Bundle Trust Board Public 5 September 2024

1 OPENING BUSINESS

1.1 11:15 - Presentation of SOX certificates
July SOX of the month – Kelly Hogan and Liam Gondelle, ED and Helen Thake, IT
July Patient Centred SOX – Laura Pollard, Plastic Outpatients
August SOX of the month –
August Patient Centred SOX –

1.2 11:25 - Staff Story
Philip Rhoades, Chaplain attending
Introduced bu Melanie Whitfield

1.3 Welcome and Apologies

1.4 11:45 - Declaration of Interests, Fit & Proper / Good Character

1.5 Minutes of the previous meeting
Minutes attached from previous meetings on 4th and 22nd July
For approval
- 1.5 Draft Public Board mins 4 July 2024
- 1.5 Draft Public Board mins 22 July 2024

1.6 11:50 - Matters Arising and Action Log
- 1.6 Public Trust Board Action Log

1.7 11:55 - Chair's Business
Presented by Ian Green
For information

1.8 12:00 - Chief Executive Report
Verbal update by Lisa Thomas

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 12:10 - Integrated Performance Report to include exception reports
Presented by Niall Prosser
For assurance
- 2.1a IPR Cover Sheet - Trust Board 2024-08
- 2.1b Integrated Perfomance Report - September 2024 FINAL

2.2 12:40 - Trust Management Committee 24th July and 28th August
Presented by Lisa Thomas
For asurance
- 2.2 TMC Escalation Report 05.09.24

2.3 12:45 - Clinical Governance Committee 30th July
Presented by David Buckle
For assurance
- 2.3 CGC Escalation Report

2.4 12:50 - Finance and Performance Committee 30th July
Presented by Debbie Beaven
For assurance
- 2.4 Finance and Performance Escalation Report July 2024

2.5 12:55 - People and Culture Committee 25th July
Presented by Eiri Jones
For assurance
- 2.5 PCC Escalation Report to Trust Board from PCC July 2024 to Board Sept 2024

2.6 13:00 - BREAK

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 13:30 - SIRO Annual Data Security and Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)
Presented by Jon Burwell
For assurance
- 3.1 SIRO Annual DSP Assurance Report Sept 2024

4 QUALITY AND RISK

4.1 13:45 - Women and Newborn Divisional Governance Report
Presented by Abi Kingston
For assurance
4.1 Trust Board 05.09.24 W&NB Div Gov Report July 24

4.2 13:55 - Perinatal Quality Surveillance Report July, June data
Presented by Vicki Marston
For assurance
4.2a Front sheet Perinatal quality surveillance July (June data)
4.2b Perinatal Quality Surveillance JULY 2024 Slides (June data)

4.3 14:05 - Maternity Safety Support Programme Application to exit
Presented by Vicki Marston
For approval
4.3a Application to exit the maternity safety support programme Front Sheet
4.3b Application to exit the Maternity Safety Support Programme SFT

4.4 Research Annual Report – deferred to October

5 GOVERNANCE

5.1 14:25 - 2023/24 Annual Report and Accounts
Presented by Kylie Sanders
For information
5.1a Annual Report and Accounts 2023_24 Cover sheet
5.1b Final SFT Annual Report and Accounts 2023_24 Parliament version

5.2 14:30 - Consideration of establishing formal group with RUH and GWH
Presented by Lisa Thomas
For approval
5.2a AHA_CIC_220724_Collaboration_Leadership_Governance_Proposal_100724_ Top CopyV1.0
5.2b AHA_CIC_220724_Appendix1_DRAFT AHA Joint Committee Terms of Reference_100724_V0.1

6 PEOPLE AND CULTURE

6.1 Organisational Development and People Annual Report (to include Equality and Diversity Annual Report, Education and Development Annual Report) - deferred to October

6.2 14:40 - Freedom to Speak up Guardian Annual Report
Presented by Melanie Whitfield
For assurance
6.3 FTSU Trust Board 23-24 Annual Report (Final)

6.3 Health and Safety Quarter One Report - Deferred to October

7 CLOSING BUSINESS

7.1 14:50 - Any Other Business

7.2 14:55 - Agreement of Principal Actions and Items for Escalation

7.3 15:00 - Public Questions

7.4 Date next meeting 3rd October 2024

Draft
Minutes of the Public Trust Board meeting
held at 10:00am on Thursday 4th July 2024, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DBe)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Judy Dyos (JDy)	Chief Nursing Officer
Mark Ellis (ME)	Interim Chief Finance Officer
Peter Collins (PCo)	Chief Medical Office
Lisa Thomas (LT)	Interim Chief Executive Officer
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Sasha Godfrey (SG)	Executive Assistant and Board Support Officer (minutes)
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Frances Owen (FO)	Governor (observer via Teams)
Kirsty Matthews (KM)	Associate Non-Executive Director
Paul Cain (PCa)	Associate Non-Executive Director
Victoria Aldridge (VA)	Head of Patient Experience (for item 1.2)
Helen Rynne (HR)	Patient Engagement Lead (for item 1.2)
Vicki Marston (VM)	Director of Midwifery (for items 3.1, 3.2 and 3.3)
Thalina Wijetung (TW)	Visiting fellow

ACTION

TB1 4/7/1 **OPENING BUSINESS**

IG referred to the Improving Together Program and noted the Trust used the approach and methodologies to bring about improvement, IG asked members and attendees to ask appropriate questions as part of the process of seeking assurance and to be present in the room, reminding them to highlight if they needed to step out during the meeting. IG noted he would take call at 12 o'clock and EJ would take the Chair.

IG welcomed Anne Stebbing to her first Trust Board meeting as Non-Executive Director. PCo introduced Thalina Wijetung who was completing a masters in medical administration and had joined the Trust for a year.

TB1 4/7/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

IG noted the following members of staff had been awarded a SOX Certificate and details of the nominations were given:

May SOX of the month – Sharon Bury, Radnor ICU and Kim Blencowe, Radiology

May Patient Centred SOX – Anne Macrae, Gastroenterology

June SOX of the month – Teodor Strugariu, Housekeeping

June Patient Centred SOX – Andrea Taylor, Clinical Science and Engineering

IG congratulated all the staff that had been recognised in May and June on behalf of the Board and also thanked all the staff that had been nominated for their hard work, diligence, and innovation.

TB1 4/7/1.2 **Patient Story**

VA introduced the Patient Story and noted the story had started off as a complaint but learning from the patient's experience had triggered a Hard of Hearing and Deaf Awareness Project which had been launched in May, and ultimately did not follow the complaints process.

VA presented the story and noted the patient was deaf and used British Sign Language (BSL) as her only way to communicate. The story had shown a gap in staff understanding of people who use BSL and tools and resources available on the wards were very limited, the following resources are now in place –

- Face to face BSL interpreters (24 hour notice required)
- Introduced on demand BSL service via Trust i pads in Maternity and ED.
- Application that patients can download to connect directly to Switchboard and to PALs team.
- Hard of hearing resource boxes introduced containing picture communication cards, BSL flash cards, white boards, bedside posters, spare batteries for hearing aids and basic communication guidance.
- Resource page on Intranet.
- Trolley dash during Deaf Awareness Week to introduce hard of hearing resource boxes.
- Posters to make staff and patients aware of the resources available.

Discussion:

IG noted the importance of reflecting on this patient's experience and asked how we heard about the story. VA noted when the patient moved wards it was recognised that there needed to be more help with communication and a speech and language therapist became involved.

DBu referred to his personal experience and commented that hospitals regularly mislaid hearing aids or didn't always check the patient was using them. He also noted that poor hearing contributed to dementia and some patients could improve by simply checking their hearing was effective.

JDy noted the education and communication regarding available resources had been and would continue to be repeated. Personal bedside boxes had been introduced to safely store patient's hearing aids, glasses and teeth.

RH asked if the Trust was confident that other patients whose first language was not English were sufficiently supported by interpreters on a as required basis. VA noted many requests were received daily for language interpreters so was reasonably assured that staff knew how to access this.

LT reflected that Salisbury was an inclusive organisation but clearly the awareness and understanding of deafness was lacking and needed reaffirming.

AS suggested looking at the admission processes and to include a check for any special needs the patient may have.

VA noted the project continued to grow and it was planned to add a communication alert to Lorenzo and funding for staff to learn basic BSL.

EJ suggested a broad review of patient communication to include children using Makaton and patients whose first language is not verbal English.

DBe referred to a recent Board Safety Walk and noted a nurse had been communicating with patients using her own picture cards which had made a big difference to the patient's experience.

IG thanked VA and the PALs team for their work on this project which was clearly benefiting patients. IG reflected there was more work to do on the Trust's approach to communication.

VA and HR left the meeting.

TB1 4/7/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted apologies had been received from

- Jon Burwell, Interim Chief Digital Officer

TB1 4/7/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of conflict of interest pertaining to the agenda.

TB1 4/7/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 2nd May 2024**

IG presented the public minutes from 2nd May 2024 and the following changes were noted:

JDy noted the concerns in the staff story related to family accommodation. DBu noted some changes to page 10 which he would pick up outside the meeting.

Subject to these changes the minutes were approved.

TB1 4/7/1.6 **Matters Arising and Action Log**

FMc presented the action log and noted the following update:

- **TB1 2/5/3.1 Integrated Performance Report (IPR) (M11)/Outpatients –** DBe noted this was an action for Finance and Performance Committee and asked for the action to be transfer to the F&P Committee's action log.

It was noted that all other actions on the action log were either closed.

RH referred to the recent Audit Committee and subsequent Private Trust Board where the accounts had been approved for submission.

TB1 4/7/1.7 Chair's Business

IG noted discussions regarding the possibility of a group arrangement with Royal United Hospital and Great Western Hospital were continuing and there was a Council of Governors planned for 18th July followed by a Trust Board meeting on 22nd July to consider the recommendations. IG noted the case for collaboration developed by Carnall Farrar had been circulated to Council of Governors and members of the Trust Board and would be discussed further in the Private session of the Trust Board later that day.

The update was noted.

TB1 4/7/1.8 Chief Executive's Report

LT presented the Chief Executives Report and highlighted the following key points:

- Recognised the coordination and planning involved for the recent junior strikes and gave thanks to colleagues who helped fill shifts and work in other ways.
- The recent Trust open day had been a big success.
- Gave thanks to Communication and Organisational Development and People teams for organising the recent Tent Talks.

IG thanked LT for providing steady, professional leadership over the last few months and noted LT had agreed to continue as Interim Chief Executive.

The Board report the report.

TB1 4/7/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 4/7/2.1 Integrated Performance Report (IPR) (M2)

JDy presented the Integrated Performance Report which provided a summary of Month 2 (May 2024). JDy noted the purpose of the report and highlighted the following key points:

- Small improvement in breakthrough objective regarding patient deterioration and further changes made to improve data.
- Staff turnover had been 19% against a target of 15%.
- Slight improvement in Outpatients.
- ED waiting time slightly improved, and ambulances unloaded more effectively than other trusts in the area.

- Diagnostic waiting time, stroke activity and vacancies had improved.
- Pressure injury metric had deteriorated with two wards of particular concern, Tissue Viability Team had helped to understand and improve.
- Cancer waiting times were a concern.
- Slight increase in complaints received but overall, less received in year than last year.

Discussion:

DBe acknowledged the new format of the Integrated Performance Report and noted it helped steer focus to areas that required assurance.

IG referred to the Breakthrough Objectives and noted the improving position, IG asked if the Trust was on plan to meet the productivity trajectory. ME explained the Trust was not on track due to a shortfall in elective output caused by the delay in opening Imber Ward and theatre utilisation. ME added from a pay perspective there had been a significant increase in demand for beds and agency cost were high due to agency medics covering hard to recruit specialities.

IG asked if the financial context of the system was having an impact on the Trust. ME noted the financial pressure the Trust was under was reflected in the rest of the BSW system. IG noted the challenge in month two and three and asked if anything needed to shift for the financial recovery plan to be effective. ME noted there was an action plan for the key contributors which were elective outputs and surgery and operational teams planned to reduce and reconfigure the bed base over the summer.

EJ referred to two metrics and asked for assurance that bed moves for elderly and frail became a focus over the summer and flagged non-medical appraisals. MW noted the appraisal process had been refreshed and had been a focus in divisional reviews, but managers needed to continue recognising performance. JDy noted infection prevention contributed to bed moves. NP added sometimes the ideal patient pathway involved three or four bed moves so the team were trying to find a way of distinguishing essential bed moves from unnecessary bed moves. EJ asked for more assurance on the risk of reducing harm.

PCo reminded the Board that the data was month two and noted the process of coaching teams to come up with solutions was the right approach but would take longer to see improvements.

DBe referred to Finance and Performance Committee and noted the committee was working on prioritising metrics with the greatest impact or biggest improvement to find out what was working effectively and provide more assurance to the Board.

NP referred to the growth in urgent care demand and noted the increase in demand from the previous year which had been driving pressure in the first quarter. Primary care had increased their activity and he was working with the system to find the root cause and work out how to help support. NP referred to improvements in the Trust's cancer performance and noted the Trust was in tiering for cancer treatments but was now above the threshold,

unfortunately the Trust was being held in tiering due to system performance and was now trying to support improvements within the system.

RA asked if learning from improvements could be applied in other areas. JDy referred to improvements on Amesbury Ward and noted go and sees had been organised to understand what had allowed the improvements to happen in that way, there had been really good examples of experimentation and learning.

IG noted the IPR needed to be consistent in applying the Improving Together methodologies and take a resilient approach which would result in improvements. IG referred to the financial recovery and noted assurance needed to be provided to the system that our plans were robust and will be discussed further at the Finance and Performance Committee.

The Board noted the report.

TB1 4/7/2.2 **Charitable Funds Committee – 20th June**

IG gave a verbal presentation and noted the following points from the meeting held on 20th June 2024:

- There had been no items for approval.
- The committee discussed its responsibility to utilise its resources in the most effective way.
- The charity had considerable assets and applications to use the money had been submitted from across the organisation which had suggested some opportunities.
- The governance of the charity was aligned to the Trust strategy, so charity resources had to be used to help deliver the trust strategy in the most effective way.

The Board noted the report.

TB1 4/7/2.3 **Trust Management Committee – 22nd May and 26th June**

LT presented the report which provided a summary of escalation points from the meetings held on 22nd May and 26th June. LT asked the Board to take the report as read and noted the May Committee had discussed health inequalities, the Committee would work on some practical applications for a future discussion regarding the Trust's commitment at a future board development day.

Discussion:

DBu referred to an alert around Urology's contribution to the 56 week backlog and asked when we might see changes in Urology performance. NP noted Urology was a recognised challenge across BSW and there was a review of the current pathway against best practice, Urology were using the A3 approach to understand their pathway but there were a number of contributing factors.

EJ asked for assurance that the new procedure for glaucoma patients would not cause delays which could contribute to permanent harm. ME noted the procedure had to be approved by the Trust, the ICB and NHSE but this was an alternative procedure and patients were still receiving treatment. PCo added if funding was not approved the Clinical Governance Committee would receive a quality impact assessment that would describe the impact on the population.

AS asked if divisions were given guidance on business cases. ME noted teams had been asked to review additional options and come back to the next meeting, both business cases had already been challenged at the Trust Investment Group. AS asked if there was a clinical risk in not approving the business cases. PCo noted TMC had asked for other options as the Trust did not have the money to invest in the full business case and more information would help take the business case through the approval process. IG noted TMC were being asked to approve business cases in a very challenging, cash strapped environment and needed to be confident that the case had the potential to be approved by the ICB investment panel. ME noted TMC had decided both the business cases had not made appropriate cases for the value of the investment. DBe noted it was best practice to demonstrate value for money and clinical benefits and suggested she pick up outside the meeting with ME.

The Board noted the report.

TB1 4/7/2.4 **People and Culture Committee – 27th June 2024**

EJ presented the report which provided a summary of escalation points from the meeting held on 27th June. EJ noted the Committee had used the Improving Together approach and noted the following points:

- There were several trust policies outstanding, LT had provided assurance and the Committee hoped to see traction the following month.
- It had taken longer than planned to get the medical workforce onto the ERoster system.
- The risk relating to staffing had reduced from 20 to 12 due to lower vacancies, there had been an improved turnover position and sickness absence down.

Discussion:

IG asked if the Committee were assured that the staffing risk reduction was appropriate. EJ noted the Committee had looked at the evidence and had come to the conclusion that it was appropriate. EJ noted if the community services tender was successful, it would create a new workforce risk. JDy noted there were no nursing vacancies on wards at present and there was thirty vacancies across the organisation but skill mix challenges meant focus was on fundamental care. IG noted the achievement, the improvement in patient care and financial implications in terms of agency costs. PCo noted using the Improving Together approach the Trust had addressed the staffing risk and would provide a sustainable solution. ME noted this demonstrates that focusing on the right things delivered sustainable results.

The Board noted the report.

TB1 4/7/2.5 **Finance and Performance Committee – 25th June**

DBe presented the report which provided a summary of escalation points from the meeting held on 25th June. The following points were noted:

- Not a good start to the year financially but the Committee had picked up on points of optimism with a can-do attitude.
- The impact of non-elective activity that was over plan and had costs associated which was impacting income.
- There had been a discussion about cash flow mitigation, a short term plan had been developed but long term it was hoped the ICB would support and partners would support each other across the system.
- There had been some resignations in the coding team which had raised a concern as it may not be possible to provide the depth of coding required to generate data analysis and income.
- There would be a deep dive into the BAF and risks out of tolerance on the corporate risk register.

Discussion:

IG asked if there were appropriate measures in place to ensure a positive cash position. ME noted the Trust was working with the ICB to phase payments and LT added mitigations were in place for the short term but the national system was unclear. IG suggested an item on the next agenda to give assurance and more clarity to the Board on the Trust's financial resilience and the mitigations required to maintain a positive cash position. **ACTION ME**

ME

LT referred to a letter from the region to the ICB regarding the Southwest financial position which indicated recovery plans would be required.

AS expressed concern that elective activity was down due to theatre utilisation and asked if the Committee was assured that the problem had been resolved and would not recur. DBe noted the Committee was assured that action had been taken to resource Central Booking. NP noted the Committee had agreed to have a deep dive into theatre productivity and the programme to improve it. NP added there was currently a 25% vacancy rate in the Central Booking team and execs had recently reviewed a recovery action plan and had agreed some short term actions. NP referred to theatre utilisation and a recently formed productivity group led by senior clinicans which was having a positive impact.

IG requested the theatre productivity deep dive is included in the next Finance and Performance Escalation Report. **ACTION ME/DBe**

ME/ DBe

The Board noted the report.

TB1 4/7/2.6 **Clinical Governance Committee – 25th June**

DBu presented the report which provided a summary of escalation points from the meeting held on 25th June, DBu took the report as read and asked if the Board had any questions.

Discussion:

JDy clarified the risk around sepsis referred to neutropenic sepsis patients from the cancer pathway and there were mitigations in place which had now reduced the risk.

IG referred to the six monthly GIRFT report and asked for more detail. DBu noted he had no concerns regarding the report, EJ added there had been good progress and productivity gains had helped to manage workloads. PCo noted the governance around GIRFT had become more complex.

IG referred to improvements in waiting times at Lloyds Pharmacy and DBu noted the Chief pharmacist had given the Committee assurance that the problem was being addressed and there had been an improvement in the last three months but there was a shortage of pharmacists in the region.

IG asked if the Trust had considered the implications of the infected blood enquiry report. PCo noted organisations had been asked to look at their patient base to identify possible implications and suggested a review to look at the effects, learning and the impact on patients. IG asked for a report to look at the recommendations in the report and the impact on the Trust to a future meeting. **ACTION PCo** **PCo**

The Board noted the report.

TB1 4/7/3 QUALITY AND RISK

TB1 4/7/3.2 & 3.3 Perinatal Quality Surveillance Report May (April Data) and June (May data)

This item was taken after agenda item 3.4.

IG left the meeting and EJ took over the Chair.

VM joined the meeting to present the Perinatal Surveillance Report May (April Data) and June (May Data), the report asked the Board to note the contents.

JDy noted one of the requirements of the maternity improvement programme was for a member of the division to present the data to the Board.

This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

VM referred to the cover sheets which summarised the key points and highlighted the following:

April

- 1:1 care and compliance with labour ward being supernumerary had been always achieved.

- Two incidences reported as moderate, both perineal tears.
- One still birth reviewed at PMRT.
- CNST work was on going.

May
- There had been a reduction in midwifery vacancies.
- Midwife to birth ratio 1:28.
- 1:1 care and supernumerary status of labour ward had been always achieved.
- Six moderate instances reported.
- There was a concern around anaesthetic attendance at PROMPT multidisciplinary training which could have an effect on compliance.
- There were concerns around the compliance with the saving babies lives care bundle.

Discussion:

MW thanked the Maternity Team for their progress with recruitment and VM noted the support from Divisional Performance Reviews and the Improving Together process had really helped their improvement.

EJ referred to the earlier staff story and reflected on a previous PMRT where an interpreter would have improved the patient's experience.

The Board noted the report.

TB1 4/7/3.1 **Quarterly Maternity and Neonatal Quality and Safety Report Q4**

VM presented the report and asked the Board to note the contents of the monthly Perinatal Quality Surveillance Report.

This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

- There was one still birth in Q4 which will be revied by PMRT with external scrutiny.
- There had been three reportable neonatal deaths.
- There had been one maternity PSII commissioned under the PSIRF framework.
- There was a challenge in training compliance but there was support and a plan in place.
- 1:1 care in labour and supernumerary status for labour ward coordinator maintained 100%.
- Good progress made with the Maternity Safety Support Programme.
- An exit meeting had been planned for July which will be reported at Trust Board and ICB Board. JDy referred to the challenges in arranging a date when regional, national, ICB and staff from the Trust were able to attend.
- There would be a targeted focus on safeguarding supervision.

Discussion:

EJ referred to severe tears and asked if there was a theme, EJ suggested a future deep dive at Clinical Governance Committee. VM noted there was no regular pattern but agreed to prepare a report to provide some assurance for the September Clinical Governance Committee Meeting. **ACTION VM/DBu** **VM/ DBu**

Jdy noted there were now more assisted deliveries in response to the scrutiny and concerns raised around maternity safety.

RH referred to safeguarding training and asked for assurance that members of staff were not put in safeguarding situations. VM noted middle grade doctors and trainees would not be on their own with patients, they would accompany consultants who were 100% trained and midwives who were 89% trained.

JDy noted there was a safeguarding midwife with specialist knowledge who reviewed all cases.

JDy referred to her role as Executive Safety Champion and noted she undertook monthly walk abouts.

JDy noted there was no Trust Board scheduled for February and asked if the February Trust Development day could review the CNST submission to help with achieving the CNST standards. EJ agreed to speak to IG **ACTION EJ** **EJ**

EJ referred to her latest walk about as Non-Executive Safety Champion and noted no issues had been raised.

EJ thanked the Maternity Team for their work in producing the maternity incentive scheme reports and noted it was important to remember the scheme was there to support organisations to deliver as safe as care as possible.

The Board noted the report.

VM left the meeting.

TB1 4/7/3.4 **Board Assurance Framework and Corporate Risk Register**

This item was taken after agenda item 2.6.

FMc presented the report and referred to the triangulation and focus on risks from the Board and sub committees. FMc noted the following points:

- Since January three risks had moved to within tolerance which showed a positive shift in the reporting period.
- Supply chain risk had been deescalated.
- Two new risks have been added, EPR and executive capacity to deliver.
- The financial deficit score had gone up to 20 and the risk description would be aligned.
- The BAF had been compared with the ICB BAF and was aligned around staff, finance, operational performance and partnership working.

- There would be some time at the Trust Board Development Day on 8th August to look at the BAF and the controls in place.

IG referred to discussions that had taken place during the meeting and noted many of the key issues were reflected in the BAF.

DBe suggested the group structure and the position of the governors should be captured as a risk. IG noted this would be included in the existing governance risk.

RH referred to the digital delivery plan risk and noted cybersecurity was included as part of that risk, RH suggested cybersecurity was a big organisational risk and asked if the risk was at the right level. LT agreed to reflect and report back to the Board. **ACTION LT** **LT**

LT noted if the Trust was successful in the community services tender a risk would be added around the organisation moving from a standalone acute trust to an integrated care organisation and the significant impacts on culture.

AS noted if the community services tender was successful it would significantly increase the workforce which would add to the cybersecurity risk.

EJ suggested a refresh of the mitigations and controls in the Corporate Risk Register at the 8th August development day.

IG referred to BAF risk four and noted the risk was above where he would like it to be but was an ongoing challenge with an aging site.

FMc noted internal audit were looking at cybersecurity.

The Board noted the report.

TB1 4/7/3.5 **Risk Appetite Statements – Workforce, Operational and Clinical Risk**

This report was taken after 3.1.

FMc presented the report and referred to the Board Development session in February where the five themes and twenty four sub definitions had been agreed and an action taken to work on the risk definitions. The current risk appetite of open had been set at the beginning of the pandemic and since that time had shifted towards a more cautious risk appetite.

Discussion:

RH thanked FMc for her report and noted the categories and explicit descriptions had really helped his understanding of the level of appetite needed. RH added at the next Board Development Day, each of the BAF risks should be defined and discussed if there needed to be more resources to mitigate each risk or if the Board were comfortable to tolerate the risk.

