Chief Operating Officer.

During what has been another exceptional year in which reporting of contractual performance indicators was suspended due to the pandemic, the trust has maintained oversight of key quality performance and activity metrics, benchmarking these with regional and national partners. The trust has been assured that it has provided consistently good performance in respect of recovery of cancer services standards and maintaining good ambulance handover times.

The CQC continued to suspend all planned onsite inspections this year as the Covid-19 pandemic continued to evolve, taking a risk based approach to inspections. Quarterly engagement meetings continued with our Local and Regional Inspectors via virtual meetings. Monthly virtual catch-up meetings also took place with the DCH Quality Assurance Manager and the CQC Local Inspector. There are no current issues or risks raised with the Trust and the Trust has not triggered any risks escalations that would prompt an inspection. The Trust did participate in CQC system theme reviews.

The CQC has continued to virtually attend the shadow ICS Quality Surveillance Group to provide further scrutiny of quality in the Trust, with wider regulatory and non-regulatory partners. Throughout the year the Trust has continued under 'routine surveillance', meaning that no concerns were raised or escalated for further scrutiny.

Following the publication of the CQC Strategy in 2021, the CQC have introduced a risk based approach to regulation through their Direct Monitoring Approach which is driven through a regular review of information they receive, engagement with people who use the services and relationship meetings with the Trust.

The Trust continues to self-assess itself and continues to strive to provide outstanding quality care.

The Quality Committee has continued to scrutinise quality governance arrangements and performance in the Trust and provide assurance to the Board. The Chief Nursing Officer and the Chief Medical Officer are Executive leads at the Quality Committee which continued to meet on a monthly basis and received key reports in support of effective infection prevention and control practices and staff and public safety.

Additionally, the Finance and Performance Committee also met on a monthly basis and the Chief Finance Officer and the Chief Operating Officer are the Executive leads. The focus of business has remained on delivery of urgent care, diagnostic and cancer services, the elective activity recovery programme and reduction in waiting times for patients and ensuring that essential changes to the trust's estate were completed in line with the trust's Standing Financial Instructions.

The People and Culture Committee has provided a greater focus on people and culture. Staff wellbeing and support has been a key focus of the committee ensuring that staff have access to ongoing support and wellbeing services and facilities. Additionally, the committee has supported the development of an inclusive culture and supported the developments of a number of recruitment and retention initiative during the year. The Chief People Officer has been the executive lead for this, alongside the Chief Executive Officer.

The Risk and Audit Committee has maintained oversight of the Trust's system of internal control and the Non-Executive Chair is supported by the Chief Finance Officer who is the identified Executive lead. A new Risk and Audit Committee Chair commenced in role in January 2022 following the departure from the Trust of the previous committee Chair. Delivery of the Internal Audit Programme has been challenging during the year although a number of audits continued to be undertaken; providing assurances on areas of key risk identified within the programme.

Key Risks

The Board has refreshed its strategy in year and refocussed its strategic objectives to reflect it People, Place and Partnership ambitions. Accordingly, the Board Assurance Framework that outlines the risks to delivery of the Trust's strategic objectives has been reviewed and reframed in year.

The following risks are recorded within the Board Assurance Framework against the respective strategic objectives of the trust and are risk rated 20:

1. If we fail to attract and retain the right people with the right skills, then more pressure on result on existing teams.

2. If there is a continuous inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives.

3. If we continue to not achieve the national performance standards due to long waiting times, then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.

4. If our emergency and urgent care pathways do not meet the increase in unplanned attendances, then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met.

5. If we do not embed appropriate business case approval processes, then plans will not be sustainable so we will not be able to meet the needs of patients and populations.

6. If the Trust fails to deliver sustained financial breakeven and to be self-sufficient in cash terms, then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash

The Trust is able to assure itself of the validity of its Corporate Governance statement; (NHS Foundation Trust Licence Condition 4 requirement) through the following mechanisms that have been deployed during 2021/22:

- the Board has maintained a strong emphasis on quality and safety in its meeting agendas to ensure that these remain the focus of decision making and planning.
- the Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work.
- The Board has continued to undertake visits to wards to meet with staff and gain feedback on an intermittent basis where pandemic circumstances have allowed. Whilst Governors have not participated in these visits this year, they have continued to observe Board and committee meetings where feedback has been shared.

- The Board has continued to deliver optimal elective, diagnostic and cancer care to patients as the pandemic has allowed
- The Board has maintained appropriate oversight of regulatory and compliance regimes through robust incident management arrangements in line with regional and national guidance and support.

All staff within the Trust graded at Agenda for Change pay scale Band 8a / equivalent very senior manager grade or above are required to declare any interests in line with national guidance, on an annual basis. The Register of Interests is reviewed by the Risk and Audit Committee and published on the trust website. The Trust uses an automated process to seek appropriate declarations using the Electronic Staff Record.

The Trust involves its stakeholders in managing risk in the following ways:

- regular reporting to the Council of Governors on quality, finance and performance, with an emphasis on the reporting of risks, current concerns and complaints.

- Governor attendance by videoconference at key meetings including the Board of Directors, Quality Committee, Risk and Audit Committee, People and Culture Committee and Finance and Performance Committee; and stakeholder attendance at Patient Experience Group which reports to the Quality Committee.

- regular meetings with the Trust's principal commissioners and the Regional Office to benchmark quality performance against risks relating to service delivery during the pandemic.

- consulting with its membership on key strategic direction decisions as part of the planned refresh of the trust's strategy and enabling strategies (Clinical, People and Digital) and progression of the Integrated Care System.

- joint working with local and regional healthcare providers to shape optimum care pathways and mitigate risks and with other system partners in the development of the Integrated Care System approach.

- membership and wider patient and public engagement strategies.

Workforce

As an employer of 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 the 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. Delivery of the Workforce Race Equality Scheme plan for the trust is monitored by the People and Culture Committee and escalated to the Board. Reporting requirements have been satisfied in respect of the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap reporting.
The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff *(as defined by the trust with reference to the guidance)* within the past twelve months as required by the *Managing Conflicts of Interest in the NHS guidance*.

The foundation trust has undertaken risk assessments and has plans in place which take account of *'Delivering a Net Zero Health Service' report under the Greener NHS Programme*. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with and has refreshed its Climate Change Adaption Plan 2020-25 in year. The Trust approved its Green Plan in year.

Review of Economy, Efficiency and Effectiveness of the Use of Resources
The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income, expenditure and capital investments. The plan incorporates the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board, having been previously assessed by the Finance and Performance Committee.

Trust has continued to operate under the national funding regime in response to the pandemic throughout the year.

The Board and its committees have received regular detailed reports covering finance, activity, capacity, workforce management, risk and performance throughout the year.

In June 2021 the NHS published the System Oversight Framework for NHS organisations for the 21/22 financial year. The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document.

The NHS System Oversight Framework reflects an approach to oversight that reinforces system-led delivery of integrated care, in line with the vision set out in the NHS Long Term Plan, the White Paper – Integration and innovation: Working together to improve health and social care for all, and aligns with the priorities set out in the 2021/22 Operational Planning Guidance. This framework applies to all Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), NHS trusts and foundation trusts. In November 2021 DCH was placed in to segment 3. The Dorset ICS overall was placed in to Segment 2. In 2021/22 no further action was taken by NHS England and no action was required of DCH.

The Board is provided with assurance on the use of resources through a regular performance, activity and expenditure reports. The Finance and Performance Committee also undertakes a detailed review on a monthly basis. External auditors review the use of resources and a comprehensive value for money assessment each year as part of the annual audit programme. Internal audit resources are directed to areas where risk is attached or where issues have been identified although the programme of planned work in year has been somewhat impacted by the pandemic. Any concerns on the economy, efficiency and effectiveness of the use of resources are well monitored and addressed in a timely and appropriate manner.