PCa suggested giving a score in the open category to show the consequences and likelihood.

NP referred to the infection control risk and asked if there was a driver that had led to a more cautious score than the minimal threshold. FMc noted the

scores had been discussed with the appropriate teams and welcomed a discussion if the Board felt the scores were too cautious. PCo noted the infection control team had based their score on achieving 100% training and suggested the score should be based on life experiences eg mixing patients with different respiratory viruses. JDy noted the Trust had operationally been less cautious to keep flow and maintain safety.

DBe referred to the information security risk and noted it had a minimal score due to the impact on clinical practice which was fine for the short term but may leave the security vulnerable in the longer term. PCo expressed concern that the example used in the narrative would guide the scoring. AS referred to a national directive that patches had to be incorporated even if it meant clinical systems being off-line.

KM referred to the last slide and noted using scales of one to five led to being drawn to a score of three.

MW expressed concern regarding the cautious score for training and health and safety.

IG joined the meeting.

LT noted there was more work to do to make the scores fit with reality.

AS noted subject matter experts asked to focus on their area of expertise will inherently be more cautious and the Board's job was to look at the bigger picture.

RA suggested the Board Committee papers should focus on risk areas so that risk appetite becomes embedded in the oorganisation.

FMc noted the committee cover sheets often included a board assurance framework but it could be more explicit. FMc added the level of assurance should also be included but could be quite subjective.

EJ summarised the discussion and noted execs would work on the risk appetites and align with the Finance section, a report would come back to Board in September.

The Board noted the report.

TB1 4/7/3.6 **Q4 Patient Experience Report**

IG thanked EJ for Chairing in his absence and took the Chair.

JDy presented the report which detailed the work of the Patient Liaison Team in triangulating patient experience in the organisation. JDy highlighted the following points:

- There had been just under 120,000 interactions of care in the reporting period, 44 complaints had been received and 58 concerns.
- There had been a dip in communication response times in March but work with Surgery had helped to bring it back to 60%.
- There had been an increase in reopened complaints.

- 2042 Friends and Family responses had been received, 97% of which were good or very good. A Friends and Family app had since been launched which had increased responses by 17%.

Discussion:

DBe asked if it was possible to compare the staff survey results with the complaints values and behaviours data to see if there was a correlation between engagement or dissatisfaction with the level of complaints. MW referred to a meeting attended by Patient Services, Freedom to Speak Up and Health and Safety which looked at groups of staff who were experiencing greater sickness absence, higher turnaround or more complaints. LT noted complaints were correlated with departments having extra training, intensive support or greater oversight from the leadership team. JDy noted Medicine and Surgery received the greatest number of complaints due to their size and number of patient interactions. EJ reflected how many of Surgeries complaints were due to cancelled electives or long waiting lists.

MvB referred to real time feedback and asked if there was also real time action or a process to follow before action could be taken. JDy noted the Head of Patient Experience was very responsive as evidenced in the Patient Story, she met with divisions on a regular basis and there was a Patient Experience group attended by a patient representative who gave an objective view.

LT reflected that the report was very comprehensive and detailed the actions taken and the level of engagement. PCo suggested the report could show figures on how many procedures were carried out and how many complaints were received regarding that procedure. AS suggested the report was too detailed and asked for more assurance on feedback and learning from complaints. JDy noted the report tried to capture the valuable patient led projects and patient interactions data.

The Board noted the report.

TB1 4/7/3.7 **Q4 Learning from Deaths Report**

PCo presented the report which provided assurance that the Trust was learning from deaths and making improvements. PCo highlighted the following points:

- There had been a national reset for both the HMSR and SHMI modelling which provided assurance to the Board that previous issues with ‘no significant harm occurring’ data was due to national modelling.
- The report was very detailed at the request of the Board and the NHSE mortality insights visit.
- The report focused on the care of patients at the end of life and the bereavement experience of patients and their families.
- Better documentation and coding had led to a stabilisation of mortality.

Discussion:

PCa suggested the report could contain more details of learning points that had been identified and asked if there was a mechanism for checking that the organisation was changing and learning. PCo noted the new AMaT system enabled the organisation to capture actions from learning and that actions are being closed off. There was a monitoring process in place and governance had been improved to check that the actions resulting from learning were making a difference.

AS asked if the number of coroners cases reported was as expected. PCo noted the introduction of the medical examiner role had meant the number of cases brought to inquest were low but stable.

DBu noted Charles Ranaboldo now chaired the Mortality Surveillance Group which reported to the Clinical Governance Committee on a regular basis.

NP referred to the SHMI data and asked if there was a reason the organisation was slightly above the average. PCo noted differences in national reporting meant sometimes the Trust was within the expected range and sometime outside but would always look to understand why.

JDy noted the Trust's lawyer was also a lay coroner which helped to manage the number of cases reported.

The Board noted the report.

TB1 4/7/3.8 **Director of Infection Prevention Control Report**

JDy presented the annual report which noted the Trust's performance regarding Infection prevention and highlighted the following points:

- There had been five COVID 19 out breaks.
- One case of CPE from a patient transferred from Hampshire Hospitals.
- One C difficile outbreak in Surgery.
- Changes in the way hand hygiene assessments were carried out had improved compliance.
- Cases of whooping cough, Hepatitis A, Norovirus and TB were also present during the reporting period.
- Anti-microbial stewardship had returned to twice weekly.
- Water quality was a concern but was being continuously tested.

Discussion:

IG asked how the Trust compared to other similar Trusts. JDy noted the Trust normally benchmarks well but the data was not available for this report, there had been no spikes to indicate the Trust would be outside were it normally was.

MVB asked if staff recruited from overseas were screened for tuberculosis. JDy noted overseas staff were fully reviewed in occupational health before starting work, RA added screening was part of the immigration process.

EJ thanked JDy and the team for their continued vigilance and asked if a long-term solution had been found for the supply of hand washing materials. JDy noted dispensers were being fitted by the new supplier Tork and confirmed there had been no issues with supply in clinical areas.

The Board noted the report.

TB1 4/7/3.9 **Q4 Incident Reporting and Risk Report**

JDy presented the report which noted the process, data and management of risk registers and highlighted the following points:

- There was a robust process in place which reviewed risks on a daily basis against a standard operating procedure.
- 3.16% of incidents are moderate or above harm. Any incidents scoring moderate or above are revied at the Patient Safety meeting.
- Risk reporting had been stable over the course of the last year.
- Implementation of care was the most reported risk which related to pressure injuries.
- The risk team were linking with divisions to make sure the risks were monitored and managed.

Discussion:

IG asked if the new processes were working effectively. JDy referred to feedback from staff and noted actions were much quicker which in turn had helped with Duty of Candour reporting.

DBe referred to the medication incidents and asked if there was a particular type of medication that kept repeating. PCo referred to the Safety of Medicines Committee which reported to the Chief Pharmacist and the Clinical Governance Committee and noted missed doses of critical medication, incorrect insulin prescribing and anticoagulation where the common incidences. PCo offered to supply more information outside the meeting.

RH referred to the wrong site surgery incidence and asked for assurance that it wouldn't happen again. JDy explained the incident referred to a patient with multiple moles and the wrong mole was removed, the correct mole was removed immediately. PCo added patients sometimes found difficulty describing their symptoms in clinical situations and offered to provide more information outside the meeting.

EJ noted the Trust was very open, honest, and transparent regarding safety, learnt from mistakes and put things right when they went wrong.

IG asked JDy to thank risk colleagues for the report which was clear and easy to read.

The Board noted the report.

TB1 4/7/3.10 **Research Annual Report**

The Board noted the Research Annual had been deferred to September.

TB1 4/7/4 **STRATEGY AND DEVELOPMENT**

TB1 4/7/4.1a **Care Quality Commission Update June 2024**

FMc presented the report which provided assurance on preparing the Trust for the changes to the CQCs monitoring and regulatory approach and highlighted the following points:

- Support to core services in self-assessment which had received positive feedback and subsequent learning.
- Divisions made aware of the types of evidence that may be required if there is an inspection so that the information is accessible.

Discussion:

RH noted in his experience when regulations changed the organisation had to change but also the regulators therefore if the Trust had an early inspection under the new regulations it must respect that the people doing the inspection will still be learning.

IG noted the CQC were on hold due to the general election.

FMc noted work was ongoing in preparation for an inspection.

PCo referred to a government review of the CQC that he had been asked to contribute to and asked the Board to feedback any comments to him.

The Board noted the report.

NP left the meeting.

TB1 4/7/4.1b **Well-Led areas for Improvement Progress Report**

FMc presented the report which noted progress on the areas of improvement identified in the external well-led review. FMc highlighted the following points:

- An external company had been commissioned to carry out well-led reviews across Salisbury Foundation Trust, Royal United Hospital Bath and Great Western Swindon.
- A Board workshop had been held in December where the development areas had been agreed.
- Work was still on-going but much had been achieved.

Discussion:

DBe referred to the action regarding attending report writing courses and noted reports had improved but were still lengthy. DBe suggested creating a reading room to provide more details if required. FMc noted the executive

summary should contain the key messages so that reading the whole report was not always necessary.

ACTION: The Board to consider how reports could be presented differently. **All**

The Board noted the report.

NP rejoined the meeting.

TB1 4/7/4.2 Improving Together Quarterly Update Report

The Board noted the Improving Together Quarterly Update Report had been deferred to September.

TB1 4/7/5 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 4/7/5.1 Estates Technical Service Quarterly Update

ME presented the report which summarised the work of the Estates Technical Services and Capital Projects teams and highlighted the following:

- The report had been scrutinised by the Finance and Performance Committee.
- There had been a significant reduction in the amount of risks the team was managing.
- The risks rated at high were scheduled for mitigation by September 2024
- The extreme risk related to the system used to manage the Estates programmes of work.

Discussion:

DBe noted the significant progress in reducing risks.

EJ referred to the progress and development in the team which was evidence of the investment and support they had received.

The Board noted the report.

TB1 4/7/6 PEOPLE AND CULTURE

TB1 4/7/6.1 Medical Revalidation and Appraisal Annual Report – including Statement of Compliance

PCo presented the report which assured NHSE that the Trust's Medical Director had sufficient resources to appraise and revalidate medical staff in the organisation. PCo noted that he was the responsible officer for the Trust and confirmed he was satisfied he had the resources and the correct competencies of staff.

Discussion:

EJ confirmed the People and Culture Committee had reviewed the report and had been assured that people were safe.

IG asked if there was proactive engagement with the GMC. PCo confirmed he met with an employee liaison officer four times a year to discuss cases and a Responsible Officer Advisory Consistency Panel had been set up to raise concerns and give doctors and dentists advice and oversight. IG asked what support had been provided to the three employed doctors undergoing investigation. PCo confirmed he, the clinical director and clinical lead would meet with each individual to discuss support and provide assurance.

DBu asked how the figure of 22% of doctors late with appraisal compared to previous years. PCo confirmed the percentage had reduced and noted three months slippage was reasonable but not beyond that.

RH asked for assurance that the same level of scrutiny was undertaken for other clinicians. JDy confirmed nurses were required to undertake a revalidation process every three years which was countersigned by another registrant. IG confirmed all registrants in the organisation would go through a similar process.

AS asked if the appraisal team had the opportunity to review the quality of appraisals to seek assurance that we are providing support for development. PCo confirmed there was a quality assurance process and noted in his experience the level of satisfaction and engagement in this organisation was relatively high in comparison to other organisations.

MvB asked if divisional leads had the opportunity to see appraisals and use them for development. PCo noted some trusts included performance management in appraisals, but SFT did not. MvB asked if talent management and development was emphasised in divisional teams. MW noted there was limited talent management and succession planning in the organisation. A Trust definition, approach and implementation plan was in the early stages of design and discussion further to discussion at Trust Management Committee (TMC). Appraisals were currently linked to personal development plans; these were retained by individuals. Staff taking part in leadership training were offered the NHS 360 tool and the Executive Team had recently used a locally designed 360 tool which is more closely aligned to our leadership behaviours framework.

IG asked the Board if they agreed to approve the responsible officer function and the signing of the statement of compliance. The Board agreed.

TB1 4/7/6.2 **Health and Safety Quarterly Report**

MW presented the report which asked the Board to note the improved performance since last year and the ongoing management of risks. MW highlighted the following points:

- Analysis of Datix reporting on violence and aggression to provide support to staff managing difficult situations.
- Introduction of robust processes to provide emotional and practical support to staff.
- Progress on safety in the environments teams are working in.
- Routes used by hospital tugs and the hearing and safety of staff driving them.

RH referred to two RIDDOR reports mentioned in the report and asked for assurance that neither had resulted in Health and Safety Executive action. MW agreed this information should be included in the annual report and to provide more details outside the meeting. **ACTION:MW**

MW

The Trust Board noted the annual report.

TB1 4/7/7 GOVERNANCE

TB1 4/7/7.1 Register of Seals

FMc presented the report and noted there had been three occasions where the seal had been used in the last quarter. There were no conflicts of interest to note.

EJ asked why part of a house in Fordingbridge was being leased. ME noted it was used as a clinical space.

The Board noted the use of the seal.

TB1 4/7/7.2 Non-Executive Director Responsibilities

IG presented the report and noted the new Non-Executive Director roles.

The Board noted the report.

TB1 4/7/8 CLOSING BUSINESS

TB1 4/7/8.1 Any Other Business

The Board discussed approval routes for Trust Board reports and asked for future reports to contain more details on what happens to the report once it has been approved.

TB1 4/7/8.2 Agreement of Principle Actions and Meeting Reflection

IG referred to the principal actions from the meeting and noted there were no escalations.

TB1 4/7/8.3 Public Questions

JP referred to the link between deteriorating patents and Martha's Rule and asked how patients could get a second opinion. JDy noted the Trust had just implemented Martha's Rule and a project group had been set up. There was a Critical Care Outreach Team available twenty four hours a day although there were some gaps in cover at present. Work was ongoing to introduce communications throughout the organisation and plans were in place to introduce checking patients in a more structured way on a daily basis.

TB1 4/7/8.4 Meeting Reflection

The Board reflected on the meeting and the following was discussed:

- MVb suggested a register of risks to keep track of work.
- MvB referred to the Leaning from Deaths Report and noted it was informative and well written.
- EJ noted there had been a good balance in challenges and discussion around finance, performance and quality.
- LT referred to the new Non-Executive Directors and the challenge they had brought to the discussions.

TB1 4/7/8.5 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 5th September 2024, in the Board Room, Salisbury NHS Foundation Trust and an Extraordinary virtual meeting to be held on 22nd July.

TB1 4/7/8.6 **RESOLUTION**

Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Draft
Minutes of the Public Trust Board meeting
held at 10:30am on Thursday 22nd July 2024, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Ian Green (IG)	Chair (via Teams)
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DBe)	Non-Executive Director (via Teams)
David Buckle (DBu)	Non-Executive Director (via Teams)
Michael von Bertele (MVB)	Non-Executive Director (via Teams)
Rakhee Aggarwal (RA)	Non-Executive Director (via Teams)
Judy Dyos (JDy)	Chief Nursing Officer (via Teams)
Mark Ellis (ME)	Interim Chief Finance Officer
Peter Collins (PCo)	Chief Medical Office
Lisa Thomas (LT)	Interim Chief Executive Officer
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer (via Teams)
Anne Stebbing (AS)	Non-Executive Director (via Teams)

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance (via Teams)
Sasha Godfrey (SG)	Executive Assistant and Board Support Officer (minutes) (via Teams)
Jane Podkolinski (JP)	Governor (observer)
Kirsty Matthews (KM)	Associate Non-Executive Director
Paul Cain (PCa)	Associate Non-Executive Director
Dave Roberts (DS)	Associate Director of Communication, Engagement and Relations
Peter Russell (PR)	Governor (Observer) (via Teams)

ACTION

TB1 22/7/1 **OPENING BUSINESS**

TB1 22/7/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted apologies had been received from

- Jon Burwell, Interim Chief Digital Officer
- Richard Holmes, Non-Executive Director

TB1 22/7/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of conflict of interest pertaining to the agenda.

TB1 22/7/2 **STRATEGY AND DEVELOPMENT**

TB1 22/7/2.1 **Development of a Group Model**

IG welcomed everyone to the meeting and explained the purpose of the extraordinary meeting. IG noted that whilst the Board can see the clear

benefits of entering into a Group with RUH and GWH and fully supports collaboration, the Board are aware that the Council of Governors have requested further information about how the Group would operate and have some yet unanswered questions which require consideration. As such, the Board have decided to pause the consideration of the recommendations for a short period to undertake further engagement with Governors over the summer as it is important that they have further assurance.

IG invited questions from the governors present.

TB1 22/7/3 **CLOSING BUSINESS**

TB1 22/7/3.1 **Public Questions**

JP confirmed she had no further questions.

PR concurred with the summary that IG presented noting this was a positive step in supporting and engaging with Governors.

TB1 22/7/3.2 **Agreement of Principle Actions and Meeting Reflection**

There were no actions.

TB1 22/7/3.3 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 5th September 2024, in the Board Room, Salisbury NHS Foundation Trust.

Master Action Log

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	Deadline in future

Contact Kylie Nye, kylie.nye1@nhs.net for any issues or feedback

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 2/5/3.1 Integrated Performance Report (IPR) (M11)/ Outpatients	TBC	Niall Prosser, NP	It was agreed that an update would come to the F&P Committee on the plan and how the culture of OP will be addressed from an A3 thinking approach.	update from NP - undertake an Outpatient deep dive later in the year and will present A3 to the committee at that stage. Dbe requested this acton is transfreed to Finance and Performance Committee action log. Closed	Y	3
Trust Board Public	Sasha Godfrey	TB1 4/7/2.5 Finance and Perforamcne Committee 25 June	03/10/2024	Mark Ellis, ME	Item on the next Trust Board agenda to give assurance and more clarity to the Board on the Trust's financial resilience and the mitigations required to maintain a positive cash position.	Paper setting out key financial risks, mitigation, and controls, including cash flow forecast went to F&P 30/07. H2 cash requirements to be set out in paper to board Oct'24.	N	4
Trust Board Public	Sasha Godfrey	TB1 4/7/2.5 Finance and Perforamcne Committee 25 June	05/09/2024	Mark Ellis, ME and Debbie Beaven, Dbe	Include the theatre producitvity deep dive in the Finance and Performance Escalation Report	Included in the escalation report. Action closed	Y	3
Trust Board Public	Sasha Godfrey	TB1 4/7/2.6 Clinical Governance Committee	03/10/2024	Peter Collins, Pco	Report regarding the recommendations in the infected blood enquiry report and the impact on the Trust		N	4
Trust Board Public	Sasha Godfrey	TB1 4/7/3.1 Quarterly Maternity and Neonatal Quality and Safety Report Q4	24/09/2024	Vicki Marston, VM and David Buckle, DBu	Deep dive regarding severe tears to September Clinical Governance Committee		N	4
Trust Board Public	Sasha Godfrey	TB1 4/7/3.1 Quarterly Maternity and Neonatal Quality and Safety Report Q4	05/09/2024	Eiri Jones, EJ	EJ to speak to IG regarding reviewing the CNST submission at the February Trust Board Development Day	EJ discussed with IG who supports this action. Time will be made available in the February Board Development session to facilities the sign off.	Y	3
Trust Board Public	Sasha Godfrey	TB1 4/7/3.4 Board Assurance Framework and Corporate Risk Register	05/09/2024	Lisa Thomas, LT	Reflect on the level of the cyber security risk which is included in the digital delivery plan risk	BAF risk currently being reviewed and update will be presented to Board Committees in September. Action closed.	Y	3
Trust Board Public	Sasha Godfrey	TB1 4/7/4.1b Well-Led areas for Improvement Progress Report	05/09/2024	All	The Board to consider how reports could be presented differently.	This action is being picked up through executive meeting. Leader standard work to be developed. Executives to sign off all Board and Board Committee reports prior to publication. Close action	Y	3
Trust Board Public	Sasha Godfrey	TB1 4/7/6.2 Health and Safety Quarterly Report	05/09/2024	Melanie Whitfield, MW	When RIDDOR reports are mentioned in the Health and Safety report include information on any Health and Safety Executive action	No concerns from HSE from recent RIDDOR and the item will be captured in future reports	Y	3

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	05th September 2024		

Report title:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Niall Prosser, Chief Operating Officer			
Appendices				

Recommendation:

The Trust Management Committee are asked to note the Trust's operational performance for Month 4 (July 2024).

Executive Summary:

Breakthrough Objectives

- *Wait Time to 1st Appointment* reduced from 138 to 132 days average and its lowest point in more than 12 months.
- *Managing Patient Deterioration* continued incremental improvement from 31.3% to 34.6% making a total 4.5% gain since April against the target of 50%.
- *Staff Turnover* of Additional Clinical Services saw a marginal increase from 18.8% to 19.2% however maintains an improved position of 1.2% since April against the target of 15%.
- *Productivity* continued steady reduction from -15.2% to -15.1% against the 2019/20 equivalent period, making a total 2.2% improved position since April.

Deteriorating Performance

- Cancer performance, whilst improving, remains under national monitoring across the BSW system, where all Trusts are collectively in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards.* Our performance continued to improve:
  - *28-day Faster Diagnosis Standard (FDS)* from 70.4% to 74.8% (below plan).
  - *62-day Standard* from 76.6% to 78.1% (above plan).
  - Number of patients waiting *>62 days for cancer treatment* reduced from 76 to 63 and restores path of steady decrease overall.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

The criteria to exit national tiering is to achieve >70% performance against the *28-Day FDS Standard* and >60% performance against the *62-day Standard* for all of Q1 2024/25 and is a collective target for all BSW Trusts, requiring all to achieve this to exit tiering arrangements.
Note: Cancer data is one month behind, reporting June in this IPR.

Alerting Metrics

- The number of *High Harm Falls* was stable for a second month at 2.
- Emergency Department (ED) metrics:
  - *Attendances* remain high and increased from 7,166 to 7,251 with year to date 10% higher than in 2023/24.
  - *Ambulance Handovers >60 minutes* reduced from 129 to 92.
  - Patients with ED *Arrival to Departure >12 hours* reduced from 53 to 27.
- *RTT Incomplete Pathways* across all metrics:
  - 52ww patients reduced in month from 923 to 901 (above plan).
  - 65ww patients reduced in month from 96 to 70 (above plan).
  - 78ww patients reported one breach after discovery of administrative error regarding RTT clock start date.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe):	☐

Integrated Performance Report

September 2024

(July 2024 data)

Our Strategy 2022-26
IMPROVING together

Summary

Trust performance in July demonstrates annual progress and recovery from a challenging June. The Emergency Department (ED) restored *4-hour performance* back to recent familiar levels at 73% and saw the *Ambulance Handover* time also reduce to 26 minutes, despite *Attendances* consistently remaining high at 7,251 in month, year to date 10% higher than in 2023/24.

Cancer performance remains under national monitoring across the BSW system, where all Trusts are collectively in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards*. Performance at SFT continues to improve, with the *28-day FDS* increasing for the third month in a row from 70.4% to 74.8% and fractionally below trajectory of 75%. The *62-day Standard* also increased again from 76.6% to 78.1% and is above the trajectory of 66%. The number of patients waiting over 62 days for cancer treatment reduced in month from 76 to 63 patients and now rejoins path of steady reduction overall since monitoring began. *Note: Cancer data is one month behind, reporting June in this IPR.*

Diagnostics *6-week Standard (DM01)* saw the mechanical failure of an MRI scanner negatively impact performance, reducing to 83.4% overall against the trajectory of 86%. However, this sustains improvement compared to the previous 12 months average. The Stroke care measure of *Arrival on Stroke Unit within 4 hours* reported the highest performance in two years at 68% maintaining improved position for the fourth month.

Waiting list related metrics were contrasting, with the breakthrough objective of *Wait Time to 1st Appointment* reducing to 132 days and its lowest point in over a year, whereas the overall *Referral to Treatment (RTT) waiting list* increased for the first time in four months to 28,094 patients, although remains below the trajectory of 30,756. Progress continues in reducing patients with long waits in both the 65 weeks and 52 weeks categories. In month 3 the Trust performed 111% Elective Recovery Fund (ERF) activity against a target of 112%. Month 4 performance, as of the 18th, is 100% compared to a target of 115%, with 54% of patients uncoded at present.

The quality related breakthrough objective of *Managing Patient Deterioration* continued incremental improvement by rising again to 34.6% of subsequent observations completed on time. Quality metrics were generally positive, with *Pressure Ulcers* per 1,000 bed days seeing negative growth to 2.51 whereas *Incidents* and *Infection Control C-Difficile* reduced to 4.83 and 2 respectively. More notably, *Care Hours per Patient Day (CHPPD)* improved to 8.5 and is at its highest point in two years.

Further workforce metrics were varied although marginal shifts, with the breakthrough objective relating to retention measured by *Staff Turnover* seeing a slight increase to 19.2% however maintaining its improved position. *Staff Absence* saw a minor increase to 3.7% and *Vacancies* a slight decrease to 3.9% which are comparatively improved positions and the latter now below the target of 5% for the last year.

The finance breakthrough objective of *Productivity* continued steady reduction to -15.1% against the 2019/20 equivalent period and is an overall 2.2% improved position since launch. The Trust recorded an in-month control total deficit of £1.6m against an original deficit target of £0.2m - an adverse variance of £1.4m.