Information Governance
The Trust operates under the guidelines and legislation which govern Information Governance within the NHS and has embedded the processes necessary to meet the standards required. Our Information Risk Management Policy and risk management structure is owned by the Trust's Senior Information Risk Owner and reviewed via the Information Governance Group, alongside Information Asset Assurance Reports from the Trust's Information Asset Owners and a rolling overview of all Information Security and Information Governance incidents at each bi-monthly meeting. The Trust's Information Risk Policy is aligned with the Trust's Information Security Policy, which details the security arrangements, is in place for systems and devices.

The Trust reported no serious incidents during the 2021/22 to the Office of the Information Commissioner and NHS Digital. The Risk and Audit Committee maintains oversight Information Governance.

Data Quality and Governance
Governance and Leadership
The Board is actively engaged in quality improvement and is assured that quality governance is subject to rigorous challenge through Non-Executive Director engagement and Chairmanship of the key board committees. The Board membership includes the Executive role of Chief Information Officer and the Chief Finance Officer is the accountable Senior Information and Reporting Officer. The T Information Governance Manager / Data Protection Officer leads the operational delivery of the Data Security and Protection Toolkit and other regulatory requirements across the Trust.

The Role of Policies and Plans in Ensuring Quality Data
The revised Information Strategy recognises data quality as one of the five core elements of the Information Maturity Model. As the Trust becomes increasingly paper light, information plays an integral part of the processes to deliver effective and timely healthcare across the organisation. Therefore, excellent data quality is pivotal in order to ensure that the data from different systems can be seamlessly joined together and provided to healthcare professionals in a timely, secure and accurate manner.

Systems and Processes
Specific actions have been taken to strengthen the existing processes around data quality throughout the year, building on the data quality processes and procedures that have been in place for some time in the Trust. Current processes and procedures as well as recent initiatives to improve data quality include the following:

- **Information Assurance:** The Data Quality Management Group has provided a robust mechanism to monitor and control data quality measures for the clinical information systems. This group is an Information Assurance Group that will extend data quality assurance to cover all aspects of data quality within the Trust including the data items reported on the Trust dashboards. In addition, the Information Assurance Manager, reporting to the Information Assurance Group works with divisional and change management teams to educate, reinforce and monitor data quality and information management processes across the Trust for all patient based applications.

- **Governance.** Governance improvements around the Information Assurance Group have been made in order to allow other groups such as the Clinical Coding Task and Finish Group and the Digital Portfolio Group to escalate all data quality issues to the Information

Assurance Group. Finally, bi- monthly highlight reports to Digital Portfolio Programme Board will provide appropriate visibility on any major data quality issues.

- **Information Dashboards.** The performance dashboards have been kept under review and a process of continual development and improvement has been implemented. Specific dashboards are available for respective Board committees and divisional services.

- **Ownership.** Improving ownership of data quality issues is a long-term objective of the Information Strategy. The Information Assurance Group ensures that ownership and responsibilities are agreed and supported at executive level and cascaded through divisional directors and managers who hold staff accountable. The two Divisional Information Analysts work closely with the senior divisional management and clinical teams to identify and resolve any data quality issues that might arise.

- **Regular audit and external assurance**. Audits and in-depth analysis of data quality are conducted in a number of areas, including: mortality; specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations); in additional to departmental clinical audits. Key issues will be discussed at the Information Assurance Group to ensure a culture of continuous improvement on data quality. Late last year the Trust underwent a full reassessment against the ISO27001 standard and retained the high standard for the Digital department. The Trust is in the process of reaccrediting against the DCB1596 NHS Secure Email Accreditation and continues to migrate email services and will again seek to reaccredit the new environment against the NHS secure email accreditation by the end of the financial year.

- **Information Systems**. As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. The Information Assurance Group continues to work closely with the system managers and key business users to address any data quality issues. Of particular note has been the DCH contribution to the Dorset Care Record in sharing core clinical information with health and social care partners in Dorset. We now have greater visibility of data quality reporting across partner organisations which has shown good performance for DCH particularly with regard to accuracy of NHS numbers which is the key patient identifier in bringing records together from different care settings across Dorset. Where data quality issues are identified they are rectified quickly with feedback to users of source systems to reinforce the importance of accuracy and completeness in recording of patient data.

Quality Account

Production of a Quality Report 2021/22 will not be subject to external audit due to the COVID-19 pandemic and there is no requirement for this report to be submitted with the Annual Report and Accounts for 2021/22.

Well Led Review

The Trust commissioned the services of PriceWaterHouseCoopers during November and December 2021 to undertake an independent external review of the Trust against the CQC Well Led Framework. The review identified that:

The Board is operating at the higher end of NHS Trust Board effectiveness. The Board is stable, diverse and has a good mix of skills. The strategic refresh (undertaken in year) has clarified the strategic direction of the Trust.

The report concludes that the Trust has an open and inclusive culture focussed on continuous improvement and innovation, providing training and career development opportunities for staff and that the divisional and governance structures provided clear lines of accountability.

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 the content of the Annual Report and other 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 Risk and Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust continually seeks to improve the effectiveness of its systems of internal control and put action plans in place to meet any identified shortfalls. Following the review of committee effectiveness in 2020/21, oversight of strategic risk mitigation has been strengthened via reviews of the Board Assurance Framework by Board committees in addition to those undertaken by the Risk and Audit Committee. Trust Board meetings are open to members of the public and Board Committees are attended by nominated governor observers. The Board reporting cycle ensures that the Board receives regular reports from its committees, operational reports from Executives, the Board Assurance Framework and bimonthly Risk Register and planned reports on business and other operational issues. The Escalation Report process from Board committees to Board immediately following each meeting, has ensured timely escalation of risks and issues for the Board's attention.

The governance structure is as follows:

The Board: The powers reserved to the Board are, broadly, regulation and control; strategy; business plans and budgets; risk management; financial performance and reporting and audit arrangements.

Risk and Audit Committee: Provides assurance to the Board as to the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It reviews the establishment and maintenance of an effective system of integrated governance, risk management, finance, counter fraud, security management, and internal control across the whole of the organisation's activities, both clinical and non-clinical. The committee utilises the Board Assurance Framework, risk register, internal and external audit reports, the work of the Quality Committee and the ability to question the Chief Executive regarding the Annual Governance Statement to support its work.

Finance and Performance Committee: Provides assurance to the Board and does not remove the requirement for the Board to monitor financial and operational performance. The committee provides scrutiny and makes recommendations to the Board to assist in decision making.

Specific areas scrutinised by the Finance and Performance Committee include financial planning, operational performance, business case assessments and the delivery of efficiency and cost improvement programmes. The Finance and Performance Committee is able to approve business cases within delegated limits.

Quality Committee: provides assurance that the Trust has an effective framework within which it can work to improve and assure the quality and safety of services it provides in a timely, cost effective way. The committee assesses, reviews and monitors performance, including safer staffing and mortality data which is then published on the trust's website, internal control, external validation and assessment, the annual Quality Report and plans and national guidance and policy.

People and Culture Committee: The purpose of the committee is to be responsible for the consideration of matters relating to Workforce Planning and development, efficiency, human resources policy and the Trust's People Strategy. It also has responsibility for leadership development and talent management; recruitment and retention; education and training; people policies, processes and systems; diversity and inclusion and health and wellbeing. The committee ensures that workforce strategies and staffing systems are in place that assure the Board that staffing processes are safe, sustainable and effective.

The committee act as a means of internal assurance for compliance against the Care Quality Commission's fundamental standards of quality and safety and safe, caring, effective and well-led domains.

My view is further informed by:

- Opinions and reports by Internal Audit, who work to a risk based annual plan. The Head of Internal Audit Opinion for 2021/22 was as follows: "Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently".
- Opinion and reports from the Trust's External Auditors
- Monthly reports to NHS Improvement
- Full compliance with the Care Quality Commission essential standard for quality and safety for all regulated activities across all locations
- Results of patient and staff surveys
- Investigation reports and action plans following serious incidents
- Council of Governors feedback
- Clinical audit reports
- Trust evaluations and responses to national peer review findings and reports.
- Outcome of an independent external review against the CQC Well Led Framework

Conclusion
The trust has been required to operate flexibly throughout the year, responding to significant operational service pressures arising from the COVID-19 pandemic. The Board has adapted its governance approach in accordance with national guidance in order to focus on key risks to quality, patient safety, staff wellbeing and recovery.

No significant internal control issues have been identified for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Nicholas Johnson
Interim Chief Executive
20 June 2022

The Accountability Report was approved by the Board of Directors on 25 May 2022 and signed on its behalf by

Nick Johnson
Interim Chief Executive
20 June 2022

Independent Auditors Report

Independent Auditor's Report to the Council of Governors of Dorset County Hospital NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Dorset County Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2022 and of the Group's and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Risk and Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Risk and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Group's accounting policies.

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

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition because of the non-complex recognition due to the nature of the revenue, which limits the opportunities to fraudulently misstate revenue.

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

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to expenditure accounts, unusual postings to cash or borrowings accounts and journals posted by a specific user.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting cash payments and purchase invoices in the period prior to and following 31 March 2022 to verify expenditure had been recognised in the correct accounting period.
- Evaluating a sample of accruals posted as at 31 March 2022 and verifying accruals posted as at 31 March 2022 are appropriate and accurately recorded.

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

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Group's and Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

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

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

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

The Group is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

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

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

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

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

Other information in the Annual Report

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

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

- we have not identified material misstatements in the other information.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion those reports have been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 80, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

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

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

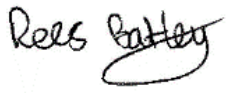
We have nothing to report in this respect.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

20 June 2022

Foreword to the Accounts

These accounts for the year ended 31st March 2022 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the annual reporting guidance for NHS Foundation Trusts within the Department of Health and Social Care Group Accounting Manual 2021/22.

Dorset County Hospital NHS Foundation Trust's Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006.

Nick Johnson
Acting Chief Executive
20 June 2022

Statement of Comprehensive Income for the year ended 31st March 2022

		Group		Trust	
		2021/22	2020/21	**2021/22**	2020/21
	Note	**£000**	£000	**£000**	£000
Operating income from patient care activities	3	230,615	195,054	230,615	195,054
Other operating income	4	25,928	39,454	26,018	39,549
Operating expenses	5	(253,280)	(231,915)	(253,394)	(232,132)
Operating surplus		**3,263**	**2,593**	**3,239**	**2,471**
Finance costs:					
Finance income	10	27	-	27	-
Finance expenses	11	(265)	(223)	(265)	(224)
PDC dividends charge		(3,069)	(1,919)	(3,069)	(1,919)
Net finance costs		**(3,307)**	**(2,142)**	**(3,307)**	**(2,143)**
Losses on disposal of assets	12	(4)	(41)	(4)	(41)
Corporation tax expense		(5)	(23)	-	-
(Deficit)/Surplus for the year		**(53)**	**387**	**(72)**	**287**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairment of property, plant and equipment		(29)	-	(29)	-
Revaluation gains on property, plant & equipment		25,061	-	25,061	-
Total comprehensive income for the year		**24,979**	**387**	**24,960**	**287**

The notes on pages 105 to 143 form part of these accounts.

Statement of Financial Position as at 31st March 2022

		Group		Trust	
		31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	14	12,294	8,424	12,294	8,424
Property, plant and equipment	15.4	141,449	101,717	141,447	101,713
Trade and other receivables	18.1	579	908	579	908
Total non-current assets		**154,322**	**111,049**	**154,320**	**111,045**
Current assets					
Inventories	17	2,875	2,610	2,686	2,456
Trade and other receivables	18.1	7,101	6,177	6,992	6,073
Cash and cash equivalents	19	25,951	17,698	25,827	17,648
Total current assets		**35,927**	**26,485**	**35,505**	**26,177**
Current liabilities					
Trade and other payables	20	(35,791)	(29,512)	(35,663)	(29,477)
Borrowings	21	(343)	(190)	(343)	(190)
Provisions	22	(49)	(50)	(49)	(50)
Other liabilities	23	(3,119)	(2,065)	(3,119)	(2,065)
Total current liabilities		**(39,302)**	**(31,817)**	**(39,174)**	**(31,782)**
Total assets less current liabilities		**150,947**	**105,717**	**150,651**	**105,440**
Non-current liabilities					
Borrowings	21	(8,238)	(7,022)	(8,238)	(7,022)
Provisions	22	(278)	(792)	(278)	(792)
Total non-current liabilities		**(8,516)**	**(7,814)**	**(8,516)**	**(7,814)**
Total assets employed		**142,431**	**97,903**	**142,135**	**97,626**
Financed by taxpayers' equity:					
Public dividend capital		122,832	103,283	122,832	103,283
Revaluation reserve		51,014	25,982	51,014	25,982
Income and expenditure reserve		(31,415)	(31,362)	(31,711)	(31,639)
Total taxpayers' equity:		**142,431**	**97,903**	**142,135**	**97,626**

The financial statements on pages 101 to 143 were approved by the Board on 25 May 2022 and signed on its behalf by:

Nick Johnson
Acting Chief Executive
20 June 2022

Statement of Changes in Taxpayers' Equity

Group	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021	**97,903**	**103,283**	**25,982**	**(31,362)**
Surplus for the year	**(53)**	-	-	(53)
Net impairments on property, plant and equipment	**(29)**	-	(29)	-
Revaluations on property, plant and equipment	**25,061**	-	25,061	-
Public Dividend Capital	**19,549**	19,549	-	-
Taxpayers' equity at 31 March 2022	**142,431**	**122,832**	**51,014**	**(31,415)**
Taxpayers' equity at 1 April 2020	**82,015**	87,782	25,983	(31,750)
Surplus for the year	**387**	-	-	387
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**15,501**	15,501	-	-
Taxpayers' equity at 31 March 2021	**97,903**	**103,283**	**25,982**	**(31,362)**

Trust	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021	**97,626**	**103,283**	**25,982**	**(31,639)**
Surplus for the year	**(72)**	-	-	(72)
Net impairments on property, plant and equipment	**(29)**	-	(29)	-
Revaluations on property, plant and equipment	**25,061**	-	25,061	-
Public Dividend Capital	**19,549**	19,549	-	-
Taxpayers' equity at 31 March 2022	**142,135**	**122,832**	**51,014**	**(31,711)**
Taxpayers' equity at 1 April 2020	**81,838**	87,782	25,983	(31,927)
Surplus for the year	**287**	-	-	287
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**15,501**	15,501	-	-
Taxpayers' equity at 31 March 2021	**97,626**	**103,283**	**25,982**	**(31,639)**

The Revaluation Reserve consists of £51,014k (£25,982k at 31 March 2021) relating to property, plant and equipment.