Strategic Priorities

Our Vision is to provide an outstanding experience for our patients, their families and the people who work for and with us.

People working for us	Population our patients and their families	Partnerships working with us

Vision metrics 7 – 10 years

People			Population			Partnerships		
Engagement Score in Staff Survey	Reduction of unwanted turnover (people leaving the Trust or the NHS)	Proportion of WDES & WRES at median	# of wait metrics at median	Total incidents with moderate or high harm	Patient Engagement Score	Increase in Healthy Life Years	Overall Length of Stay	Organisational Sustainability

Strategic initiatives 3-5 years

- Continuous improvement culture
- Delivering our people promise
- Delivering Digital Care
- Improving health and reducing health inequalities

Corporate Projects

Breakthrough Objectives 12-18 months

- Recognising and managing patient deterioration
- Reducing patients' time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

What is an Integrated Performance Report (IPR)

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections: Quality of Care, Access and Outcomes, People and Finance and Use of Resources which contain the following within them:

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

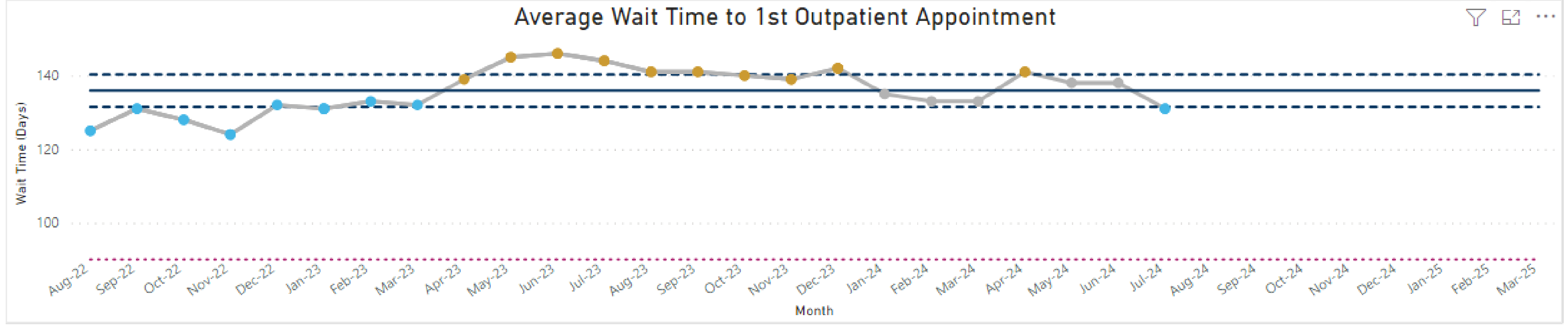
Partnerships

Reducing Patients' Time to First Outpatient Appointment

Breakthrough Objective

We are driving this measure because…	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% Referral to Treatment (RTT) 18-week elective treatment target since October 21. A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18-week RTT target at risk. It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Target: ≤90 days   Performance: 132 days   Position: Special Cause Improvement



Understanding the Performance
Average wait to first outpatient reduced, for the third consecutive month, by 6 days to 132 days. Top contributors for improved waits were: Colorectal (-40), ENT (-24) and Paediatrics (-19). Areas of worsening waits were Dermatology (+21), Ophthalmology (+6) and Plastic Surgery (+5). A process mapping exercise has been completed both on the wider Process to Booking and at the specialty level for Colorectal, Oral Surgery and Urology which are the three specialties to be focused on initially.

Countermeasure Actions	Due Date
• Weekly meeting in place for three focus specialties. Focus on ho we engage with patients, how could we improve the management of waiting lists, how could rebooking of clinic slots be more effective and understanding what is driving patients not attending their appointments (DNA).	18th September
• Develop project documentation to support the emerging project plan	18th September
• Development of process to booking dashboard with metrics to support the measurement of improvement actions.	18th September

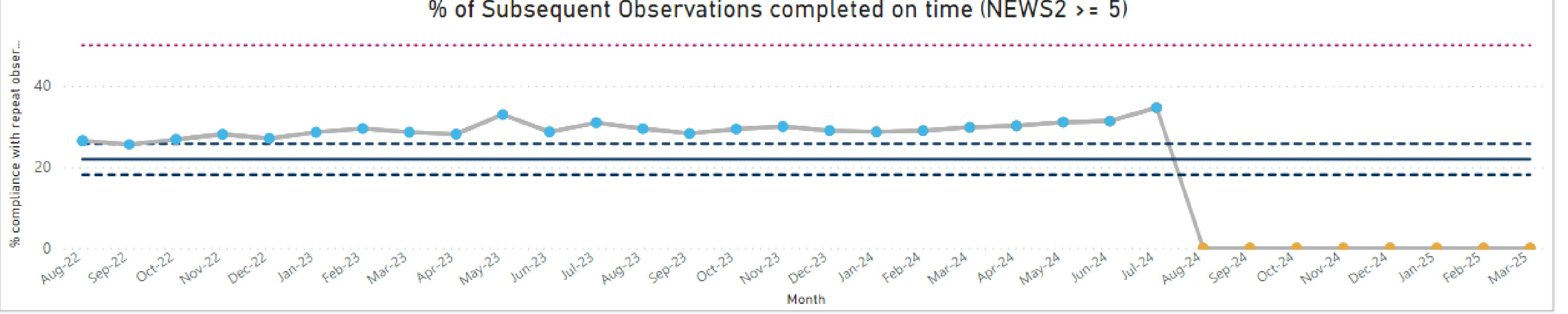
Risks and Mitigations
• There are high vacancies within the central booking service which may limit the ability to release key staff to attend meetings or implement improvement actions. This is being monitored closely by the Surgical Division with approval to use a level of bank/agency staff. • Unknown impact from Industrial Action in Primary Care – may impact upon referrals rates with an increased level of queries or referrals which could place greater pressure on stretched admin teams. Local monitoring in place.

Recognising and Managing Patient Deterioration

Breakthrough Objective

We are driving this measure because…	Improving the early recognition of patient deterioration is a multidisciplinary team activity and comprises of three recognised steps – Record, Recognise and Respond. The first step is regular measurement and recording of clinical observations and in line with recommendations from the *Royal College of Physicians* and *Academy of Medical Royal Colleges*, frequency of these physiological measures is determined by the NEWS2 score. Monitoring trends in both the patient's physiology and NEWS2 score will provide information to the clinical teams to triage workload and to identify potential patients at risk of deterioration. Our aim is to improve upon the current compliance for the recording of these measures with reductions in both mortality, morbidity and late escalations of care.

Target: ≥50% Performance: 34.6% Position: Special Cause Improvement



Please note the data being presented ends in July 2024 and therefore the markers shown on the x-axis after that point should be ignored.

Understanding the Performance

RECORD: There continues to be an improvement in repeating clinical observations for those patients who score 5 and above. The data however represents only 10-15% of the total as currently it does not include NEWS2 score of 0-4 including single parameter 3. Currently examining other measures.

RECOGNISE: Trust training sessions being well attended.

RESPOND: Manual audit outstanding.

Countermeasure Actions	Due Date
1. Change data collection to include scores of 0-4.	Sept 24
2. Establish whether the neurological observation score can be removed.	TBC
3. Establish whether a single parameter 3 can be included cope training gaps on the use of POET.	TBC

Risks and Mitigations

Risk: There is still a risk of unrecognised deterioration which may lead to patient harm. However other measures allow us to monitor that risk:

- Overall mortality rates decreasing.
- Cardiac arrest rates remain low.
- Medical emergency Team calls increasing signalling earlier recognition.
- Unplanned admissions to ITU.

Emergency Access 4-hour Standard

Target: ≥78% Performance: 73.0% Position: Common Cause

SFT A&E 4 Hour Performance (%)

Percentage: 65, 70, 75, 80

Month: Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25

Understanding the Performance

The Trust 4-hour performance improved to 73% in M4 despite increased attendances from 7,166 to 7,251. This is a sustained increase of 11.13% up on the average monthly attendances in M4 from 2023. Type 1 attendances (ED) remain high at 163 average a day, which continues to exceed staffing establishment.

The Department has introduced 'Streaming' at the front door by a Senior Nurse prior to booking in which helps with recognising 'sick' patients and starts their treatment journey earlier. Despite only introducing this in the middle of M4 this has already improved the % of time for 1st assessment within 15 minutes from 34.70% to 62.54%.

Countermeasure Actions	Due Date
• Streaming will also be used to improve data on GP referrals to the Department to determine any affect the GP's collective action will have on attendances.	Start 19/08/2024
• ED has also introduced a Daily Safety Recording 'live' spreadsheet to record 2 hourly the current position of the dept and any concerns.	Ongoing
• A meeting is planned in M5 with Lead Clinician and ECIST to discuss demand and capacity analysis.	06/09/2024
• Analysis is underway to evidence whether Specialty waits in Department have an adverse effect on performance re limiting capacity to see and treat patients.	30/09/2024
• Focus remains on the use of CDU beds on SSEU when capacity allows.	Ongoing

Risks and Mitigations

- Flow out of the Department continues to impact both 4-hour and 12-hour performance targets with high bed occupancy levels.
- Streaming at the front door is seeing improvement not just in the time for 1st assessment but in improving patient safety and patient experience.
- Lack of resources to realise improvement and Operational pressures vs working group engagement – Time has been planned with the SLT in M5 to regroup, establish roles and plan improvement ideas.

Ambulance Handover Delays

Target: ≤15 mins   Performance: 26 mins   Position: Common Cause

Average Handover Time per Ambulance Arrival (mins)

Handover Time (mins)

60
50
40
30
20

Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25

Month

Understanding the Performance

Ambulance handovers improved in month to 26 minutes average. The number within 15 minutes remains in standard variation in M4 at 41.25% compared with 35.71% in M3.

Number of patients arriving by Ambulance reduced slightly to 1,292 in M4 compared with 1,329 in M3. This represents a daily average of 42 compared with 38 in 2023.

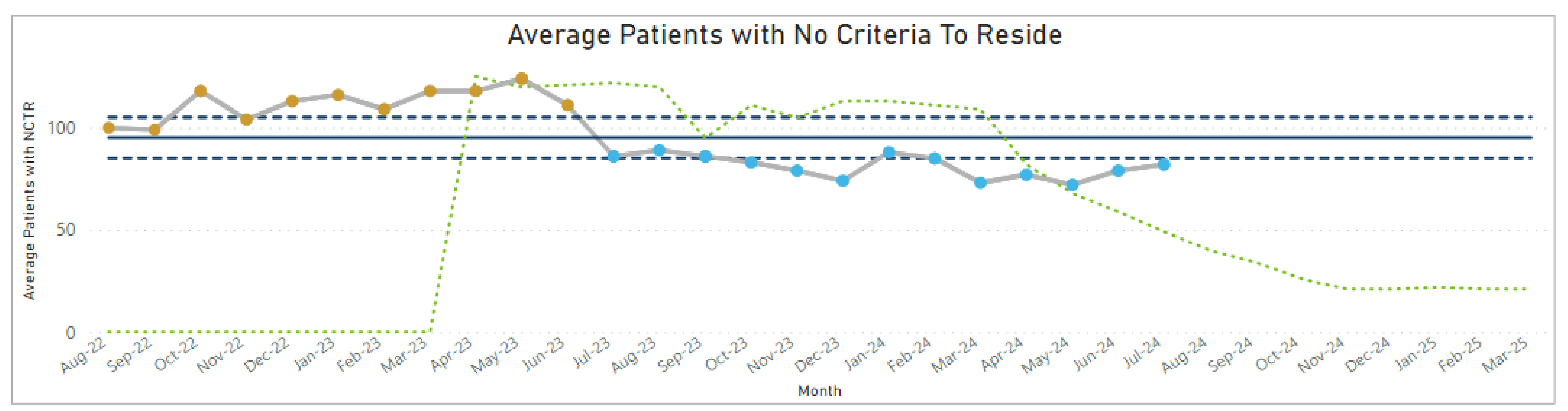
Countermeasure Actions	Due Date
• Monthly meetings with the South-West Ambulance Service (SWAS) continue which maintains a positive relationship between the Teams. Meeting arranged in M5 to discuss and agree process if a SWAS cohort is necessary.	30/09/2024
• Rapid Assessment Treatment and Triage (RATT) paper to support investment to deliver Medical led RATT 12 hours per day is part of the Medical Workforce paper.	30/09/2024
• Further work planned to improve the RATT process when multiple ambulances arrive at once.	30/09/2024

Risks and Mitigations

- Occasional bottleneck in Rapid Assessment Ambulatory (RAMBO) when multiple attendances arrive consecutively – mitigated by ensuring ambulances offloaded to any available space when RAMBO is full will be further addressed by the countermeasures above if there is no available space.

Optimising Beds

Target: <25 (5%)   Performance: 82   Position: Special Cause Improvement



Understanding the Performance

The number of patients with No Criteria to Reside (NCTR) has risen once again in M4 to 82 from 79 in M3. However, the number of delayed bed days has fallen to 1,009 in M4 compared to 1,080 in M3.

Referral time for patients with NCTR has risen slightly to average 1.64 days from 1.3 days. There is still work to be done to ensure good data quality.

Progress was seen in the delayed Length of Stay (LoS) metric as patients are waiting on average the following number of days from NCTR to leaving hospital:

- Pathway P0: 3.44 from 6.75
- Pathway P1: 9.86 from 11.28
- Pathway P2: 9.91 from 32.5
- Pathway P3: 22.69 from 21.88

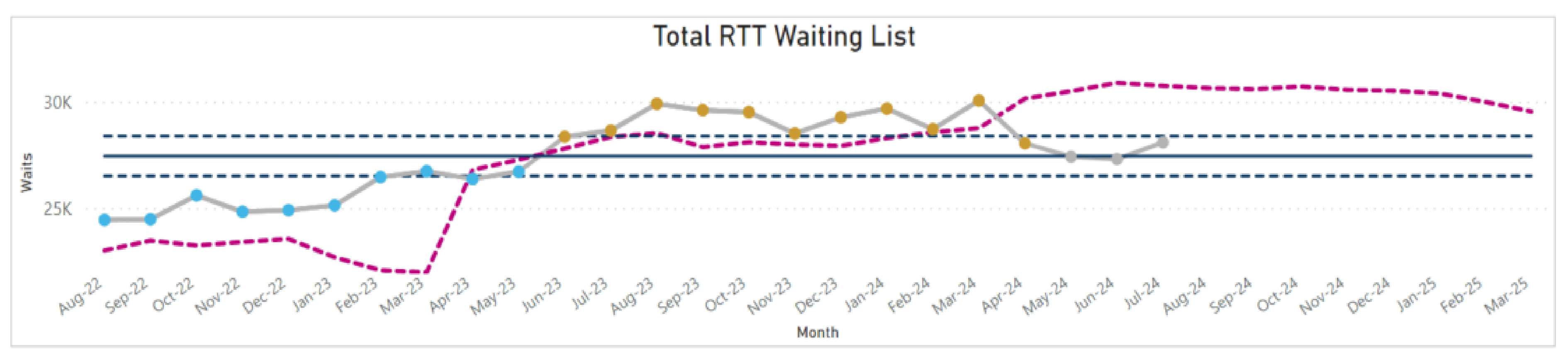
Countermeasure Actions	Due Date
• BSW supporting in getting visibility of where all Wilts pats are in discharge pathway.	Sept 24
• Daily system partners calls in place.	Ongoing
• Digitisation of Decision to Admit (D2A) process.	Oct 24
• Working on putting narrative on local CTR report that give full internal visibility	Aug 24
• Working to improve time to D2A referral to 24 hours.	Nov 24
• Review of internal IDS team roles complete to support push model.	Aug 24
• CHC fast track training to be delivered on site for MDT colleagues.	Sept 24

Risks and Mitigations

- External conflicts such as reduction in capacity in local authority social care teams.
- Significant challenges in understanding patient level detail of those waiting social care interactions.
- DQ challenges.
- Changes to community model.
- Future industrial action.
- Clinical capacity conflicts.
- Clinical engagement.

Total Elective Waiting List (Referral to Treatment)

Target: ≤30,503 Performance: 28,904 Position: Common Cause



Balancing metric	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Longest waiting patient	76	77	243	200	194	153	139	110	94	72	68	73	74	78

Understanding the Performance

July saw the total referral to treatment (RTT) waiting list increase for the first month in four, as additional staff supported processing of referrals. The long waits position is improving as patients waiting more than 65 weeks in July reduced from 96 to 70 however one patient waiting 78 weeks was discovered without an RTT clock started and dated for surgery. Investigations into this are underway.

Top 3 specialties with increases in month:

- Paediatrics (+326)
- Colorectal (+183)
- Trauma and Orthopaedics (+150)

Top 3 specialties with reductions in month:

- Plastics (-144)
- Gastroenterology (-82)
- General Surgery (-48)

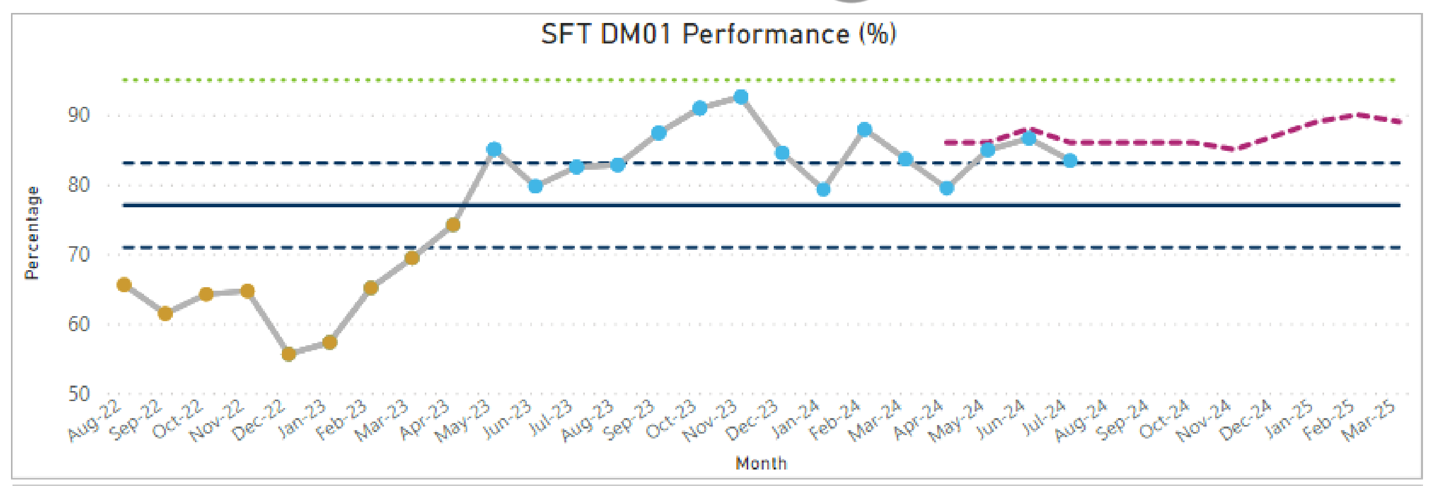
Countermeasure Actions	Due Date
• Complete investigation into 78ww patient and implement steps to prevent this happening in future.	31/08/2024
• Continue weekly Access Meeting to focus on reducing long waits of patients in line with national targets: Zero waiting >65 weeks by the end of September 2024, Zero waiting >52 weeks by the end of March 2025 and Zero waiting >78 weeks as standard.	Ongoing
• Work with Trust CCS software provider to develop reports that can better guide waiting list management (Pre-Op status, Access plan creation date, Duplicate access plans, non-RTT patients).	30/09/2024
• Continue validation programme of reviewing all patients waiting >12 weeks.	30/09/2024

Risks and Mitigations

- Risk of long wait patients having incorrect status (particularly non-RTT) needs full review and action plan to mitigate.
- Risk of lost capacity owing to any future Industrial Action remains.
- Risk of increase to waiting list through IA by GPs and action to stop providing advice and guidance, being replaced with direct referral.
- Weekly Access Meeting continuing with aim to reduce risk of long waiters and continue drive towards national reduction targets.

Diagnostic Waiting Times

Target: ≥95% Performance: 83.4% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	69.4%	234	Dexa	100%	0	Colonoscopy	54.1%	133	Urodynamics	57.8%	27
CT	88.2%	88	Neurophysiology	100%	0	Gastroscopy	88.9%	18	Cystoscopy	91.3%	2
Ultrasound	97.1%	34	Echo	88.1%	33	Flexi Sigmoid	50.6%	44	Audiology	74.9%	176

Understanding the Performance

Diagnostic performance reduced in M4 to 83.41% from 86.6% in M3, slightly below trajectory position of 85.82%. The adverse position has been influenced by 7 days unexpected loss of capacity in MRI, losing capacity for 90 scans (due to a mechanical failure of the scanner). MRI, Audiology and Endoscopy have all reported increased number of breaches in M4 compared to M3. The significant and earlier recovery in the USS position supports the overall Trust position to not deteriorate significantly off plan.

MRI: 234 breaches M4 compared to 183 in M3
CT: 88 breaches M4 compared to 112 M3
USS: 34 breaches in M4 compared to 28 in M3
Audiology: 176 breaches compared to 125 in M3
Echo: 33 breaches compared to 88 in M3
Endoscopy: 195 breaches compared to 134 in M3

Countermeasure Actions

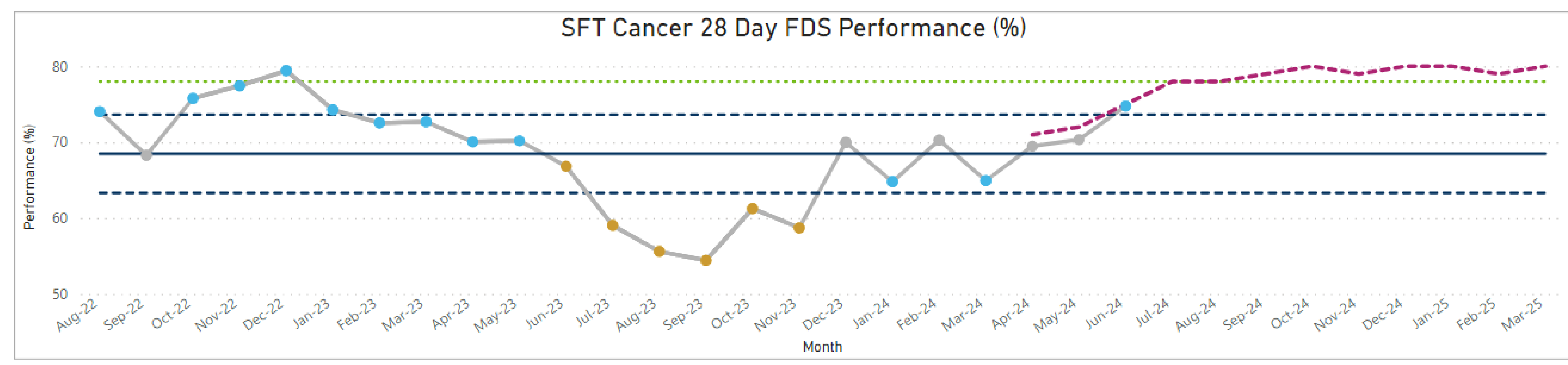
Countermeasure Actions	Due Date
• Weekend Endoscopy lists (additional capacity).	M6
• Endoscopy 4th room online, increased core substantive capacity.	M6
• Endoscopy insourcing provision.	M7
• Maintenance levels of enhanced overtime rates in USS to sustain position.	M5
• New Audiologist in post, focus on long waiters.	M5
• Maintenance levels of Echo insourcing provision to sustain position.	M5
• Cardiac MRI outsourcing – approx. 50 scans to reduce long waiters.	M5 & M6

Risks and Mitigations

There is risk to the SFT DM01 position due to increasing breach numbers within Endoscopy and a backlog of surveillance patients which, at end of Q2, will add to DM01 as overdue planned. The planned additional capacity from M6 will be critical to ensure sufficient capacity for DM01 compliance.

Cancer 28 Day Faster Diagnosis Standard

Target: ≥78% Performance: 74.8% Position: Special Cause Improvement



Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

28-day performance improved in M3, with month-end position of 74.8%. Whilst this remains below the national standard of 78%, some specialties reported a position above this target. This includes:

- Breast: 96.8%
- Head & Neck: 81%
- Lung: 90%
- Skin: 96.4%
- Upper GI: 81.3%

Lower GI continues to be challenged by historical and complex pathways, although this is improving. Broader impact of BSW Bowel Cancer Screening Programme performance on LGI FDS scoped.

Urology performance predominantly driven by Prostate diagnostic pathway.