Statement of Cash Flows for the year ended 31st March 2022

	Group		Trust	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Cash flows from operating activities				
Operating surplus	3,263	2,593	3,239	2,471
Depreciation and amortisation	7,345	5,917	7,343	5,915
Impairments and reversals	43	-	43	-
Income recognised in respect of capital donations (cash and non-cash)	(288)	(653)	(288)	(653)
(Increase)/Decrease in trade and other receivables	(609)	4,459	(604)	4,480
(Increase)/Decrease in inventories	(265)	382	(230)	327
Increase/(Decrease) in trade and other payables	1,392	(16)	1,282	95
Increase in other liabilities	1,054	263	1,054	263
(Decrease)/Increase in provisions	(513)	64	(513)	64
Corporation tax paid	(23)	(22)	-	-
Net cash generated from operations	**11,399**	**12,987**	**11,326**	**12,962**
Cash flows from investing activities				
Interest received	12	4	11	4
Purchase of intangible assets	(2,994)	(1,756)	(2,994)	(1,756)
Purchase of property, plant and equipment	(16,926)	(14,111)	(16,926)	(14,111)
Sales of property, plant and equipment	52	31	52	31
Receipt of cash donations to purchase capital assets	237	100	237	100
Net cash used in investing activities	**(19,619)**	**(15,732)**	**(19,620)**	**(15,732)**
Cash flows from financing activities				
Public dividend capital received	19,549	15,501	19,549	15,501
Capital element of finance lease obligations	(142)	(199)	(142)	(199)
Interest Paid	(97)	(97)	(97)	(97)
Interest element of finance lease obligations	(150)	(161)	(150)	(161)
PDC dividends paid	(2,687)	(1,936)	(2,687)	(1,936)
Net cash used in financing activities	**16,473**	**13,108**	**16,473**	**13,108**
Increase in cash and cash equivalents	**8,253**	**10,363**	**8,179**	**10,338**
Cash and cash equivalents at 1 April	17,698	7,335	17,648	7,310
Cash and cash equivalents at 31 March	**25,951**	**17,698**	**25,827**	**17,648**

Notes to the Financial Statements

1 Accounting policies and other information

NHS England and 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 (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the DHSC 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 DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below.

These have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

Valuation of land and buildings
Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

Of the £115.7 million net book value of land and buildings subject to valuation, £107.5 million relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the COVID-19 pandemic and inflation will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient information to indicate what the impact of this will be.

Depreciation of property, plant and equipment and amortisation of computer software
The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

1.2 Consolidation

1.2.1 Subsidiaries

Entities over which the Trust has power to exercise control are classified as subsidiaries. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves of the subsidiary are included as a separate item in the Statement of Financial Position.

Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust (including where they report under UK FRS 102) or where the subsidiary's accounting date is not coterminous. The amounts consolidated are drawn from the financial statements of DCH SubCo Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust wholly owns DCH SubCo Ltd which forms part of the consolidated accounts. DCH SubCo Ltd provides outpatient pharmacy services. Its turnover for the period ended 31st March 2022 was £6.3m and its gross assets at 31 March 2022 totalled £0.6 m.

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

1.2.2 Joint Ventures

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

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.

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.

The Trust has one joint venture DCH Estates Partnership LLP OC418519, which is a commercial partnership with Partnering Solutions (Dorset) Ltd (Interserve Prime) creating a Strategic Estates Partnership. No assets or transactions have taken place during 2021/22.

1.3 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC 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 service is unconditional a contract receivable 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.

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

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and, in 2021/22, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

During 2021/22 the Trust received additional fixed income support in relation to the COVID-19 pandemic as part of the Dorset system funding envelope, this income was distributed by Dorset CCG to the Trust's through the block payment arrangements.

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

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.

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 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.

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.

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.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

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

1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

NHS Pension Scheme:

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 employer, GP practices and other bodies, allowed under the direction of the Secretary of State 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 employer's pension contributions payable to that scheme for the accounting period.

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

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore, does not pay employer contributions into this scheme.

1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised 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 when it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which 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, or refurbishment of a 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. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives (UEL).

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

1.6.2 Measurement

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

All land and buildings are revalued using professional valuations in accordance with accounting standard IAS 16 Property, Plant and Equipment every five years. A three year interim valuation is also carried out. Additional valuations 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.

Professional valuations are carried out by the Trust's external valuer (Avison Young). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (ICS) Appraisal and Valuation Manual.

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.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1st April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The last full valuation survey was assessed by the valuer of Avison Young at 31 March 2022.

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 expenses.

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 DHSC GAM, impairments that arise from a clear consumption of economic benefits, or 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) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

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

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

1.6.3 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 the 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 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.

1.7 Intangible assets

1.7.1 Recognition

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

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

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.7.2 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 is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the definitions of IAS 40 Investment Properties or IFRS 5 Assets Held for Sale.

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

1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

The following table details the useful economic lives currently used for the main classes of assets:

Asset class	Min Life Years	Max Life Years
Buildings exc. dwellings	10	66
Dwellings	44	79
Plant & machinery	3	15
Information technology	3	15
Furniture & fittings	5	15
Intangible assets	3	19

Property, plant and equipment which have been re-classified as 'held for sale' cease to be depreciated upon the re-classification.

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.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.9 Donated 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 future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the DHSC 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.

1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

1.11 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.

1.11.1 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 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 calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.11.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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.

1.11.3 Leases of land and buildings

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

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the DHSC 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 that form an integral part of the Trust's cash management.

1.14 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 that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation.

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

Term	Years	Nominal rate	Prior year rate
Short	Up to 5	0.47%	Minus 0.02%
Medium	After 5 up to 10	0.70%	0.18%
Long	After 10 up to 40	0.95%	1.99%
Very long	Exceeding 40	0.66%	1.99%

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

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

1.15 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. The contribution is charged to expenditure. 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 22.2 but is not recognised in the Trust's accounts.

1.16 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 any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and 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, these are disclosed where an inflow of economic benefits is probable. The Trust currently has no contingent assets to disclose.

Contingent liabilities are not recognised, but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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 Trust. 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.

Where additional assets were purchased relating to the COVID-19 pandemic, the value of these assets will be excluded from average relevant net assets for PDC Dividend calculations, in the same manner as donated and grant funded assets. Such assets will therefore not attract a PDC dividend charge. 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, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) 111 and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) approved expenditure on COVID-19 capital assets, (iv) assets under construction for nationally directed schemes and (v) any PDC dividend balance receivable or payable.

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

In accordance with the requirement laid down by the DHSC (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 thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Financial instruments and financial liabilities

1.19.1 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 DHSC 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.

1.19.2 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.

1.19.3 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 as 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.

1.19.4 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).

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.

1.19.5 Derecognition

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

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

1.20 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.

1.21 Corporation Tax

Section 148 of the Finance Act in 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trusts activities are related to core healthcare and are not subject to tax.

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and
Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

However, the Trust's commercial subsidiary is subject to corporation tax, and this has been included in the group accounts.

1.22 Foreign currencies

The Trust's functional currency and presentational currency 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 transaction.

Exchange gains and 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.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However they are disclosed in Note 29 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

1.24 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following standards and interpretations to be applied in 2021/22. These standards are still subject to HM Treasury FReM adoption:

IFRS 14 Regulatory Deferral Account – Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC Bodies.

IFRS 16 Leases – Standard as interpreted and adapted by the FReM, is to be effective from 1 April 2022.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, Standard is not yet adopted but the FReM which is expected to be from April 2023: early adoption is not therefore permitted

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations, which is in line with guidance contained in the DHSC GAM 2021/22.

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 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 0.95% but this may change between now and the adoption of the standard. The related right of use asset will be measured equal to liability adjusted for any prepaid or accrued lease payments.

For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The Trust has estimated the impact of applying IFRS 16 in 2022/23 in note 34 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions.

1.25 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 general payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 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.

1.27 Going concern
International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

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 going concern period, being 12 months from the date of signing this Annual Report before the discussion on the financial position.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating surplus in 2020/21 of £0.4 million and is reporting a deficit of £0.1 million for the year ended 31 March 2022, with a cash balance of £26.0 million. The Trust anticipates an operating deficit of £17.0 million in 2022/23 and will need to apply for financial support through interim revenue public dividend capital anticipated to be to the value of £9.0 million.

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.

2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, "healthcare". Analysis of income by different activity types and sources is provided in note 3.