Countermeasure Actions

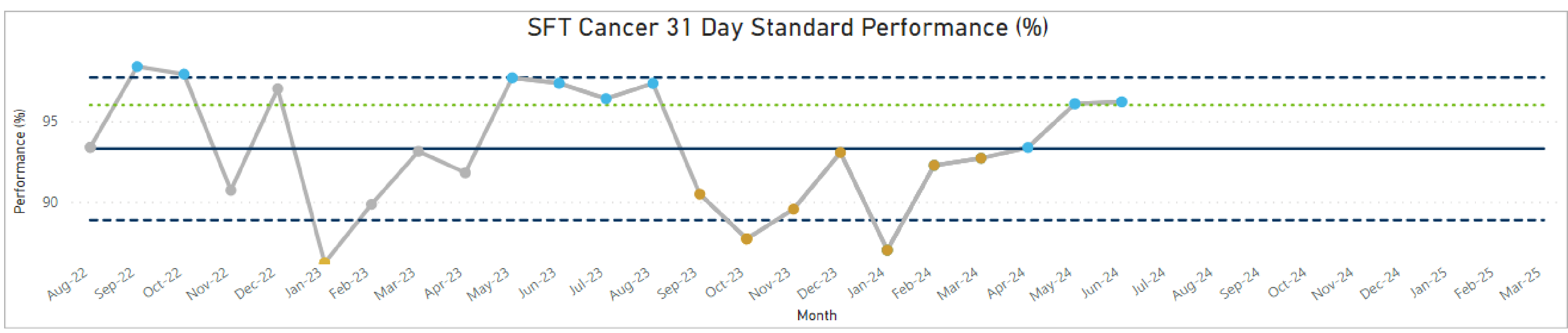
Countermeasure Actions	Due Date
• Maintain regular site-specific 'Faster Diagnosis touch point' meetings.	Monthly
• Maintenance of sufficient Breast and Skin capacity for first appointments to support overall Trust delivery of FDS.	Monitored weekly
• Analysis of Best Practice Timed Pathway priorities underway for Lower GI and Urology.	Q3 2024/25
• Deep dive to be undertaken into Head & Neck and Gynaecology breach reasons to identify trends and themes.	Q3 2024/25
• Development of FDS 'A3' for Lower GI, Head & Neck, Gynaecology and Haematology. Lung and Urology also under development.	Q3 2024/25
• Impact of BSW-wide Bowel Cancer Screening pathway on LGI FDS performance has been scoped.	Q4 2024/25

Risks and Mitigations

- Skin service remains vulnerable to demand and capacity issues. Bid approved by NHS England to support further insourcing capacity; surgery are working through procurement processes ahead of utilisation.
- Resource within MDT cancer services team remains challenging in terms of capacity. Cancer Transformation Funding bid successful to recruit fixed-term assistant MDT co-ordinator posts.
- Cancer escalation policy routinely in use across all tumour sites.
- **Due to an error, the Trust did not make an accurate submission of CWT data for any of the standards. This effects the data for each month of Q1 2024/25 and will be resubmitted at the next opportunity at end of Q3 24/25.**

Cancer 31 Day Standard

Target: ≥96% Performance: 96.2% Position: Special Cause Improvement

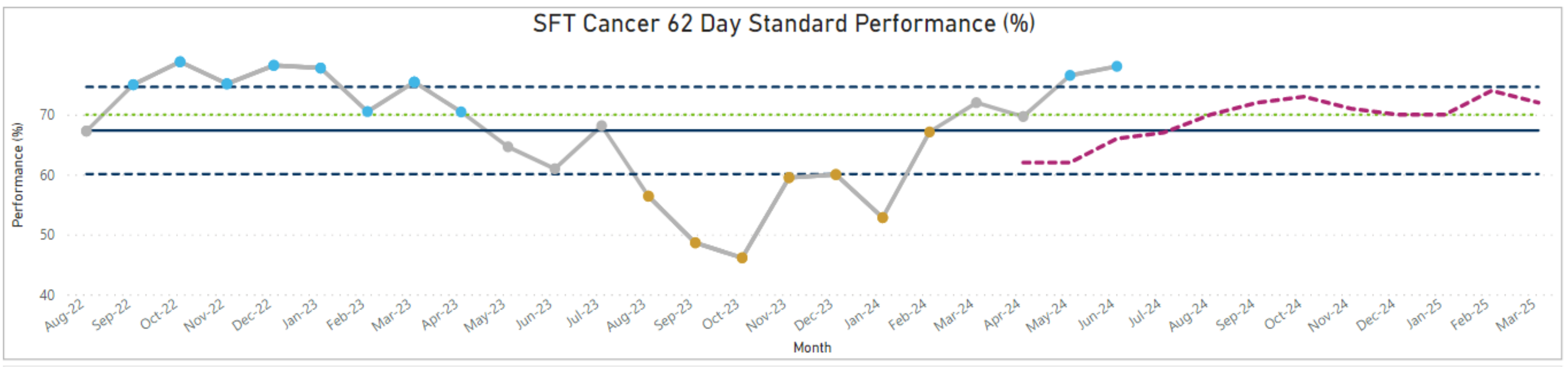


Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
31-day performance has incrementally improved since January 2024, with M3 position of 96.2%. This represented 6 breaches of the 163 patients treated. All specialties achieved the standard, with exception of the following: • Breast: 91.7% (3 patients not treated within 31 days of DTT). • Lower GI: 91.7% (1 patient not treated within 31 days of DTT). • Head & Neck: 50% (1 patient not treated within 31 days of DTT).	• Maintain regular site-specific 'Faster Diagnosis Touch-point' meetings • Early escalation of booking where the patient is booked beyond target date; increased visibility of upcoming breach dates within weekly PTL meetings established. Further consideration underway in relation to awareness and visibility of breach dates within booking teams.	Monthly End of Q2 2024/25	• Skin service remains vulnerable to demand and capacity issues. • Resource within MDT cancer services team remains challenging in terms of capacity. Cancer Transformation Funding bid successful to support recruitment of fixed-term assistant MDT co-ordinator posts to support more timely management of patients. • Insufficient capacity within Central Booking department • Risk of Oncology capacity associated with: Aseptics and requiring outsourcing. • **Due to an error, the Trust did not make an accurate submission of CWT data for any of the standards. This effects the data for each month of Q1 2024/25 and will be resubmitted at the next opportunity at end of Q3 2024/25.**

Cancer 62 Day Standard

Target: ≥85% Performance: 78.1% Position: Special Cause Improvement



Patients waiting over 62 days for treatment	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	109	89	78	102	167	119	87	158	145	117	91	73	76	65

Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

Incremental improvement in 62-day performance since April '24, with month-end position of 78.1%. Data is subject to change upon receipt of post-op histology and confirmed cancer diagnosis treatments recorded after the monthly submission. Data will be updated within quarterly submission.

115 patients were treated in total against the 62-day target in M3, with 25 patients not meeting the standard. Notable specialty performance as below:

- Lower GI: 54.5% (5 breaches/11 patients)
- Head & Neck: 60% (1 breach / 2.5 patients)
- Urology: 62% (9.5 breaches / 25 patients)

Countermeasure Actions

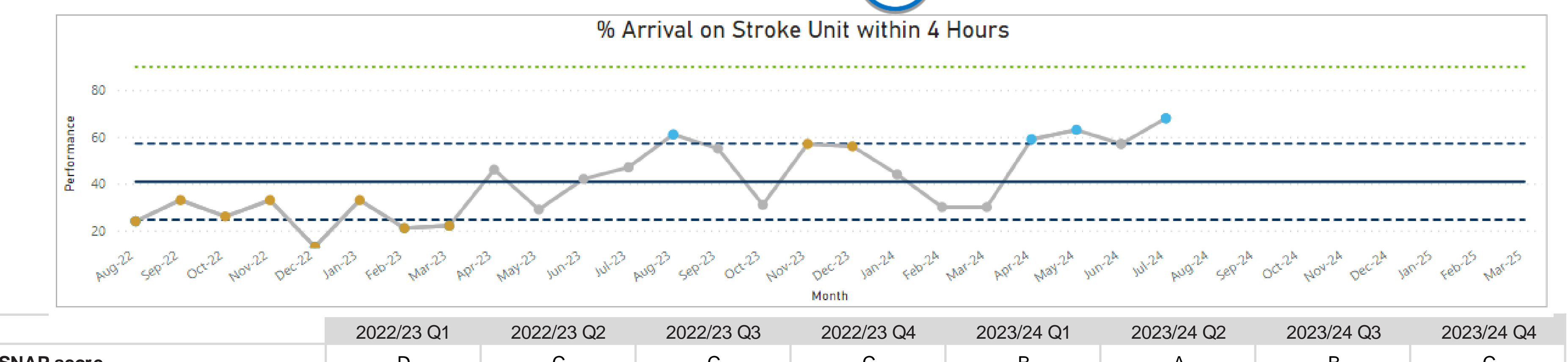
Countermeasure Actions	Due Date
• Sustain robust patient tracking list meetings, with improved resilience and standardisation across all tumour sites.	Weekly
• Backlog trajectories scope by Cancer Services and agreed with Operational Management teams, with stretch target of 6% of overall PTL size. Aspirational figure provided to each specialty to support focussed delivery of backlog reduction.	Monitored weekly

Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day % compliance will be impacted. Aiming for <6% of PTL size for patients over 62 days in their pathway.
- Resource within MDT cancer services team remains challenging in terms of capacity.
- Risk of Oncology capacity associated with: Aseptics and requiring outsourcing.
- Cancer escalation policy routinely in use across all tumour sites.
- **Due to an error, the Trust did not make an accurate submission of CWT data for any of the standards. This effects the data for each month of Q1 2024/25 and will be resubmitted at the next opportunity at end of Q3 2024/25.**

Stroke Care

Target: ≥90% Performance: 68% Position: Special Cause Improvement



	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
SSNAP score	D	C	C	C	B	A	B	C

Understanding the Performance
M4 performance was 68%, which is a 11% increase on M3. This is a modest change felt to be reflective of expected variation although notably highest position in two years. Key themes from the data: • Delay in initial diagnosis/identification: 6 of the patients who failed to reach the stoke unit within 4 hours presented with obvious stroke symptoms. This is a small decrease from last month reflective of ongoing training for identification. However, delays in doctors reviews has also been identified as a contributing factor since last month to delaying diagnosis. • Out of Hours (OOH) performance: 22 of the 34 patients were admitted OOH. This continues to impact our performance due to limited staff cover during these hours.

Countermeasure Actions	Due Date
• OOH continues to have the biggest impact on SNAPP score. Driver metrics for the department changed to 4 hour performance with a emphasis looking at OOH patients. A working group has been established to begin in M6	01/10/24
• Training on non-specific stroke symptoms: education leads for the Emergency Department (ED) and Stroke have arranged training for nurses aimed at addressing delays in identification. This is continuing education and will be reviewed quarterly	01/10/24
• Stroke B6 nurse Liaison with ED: from M5, B6 has been supernumary to the ward numbers and given responsibility for liaising with ED to address potential stroke patients with a view to reducing communication delays. An early review of results indicated that the impact has improved performance in hours, but the variable of OOH is not covered.	01/09/24

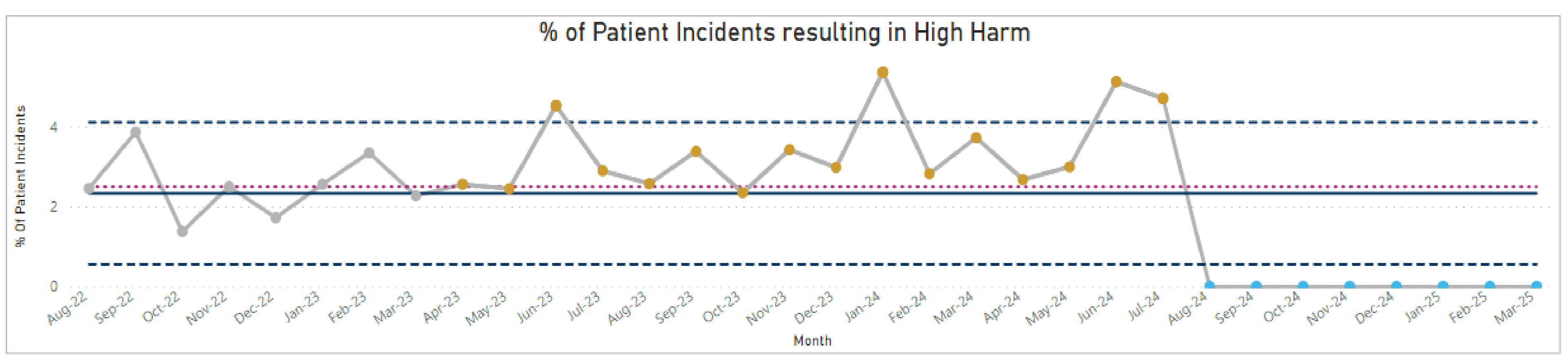
Risks and Mitigations
• OOH cover represents a source of concern for variation in the Trusts 4-hour performance. A significant driver for this are the delays in doctors reviews in this timeframe. Work on improving communication and education to mitigate potential delays in continuing. • Bed Flow / Length of Stay (LoS): the Stroke Unit's LoS is 16 days. Driver metrics for the unit are discharges before midday, with a view to improving bed flow. A key driver for performance has been identified as Electronic Discharge Summary (EDS) timing. Doctors have been invited to the huddle to identify areas in the process where EDS's have been delayed.

Incidents

Target: ≤2.5% Performance: 4.7%

Position:

Special Cause Concern



Please note the data being presented ends in July 2024 and therefore the markers shown on the x-axis after that point should be ignored.

Understanding the Performance

There were 968 incidents reported in July. This was an increase compared to 789 in June. *(To note there may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively*). A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred.

In July there were:

- 29 reported moderate incidents, (a decrease of 1 incident from June).
- 1 major incident reported (oral surgery).
- 1 reported Never Event (*wrong route medication*).

Countermeasure Actions	Due Date
Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required.	Daily / Ongoing
Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed.	Weekly / Ongoing
Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients.	Ongoing
Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated.	Ongoing
Learning from incidents forum.	Monthly / Ongoing

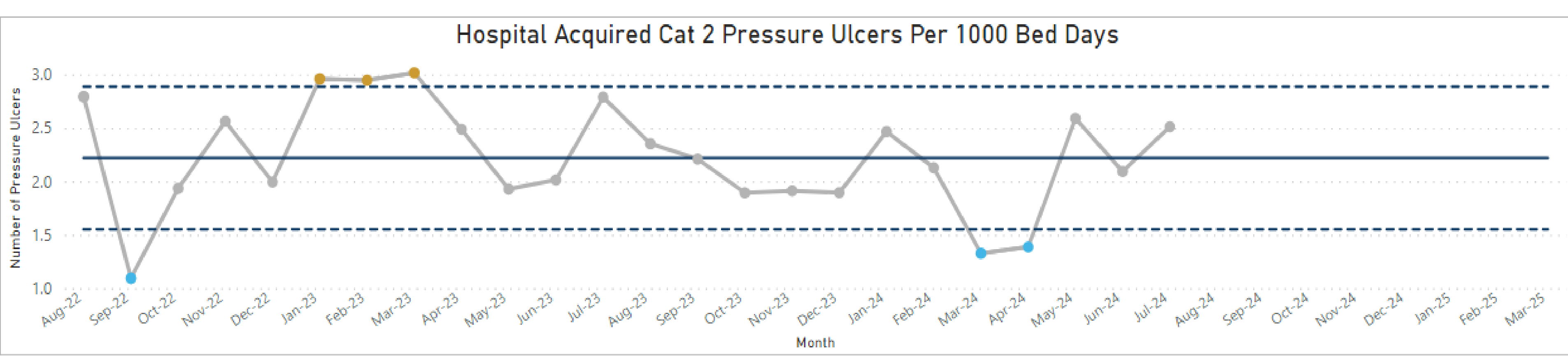
Risks and Mitigations

There were 2 Patient Safety Incident Investigations (PSII's) commenced in July.

- *1 PSII for a Never Event as above (National Priority).*
- *1 PSII discharge process (Local priority).*

Pressure Ulcers

Target: N/A   Performance: 2.51   Position: Common Cause



Understanding the Performance

There has been an overall increase in Hospital acquired Pressure Ulcers (PUs) from 36 (affecting 39 patients) in June to 59 (affecting 51 patients) in July 2024.

The number of Moisture Associated Skin Damage (MASD) which was reported to have developed in hospital was 39 (affecting 35 patients).

The total number of incidences of **PUs** in the Trust in July was 118.

The total number of incidences reported of **MASD** by the Trust was 87

Hospital Acquired Increases:

- Category 2 PUs from 29 to 36 (six of these were medical device related).
- Deep Tissue Injury (DTI) from 5 to 17 (four of these were medical device related).
- Unstageable PUs from 1 to 5.
- Medical device related PUs from 4 to 10.

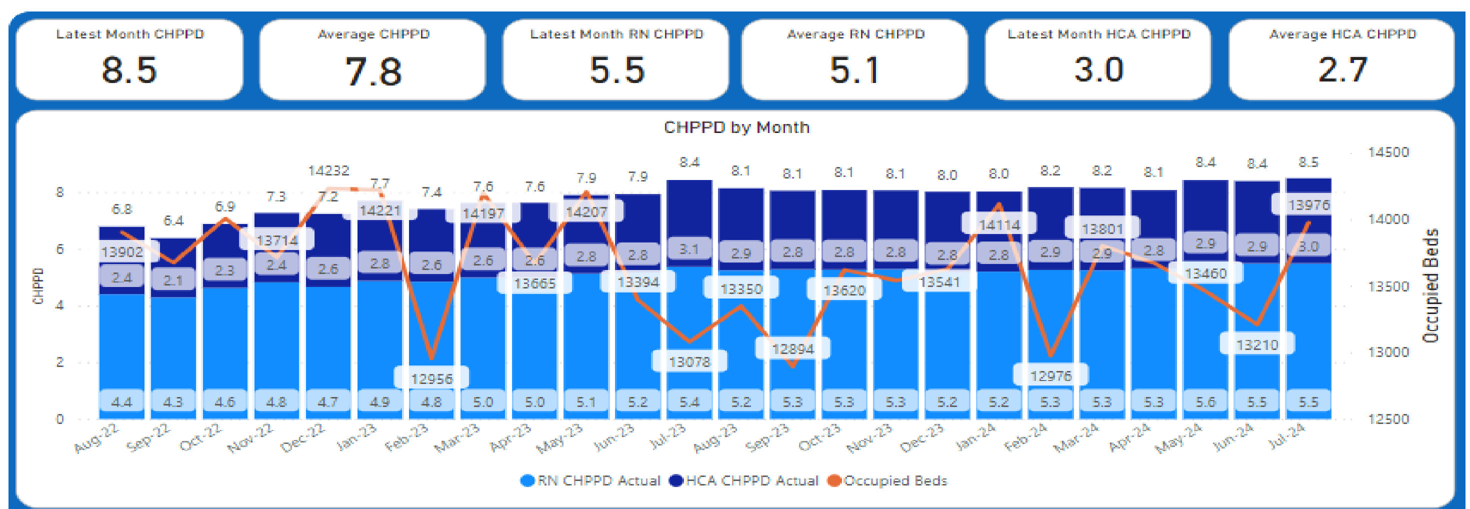
Countermeasure Actions	Due Date
7.5 hours per week filled with a RN bank nurse to support with patient reviews	Ongoing
Continue to review data for pressure ulcers and MASD monthly.	Ongoing
Ward leaders to ensure TV Link Workers attend the TV study days.	Ongoing
Wards to utilise Link workers to support with wound care management and prevention of skin tissue injury.	Ongoing
Wards to have additional training on VAC dressings.	01/10/2024
Tissue Viability (to work with supplies to review continence products.	In progress
MASD care pathway to be completed.	In progress
Review the PURPOSE T risk assessment tool.	In progress

Risks and Mitigations

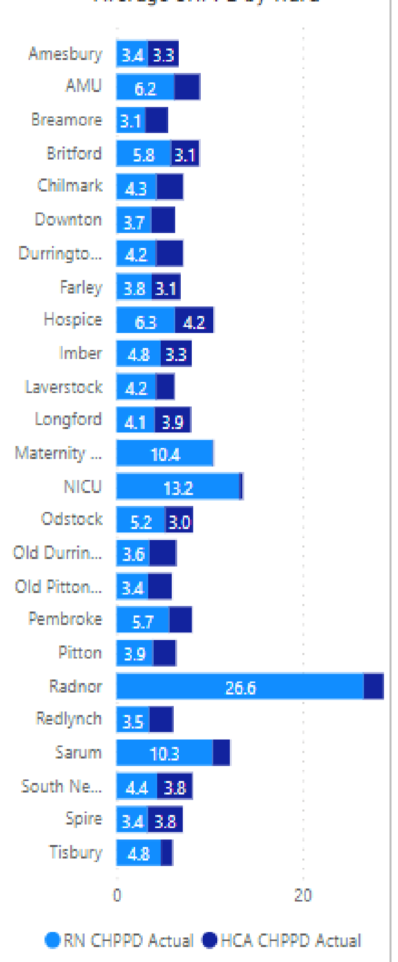
- There was a reduced TV service in July due to a high level of planned and unplanned leave. More photograph reviews of patient wounds were completed.
- ICB TV working for dressings formulary commenced.
- Business Case for additional TVN/s to be completed.
- aSSKINg Care Plan training video completed and sent to wards.

Care Hours Per Patient Per Day (CHPPD)

Target: N/A   Performance: 8.5   Position: Common Cause



Definition: CHPPD (Care Hours per Patient Day) measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight and is nationally reported. NB: There is no national target as is a benchmark to review wards.



Understanding the Performance

CHPPD 8.5 in month and 7.9 when excluding critical care and maternity. CHPPD remains high in Sarum due to empty beds.

CHPPD has sustained at around 8 for several months. Imber ward opening has not impacted as expected. Some work is being undertaken to review reporting..

Fill rate has has remained broadly similar this month.

Agency spend on nursing has increased slightly at £143k (areas using continue to be predominantly Theatres, ICU, ED and Paediatrics). Bank spend at £635k is small decrease on previous month.

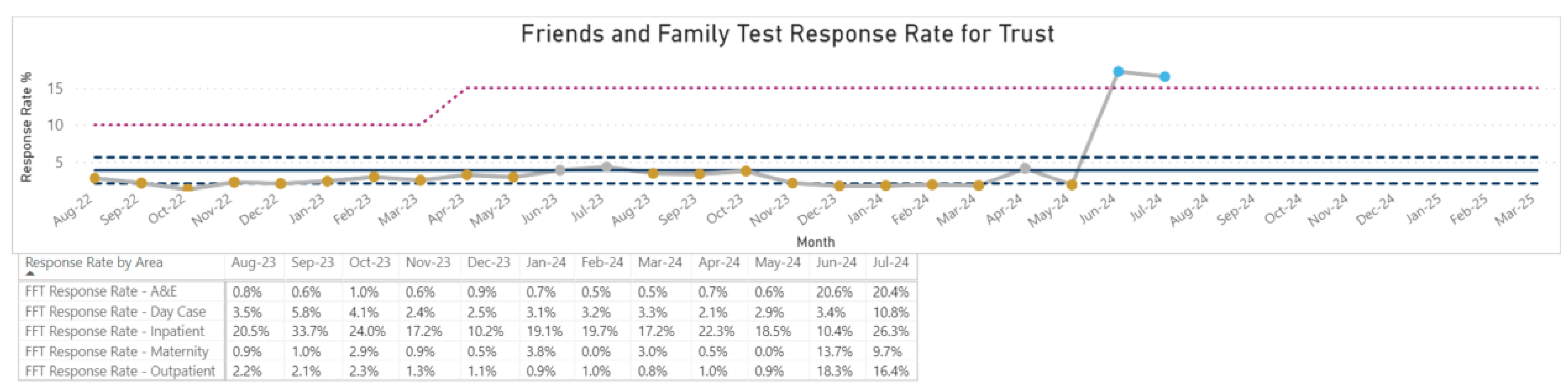
Countermeasure Actions	Due Date
• SNCT data collection completed in June and will be used to inform annual Safe Staffing reviews.	Ongoing
• Weekly forward review of staffing meeting continues.	Ongoing
• Continue to await delivery of trailers for teaching space for IENs - expected July / August.	End Aug 2024
• Review of CHPPD data.	End Sept 2024

Risks and Mitigations

- Business cases for RNDA and Nurse Associate to RN top-up, approved in 2023 remain with execs for decision on funding - needed to support growing own workforce (risk).
- Requirement to reduce head-count (risk).
- Ongoing demand for patients requiring RMN support (risk).
- Ongoing demand for corridor nurse in ED, additional 5.5wte per week (risk).
- Domestic and international recruitment campaigns (mitigation).
- OD&P led work on retention, turnover and inclusion (mitigation).

Friends and Family Test Response Rate

Target: ≥15% Performance: 16.51% Position: Special Cause Improvement



Response Rate by Area	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
FFT Response Rate - A&E	0.8%	0.6%	1.0%	0.6%	0.9%	0.7%	0.5%	0.5%	0.7%	0.6%	20.6%	20.4%
FFT Response Rate - Day Case	3.5%	5.8%	4.1%	2.4%	2.5%	3.1%	3.2%	3.3%	2.1%	2.9%	3.4%	10.8%
FFT Response Rate - Inpatient	20.5%	33.7%	24.0%	17.2%	10.2%	19.1%	19.7%	17.2%	22.3%	18.5%	10.4%	26.3%
FFT Response Rate - Maternity	0.9%	1.0%	2.9%	0.9%	0.5%	3.8%	0.0%	3.0%	0.5%	0.0%	13.7%	9.7%
FFT Response Rate - Outpatient	2.2%	2.1%	2.3%	1.3%	1.1%	0.9%	1.0%	0.8%	1.0%	0.9%	18.3%	16.4%

Understanding the Performance

Slight reduction in month to 16.5% although maintaining improved position above target since introduction of SMS service.
The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Feedback reports are sent to leads showing feedback received allowing them to pick up any immediate causes for concern and mitigate these where possible. Negative feedback should be reviewed by the ward / area regularly and reporting bi-annual is provided by PALS to the Patient Experience Steering Group.

Countermeasure Actions	Due Date
• SMS messages are now being sent to all eligible patients attending our maternity services, Outpatients and ED. This has already demonstrated a significant improvement to the Trust's response rate.	Ongoing
• New online forms have now also gone live and work is underway to advertise these changes through a new poster. Redesign of the FFT boards currently in the inpatient areas are also close to finalisation, with a second phase rollout planned for outpatient) areas. The patient experience team will be working with individual clinics and services not included in the new hierarchy data structure, to consider alternative data collection methods for informing service improvements.	Ongoing

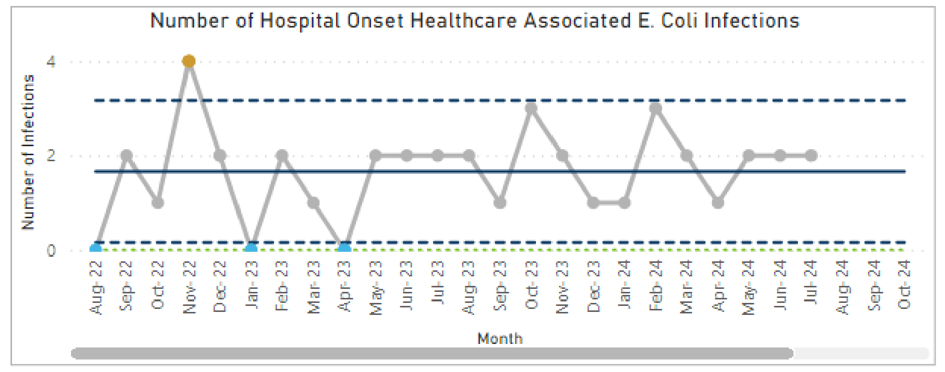
Risks and Mitigations

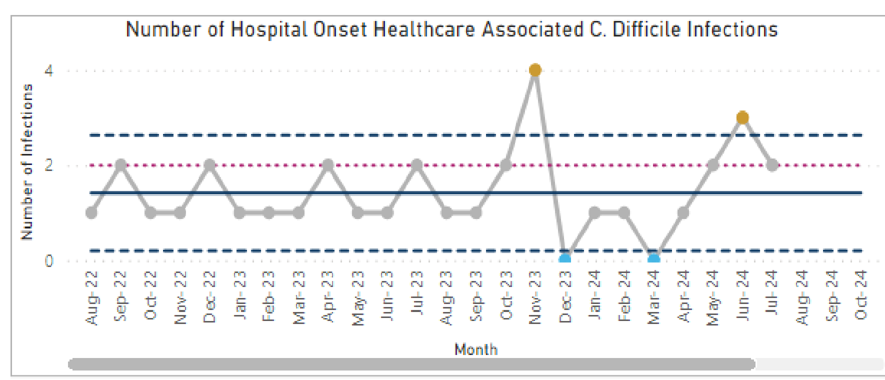
The new dashboard is already enabling better theming and insights analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstated a successful drive towards the Trust's 15% improving together response rate target set for 2024/25.

Infection Control

Position: Common Cause

Position: Common Cause





Year	2022-2023	2023-2024	2024-2025
MSSA Bacteraemia Infections: Hospital Onset	10	10	2
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Understanding the Performance

There have been 2 Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bacteraemia infections, the same number as last month.

For HOHA reportable *C.difficile*, there have been 2 cases compared to 3 cases last month.

There have been no HOHA *MSSA* bacteraemia infections, compared to one case last month.

A period of increased incidence of *C.difficile* was declared for Durrington AFU following the identification of 3 positive cases. Reviews remain ongoing by the division for the positive cases. Control measures have been implemented and assurance regarding practices remains outstanding.

A continued level of diarrhoeal and respiratory activity has been experienced across inpatient areas.

Countermeasure Actions

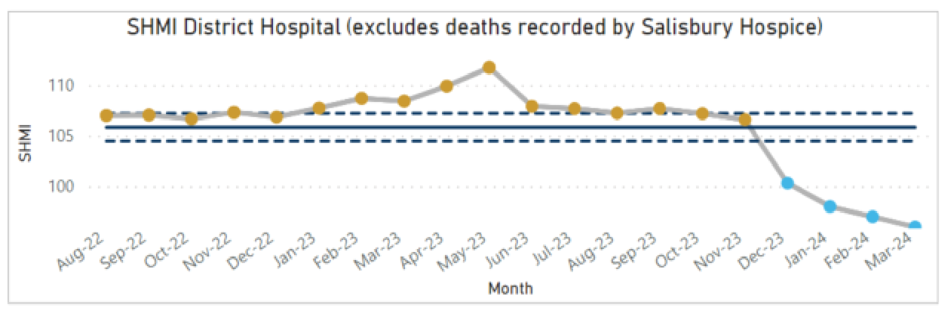
Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas to identify good practice and any new learning continues within identified timeframes.	Monthly
• From the reviews completed for *C.difficile,* lapses in care have been identified relating to timely escalation of reviews and prompt isolation of patients, and delays in sampling. The divisions continue to monitor those areas that have produced action plans and provide updates to the Infection Prevention & Control Working Group (IPCWG).	Monthly
• The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and use educational opportunities with different staff groups.	Ongoing

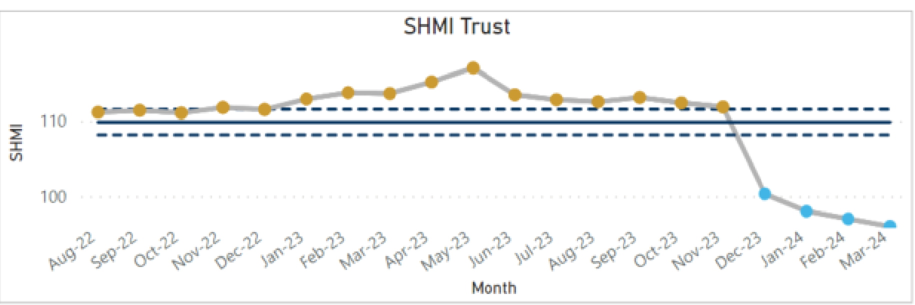
Risks and Mitigations

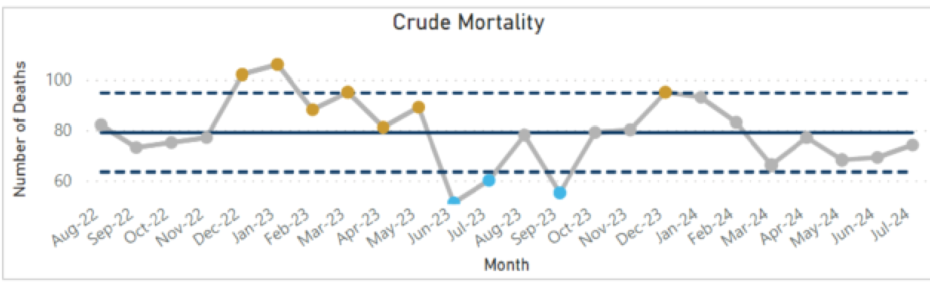
- Ongoing clinical workload for IPC nursing team continues to have an impact on progression with policy reviews and other HCAI prevention work.
- An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. As of 1st April 2024, the admission date definition for reporting HCAIs has changed, which **may** lead to an increase in cases classified as HOHA.
- Soap and gel installation work paused this month due to unforeseen circumstances. New plan agreed with external provider to recommence in August.

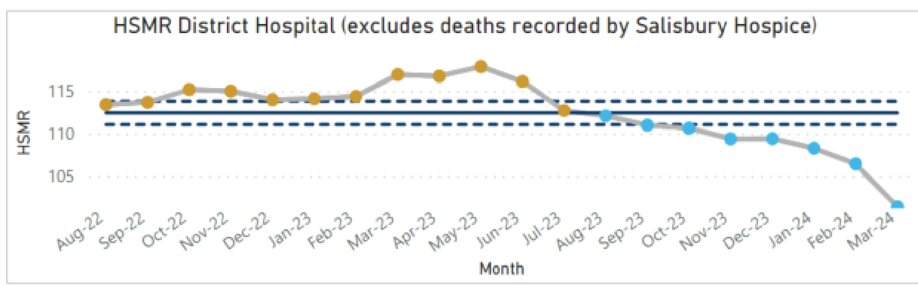
Mortality

Target: N/A Performance: N/A Position: N/A









Understanding the Performance

The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in March 2024 for Salisbury District Hospital has significantly improved and is now 0.96.*
The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in March 2024 for Salisbury District Hospital is 101.35 (a further reduction to the 12-mothly rolling figures seen ending in Jan '24, which were > 108 at this time).

Mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services), therefore the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels.

Countermeasure Actions	Due Date
• A revision to the methodology for calculating the SHMI has come into effect (rolling 12-months from December '23). Prior to this, the Trust had already started to see a positive reduction in the SHMI and HSMR figures.	Ongoing / Bi-Monthly
• Actions related to a Board requested mortality visit continue to be progressed through the Trust's Mortality Surveillance Group (MSG). However, a recommendation has been made to formally close the visit process following positive improvement in the Trust's benchmarking figures.	Ongoing / Bi-Monthly
• An online mortality system to support learning from deaths was launched in March with focus on engagement of our new processes at M&M meetings.	Ongoing / Bi-Monthly

Risks and Mitigations

- The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups.
- Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	57	129	92		0		Common Cause Variation	X	48
Complaints Closed within agreed timescale %	50.0%	47.0%	48.0%	90.0%			Special Cause Improving - Above Upper Control Limit	X	48
ED 12 Hour Breaches (Arrival to Departure)	26	53	27		0		Special Cause Improving - Run Below Mean	X	48
ED Attendances	7366	7166	7251				Special Cause Concerning - Above Upper Control Limit		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	42.4%	41.9%	42.0%		95%		Special Cause Improving - Above Upper Control Limit	X	48
Number of High Harm Falls in Hospital	0	2	2	0	0		Special Cause Improving - Run Below Mean	X	2
RTT Incomplete Pathways: Total 52 week waits	1069	923	901	820	0		Special Cause Concerning - Above Upper Control Limit	X	19
RTT Incomplete Pathways: Total 65 week waits	129	96	70	49	0		Special Cause Improving - Run Below Mean	X	11
RTT Incomplete Pathways: Total 78 week waits	0	0	1	0	0		Special Cause Improving - Below Lower Control Limit	X	1

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Understanding the Performance

Watch metrics alerting positively:

- Long waits in the emergency department remain low at 27 in M4 and ambulance handover delays over 60 minutes were static at 92.
- The number of inpatients that had a VTE Risk Assessment completed within 24 hours of admission shows some improvement when considered over an 18 month trend, however remains significantly below the target of 95% at 42%.
- The number of patients waiting on an elective pathway for appears to alert positively as there has been improvement in the 18 month period of data used in the SPC chart, however the number of patients waiting over 52, 65 and 78 weeks all are above the planned level.

Watch metrics alerting concerningly:

- ED attendances remain high with attendances in M4 11% higher than the same month in 23/24, year to date attendances are 10% above in comparison to the same period last year.
- The number of patients waiting on an elective pathway for appears to alert positively as there has been improvement in the 18 month period of data used in the SPC chart, however the number of patients waiting over 52, 65 and 78 weeks all are above the planned level.

Countermeasure Actions

- A review of the medical staffing model in the Emergency Department is due to be completed in M5 to understand what level of staffing is required for the level of attendances
- Insourcing provider to be sourced for Urology 65-week backlog; long outpatient waits in Urology are currently the biggest contributor to the risk in achieving the 65-week target at the end of September. Daily calls with procurement and division in place to ensure capacity can be secured by September.

Risk and Mitigations

- Risk of lost capacity owing to any future Industrial Action remains, although risk reduced currently with pay deal offered.
- Risk of increase to waiting list through IA by GPs and action to stop providing advice and guidance, being replaced with direct referral.
- Weekly Access Meeting continuing with aim to reduce risk of long waiters and continue drive towards national reduction targets.

Watch Metrics: Non-Alerting

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Beds Occupied %	96.7%	94.0%	89.9%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	✓	0
Diagnostics Activity	8817	8443	9318	0			Special Cause Improving - Above Upper Control Limit	✓	0
Mixed Sex Accommodation Breaches	0	0	0	0	0		Common Cause Variation	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	72.6%	84.0%	86.0%		0%		Special Cause Improving - Above Upper Control Limit	✓	0
Pressure Ulcers Hospital Acquired Cat 2	36	29	36				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	7	2	1				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0				Common Cause Variation		
Proportion of patients spending more than 12 hours in an emergency department	0.5%	1.1%	0.5%				Special Cause Improving - Run Below Mean		
Stroke patients receiving a CT scan within one hour of arrival	63.0%	67.0%	74.0%		50%		Special Cause Improving - Above Upper Control Limit	✓	0
Total Incidents (All Grading) per 1000 Bed Days	59	59	61				Common Cause Variation		
Total Number of Complaints Received	30	17	17				Common Cause Variation		
Total Number of Compliments Received	68	74	49				Common Cause Variation		
Total Patient Falls per 1000 Bed Days	5.98	6.11	6.65	7			Special Cause Improving - Run Below Mean	✓	0

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

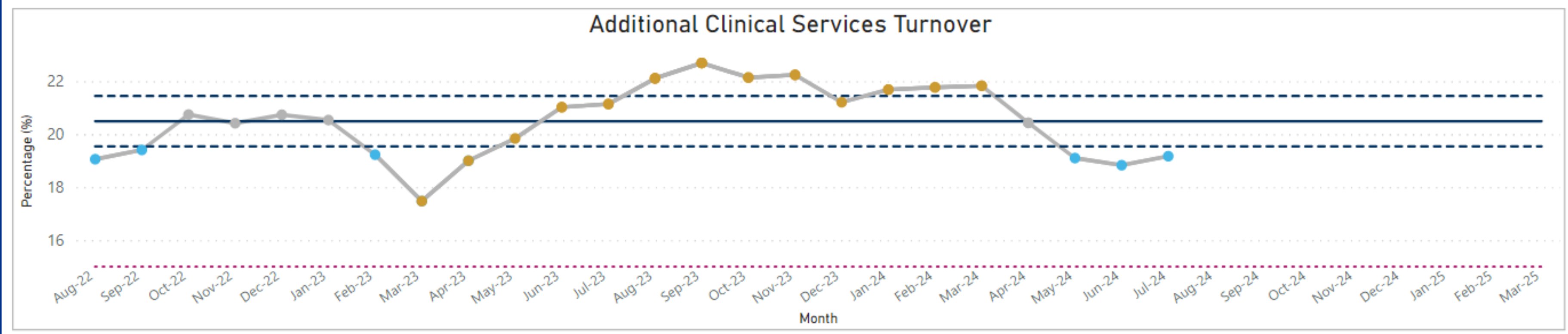
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest turnover areas by staff group (HCA), length of service and Age of Leavers. We have developed an A3 approach to focus on improving retention in this staff group due to the significant impact this turnover has on direct patient care. This will enable more direct patient care hours due to more available HCAs working each shift.

Target: ≤15% Performance: 19.2% Position: Special Cause Improvement



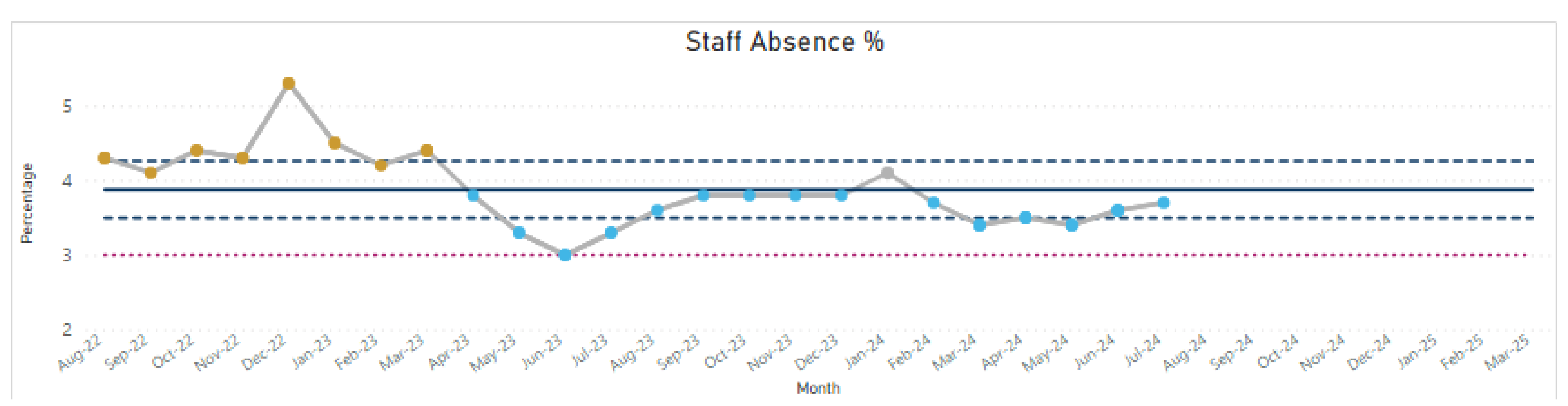
Understanding the Performance
The rate of turnover for Additional Clinical Services (ACS) staff was 19.17% July (up from 18.8% for June) the first increase since adoption as a breakthrough objective. The overall turnover rate for the Trust sits at 13.34% (second lowest since Aug '22). Against the divisions, W&NB have the highest turnover at 15.15%. 12 staff (10.72 FTE) left the Trust in June 2024, this represents a reduction of 8 staff/7.92 WTE compared to the previous month.

Countermeasure Actions	Due Date
•Launch and review success of HCA Preceptorship to improve training/induction experience. First cohort due to complete in December 2024 (HCA retention lead).	Jul 24 (launch)
• New to care HCA tagged at Induction, shadow shifts provided in first 3 months of employment. (HR/HCA retention leads).	May - Sep 24
• Lack of development of HCA colleagues. Apprenticeship/career development routes. HCAs onboarded directly onto "apprenticeship route". Other HCAs have option to step on to route. Completes higher development award, CC, +/- maths and English and L3 senior HCA apprenticeship (HCA Retention lead).	Q2 2024

Risks and Mitigations
• Impact of raise of national living wage and delay of pay review body announcement risks loss of staff to other roles. Mitigation to ensure all staff move to Band 3 provision as quickly as possible. This was approved at July TMC for immediate implementation. New pay award implemented August 2024. • Demand for ACS staff outstrips local supply. Staff at lower pay levels cannot travel. Wider engagement through local schools, colleges and job centres to attract individuals new to care.

Sickness Absence

Target: ≤3% Performance: 3.70% Position: Special Cause Improvement



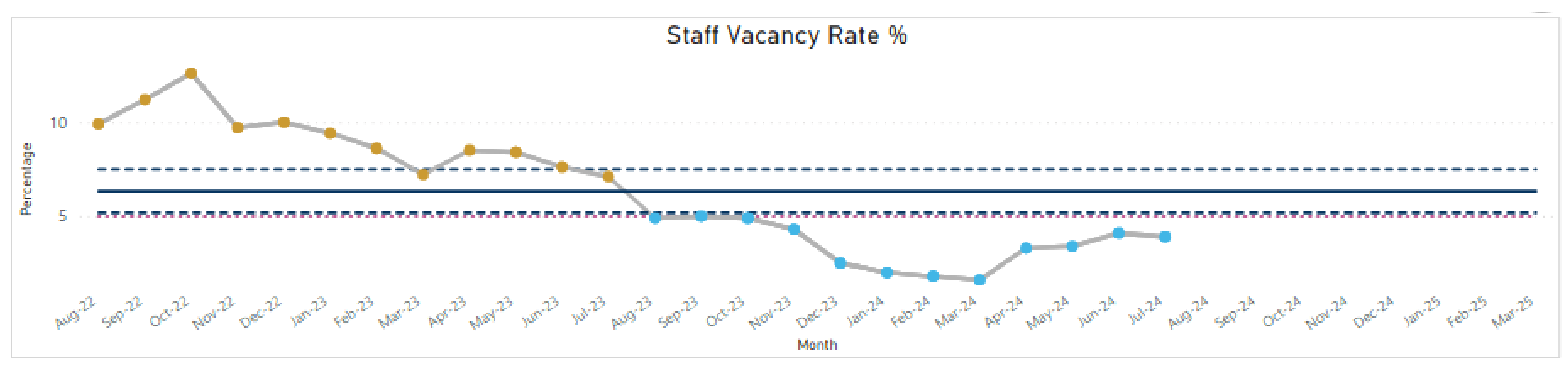
Understanding the Performance
Sickness absence has stabilised over the last 3 months at an average of 3.57%, below the 12 month average and much lower than 18 month average. WNB are the best performing division in month (2.58%), with EFM the worst (5.71%). Additional clinical services continue to average over 5.62% (down from 5.92%), the worst performing staff group, which triangulates with high turnover rates as well. Sickness accounted for 4,606 FTE days lost to the Trust, of which c1/3 were for long term and c2/3 short term absence. Highest absence rate remains Anxiety / Stress / Depression, accounting for c.1 in 6 absence days.

Countermeasure Actions	Due Date
• Line Manager training on Absence Management policy and actions seeking to deliver training opportunities for all LM by year end. sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy)	Dec 24
• Reduction of violence and aggression on wards and in ED/AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions for ward staff planned each month. Excellent feedback so far.	Mar 25

Risks and Mitigations
• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. • The ER team has been recruiting to better support the programmed activity but this currently remains a risk until new starters are in post. As of August 2024 the HR team has no substantive HRAs in post until 1 WTE commences 19/8. There will be reliance on temp staff (currently 0.8 WTE in post and 1.0 WTE due to start 27/8. • B7 team manager role being covered by HR BP. • 1.6 B6 HRA on maternity leave. 2.2 WTE vacancies. 0.5 B5 vacancy. B4 currently FTC cover for Maternity leave.

Vacancies

Target: ≤5% Performance: 3.90% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
A drop of c.8 FTE (167 FTE to 159 FTE vacancies) in the Trust saw the headline rate fall again from 4.08% to 3.81% for the month, consistently below the Trust target of 5% for the 12th month running. The highest vacancy rates are in Informatics, Pathology and Emergency Medicine, the latter specialty being the one which generates the highest Temporary staffing spend.	• Focus attraction campaigns to meet high vacancy and hard to recruit areas. Current focus is Theatres, Emergency Department, Maternity, HCAs and Housekeeping. A campaign has also been launched to attract consultant staff in hard to recruit posts. • Identification of new areas for apprenticeships through Coventry Programme. Nursing Associate Degree Apprenticeships initial focus.	Aug 24 Sep 24	• Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and onboarding processes. Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations. • Resignation of Recruitment manager. Replacement due to start 2 September.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	85.6%	85.0%	85.4%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	18
Non-Medical Appraisal Rate %	78.3%	78.1%	78.4%		90%		Special Cause Improving - Above Upper Control Limit	X	48
Staff Turnover (Trust overall)	13.5%	13.3%	13.3%	13.0%			Special Cause Improving - Below Lower Control Limit	X	48

Watch Metrics: Alerting Narrative

People

Understanding the Performance

Mandatory training remains below target at 85.4% completion. This has been the picture since Feb 23, with the average sitting at around 86%, some 4% below the 90% target. Only Facilities have consistently met this target, through the application of significant oversight from their management team.

Medical appraisals have, for the third consecutive month since Aug 23, met the 90% target with appraisals in July at 92.5%. The number of medical appraisals out of date continues to gradually reduce, sitting at 18 in July.

Having seen a rising trend for non-medical appraisals for 8 months, the start of FY 24/25 has seen a drop in completion rates to 78.1% in June. The application of significant oversight is required to reverse this trend moving forward .

Turnover trends at the Trust in the last 4 months have averaged c.13.4%, from last years' high of 14.5% average. In July the Trust had an increase in net numbers of 4.3 FTE, the first monthly imcrease since March 2024, but still over 1% lower than July 2023.

Countermeasure Actions

• A review of Mandatory training requirements, aligned to the core skills training framework, and national guidance seeks to better understand the mandated training environment and the time required to complete training. On completion this review identify any changes to the provision and need for statutory and mandatory training in different roles and professions. The review was due to report in Jul 24.

• Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.

• Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. Further analysis of organisational structure to support those managers with a high appraisal burden is ongoing and due to report in Aug 24.

• Turnover: Training and education to improve exit conversations will support further work across the Trust to better investigate the negative reasons for leaving and target these areas to mitigate negative reasons for leaving the Trust.

Risk and Mitigations

• The ability to accurately record and assign statutory and mandatory training to staff is a key function in understanding risk to the Trust from training gaps. A programme of work is underway to improve the MLE system in assigning and identifying staff gaps in training.

• Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers. This training and revision to the guidance has been delayed due to significant/ongoing vacancies in the HR Operations team.