3. Income from patient care activities

Analysis by activity	Group		Trust	
	Year ended	Year ended	**Year ended**	Year ended
	31 March	31 March	**31 March**	31 March
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Block contract/system envelope income	205,994	168,913	205,994	168,913
High costs drugs income from commissioners	15,739	15,213	15,739	15,213
Other NHS clinical income	1,132	4,167	1,132	4,167
Private patient income	982	617	982	617
Additional pension contribution central funding*	6,245	5,765	6,245	5,765
Other clinical income	523	379	523	379
Total	**230,615**	195,054	**230,615**	195,054
Income from Commissioner Requested Services	229,110	194,058	229,110	194,058
Income from non-Commissioner Requested Services	1,505	996	1,505	996
Total	**230,615**	195,054	**230,615**	195,054

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2021/22, NHS providers 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.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service has to continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

Analysis by source	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
NHS - Foundation Trusts	1,031	2,063	1,031	2,063
NHS - Trusts	-	1	-	1
NHS - NHS England	41,522	40,503	41,522	40,503
NHS - CCGs	186,457	151,445	186,457	151,445
Local Authorities	-	19	-	19
NHS - Other	101	27	101	27
Non NHS - Private patients	982	617	982	617
Non NHS - Overseas patients	57	22	57	22
NHS Injury Scheme	391	292	391	292
Non NHS - Other	74	65	74	65
Total	**230,615**	195,054	**230,615**	195,054

NHS Injury Scheme income relating to the 2021/22 financial year is subject to a provision for doubtful debts of 23.76% (2020/21: 22.43%) to reflect expected rates of collection.

The Group and Trust overseas patient income for the year amounted to £57k (2020/21 £22k). Cash received amounted to £52k (2020/21 £12k) in respect of current and previous years' income. The amounts written off in respect of current and prior years amounted to £nil (2020/21 £nil).

4. Other operating income

	Note	Group Year ended 31 March 2022 £000	Group Year ended 31 March 2021 £000	Trust Year ended 31 March 2022 £000	Trust Year ended 31 March 2021 £000
Research and development		920	673	920	673
Education and training		10,121	8,853	10,121	8,853
Education and training - notional income from apprenticeship fund		590	363	590	363
Received from NHS Charities: Cash donations		237	100	237	100
Received from NHS Charities: Contributions to expenditure		17	47	17	47
Donated equipment from DHSC for COVID response (non-cash)		51	553	51	553
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold		-	59	-	59
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response		584	3,269	584	3,269
Non-patient care services to other bodies		10,558	7,859	10,638	7,939
Reimbursement and top up funding		870	15,910	870	15,910
Staff recharges		426	470	430	478
Rental revenue from operating leases	6.2	88	53	95	60
Car parking		199	124	199	124
Catering		395	366	395	366
Pharmacy sales		51	38	51	38
Staff accommodation rentals		493	402	493	402
Estates recharges		6	40	6	40
IT recharges		6	4	6	4
Clinical excellence awards		100	44	100	44
Other income generation schemes		55	36	55	36
Other income		161	191	160	191
Total		**25,928**	39,454	**26,018**	39,549

5. Operating expenses

	Note	Group Year ended 31 March 2022 £000	Group Year ended 31 March 2021 £000	Trust Year ended 31 March 2022 £000	Trust Year ended 31 March 2021 £000
Employee expenses	7.1	165,742	154,859	165,667	154,794
Employee expenses - Non-executive directors		138	127	138	127
Purchase of healthcare from NHS and DHSC bodies		7,209	7,042	7,209	7,042
Purchase of healthcare from non-NHS and non-DHSC bodies		8,836	4,191	15,121	9,476
Supplies and services - clinical (excluding drug costs)		18,185	15,702	18,185	15,702
Supplies and services - clinical utilsation of consumables donated from DHSC for COVID response		584	3,269	584	3,269
Supplies and services - general		1,982	1,763	1,982	1,763
Supplies and services - general notional cost of equipment donated from DHSC for COVID response below capitalisation threshold		-	59	-	59
Drug costs		21,816	18,456	15,839	13,469
Inventories written down (net, including drugs)		9	18	9	18
Consultancy costs		195	325	186	318
Establishment		1,512	1,307	1,512	1,306
Premises - Business rates payable to Local Authorities		1,000	692	1,000	692
Premises - Other		6,944	7,569	6,944	7,569
Transport (business travel only)		398	355	398	355
Transport (other)		591	251	591	251
Depreciation on property, plant and equipment		6,511	5,283	6,509	5,281
Amortisation on intangible assets		834	634	834	634
Impairments net of (reversals)	13	43	-	43	-
Movement in credit loss allowance		-	(14)	-	(14)
Change in provisions discount rate		3	94	3	94
External audit - statutory audit services*		63	54	58	50
External audit - audit assurance services*		-	-	-	-
Internal Audit Costs - (not included in employee expenses)		76	75	76	75
Clinical negligence - NHS Resolution (premium)		5,619	5,580	5,619	5,580
Legal fees		55	175	55	175
Insurance		120	119	120	119
Research and Development		24	9	24	9
Training courses and conferences		1,129	1,441	1,129	1,441
Education and training - notional expenditure funded from apprenticeship fund		590	363	590	363
Rentals under operating leases - minimum lease payments	6.1	173	116	173	116
Car parking and security		1,093	898	1,093	898
Losses, ex gratia & special payments		9	3	9	3
Other services		1,107	561	1,107	561
Other		690	539	587	537
Total		**253,280**	231,915	**253,394**	232,132

*no other remuneration was paid to the auditor, except for the amounts disclosed above

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Minimum lease payments:				
Buildings	78	50	78	50
Other	95	66	95	66
Total minimum lease payments	**173**	116	**173**	116

Future minimum lease payments on buildings leases due:	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Not later than one year	500	50	500	50
Later than one year and not later than five years	1,943	202	1,943	202
Later than five years	6,657	152	6,657	152
Total	**9,100**	404	**9,100**	404

Future minimum lease payments on other leases due:	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Not later than one year	45	26	45	26
Later than one year and not later than five years	98	43	98	43
Total	**143**	69	**143**	69

6.2 As lessor

Rental recognised as an income	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Minimum lease payments: Land	88	53	95	60
Total minimum lease payments	**88**	53	**95**	60

Future minimum lease payments on Buildings leases due:	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Not later than one year	86	88	93	95
Later than one year and not later than five years	344	344	344	351
Later than five years	-	86	-	86
Total	**430**	518	**437**	532

7. Employee expenses and numbers

7.1 Employee expenses

	Group		Trust	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021
	£000	£000	**£000**	£000
Staff & executive directors	163,718	152,996	163,643	152,931
Research and development staff	924	760	924	760
Education and training staff	1,078	1,055	1,078	1,055
Redundancy	17	47	17	47
Early retirements	5	(4)	5	(4)
Special payments	-	5	-	5
	165,742	154,859	**165,667**	154,794
Salaries and wages	121,585	115,262	121,518	115,205
Social security costs	11,978	10,688	11,972	10,682
Apprenticeship levy	606	551	606	551
Employer contributions to NHS Pension scheme	14,319	13,227	14,319	13,227
Employer contributions paid by NHSE on provider's behalf (6.3%)	6,245	5,765	6,245	5,765
Pension cost - other	49	48	47	46
Agency and contract staff	12,086	10,383	12,086	10,383
Termination benefits	110	169	110	169
Less: Staff costs capitalised as part of assets	(1,236)	(1,234)	(1,236)	(1,234)
Employee benefits expense	**165,742**	154,859	**165,667**	154,794

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2022 was £20,613k (2020/21: £19,040k), £6,245k of this figure is paid by NHSE on behalf of the Trust. Of this total, an amount of £1,2113k (2020/21: £1,023k) was unpaid at the reporting date.

7.2 Retirement benefits

NHS Pension Scheme

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

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

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

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

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

8. Retirements due to ill-health

During 2021/22 there were two cases (2020/21: two case) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £75k (2020/21: £25k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

9. Salary and pension entitlement of directors and senior managers

9.1 Directors remuneration

	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Directors remuneration - Salaries and wages	997	1,018	997	1,018
Employers pension contributions in respect of directors	123	132	123	132
	1,120	1,150	**1,120**	1,150
	Number	Number	**Number**	Number
The total number of directors to whom retirement benefits were accruing under:				
Defined benefit schemes	7	6	7	6

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 31 to 41 of the Remuneration Report.