• Loss of staff due to poor reward and recognition is recognised as a risk in the Trust. Work is underway to mitigate this risk through the identification of an Employee Value Proposition, which will seek to identify a framework to better exploit all elements of reward and recognition within the Trust. First elements of this project will be delivered in Q2.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

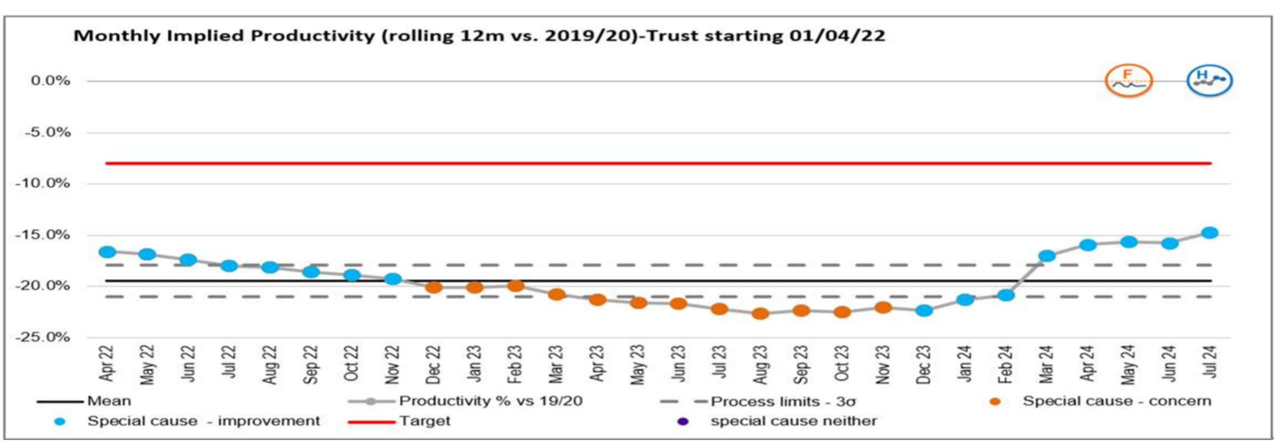
Partnerships

Creating Value for Our Patients

Breakthrough Objective

We are driving this measure because…	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: N/A Performance: -15.1% Position: N/A



Understanding the Performance
In Month 4 pay pressures due to sickness, annual leave cover and vacancies combined with lower levels of Elective inpatients and Outpatients activity but higher A&E and Non-Elective have driven the productivity delivery. There is an improvement of 2.2% delivery since March which is due to pay cost increases being mitigated by A&E and Non-Elective activity increases. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.

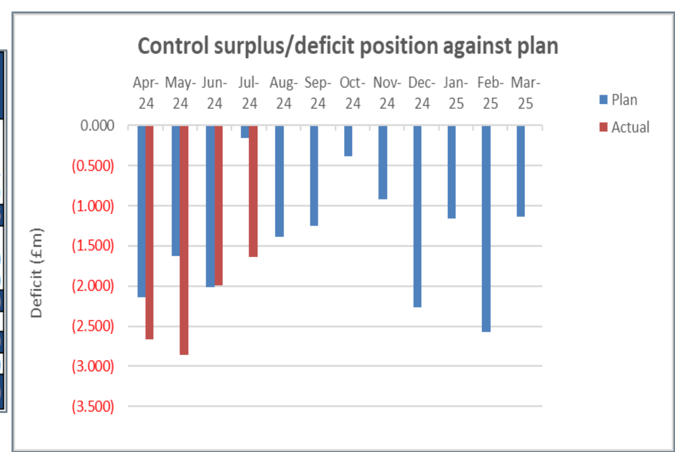
Countermeasure Actions	Due Date
• FRG task and finish group operating on alternate fortnight to review headcount above March 2023 levels.	Ongoing
• Modernisation and consistency of admin processes.	Ongoing
• Workforce utilisation modelling to consider annual and study leave, sickness and roster overlaps.	September
• Financial controls actions are ongoing with the number of Purchasing cards reducing to 21.	September

Risks and Mitigations
• The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Target: N/A Performance: N/A Position: N/A

	July '24 In Month			July '24 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	26,637	25,972	(665)	103,821	102,145	(1,676)	311,071
Other Clinical Income	1,250	1,095	(155)	3,861	4,274	413	10,794
Other Income (excl Donations)	3,275	2,811	(464)	13,100	12,254	(846)	39,300
Total income	31,162	29,878	(1,284)	120,782	118,673	(2,109)	361,165
Operating Expenditure							
Pay	(19,635)	(20,258)	(623)	(79,164)	(80,875)	(1,711)	(236,139)
Non Pay	(9,790)	(9,618)	172	(40,003)	(40,248)	(245)	(119,377)
Total Expenditure	(29,425)	(29,876)	(451)	(119,167)	(121,123)	(1,956)	(355,516)
EBITDA	1,737	2	(1,735)	1,615	(2,450)	(4,065)	5,649
Financing Costs (incl Depreciation)	(1,887)	(1,641)	246	(7,549)	(6,711)	838	(22,654)
NHSI Control Total	(150)	(1,638)	(1,488)	(5,934)	(9,161)	(3,227)	(17,005)



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The financial plan submitted to NHS England on 12 June shows a £17m deficit position for the year and includes an efficiency requirement of £21.1m. The Trust recorded an in-month control total deficit of £1.6m against an original deficit target of £0.2m - an adverse variance of £1.4m. The deficit position year to date is driven by underperformance on Elective recovery funding (ERF) points of delivery, the impact of industrial action and pay pressures largely driven by non elective activity volumes and pathways.	• Financial recovery group (FRG) in place to review recovery actions with alternate fortnightly workforce group to review headcount.	Ongoing	• Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working. • Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and recruitment. • The Trust's £21.1m efficiency savings plan includes more than 40% non recurrent delivery and signals a risk into 25/26.

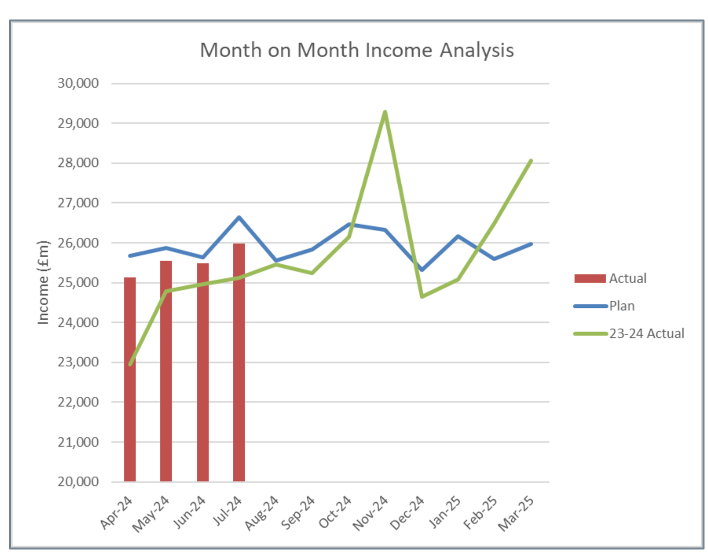
Income and Activity Delivered by Point of Delivery

Target: N/A Performance: N/A Position: N/A

Income by Point of Delivery (PoD) for all commissioners	July '24 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	3,994	4,313	319
Day Case	8,556	8,837	281
Elective inpatients	7,186	5,004	(2,182)
Excluded Drugs & Devices (inc Lucentis)	9,136	9,941	805
Non Elective inpatients	26,816	27,227	411
Other	33,517	32,174	(1,343)
Outpatients	14,616	14,649	33
TOTAL	103,821	102,145	(1,676)

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	61,618	60,528	(1,090)
Dorset ICB	10,251	9,977	(274)
Hampshire, Southampton & IOW ICB	9,135	8,621	(514)
Specialist Services	14,070	14,768	698
Other	8,747	8,251	(496)
TOTAL	103,821	102,145	(1,676)

	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	24,675	27,076	2,401	24,761	2,315
Day case	9,358	9,433	75	7,985	1,448
Elective	1,589	1,186	(403)	1,078	108
Non Elective	9,538	10,332	794	9,212	1,120
Outpatients	98,148	98,819	671	87,158	11,661

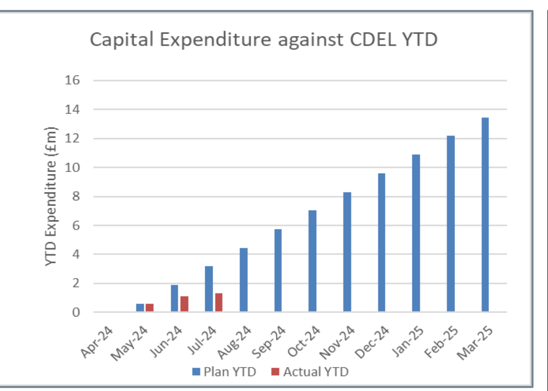


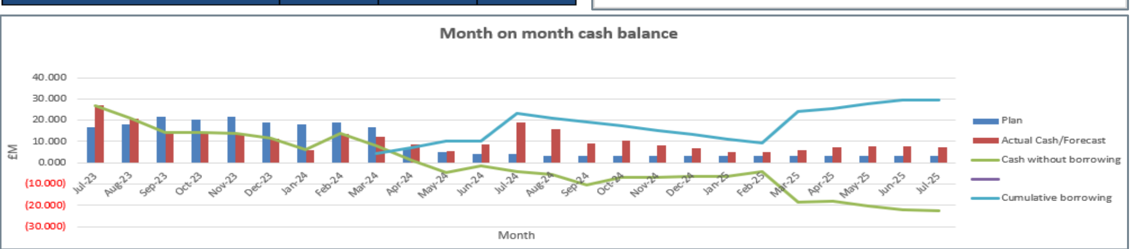
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Clinical income position is below plan year to date with underperformance across all of the main commissioners with the exception of Specialised commissioning. This is driven by lower Elective Inpatients and Industrial action impacting on the ERF income partially offset by overperformance on Day cases activity. The level of uncoded day cases and inpatient spells is 31% in June and 94% in July at the time the activity was taken for reporting purposes. Activity across all of the main points of delivery was higher in July than June with the exception of Elective Inpatients activity which was 9 spells lower in month.	• Contract values have been agreed with all commissioners and issues remain outstanding by exception. • Maximising activity recording opportunities, Advice and Guidance, productivity improvements and seeking to increase income available through contract negotiations.	Ongoing Ongoing	• Industrial action constrained the elective programme and management capacity to improve productivity in month.

Cash Position and Capital Programme

Target: N/A Performance: N/A Position: N/A

	Closing Balance March 2024 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,462	508
Debtors	24,999	28,477	3,478
Cash	28,891	19,724	(9,167)
TOTAL CURRENT ASSETS	**61,844**	**56,663**	**(5,181)**
Creditors	(58,026)	(49,147)	8,879
Borrowings	(641)	(14,388)	(13,747)
Provisions	(474)	(418)	56
TOTAL CURRENT LIABILITIES	**(59,141)**	**(63,953)**	**(4,812)**
TOTAL WORKING CAPITAL	**2,703**	**(7,290)**	**(9,993)**





Schemes	Annual Plan £000s	July '24 YTD Plan £000s	July '24 YTD Actual £000s	July '24 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	779	187	592
Building projects	2,682	898	952	(54)
Fire schemes	500	119	44	75
IM&T	6,264	1,045	152	893
Medical Equipment	393	56	10	46
Total CDEL schemes	**13,448**	**2,897**	**1,345**	**1,552**
National Funding				
Shared EPR - national element	2,231			
Digital Pathology & LIMS	634	71	71	
Community Diagnostic Centre	1,306			
South West Imaging	203			
Total National Funding	**4,374**	**71**	**71**	
IFRS 16 Leases				
Medical Equipment	1,800			
Vehicles and transport	850			
All other leases including property	350			
Total IFRS 16 Leases	**3,000**			
GRAND TOTAL	**20,822**	**2,968**	**1,416**	**1,552**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £1.4m driven by Imber ward, the decarbonisation scheme and CT2 scanner installation costs.

The cash balance at the end of Month 4 was £15.3m above the planned level of £4.4m. The improvement is due to the BSW ICB contract payment which was doubled in month to mitigate short term cash issues. Daily cash monitoring is in place and supplier payments are being actively managed to reflect supplier payment terms.

Countermeasure Actions	Due Date
• Capital cash support application	Sept 24
• Q4 revenue support application	Dec 24

Risks and Mitigations

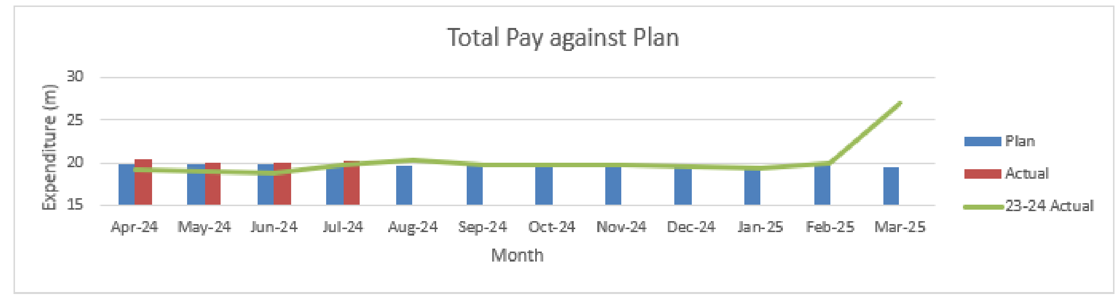
- Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.
- The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust.
- The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.

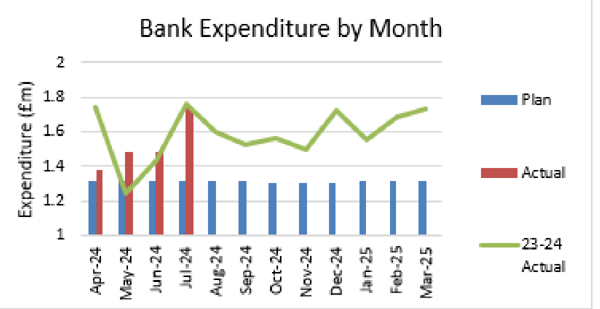
Workforce and Agency Spend

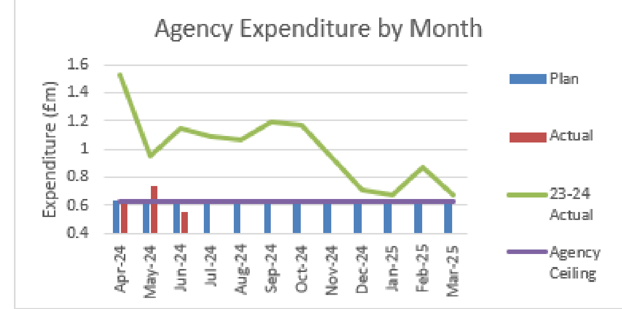
Target: N/A Performance: N/A Position: N/A

	July '24 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	71,122	72,209	(1,087)
Pay - Bank	5,248	6,079	(831)
Pay - Agency	2,552	2,270	282
Other (eg apprenticeship levy)	242	316	(74)
TOTAL	**79,164**	**80,875**	**(1,711)**
Medical Staff	19,621	22,124	(2,503)
Nursing	21,860	21,159	701
Support to Nursing	7,795	6,772	1,023
Other Clinical Staff	10,699	10,900	(201)
Infrastructure staff	18,947	19,604	(657)
Other (eg apprenticeship levy)	242	316	(74)
TOTAL	**79,164**	**80,875**	**(1,711)**

	July '24 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	533.1	527.72	(5.4)
Nursing	1,231.1	1,261.82	30.8
Support to Nursing	453.9	591.28	137.4
Other Clinical Staff	843.0	640.31	(202.7)
Infrastructure staff	1,389.1	1,439.28	50.2
TOTAL	**4,450.1**	**4,460.4**	**10.3**







Understanding the Performance

Pay costs in month were £0.6m above plan and include the planned provision for the Agenda for Change and Consultant pay awards.

The adverse variance in month is driven by unavailability increases for annual leave and sickness, specifically Junior Doctors within the Medical specialties, and increased substantive staff.

Substantive staff have increased in month by 26 WTE and there is an over-establishment of 10 WTE against the 4,450 WTE Workforce trajectory (4,309 WTE at March 25). The over-establishment varies across Pay categories with Medical Staff and other Clinical Staff under established with all other groups over established.

Countermeasure Actions	Due Date
• Trust wide and Division workforce control panels in place since November 23	Ongoing
• Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients)	Ongoing

Risks and Mitigations

Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although in the short term it is likely that the Trust will require both.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target for a single month	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 or more months in a row	Performing above target for multiple months in a row	Share success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 4 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric/increase target of Driver	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric, or increasing target of Driver metric
6	Driver is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	Driver is blue	Performance outside of expected range in a positive /improving direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Appendix

Business Rules – Watch Metrics

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – orange	Concerning performance	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
10	Watch has 2 out of 3 points low – orange	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 4 points below mean or 4 points deteriorating - orange	Worsening performance	Consider: - Upgrading to a Driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - blue	Improving performance, not yet sustained	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is grey (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

Appendix

Business Rules – Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.
Whether or not a metric has met its target each month will be indicated by a tick or a corss icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has NOT met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different action are suggested depending on hpw many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance Give structured verbal update by exception	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if counter measure summary required	Showing signs of continued difficulty meeting the target and need understanding of root cause.
18	Mandatory does not meet target for 4 or more months in a row	Performing below improvement target for a sustained length of time	Consider applying improvement target	Showing signs of continued difficulty meeting the target despite understanding of root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of Mandatory	Assess Mandatory metrics and ensure performance culture is maintained.
20	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly	Mandatory metrics are being deliberately monitored and therefore SPC rules are not strict enough for monthly performance assurance purposes

Appendix

Reading a Statistical Process Control (SPC) Chart

The two dotted blue lines represent the boundaries of "normal"

There should always be a minimum of 15 months worth of data

The solid blue line shows the mean value for the dataset

The green line shows the National Target for the KPI, if there is one

The pink line shows the plan for the KPI for the current year, if there is one

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	5th September 2024		

Report title:	TMC Escalation Report			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Christina Steele, EA to CEO & Chair			
Executive Sponsor: (presenting)	Lisa Thomas, Chief Executive			
Appendices	N/A			

Recommendation:

The Board is asked to note the following report following the Trust Management Committee meeting.

Executive Summary:

The Trust Management Committee was held on the 28th August 2024.

Assure

- Cancer performance was discussed, and it was acknowledged SFT are ahead of trajectory, however as a system we are in tiering for Cancer and Diagnostics.
- Diagnostics performance remains above 85%; SFT have committed to reach 93% by year's end.

Alert

- Three main areas that need organisational focus were highlighted in the financial update: the usage of beds, medical agency, and the delivery of our elective plan to deliver ERF income.
- Policy compliance, the current policy system issues (Microguide) and the possible transition to a new platform continues to be a significant challenge. The Corporate Risk Register reflects the significant risk related to policy compliance and our inability to publish guidelines until we transition to a new system. The Corporate Governance, Procurement and Contract Teams are working at pace to manage the situation. On 3rd September, a Policy Summit will be held with Divisions and policy owners to assess our current position.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

- The Trust has received notice from the company that acquired Lloyds Outpatient Pharmacy of their intention to novate our contract to another provider. The teams are looking into the implications of this and the TMC were assured the Trust has contractual rights to intervene if the service delivery degrades.

Advise

- The Orthopaedics LLP Business Case was presented to the committee and following discussion, and subject to further assurance, it was decided to progress to FRG for a final review before being shared with the System Investment Group.

- The business case for X-Ray Reporting Radiographers was reviewed by the committee. Option 3 of the case was approved, and this will now progress to the System Investment Group.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	5th September 2024		

Report from (Committee Name):	Clinical Governance Comitee		Committee Meeting Date:	30/7/24
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Dr David Buckle			
Non-Executive Presenting:	Dr David Buckle			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- **In spring 2024 NHSE wrote to the Trust describing concerns over hearing tests for babies. (Auditory Brainstem Response testing) The Trust responded appropriately, and it was noted by NHSE that our team had engaged positively. Further work including a patient recall process needs to be undertaken as NHSE reported that there is a serious risk that clinical care was impaired.**

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Perinatal surveillance report. The committee was assurance that the Trust is focused on the requirements of the maternity incentive scheme and is expecting to leave the improvement program soon.**
- **In March 24, NHSE advised trusts/ICBs that there had been some delays in referring women who were at high risk of breast cancer to the appropriate screening service. This service is not managed by our Trust but some of our patients may be affected. A clinical c review is underway.**

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- **Divisional report from Women and Newborn**
- **Mental health liaison committee,6 monthly report**
- **PSIRF 6monthly update . This was the first report following the launch in January.**
- **National clinical audit 6monthly report**
- **Annual Nice report**
- **5 steps to safer surgery action list update**
- **Annual research report**
- **NHSE mortality review action plan update showed good progress.**

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• None

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

Report to:	Trust Board (Public)	Agenda item:	2.4
	5th September 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	30 July 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- **BSW ICS –** urgent requirement for SFT and system to provide assurance on delivery of the 204/25 operational plan. If the system cannot provide sufficient assurance the Trust, it is likely the National Recovery Support team would be deployed into BSW. There is significant risk in the delivery of SFT's financial plan, as was clearly set out in the planning process, the £14m of risk set as part of the operating plan remains a key are of focus, with specific pressure on the cost reduction associated with a reduction in the Trust's bed base.
- **Financial Performance** – the Committee feels assured that everything reasonably possible is being done to close the financial performance gap.
  - **Non Elective –** As reported last month - 7% above plan and up on last year, for which there is no additional income, but obviously comes with cost and performance implications.
  - **ERF** is behind plan, but improving as coding is completed with a higher tariff than the average tariff being used for "interim" income purposes.
- **Trajectories & IPR**
  - **NCTR –** with 20 more beds than in plan, a "heart to heart" with the system is needed to reveal what is getting in the way of real progress. SFT's aim is to close 12 beds in Braemar in August and then close another 12 once NCTR gets into the 60s, to deliver on the plan, so NCTR is key to achieving our plan objectives. There will be a deep dive at F&p in September.
  - **ED -** attendances continue to be high, at 7% above plan at Q1. This places risk around the ability to achieve the 4-hour standard trajectory. The situation was worsened in June with the closure of AFU for 2 weeks because of a Norovirus outbreak. Lessons are being taken from this event.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Decarbonisation contract** – delays in finalising the legals continue with the hope that they can be signed in August. In the meantime, we are operating on NHS standard T&Cs, which means the "energy performance" element of the contract is not yet a supplier obligation. However, we took assurance that we have met the criteria of the funding.).

- **Debtors –** progress is being made with debtors, however UHS is the largest aged debt and whilst they have cash issues, we need to be clear that they can't pass that cash pressure on to us, and they need to clear their overdue debt.
- **Risks – BAF4 & 9, (critical plant & infrastructure and financial deficit respectively)** are out of tolerance and are overseen by F&P. We are intending to consider these in more detail in September's meeting.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- **Cancer** – continues to improve and perform above tier 2 performance.
- **LOS** – improving with more zero-day pathways.
- **Theatre Deep Dive –** activity is on plan, but with Day cases up and Elective down there has been a negative impact on income. We were assured through the presentation and discussion that actions will redress the gap, and potentially deliver an over-performance. There was a verbal update, based on data from 29th July, that SFT position has improved against the model hospital data and we are not rated green.
- **CIPS –** whilst the report shows >£5m of "unidentified CIPs" the Executive were clear that there is a full list of contributors (in the plan) to close the gap, which is acknowledged as needing acceleration, and that they remain focussed on delivery and realisation of the savings and do not want to fall into the trap of generating lots of new small scale initiatives.
- **E-rostering**– a reflective piece on the delivery of the business plan and benefits realised was delivered and whilst there are many and we are in a much better place, it was acknowledged that we are not where we need to be and an action plan to take us to the end of this year will come back.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- **Fluoroscopy** – Supply of Fluoroscopy Equipment, Maintenance and Turnkey Works via the NHS Supply Chain Framework Agreement, Static X-Ray and Associated Options and Related Services for a period of 7 years, with no option to extend. With only one compliant bid we challenged the VFM, but gained assurance that costs benchmarked with other trusts who have the same equipment. The approval was for a lease purchase.
- **Minor Works and Design contracts** – preferred supplier list approved.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	5th September 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	25th July 2024
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The committee were advised that maternity services had the highest turnover. The committee have requested that further details come back to September meeting so that we can fully understand the reasons and that the relevant support can be given to the service
- In relation to winter planning and the operational plan, no guidance was available yet. The operating plan is being considered by both the financial control group and the vacancy control panel and the committee recommend that a quality impact assessment is considered by CGC

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - A detailed discussion was held in relation to the strategic workforce plan. This was expected once purdah had completed and came back as expected to the July meeting. A lot of work has gone into this. The information presented was an analysis and described the current challenges and strategic intent for the next 5 – 10 years. Further discussion is required to make this real for the Trust. It was noted that new roles can provide an opportunity to meet some workforce gaps but there needs to be robust governance around these roles. A key workforce risk was community and mental health services. An update will come back in November to the committee
  - The IPR report (see assurance below). Areas to focus on remain understanding why people leave us and how we can improve the education and training offer and uptake
  - Staff Survey – good progress was made over the last year though noting that education and training remains low in the report
  - Other core monthly reports

To note: The annual review of committee effectiveness will be done in September and not July as previously reported.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- There is good evidence that Improving Together is how the committee and the OD and P team are doing their work

- The IPR continues to demonstrate positive improvement including a reduction in staff turnover for support workers though this still remains a priority for further improvement
- There has been positive progress in relation to OD and P policies with a shift in key policies to aligning with the just and restorative culture approach outlined in PSIRF
- As this month's meeting had a lighter agenda, in the reflection of the meeting members reported that it was positive to have good discussion time. This was echoed by Governor observers
- It was noted that the Walk for Wards had been well supported with over 2 thousand participants, many of whom were our own staff

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- Nothing for Board approval from this meeting

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	√
Partnerships: Working through partnerships to transform and integrate our services	√
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	√
Other (please describe):	

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	5th September 2024		

Report title:	SIRO Annual Data Security and Protection Assurance Report			
Status:	Information	Discussion	Assurance	Approval
			X	
Approval Process: (where has this paper been reviewed and approved):	Information Governance Steering Group reviewed content			
Prepared by:	Mark Arnold, Data Protection Officer (DPO) Jon Burwell, Acting Chief Digital Officer			
Executive Sponsor: (presenting)	Jon Burwell, Acting Chief Digital Officer			
Appendices	Data Security and Protection Toolkit Certificate 2023/24			

Recommendation:
The Trust Board is asked to note this report.