10. Finance income

	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Interest on bank accounts	27	-	27	-
Total	**27**	-	**27**	-

11. Finance expenses

	Group		Trust	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Loans from the Department of Health	97	97	97	97
Finance Leases	170	128	170	129
Total interest expense	267	225	267	226
Unwinding of discount on provisions	(2)	(2)	(2)	(2)
Total finance expenses	**265**	223	**265**	224

12. Gains/(losses) on disposals

	Group		Trust	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021
	£000	£000	**£000**	£000
Gains on disposal of other property, plant and equipment	43	25	43	25
Losses on disposal of other property, plant and equipment	(18)	(66)	(18)	(66)
Losses on return of donated COVID assets to DHSC	(29)	-	(29)	-
Total (losses) on disposal of assets	**(4)**	(41)	**(4)**	(41)

13. Impairment of non-current assets

	Group		Trust	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021
Impairment	**£000**	£000	**£000**	£000
Abandonment of assets in course of construction	12	-	12	-
Changes in market price*	313	-	313	-
Reversal of impairments*	(253)	-	(253)	-
Total impairments	**72**	-	**72**	-

* Resulting from the revaluation of land and buildings as at 31 March 2022.

Total impairments have been charged/(credited) to the following lines in the Statement of Comprehensive Income.

	Group		Trust	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021
	£000	£000	**£000**	£000
Operating expenses	43	-	43	-
Revaluation reserve	29	-	29	-
	72	-	**72**	-

14. Intangible assets

	Group and Trust	
	Software licences	**Software licences**
	2021/22	2020/21
	£000	£000
Cost or valuation at 1 April	13,835	10,237
Additions - purchased	4,704	3,603
Disposals	(113)	(5)
Cost or valuation at 31 March	**18,426**	13,835
Amortisation at 1 April	5,411	4,782
Provided in the year	834	634
Disposals	(113)	(5)
Amortisation at 31 March	**6,132**	5,411
Net book value		
Purchased	12,292	8,420
Donated	2	4
Net book value total at 31 March	**12,294**	8,424

Software licences have been assigned asset lives of between 3 and 19 years. The total reported includes £5,872k (2021: £3,261k) of software under construction.

15. Property, plant and equipment

Assets utilised by the Trust under Finance leases arrangements are capitalised as part of property, plant and equipment under IFRS. The net book value of fixed assets held at the balance sheet date that were subject to a finance lease was £3,550k (2021: £2,359k).

The Trust's land and buildings were valued by external valuers as at 31 March 2022 on the basis of fair value, as set out in the accounting policy note 1.6.2. The valuation was undertaken by Avison Young.

15.1 Property, plant and equipment, current year 2021/22

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
Group	**£000**	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	**131,894**	5,050	70,065	4,530	8,073	32,801	10,737	638
Additions - purchased	**19,532**	30	13,396	21	2,011	3,084	990	-
Additions - leased	**1,491**	-	-	-	-	1,491	-	-
Additions - equipment donated from DHSC for COVID response (non-cash)	**51**	-	-	-	-	51	-	-
Additions - assets purchased from cash donations/grants	**237**	-	7	-	-	230	-	-
Impairments charged to operating expenses	**(827)**	(49)	(778)	-	-	-	-	-
Impairments charged to revaluation reserve	**(39)**	-	(39)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**179**	152	27	-	-	-	-	-
Revaluations	**18,504**	1,395	16,501	608	-	-	-	-
Reclassification	**-**	-	4,757	-	(6,355)	1,010	588	-
Disposals	**(2,621)**	-	-	-	-	(2,553)	(66)	(2)
Derecognition - COVID equipment returned to DHSC	**(32)**	-	-	-	-	(32)	-	-
Cost or valuation at 31 March 2022	**168,369**	**6,578**	**103,936**	**5,159**	**3,729**	**36,082**	**12,249**	**636**
Depreciation at 1 April 2021	**30,177**	-	4,448	265	-	18,916	6,328	220
Provided in the year	**6,511**	-	2,339	132	-	2,690	1,321	29
Impairments charged to operating expenses	**(531)**	-	(543)	-	12	-	-	-
Impairments charged to revaluation reserve	**(10)**	-	(10)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**(74)**	-	(74)	-	-	-	-	-
Revaluations	**(6,557)**	-	(6,160)	(397)	-	-	-	-
Disposals	**(2,593)**	-	-	-	-	(2,525)	(66)	(2)
Derecognition - COVID equipment returned to DHSC	**(3)**	-	-	-	-	(3)	-	-
Depreciation at 31 March 2022	**26,920**	**-**	**-**	**-**	**12**	**19,078**	**7,583**	**247**

15.2 Property, plant and equipment, prior year 2020/21

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
Group	**£000**	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	**116,584**	5,050	67,578	4,530	2,087	28,462	8,286	591
Additions - purchased	**16,230**	-	1,929	-	7,737	4,122	2,362	80
Additions - leased	**87**	-	-	-	-	-	87	-
Additions - equipment donated from DHSC for COVID response (non-cash)	**553**	-	-	-	-	553	-	-
Additions - assets purchased from cash donations/grants	**100**	-	59	-	-	35	6	-
Reclassification	**-**	-	499	-	(1,744)	1,245	-	-
Disposals	**(1,660)**	-	-	-	(7)	(1,616)	(4)	(33)
Cost or valuation at 31 March 2021	**131,894**	**5,050**	**70,065**	**4,530**	**8,073**	**32,801**	**10,737**	**638**
Depreciation at 1 April 2020	**26,482**	-	2,206	132	-	18,505	5,411	228
Provided in the year	**5,283**	-	2,242	133	-	1,962	921	25
Disposals	**(1,588)**	-	-	-	-	(1,551)	(4)	(33)
Depreciation at 31 March 2021	**30,177**	**-**	**4,448**	**265**	**-**	**18,916**	**6,328**	**220**

15.3 Property, plant and equipment DCH Subco Ltd

Note 15.1 contains £2,000(15.2 contains £3,000) of Information technology assets relating to DCH Subco Ltd.

15.4 Property, plant and equipment financing

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2022								
Owned assets	**131,774**	6,578	97,523	5,159	3,717	14,086	4,617	94
Finance lease	**3,550**	-	2,053	-	-	1,454	43	-
Donated assets	**5,661**	-	4,360	-	-	1,000	6	295
Donated assets from DHSC for Covid response	**464**	-	-	-	-	464	-	-
Total at 31 March 2022	**141,449**	**6,578**	**103,936**	**5,159**	**3,717**	**17,004**	**4,666**	**389**
Net book value as at 31 March 2021								
Owned assets	**94,606**	5,050	60,453	4,265	8,073	12,365	4,282	118
Finance lease	**2,359**	-	2,225	-	-	17	117	-
Donated assets	**4,219**	-	2,939	-	-	970	10	300
Donated assets from DHSC for Covid response	**533**	-	-	-	-	533	-	-
Total at 31 March 2021	**101,717**	**5,050**	**65,617**	**4,265**	**8,073**	**13,885**	**4,409**	**418**

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise:

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Property, plant and equipment	1,998	3,476	1,998	3,476
Intangible assets	29	65	29	65
Total	**2,027**	3,541	**2,027**	3,541

17. Inventories

Current year 2021/22	Group			
	Drugs	Consumables	Other	Total
	£000	£000	£000	£000
Balance at 1 April	749	1,747	114	**2,610**
Additions	21,524	8,321	421	**30,266**
Inventories recognised as an expense in the period	(21,289)	(8,339)	(364)	**(29,992)**
Write-down of inventories recognised as an expense	(9)	-	-	**(9)**
Balance at 31 March	**975**	**1,729**	**171**	**2,875**

Current year 2021/22	Trust			
	Drugs	Consumables	Other	Total
	£000	£000	£000	£000
Balance at 1 April	595	1,747	114	**2,456**
Additions	15,103	8,321	421	**23,845**
Inventories recognised as an expense in the period	(14,903)	(8,339)	(364)	**(23,606)**
Write-down of inventories recognised as an expense	(9)	-	-	**(9)**
Balance at 31 March	**786**	**1,729**	**171**	**2,686**

The Trust does not currently operate a complete inventory management control system and is therefore, not able to separately evaluate any amount arising, from write-downs or losses, for inventories other than drugs.