Executive Summary:
This report is the annual SIRO report, providing an update on progress made by the organisation over the last 12 months. It highlights areas of improved compliance, and areas of concern within the Trust's compliance with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO). This report confirms that the Senior Information Risk Owner, Data Protection Officer, and members of the Information Governance Steering Group, regularly, scrutinises the Trust Risk Register, in compliance with the DSPT, and legislative standards. Where appropriate, action is taken to improve performance and compliance with the Trust's risk management and governance framework. The Trust's Freedom of Information compliance consistently exceeds the 90% set by the ICO. There was an FOI complaint upheld against the Trust during the year for failure to follow the correct procedure. The Trust self-declared one incident to the Privacy Regulator the Information Commissioners Office (ICO). The ICO assessed each and found no actions would be taken against the Trust.

The report confirms that the Trust has successfully submitted the 2023/24 DSPT assessment which included an internal audit on a subset of evidence. This audit reported a 'Significant assurance with minor improvement opportunities', with one medium and five low findings all having been responded to. Cyber controls remind in place and programmes to improve the Trust's cyber posture around areas such as unsupported technology continue. The Trust is fully engaged with the planned changes for the DSPT in 2024/25 as it becomes aligned to the Cyber Assurance Framework.

The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust, providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	X
Partnerships: Working through partnerships to transform and integrate our services	X
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	X
Other (please describe):	

1. Introduction and Purpose

1.1. This report combines the final Data Security and Protection Toolkit (DSPT) submission report and the Data Protection Officer yearly report.

1.2. This report serves to inform and advise the Board of the Trust's statutory compliance, whilst recognising areas of good practice, to ensure personal and corporate information is handled legally, securely, efficiently and effectively to deliver the highest standard of care by staff and the organisation. Information Governance plays a vital role as the foundation of all governance by supporting integrated governance within the Trust.

1.3. It provides an update on progress made by the organisation since the last submission. It highlights areas of improved compliance and areas of concern within the Trust's compliance, with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

1.4. In addition, the report provides an update on progress made in respect of our mandatory cyber security programme and the 2023/24 Data Security and Protection Toolkit assessment.

2. Data Security and Protection Toolkit 2023/24

2.1. The Data Security and Protection (DSP) Toolkit is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care, notably the 10 data security standards set by the National Data Guardian.

2.2. The baseline submission was submitted in February 2024. The internal audit took place through March and April 2024 and was adhered to the nationally mandated scope. The final report has scored the Trust's DSPT as having 'Significant assurance with minor improvement opportunities'. There were 6 findings in total. One finding had a medium priority, with the rest scored as low priority. There were no high priority findings.

2.3. In June 2024, the DSPT assessment was submitted to 'Standards Met'. The certificate is available at appendix A.

2.4. The DSPT assessment for 2024/25 is due to be published in September 2024 and has undergone a substantial change. The new format is centred on the Cyber Assurance Framework (CAF) and the majority of evidence items have either changed or require different types of evidence to previous years. The changes appear to require a significant amount of resource to complete.

3. Information Asset Management

3.1. There is a requirement in the Data Security and Protection Toolkit (DSPT) to ensure that an asset register is maintained. There is also a requirement to ensure that systems (assets) are assessed regularly to determine their level of risk and if required, that the risk is acted upon.

3.2. The Asset Register is a list of all known systems within the trust. It details the purpose of the system, who the Information Asset Owners (IAO's) and Information Asset Administrators (IAA's) are and the risk associated with each system. There are a total of 276 known active assets as of 30th June 2024. The systems have been assigned a business continuity management (BCM) level based on the impact to the Trust if the system was unavailable.

3.3. Information is added to the register throughout the year and entries are added when new assets are used. There are various workstreams to assess each asset and its security tools. This can include a data protection impact assessment (DPIA), a digital technology assessment criteria (DTAC) assessment, system audit reports and security logs. The DSPT makes recommendations on complex passwords, multi-factor authentication and user accounts.

3.4. In addition to DPIAs and DTACs, basic due diligence checks are completed for suppliers. This is done for new suppliers and also updated annually for existing suppliers. Due diligence checks showed the following companies had breaches reported in the last 12 months:

Company	Year	Details	SFT Impact
Sciensus	2024	Delivery of cancer medication to the wrong address (June '24). Email to 495 patients (only 2 were SFT) was sent using 'CC' instead of 'BCC'. Self-reported to ICO (Aug '24)	None known
Synnovis	2024	Pathology Lab (Outsourced company used by Guy's and St Thomas' NHS Foundation Trust, King's College Hospitals NHS Trust and SYNLAB) subject to cyber attack (June 2024)	Delay in physical specimens being analysed
Movianto Logistics	2024	Cyber attack allowed third party to gain access to database of their client's data	None known

3.5. The Trust is also required to maintain a Register of Processing Activities under the GDPR. Previously, the Trust has done this on separate spreadsheets known locally as data flow mapping. The IG team update the log at least annually with new data flows that have been identified through DPIAs, contracts and sharing agreements. From 2023/24, the DSPT required that the data flows are recorded on the same document as the information assets.

4. Current Risk Level

4.1. The number of risks being overseen by the IGSG Members has decreased by 1 since June 2023. **Table 1** below provides a breakdown of the risks by Division. The split is as follows:

Division/Department	No. of Risks June 2024
Transformation and Informatics	21
Clinical Support and Family Services	2
Surgery	9
Organisational Development and People	1
Facilities	1
Finance and Procurement	0
Operations	0
Medicine	0
Quality	1
Total	**35**

5. Top Three Risks – Cyber attacks, Care certs x2 and Data warehouse

5.1. There are three risks owned by Informatics, one scoring 15 regarding the risk of Cyber attacks (5360), one which consists of 2 linked risks in relation to Care Certs, scoring 9 and 10 respectively (6558 and 5627) and the other scoring 9 in relation to the Data Warehouse stability (5555).

6. CareCert Compliance

6.1. The Trust is signed up to receive notifications from the Data Security Centre, part of NHS England (formerly NHS Digital). Threat intelligence bulletins are issued by NHS Digital weekly via email when assessed as medium or low severity. High severity threats are immediately sent to organisations, rather than waiting for the weekly bulletin.

6.2. If a high severity 'CareCERT Alert' is received then these must be acknowledged within 48 hours with a status provided to NHS England which details whether the organisation is impacted. Actions, such as applying patches must then be completed within 14 days unless stated otherwise. The list of high severity CareCERTs that were relevant to the Trust since the last annual report is below:

Reference	Description
CC-4395	Cisco Releases Security Advisory for Actively Exploited Vulnerability CVE-2023-20198
CC-4392	Citrix Releases Critical Security Updates for NetScaler ADC and NetScaler Gateway
CC-4452	Critical Out-of-Bounds Write Vulnerability CVE-2024-21762 in FortiOS and FortiProxy
CC-4477	Palo Alto Releases Critical Security Update for PAN-OS GlobalProtect Gateway
CA-0001	Implementation of Tamper Protection in National Microsoft Defender for Endpoint (MDE) tenant
CC-4483	Cisco Releases Security Updates Addressing ArcaneDoor Campaign, Exploited Vulnerabilities in ASA and FTD
CA-0002	Implementation of MFA Across Remote Access Solutions

CC-4525	Exploited Unauthenticated RCE Vulnerability CVE-2023-6548 in Citrix NetScaler ADC and NetScaler Gateway

7. Unsupported Systems and Devices

7.1. The Trust has the majority of our devices running the Windows 10 platform. All devices benefit from a range of security software to provide a strong layer of protection. All devices are also registered with the Microsoft Defender for Endpoint (MED) platform.

7.2. Microsoft Defender Endpoint (MDE) monitors the Microsoft Windows operating system on a PC, laptop, or server, to identify any indicators of cyber security comprise or attack. It can then take immediate action to address the problem before it spreads. It also alerts local system managers and the DSC.

7.3. Over the last 12 months there has been significant improvement in the reduction in unsupported operating systems (servers). All unsupported servers that remain in use have Trend Deep security (Virtual Patching) installed to provide an additional layer of protection whilst activities are completed to decommission them. The server refresh programme management board (PMB) continues to progress with decommissioning/migrating. Windows Server 2016 will be end of life on the 12th January 2027 and planning will commence in November 2024 to migrate servers using this operating system.

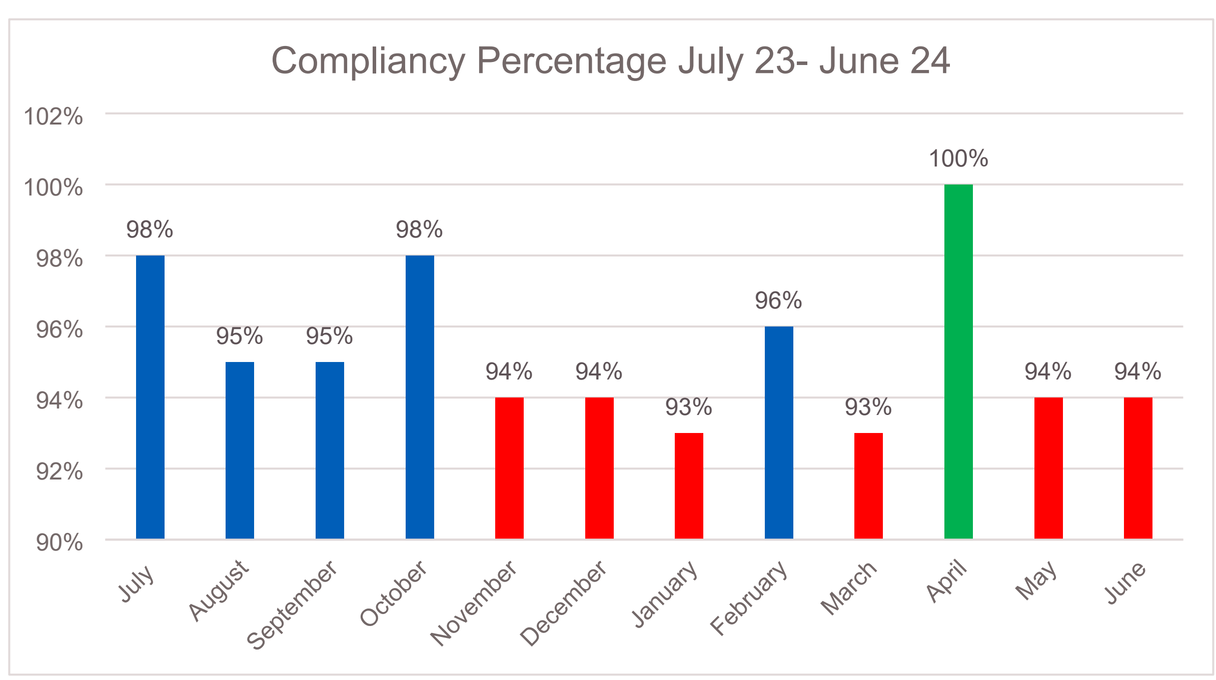
8. Freedom of Information (FOI) Compliance

8.1. Between 1st July 2023 and 30th June 2024, the Trust received 754 requests for information. 23 were processed as line of business requests and the remaining 731 as FOI's.

8.2. The Trust applied 43 exemptions. The breakdown of the exceptions is as follows. One related to Section 38, Health and Safety. 19 sighted Section 36, the release of information would prejudice effective conduct of public affairs. 6 sighted Section 43 and therefore would have resulted in legal action being taken against the Trust by breaching the commercial interests of a third-party. 17 sighted Section 12 and were refused on the grounds of cost for exceeding the appropriate 18hr time limit.

8.3. 47 FOI responses breached the 20 day response timeframe in between July 2023 and June 2024.

8.4. The ICO has mandated that authorities must respond to 90% of requests within 20 working days. **Chart 2**, below, confirms the Trust is now consistently exceeding the 90% target, average being 95%.



8.5. **Internal Reviews**

8.5.1. The Trust received correspondence from one requestor challenging the Trust's decision to apply an exemption under Section 17(7) of the FOI Act 2000. It is the responsibility of the Data Protection Officer/FOI Lead and Director of Integrated Governance to conduct the internal review process.

- In response to FOI 7273 - internal review, the FOI asked the Trust around Data Centres - The DPO and SIRO agreed the exemption had been wrongly applied and the information was released.

9. Mandatory UK GDPR, Information Governance and Cyber Security Training

9.1. This report confirms that as of the 30th June 2024 the Trust exceeded the minimum target, which requires at least 85% to have successfully completed annual Data Security and Awareness training between 1st July 2023 and 30th June 2024. Details of the requirement are set out in DSPT Standard 3.1.

9.2. **Table 3** below provides a breakdown of the percentage compliance by Division.

9.3. Clinical Support and Family Services and Women and New-born achieved 82%, whilst Surgery had a decline year on year to 80%. The Medicine Division also a decline year on year to 82% which previously was at 93%.

9.4. Facilities (88%) and Quality (100%) were the strongest performers. Surgery as highlighted above, and the Corporate Division requires the most improvement (latter also at 78%).

IG TRAINING COMPLIANCE BY DIVISION/DIRECTORATE

	Number complete	Number incomplete	Number in target group	Compliance
Bank Staff*	357	205	562	64%
Clinical Support & Family Services (Direct)	820	176	996	82%
Corporate (Trust HQ, Finance, OD&P, Informatics, and Estates)*	669	194	863	78%
Facilities Directorate (Direct)	293	41	334	88%
Medicine Directorate (Direct)	751	166	917	82%
Quality Directorate (Direct)	0	1	1	%
Surgery (Direct)	940	240	1180	80%
Women and Newborn (Direct)	191	60	251	76%
Trust Totals	4021	1083	5104	79%
Adjustments (based on average errors in MLE data attending Trust Induction.	911	225		
Revised Totals	4932	858	5790	85.2%

9.5. The Data Security and Protection Toolkit requires the Trust to report the number of Trust Board members who are compliant with their relevant data and security protection training. An extract from the Managed Learning Environment (MLE), confirms 100% of the substantive Executive Directors have completed their annual IG training.

10. Subject Access Requests

10.1. The Trust's organisational oversight of the number of SARs being processed continues to improve and there is greater engagement across the organisation.

10.2. All departments releasing and handling SARs maintain statistical compliance information which is incorporated into an overarching disclosure compliance report to IGSG measuring the trends, number of complaints received, in addition to lessons learnt and action taken.

10.3. In total, the Trust has responded to the following:

- 1701 medical records requests broken down into – 837 legal, 485 personal, 289 patient treatment, 76 pensions and other 14
- 11 various family law courts
- 118 Police requests – 5 for medical records, 113 for Legal
- 25 Statutory requests under Coroners and Justice Act
- 18 Solicitor requests
- 68 Legal which include public and employer liability
- 12 CCTV requests
- 1184 Radiology/MRI images – 484 patients – 700 solicitors
- 3 OD&P - employees
- 2 requests - both from solicitors - were processed by the Occupational Health department

10.4. The Trust claimed time limited extensions on the grounds of complexity, resources and manual nature of request in relation to three employee requests which together took two months for each. For medical records requests 7 breached the compliance date.

11. External Data Security Incident Reporting

11.1. During the 2023/24 DSPT year, the Trust submitted one notifiable incident to NHS England, NHS Digital and the ICO. This incident related to a third party employed member of staff with the ICO not taking any action against the Trust to date.

12. Recommendations

The Trust Board is asked to note this report, and in particular:

12.4.1 Data protection and information security risks are proactively managed by members of the IGSG on behalf of the Chief Digital Officer

12.4.2 The Trust submitted a Standards Met DSPT submission on 28th June 2024, with the internal audit confirming there was substantial assurance.

12.4.3 FOI compliance exceeds the 90% compliance figure set by the ICO for all Trusts. A complaint against the Trust was upheld against the Trust stating that we had not followed the correct procedure.

12.4.4 The Trust self-declared one incident to the Information Commissioners Office (ICO). No action has been taken against the Trust.

12.4.5 The work programme associated with Data Protection Impact Assessments (DPIAs) and Asset Management continue to be closely monitored by the Data Protection Officer and IGSG Members.

12.4.6 The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust. Providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

Appendix A: DSPT Certification

Data Security and Protection Toolkit

2023-24 (version 6)

SALISBURY NHS FOUNDATION TRUST

Salisbury District Hospital, Odstock Road, Salisbury, England, SP2 8BJ

Date of publication: **28 June 2024 (valid to: 30 June 2025)**

This organisation has completed a Data Security and Protection Toolkit self-assessment to demonstrate it is practising good data security and that personal information is handled correctly.

www.dsptoolkit.nhs.uk

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	5th September 2024		

Report title:	Women & Newborn Divisional Governance Report			
Status:	Information	Discussion	Assurance	Approval
	Yes		yes	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Abigail Kingston, Clinical director for WNB			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

Assurance to the Board of the Women and Newborn Governance processes.

Executive Summary:

To provide assurance that quality care and patient safety is effectively monitored and shared within the Women and Newborn Division, to understand the challenges, improve practice and maintain standards. This is being achieved by providing Divisional teams (MDT) with information required to promote changes in practice and learning from incidents at monthly Divisional Governance meetings.

These monthly meetings have a clear agenda to ensure that feedback and Patient Experience, Patient Safety and Clinical Effectiveness is shared divisionally, and to ensure escalation of concerns to the Divisional Management Team (DMT). Each service within the division is required to provide an escalation report to include information from within the specialist area, highlighting any areas of concern. This includes updates on guidelines, top risks and serious incidents, workforce and national workstreams.

The divisional behaviour charter and final sense check both form integral parts of our meeting.

December – all services represented

Divisional Staff awards noted and celebrated.
Insights visit 5th December 23 completed and discussed, report to follow.
TOR reviewed – bi-monthly risk register review, move to alert; assure; advise for escalation reports
SBLV3 - awaiting LMNS assessment. Specialist training for maternity compliant this month.
Discussion re SII compliance and agreement for matrix comparison monthly.
CQC single assessment framework presented by Alison Montgomery

January – all services represented

Beatrice maternity ward change of use from postnatal ward, gynae QR codes for patient feedback introduced
New ops band 7 appointment
Capital bid for NN ventilator approved, ATAIN action tracker discussed.
MVA suite opened in gynaecology funded by Stars Appeal
Gynaecology surgical long waiters (65 weeks) discussed and actions approved, cancer WT improvements noted.

Trajectory for updating out of date guidelines shows improvement, SII compliance discussed. Screening update shows 34/44 recommendations closed.
CNST declaration discussed. (9/10). MW to birth ratio of 1:24 noted rather than 1:26 in new Birthrate plus report.
MNVP feedback on 15 steps discussed, maternity freedom to speak up concerns are at lowest level for 2 years. Outstanding BCG vaccinations and midwife ratios escalated.

February – not quorate

ATAIN reporting corrected through Badgernet to allow region to 'see' our correct number of admissions rather than manual adjustment monthly.
NNAP data discussion, deferred cord clamping high, some data collection issues discussed, ROP timings on risk register, 2 year FU focus. Anaesthetic room resuscitation of baby incident discussed due to level of reputational risk – risk register update confirmed and mitigation discussed at length for assurance.
Impact of office moves on capacity noted across the teams.
Cancer pathways work discussed.
Continued improvement in outstanding guidelines noted, low vacancy rate, nurse to MW conversion started for 2 people celebrated.
Fertility lack of space discussed, new risk of outstanding invoices for sperm storage discussed.
Sophie Rolfe and Helen Rynne attending for patient experience discussion. Patient experience discussed Trust-wide challenge on slow complaint closure discussed (33%), patient care and communication themes noted across the Trust. Logging compliments processes discussed within the division. Pilots for feedback in Trust discussed.
MNVP feedback with discussion around personalised care in maternity, improved staffing levels on postnatal ward and pain relief education.

March – all services represented

Noted improvement in 28 faster diagnosis at cancer improvement group
Improved 65 week waiting list for gynae discussed and move to focus on 52 week wait.
Reflection and discussion on outstanding actions within the division, PSIRF processes discussed. SMART actions discussed.
NHSR scorecard discussion with triangulation discussion. No themes identified across claims, patient feedback, risks and incidents.
Risk register meeting / deep dive report noted.
Great staff feedback from SHO's in O&G noted, discussion re other staff feedback routes and ensuring these are robust.

April – all services represented

Mean ATAIN stats for rolling 12 months reviewed as Power BI watch metric showing alert for March – 4.3% mean is under 5% target. Dates for ATAIN action tracker requested.
Transitional care update and discussion. Separation time project and A3 being developed.

Cancer A3 x 2 developed and discussed.
SII compliance improvement noted. Escalation from maternity to DMT for assistance with chasing medical teams for actions.
Draft clinical Audit plan discussed with Carly Ackland. Local audits agreed at divisional level.

May – no representation by obstetrics

CQC table-top document submission noted.HFEA interim inspection due and evidence 80% collated.
ATAIN action tracker reviewed and dated as requested. Rate of admission 3.5% for April.
Nurse training funding agreed in gynaecology to develop hysteroscopy and colposcopy nurse practitioners for TT1OP driver. NICE guidance in gynaecology now all green.

All outstanding investigations in maternity now been through CRG or have draft reports.
Assurance midwife for SBL to help with manual audits now appointed. (CNST final action)
Alert for administrative gap in fertility – for escalation through DPR.
MNVP update given by Alison Lambert. First triangulation meeting of complaints and MNVP feedback has taken place – mainly positive feedback. PALS update from Victoria Aldridge. Freedom to speak up report next month.

Key successes / improvements;

- Reduction in out of date guidelines across the division
- Use of alert;assure;advise escalation from services
- Review of scorecard in triangulation of quality and safety themes
- Risk register reviews

Next steps

- Ensure governance framework in fertility is in line with the rest of the division and the Trust.
- Clear backlog of SII actions and move into PSIRF culture of learning.
- Patient engagement as a divisional driver
- Re-write clear 12 month work plan for divisional governance

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	5th September 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –July 2024 (June data)			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 19. 07.2024 DMT approval 4.7.2024 CGC 30 July 2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for June 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- Midwife to birth ratio 1:25– SFT recommended ratio 1:24
- 1:1 care in labour achieved at all times

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 5 Incidences reported as moderate.
  - Ovarian Torsion
  - ITU admission
  - 3rd Degree tear – Forceps
  - Shoulder Dystocia and 3rd degree tear
  - Term Admission to Neonatal Unit
  - 3rd degree Tear – pool birth

PMRT

- No cases for review in June

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Work continues to improve compliance with other mandatory training.
- Challenge with obtaining anaesthetic trajectory to ensure compliance reached December 2024. Non-compliant trajectory at present.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Outcome from the first Triangulation meeting was discussed. The focus being on the birth reflection service. Exploration is ongoing into how we can extend the referral process to this service.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024 and actions in progress.
- Work ongoing to improve compliance with Ockenden 2022 IEA, 23 actions ongoing, 61 actions closed.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x

Person Centred & Safe Professional Responsive Friendly Progressive

Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

Perinatal Quality Surveillance

JULY 2024 (JUNE DATA)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold			Feb '24	Mar '24	Apr '24	May '24	June '24	Comment
		Green	Amber	Red						
Midwife to birth ratio	1:24	1:24		>1:26	1:27	1:30	1:32	1:28	1.25	Improved ratio due to increase in available workforce
Compliance with supernumerary Status of LW Coordinator %	0	0		>1	100%	100%	100%	100%	100%	
1:1 care not provided	0	0		>1	0	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%		<50%	79.89	41.67%	83.3%	75.8%	75.56	Percentage of possible episodes for which data was recorded. Audit commended December 23
Consultant presence on LW (hours/week)	40	40			40	40	40	40	40	
Daily multidisciplinary team ward round	90%	>90%		<80%	100%	100%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	0	0	

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time

What are the top contributors for under/over-achievement?