18. Trade and other receivables

18.1 Trade and other receivables

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
Current	**£000**	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	2,067	1,801	2,067	1,801
Contract receivables (IFRS 15): not yet invoiced/ non-invoiced	1,719	1,215	1,719	1,215
Allowance for impaired contract receivables	(79)	(79)	(79)	(79)
Prepayments	2,340	2,200	2,338	2,198
Interest receivable	15	-	15	-
PDC dividend receivable	-	29	-	29
VAT receivables	601	772	494	670
Clinician pension tax provision	10	-	10	-
Other receivables	428	239	428	239
Total	**7,101**	6,177	**6,992**	6,073
Non-current				
Prepayments	277	62	277	62
Contract receivables (IFRS 15): not yet invoiced/ non-invoiced	185	245	185	245
Clinician pension tax provision	117	601	117	601
Total	**579**	908	**579**	908
Grand Total	**7,680**	7,085	**7,571**	6,981

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Receivables past their due date but not impaired

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
By one to two months	146	215	146	215
By two to three months	222	152	222	152
By three to six months	272	21	272	21
By more than six months	99	36	99	36
Total	**739**	424	**739**	424

18.3 Receivables past their due date and impaired

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
By up to one month	1	1	1	1
By one to two months	9	2	9	2
By two to three months	4	7	4	7
By three to six months	28	26	28	26
By more than six months	302	319	302	319
Total	**344**	355	**344**	355

18.4 Allowances for credit losses (doubtful debts)

Contract receivables and contract assets	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Balance at 1 April	79	93	79	93
New allowances arising	38	29	38	29
Reversals of allowances	(38)	(43)	(38)	(43)
Balance at 31 March	**79**	79	**79**	79

19. Cash and cash equivalents

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Balance at 1 April	17,698	7,335	17,648	7,310
Net change in year	8,253	10,363	8,179	10,338
Balance at 31 March	**25,951**	17,698	**25,827**	17,648
Made up of				
Commercial banks and cash in hand	5	5	5	5
Cash with Government Banking Service	25,946	17,693	25,822	17,643
Cash and cash equivalents	**25,951**	17,698	**25,827**	17,648

20. Trade and other payables

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
Current	**£000**	£000	**£000**	£000
Trade payables*	9,726	9,119	9,427	8,810
Capital payables	10,592	6,039	10,592	6,039
Accruals	11,827	11,237	12,006	11,537
Other taxes payable	3,293	3,117	3,285	3,091
PDC dividend payable	353	-	353	-
Total	**35,791**	29,512	**35,663**	29,477

* Trade Payables includes outstanding pension contributions of £2,040k (2021 £1,886k).

21. Borrowings

	Group Current		Trust Current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	4	4	4	4
Obligations under finance leases	339	186	339	186
Total	**343**	190	**343**	190

	Non-current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	4,600	4,600	4,600	4,600
Obligations under finance leases	3,638	2,422	3,638	2,422
Total	**8,238**	7,022	**8,238**	7,022

The Trust drew down a capital loan on the 1st August 2011 from the Department of Health against the receipt of future asset sales at an annual interest rate of 2.11%. The loan repayment date has been extended by the Department of Health and Social Care in a letter dated 4th May 2020 to 15th March 2026.

21.1 Reconciliation of liabilities current year 2021/22

	Total	**DHSC loans 2021/22**	**Finance leases 2021/22**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2021	**7,212**	4,604	2,608
Cash movements:			
Financing cash flows - principle	**(142)**	-	(142)
Financing cash flows - interest	**(247)**	(97)	(150)
Non-cash movements:			
Additions	**1,491**	-	1,491
Interest charge arising in year	**267**	97	170
At 31 March 2022	**8,581**	4,604	3,977

Reconciliation of liabilities prior year 2020/21

	Total	**DHSC loans 2020/21**	**Finance leases 2020/21**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2020	**7,357**	4,604	2,753
Cash movements:			
Financing cash flows - principle	**(199)**	-	(199)
Financing cash flows - interest	**(258)**	(97)	(161)
Non-cash movements:			
Additions	**87**	-	87
Interest charge arising in year	**225**	97	128
At 31 March 2021	**7,212**	4,604	2,608

22. Provisions

	Group and Trust Current	
	31 March 2022	31 March 2021
	£000	£000
Pensions early departure costs	20	20
Pensions injury benefits	13	13
Other legal claims	6	17
Clinician pension tax reimbursement	10	-
Total	**49**	50

	Non-current	
	31 March 2022	31 March 2021
	£000	£000
Pensions early departure costs	56	75
Pensions injury benefits	105	116
Clinician pension tax reimbursement	117	601
Total	**278**	792

22.1 Provisions movement

Group and Trust	**Total** **£000**	**Pensions early departure costs** **£000**	**Pensions Injury benefits** **£000**	**Legal and other claims** **£000**	**Clinician pension tax** **£000**
At 1 April 2021	**842**	95	129	17	601
Change in discount rate	**3**	1	2	-	-
Arising during the year	**11**	4	1	6	-
Utilised during the year - accruals	**(9)**	(6)	(3)	-	-
Utilised during the year - cash	**(40)**	(17)	(10)	(13)	-
Reversed unused	**(478)**	-	-	(4)	(474)
Unwinding of discount	**(2)**	(1)	(1)	-	-
At 31 March 2022	**327**	76	118	6	127
Expected timing of cash flows:					
Within one year	**49**	20	13	6	10
Between one and five years	**108**	48	52	-	8
After 5 years	**170**	8	53	-	109
Total	**327**	76	118	6	127

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation.

Provisions shown under the heading ‘Pensions early departure costs’ have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading ‘Legal claims’ relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by NHS Resolution and are based on the best information available at the balance sheet date.

22.2 Clinical negligence liabilities	31 March 2022	31 March 2021
Group and Trust	**£000**	£000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust	163,573	114,295

23. Other liabilities	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Deferred income - goods and services	3,119	2,065	3,119	2,065
Total	**3,119**	2,065	**3,119**	2,065

24. Finance lease obligations	Minimum lease payments		Present value of minimum lease payments	
Group and Trust	**31 March 2022**	31 March 2021	**31 March 2022**	31 March 2021
	£'000	£'000	**£'000**	£'000
Gross lease liabilities	**5,429**	3,600	**4,123**	2,654
of which liabilities are due				
not later than one year	572	325	537	302
later than one year and not later than five years	1,744	1,008	1,477	857
later than five years	3,113	2,267	2,110	1,495
Finance charges allocated to future periods	(1,452)	(992)	(1,160)	(794)
Net lease liabilities	**3,977**	**2,608**	**2,964**	**1,860**
of which liabilities are due				
not later than one year	339	186	321	172
later than one year and not later than five years	1,067	580	908	490
later than five years	2,571	1,842	1,735	1,198
	3,977	**2,608**	**2,964**	**1,860**

All finance lease obligations disclosed above relate to plant and machinery and buildings.

25. Contingencies

Contingent liabilities	31 March 2022	31 March 2021
Group and Trust	**£000**	£000
Risk pooling*	6	3
Total	**6**	3

* Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by NHS Resolution. Provisions relating to these cases are included in Note 22.

26. Financial instruments

26.1 Financial assets

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
Loans and receivables	**£000**	£000	**£000**	£000
Trade and other receivables with NHS and DH bodies	3,528	3,430	3,528	3,430
Trade and other receivables with other bodies	924	592	924	592
Cash and cash equivalents at bank and in hand	25,951	17,698	25,827	17,648
Total at 31 March	**30,403**	21,720	**30,279**	21,670

The financial assets consist of the financial element of trade and other receivables (Note 18.1) and cash and cash equivalents at bank and in hand (Note 19).

26.2 Financial liabilities

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Borrowing excluding finance lease and PFI contract	4,604	4,604	4,604	4,604
Obligations under finance lease	3,977	2,608	3,977	2,608
Trade and other payables with NHS and DH bodies	1,223	1,535	1,223	1,535
Trade and other payables with other bodies	27,764	21,448	27,644	21,439
Provisions under contract	327	842	327	842
Total at 31 March	**37,895**	31,037	**37,775**	31,028

The financial liabilities consist of the financial element of trade and other payables (Note 20), plus current and non-current borrowings (Note 21) and provisions (Note 22.1) excluding legal costs.

Maturity of financial liabilities	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Finance leases				
In one year or less	572	325	572	325
In more than one year but not more than five years	1,744	1,008	1,744	1,008
In more than five years	3,113	2,267	3,113	2,267
	5,429	3,600	**5,429**	3,600
DHSC loans				
In one year or less	97	97	97	97
In more than one year but not more than five years	4,794	4,891	4,794	4,891
	4,891	4,988	**4,891**	4,988
Trade & Payables: DHSC group bodies				
In one year or less	1,223	1,535	1,223	1,535
	1,223	1,535	**1,223**	1,535
Trade & Payables: other bodies				
In one year or less	27,764	21,448	27,644	21,439
	27,764	21,448	**27,644**	21,439
Provisions				
In one year or less	49	49	49	49
In more than one year but not more than five years	104	708	104	708
In more than five years	163	75	163	75
	316	832	**316**	832
Total				
In one year or less	29,705	23,454	29,585	23,445
In more than one year but not more than five years	6,642	6,607	6,642	6,607
In more than five years	3,276	2,342	3,276	2,342
	39,623	32,403	**39,503**	32,394

The figures above are based on undiscounted future contractual cash flow as per IFRS 7 Financial Instruments.

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

26.3.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All of the borrowings of the Trust are at fixed rates of interest.

The Trust earned interest of £27,000 (at an average rate of approximately 0.09%) during 2021/22. An increase in interest rates of 0.5% would increase interest earned by approximately £117,300.

26.3.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

With the COVID-19 pandemic it is determined that the Trust continues to have a low credit risk profile as the Trust's trade and other receivables are due from other NHS Bodies which are funded by central government.

26.3.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a deficit of £0.05m in the current financial year and has a cash balance of £26.0m. Therefore, there is minimal risk to payables.

27. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

28. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation. None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent. Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	Income in year to 31 March 2022 £000	**Expenditure in year to 31 March 2022 £000**	**Receivables at 31 March 2022 £000**	**Payables at 31 March 2022 £000**
Department of Health and Social Care	20	-	-	4,604
Dorset Healthcare NHS Foundation Trust	3,959	5,561	994	464
Health Education England	10,178	-	110	179
HM Revenue and Customs - Tax & NI	-	12,589	-	3,293
NHS Blood and Transplant	-	899	-	22
NHS Dorset Clinical Commissioning Group	186,828	972	882	71
NHS England - Central Specialised Commissioning Hub	3,923	-	107	-
NHS England - Core	1,935	-	393	160
South West Regional Office	31,240	-	76	-
NHS Somerset CCG	2,395	-	-	-
NHS Resolution	-	5,736	-	-
NHS Pension Scheme	-	20,564	-	2,031
University Hospital Southampton NHS Foundation Trust	887	226	242	65
University Hospitals Dorset NHS Foundation Trust	1,405	2,192	311	282
Dorset Council	114	458	24	547
DCH Subco Ltd	91	6,286	-	179

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital NHS Foundation Trust Charitable Fund:	**31 March 2022 £000**	31 March 2021 £000
Contributions from the Charity to non-current assets	154	100
Contributions from the Charity to expenditure	16	47

29. Third Party Assets

The Trust did not hold cash and cash equivalents which relate to monies held on behalf of patients (2020/21 £nil).

30. Losses and special payments

Group and Trust	Number of cases		Total value of cases	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	Number	Number	**£'000**	£'000
Losses;				
Losses of cash due to:				
overpayment of salaries etc	**-**	3	**-**	5
Bad debts and claims abandoned in relation to:				
other	**1**	-	**1**	-
Damage to buildings and property due to:				
stores losses	**1**	1	**9**	18
other	**1**	-	**-**	-
Special Payments;				
Compensation under court order or legally biniding arbitration award	**-**	-	**-**	-
Ex-gratia payments in respect of:				
loss of personal effects	**10**	6	**9**	2
Overtime corrective payments (nationally funded)	**-**	1	**-**	546
Overtime corrective payments (additional amounts locally agreed and funded)	**-**	1	**-**	68
other	**-**	2	**-**	1
	13	14	**19**	640

The Flowers legal case relates to the treatment of overtime payments and in particular payments for voluntary overtime in the calculation of holiday pay and the interpretation of the Working Time Directive. Joint negotiations between NHS employers and NHS trade unions during 2021 agreed that a corrective payment would be made to those staff affected. Guidance was issued asking Trusts to accrue the cost of the nationally agreed corrective payments and associated income based on nationally generated estimates, and accordingly £546,000 was accrued within the 2021 accounts.

These payments are considered special payments, for which HMT approval was sought nationally by NHS England on Trusts' behalf, with the Trust also obtaining separate approval for locally accrued amounts of £68,000. As the losses and special payments note is prepared on an accruals basis (excluding provisions), these should have been disclosed within this note in the 2020/21 accounts. In line with the national guidance the Trust has therefore restated the prior year comparative to include these payments.

31. Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £1.0million (2020/21: £1.0million).

32. Pooled Budget – Equipment for Living Partnership

The Trust, via Dorset CCG, contributes towards a pooled budget arrangement which started on the 1st April 2015. This is hosted by BCP Council to provide equipment for Living Partnership.

Payments are included in note 5 – Operating expenses under heading Purchase of healthcare from NHS and DHSC bodies. The Trust contributed £202k in 2021/22 (£198k 2020/21). This forms part of the Dorset CCG total included in the table below.

The below disclosure is based on month 12 information provided by Dorset CCG and it should be noted that these figures are un-audited.

Group and Trust	**Year ended 31 March 2022**	Year ended 31 March 2021
Funding	**£000**	£000
BCP Council	1,410	1,410
Dorset Council	1,232	1,232
Dorset CCG	5,657	5,657
Partner Contributions (excluding management costs)	8,299	8,299
Partner Allocation: Local Authority	-	-
Partner Allocation: CCG	-	-
COVID-19 Funding (Unpooled)	1,079	1,500
Total Funding	**9,378**	9,799
Expenditure		
Integrated Community Equipment Store		
Actual Spend to March	(9,378)	(9,799)
Total Expenditure	**(9,378)**	(9,799)
Total Surplus at 31 March	**-**	-

33. Other Financial Commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		**Trust**	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
not later than 1 year	2,373	2,099	2,373	2,099
after 1 year and not later than 5 years	2,222	2,664	2,222	2,664
Total	**4,595**	4,763	**4,595**	4,763

34. Accounting standards in issue but not yet adopted - IFRS 16

	Estimated future impact Accounts 01/04/2022 2022/23
Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	6,753
Additional lease obligations recognised for existing operating leases	(6,753)
Changes to other statement of financial position line items (excluding reserves)	-
Estimated impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(663)
Additional finance costs on lease liabilities	(60)
Lease rentals no longer charged to operating expenditure	692
Other impacts on income / expenditure	-
Estimated impact on surplus/deficit in 2022/23	**(31)**
Estimated increase in capital additions in 2022/23	**2,073**