- Significant increase in available workforce this month due to newly recruited staff now in post and staff returning from maternity leave
- The Midwife to Birth ratio is very close to target at 1:25 in June due to increased available workforce
- Acuity vs staffing data very good this month due to good staffing levels and reasonable activity levels

Table 1. Total WTE vacancy and availability to work - by role

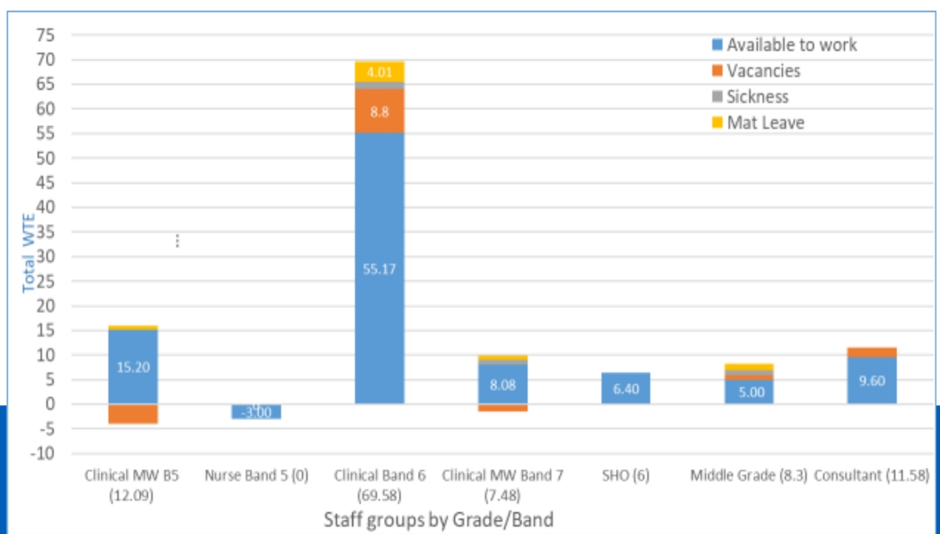
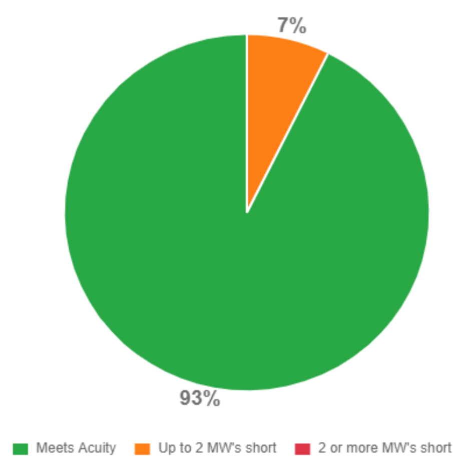


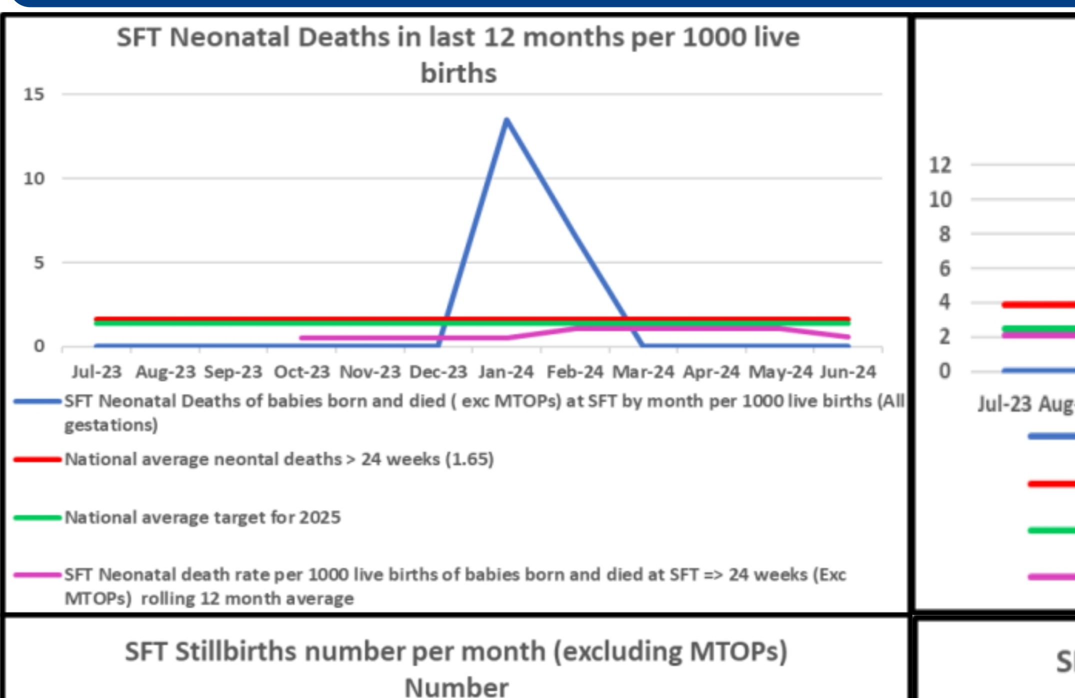
Table 2. Average midwife shift fill rates

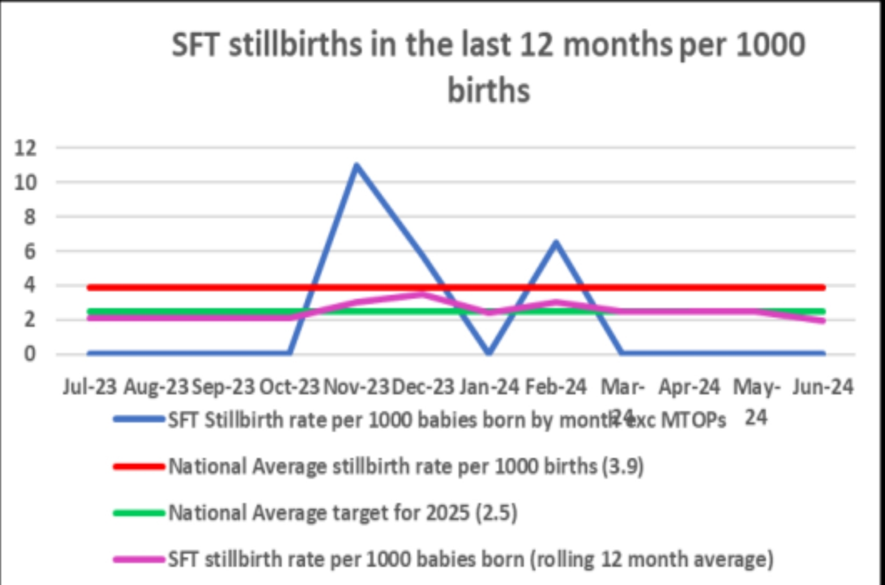
		Feb '24	Mar '24	Apr '24	May '24	June '24
Midwives	Day	95.2	94.2%	97.2%	97.1%	Awaiting data
Midwives	Night	97.8%	97.9%	99.3%	98.6%	Awaiting data
MCA/MSWs	Day	93.6%	97%	Awaiting data	93%	Awaiting data
MCA/MSWs	Night	87.2%	98.4%	Awaiting data	93%	Awaiting data

Table 3. Acuity by RAG vs staffing data



Safe: Perinatal Mortality Review Tool (PMRT)

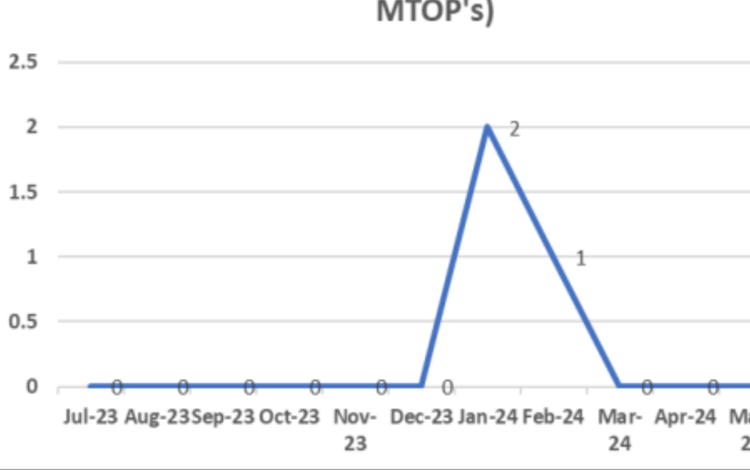




- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board. .
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.

SFT Stillbirths number per month (excluding MTOPs) Number

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Number	0	0	0	0	2	1	0	1	0	0	0	0



PMRT Action Plans for Salisbury Foundation Trust – June 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in June.			

PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
				The were no cases requiring PMRT review in June.		

INCIDENTS: DATIX ≥ Moderate Incidents and PSRs

DATIX Reported Incidents in June
(moderate harm and above)

Case Ref (Datix no)	Date of incident	Category	Incident summary	Comments?	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
166521	06/06/24	Moderate	Ovarian torsion	Ongoing (joint gynae)	**N**	**NA**	**NA**
166411	10/06/24	Major	ITU admission	Ongoing.	**N**	**NA**	**NA**
166507	12/06/24	Moderate	3rd degree tear, forceps	Ongoing	**N**	**NA**	**NA**
166508	13/06/24	Moderate	Shoulder dystocia and 3rd degree tear	Ongoing	**N**	**NA**	**NA**
166791	21/06/24	Moderate	Term admission to Neonatal Unit	Upgraded from no harm to moderate. Ongoing	**N**	**NA**	**NA**
166798	22/06/24	Moderate	3a tear - pool birth	No care omissions. Reclassified to minor harm	**N**	**N/A**	**N/A**

INCIDENTS: Investigation update

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
156876 **SII 574**	20/06/2023	Moderate	IUD	CRG booked 04/07/24
CCR 584	03/07/2023	Moderate	3rd degree tear.	Draft report with panel and staff for factual accuracy. To book CRG.
CCR 580	16/07/2023	Moderate	Term admission to NICU	CRG booked 04/07/24
CCR 588	31/07/2023	Moderate	Antenatal pulmonary embolism	CRG booked 25/07/24
158202 **SII 586**	08/08/2023	Moderate	Eclamptic Seizure	CRG booked 11/07/24
158301 **SII 587** (HSIB/MNSI)	12/08/2023	Moderate	Term Admission to NICU	Action plan with CRG panel. Tripartite meeting with family being arranged
CR 599	19/09/2023	Moderate	Postpartum haemorrhage at home	Draft report with panel to send to staff involved for factual accuracy.
CCR 613	19/11/2023	Moderate	Eclampsia	Draft report sent to staff for factual accuracy.
162915 New Process **PSII**	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Investigation ongoing-currently arranging/holding meetings with staff involved.
163944 Awaiting **SII (MNSI)**	04/03/2024 4	Moderate	Baby transferred to tertiary unit for cooling	Investigation ongoing-currently arranging/holding meetings with staff involved.

CLOSED INVESTIGATIONS: Action progress

Monthly compliance action tracker update for Maternity and Neonatal cases

Maternity and Neonatal - W&NB SII / CR Open Compliance Matrix

SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)									
				1	2	3	4	5	6	7	8	9	10
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 22-23						
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Q2 22-23	Oct 23	Aug 23					
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Q2 23-24	Feb 23	Jan 23	Jan 23	Q1 23-24	Q1 23-24	
CR 512	Click	W&NB	September 2022	Q2 23-24	Jul 23								
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24			
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23							
CR 540	Click	W&NB	November 2022	Jul 23	Q1 23-24	Sep 23	Jul 23	Jun 24					
SII 555	Click	W&NB	March 2023	Nov 23	Nov 23	Nov 23	Nov 23						
CR 565	Click	W&NB	May 2023	June 24	Dec 24	SMG/Ed.	Compl.						
SII 571	Click	W&NB	May 2022	April 24	June 24	Feb 24	Oct 24						

Responsive

MNVP Service User feedback (June 24)

Key achievements and feedback:
No further updates.

Identified Areas of Improvement:
Continued momentum given to previously identified areas of concern, ie themes of complaints and concerns discussed at the annual study days.

Exploration of translation services- the Maternity department are working with Wessex Health innovation on the application of a a translation device.

Next steps for Progression:
Continue to roll out of personalised care planning training.

Safety Champions/ Staff Feedback

Neonatal:
- CCTV- update following a recent security incident. The recorder is out of warranty, this has been escalated to the Board.
- A designated meal trolley for the NNU was discussed. This is with the Head of Estates for consideration- no further updates have been provided.

Maternity:
The recent Executive walk around was seen to be positive. Challenges discussed RE obtaining obstetric review post scan appointment.

Family Experience:
Outcome from the first Triangulation meeting was discussed. The focus being on the birth reflection service. Exploration is ongoing into how we can extend the referral process to this service.

Compliments and Complaints

No complaints and 1 concern logged in June 24.
9 compliments logged and 1 SOX.

SOX : For identified staff in the Q&S team: **"They have significantly progressed the compliance action tracker in maternity" .**

Friends and Family Test

DATA FROM 25.6.24 TO 24.6.24

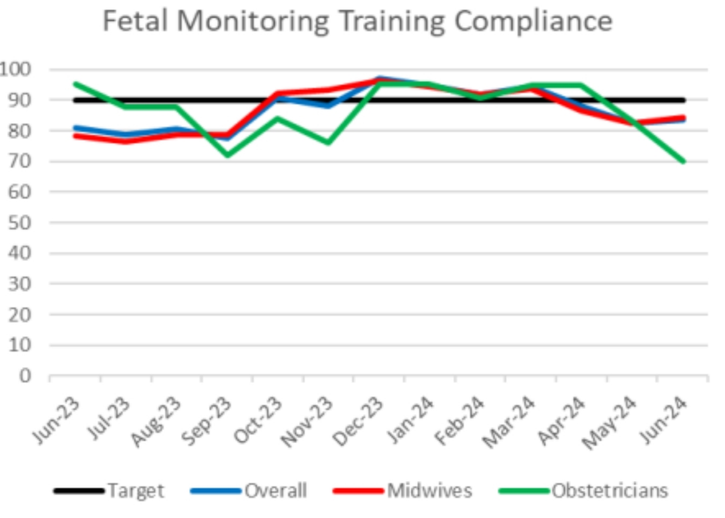
Positive: 88.71%
Negative: 8.06%
Ratings

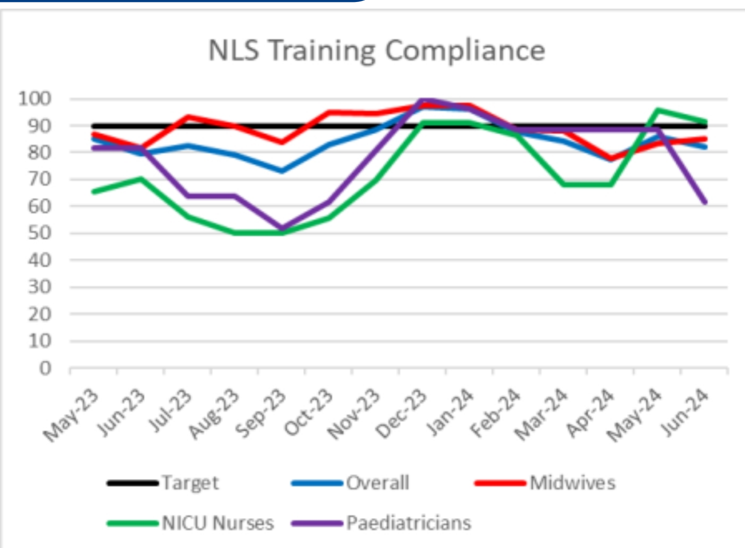
TOP 3 THEMES:

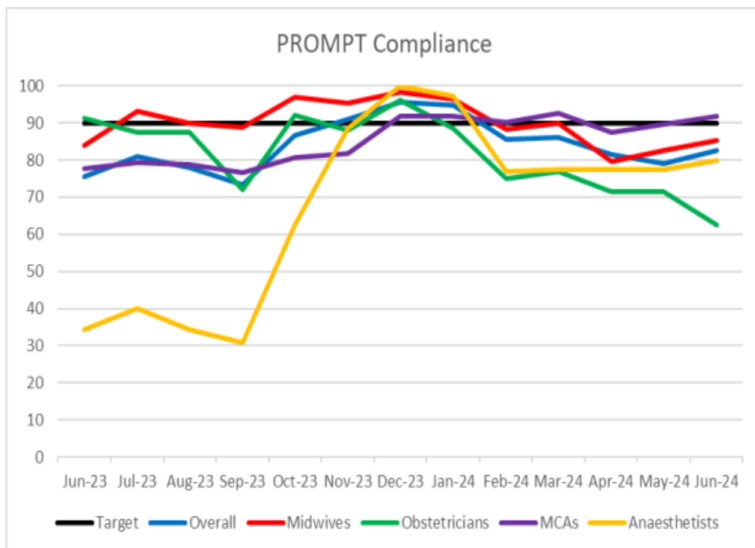
POSITIVE:	NEGATIVE:
1. STAFF ATTITUDE	1. STAFF ATTITUDES
2. IMPLEMENTATION OF CARE	2. CLINICAL TREATMENT
3. COMMUNICATION	3. PATIENT MOOD/ FEELING

NEXT STEPS FOR PROGRESSION: TO INCREASE COMPLIANCE TO THE FFT.

Well-led Training







Training

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Additional PROMPT and fetal monitoring training days created in October due to the ongoing decline of compliance in May for obstetric and anaesthetic groups.
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.
- Additional Level 3 Safeguarding Children date created in May to support midwives to attend.

Risks:

- Influx of new MDT staff in September /October /November.
- Anaesthetic conflicts of priorities to attend training – poor anaesthetic attendance for past 5 months – escalated to surgery divisional lead.
- Please note - No study week in or August due to school holidays.
- Challenges in gaining accurate safeguarding children compliance rates for Obstetric registrars, SHO's and GP trainees.

Compliance to National Guidance

NHS Foundation Trust

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated: RED	AMBER	AWAITING CLOSURE	GREEN
Jun-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	1	9
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Cor	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	1	0	6
	8	Complex Antenatal Care	0	4	0	1
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	12	Postnatal Care	0	3	0	1
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	23	1	61

Ockenden Report

Key Achievements:

- Bereavement added to Maternity Risk & Governance agenda for action tracking, progress and escalations

Next Steps for Progressions:

- Complex Antenatal Care working group to meet – attendance of key stakeholders a challenge, work ongoing to resolve

Table 2. CNST Maternity Incentive Scheme – Year 6

NHSR Maternity Incentive Scheme- Year 6 - Position July 2024				
	Description	YR 6 Submission	Comment	Current Assessment
1	Perinatal Mortality Review Tool	Compliant	Compliant at present	
2	Maternity Services Data Set	Compliant	Compliant at present	
3	Transitional Care Services	Compliant	Compliant at present	
4	Workforce	Non-Compliant	Progress begun	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	Progress begun	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progress begun	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

Maternity Incentive Scheme (CNST)

Key Achievements:

- Assurance Midwife recruited and in post to support
- Main work in progress demonstrated in Transitional Care & Workforce actions

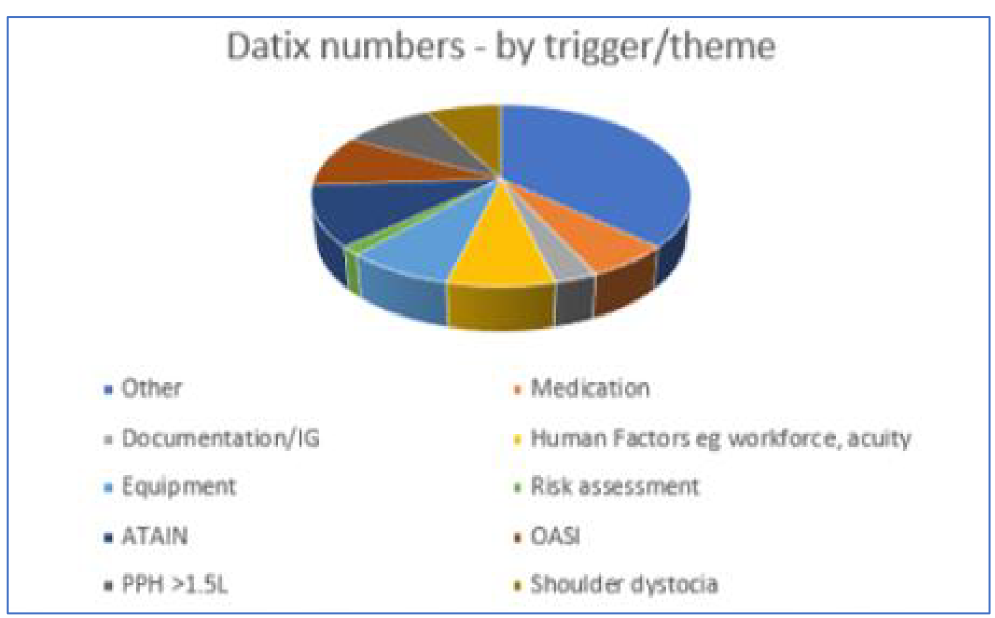
Next Steps for Progressions:

- Review at regular touchpoint meetings

Thematic Reviews

Over the last 6 months we have conducted thematic reviews on Obstetric Anal Sphincter Injuries (OASI) (3rd and 4th degree tears), post-partum haemorrhage, low apgars (<7 at 5 minutes of age), stillbirth and neonatal deaths. We continue to review these as appropriate at the Maternity Governance and Risk meeting.

Under the new PSIRF framework, we are now reviewing all DATIX's received within the month by theme (to include no harm and low harms). We will work with leads to the coming months to review and align actions around some of the common themes.



Health Inequalities

Maternity 3 Year Delivery Plan covers Health Inequalities

- Inclusion Midwife appointed

Workstream starting within LMNS to work through collaborative plan.

Next steps:

- Inclusion midwife to support with improving equity –LMNS funded fixed term post
- Allocation of actions

Report to:	Trust Board (Public)	Agenda item:	4.3
Date of meeting:	5th September 2024		

Report title:	Application to exit the Maternity Safety Support Programme (SFT)			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance – 17.8.24 Circulated via email and content supported by Regional and National Team			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services Emily Brace – NHS E Maternity Improvement Advisor			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to approve the application for exit from the Maternity Safety Support Programme.

This report is prepared to demonstrate the progress and action taken as a Trust in line with the MSSP exit criteria.

This paper has been prepared in collaboration with Trust, NHSE Maternity Improvement Advisor, LMNS, Regional and National Leads.

Executive Summary:

Salisbury NHS Foundation Trust entered the NHS England Maternity Safety Support programme (MSSP) in October 2021 following the CQC's inspection of maternity services in July 2021. The CQC report was published on the 9th of July 2021 and the MSSP commenced in October 2021. At this inspection the maternity service was rated as Inadequate for Well Led and Requires Improvement for Safety and were subsequently issued with a warning notice 29a.

Following the MSSP diagnostic phase, the diagnostic report with MSSP exit criteria was completed in April 2022 and were mutually agreed actions between the Trust Region & the MSSP.

This paper summarises Salisbury Foundation Trust's improvement journey since commencing on the MSSP, as well as work underway to continue to improve the quality and safety of Maternity services.

Key points outlined in this paper are:

- The process for entering and exiting the MSSP as of 2021
- Progress with actions since the 2021 CQC visit.
- Compliance with CNST/CQC
- Progress with the MSSP exit criteria.
- Overall improvement journey
- Sustainability plan and ongoing oversight

It is felt that significant progress has been achieved with the MSSP exit criteria to allow for exit from the programme with ongoing ICB and NHSE Regional oversight. This has been collectively agreed by all stakeholders.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

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Application to Exit the Maternity Safety Support Programme

1.1 This paper details the application for Salisbury NHS Foundation Trust (SFT) Maternity Services to seek approval to support exit the Maternity Safety Support Programme (MSSP).

2 Background

2.1 Salisbury NHS Foundation Trust entered the NHS England Maternity Safety Support Programme (MSSP) following the CQC's inspection of Maternity Services in October 2021. The CQC report was published on the 9th of July 2021 and the MSSP commenced in October 2021. At this inspection the maternity services was rated as Inadequate for Well Led and Requires Improvement for Safety and were subsequently issued with a 29a warning notice.

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England. The programme offer is to support trusts to instil sustained quality & safety improvements in line with the five Care Quality Commission domains of Safety, Effectiveness, Responsiveness, Caring and Well-Led. NHSE provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

A Maternity Improvement Advisor (MIA) was allocated to SFT in October 2021, with a change in allocated MIA in March 2022. The MIAs were allocated to work with the Executive and Divisional leaders to support the delivery outcomes identified in the CQC Report, as well as the diagnostic recommendations/findings from the MSSP.

Prior to the commencement of the MSSP the Trust had taken notable steps prior to the CQC inspection as well as in response to the CQC report. This included a significant step in the cultural temperature within the unit as well as Trust Board investment into the Senior Midwifery leadership team, and increased co-production with the MNVP.

The key areas of focus of the MIA have included the following but are not exclusive to:

- Professional Support and guidance for the senior midwifery team via 121s and support and oversight of key meetings.
- Leadership support & advice in co-producing an overarching Maternity Improvement Plan (MIP).
- Deep Dive Exercises of Governance / Screening / Education & Leadership Requirements and current processes.
- Undertaking site walkarounds, meeting staff and giving feedback to the senior team
- Supporting key CQC actions including peer reviews
- Attendance at Q&S meetings, Maternity Improvement Group Meetings, Safety Champions Meetings, etc.
- 121 meetings with Exec Chief Nurse / Exec Medical Director / Director of Midwifery, Div MD & DDO
- Support with CNST MIS
- Sharing of best practice examples, JDs / clinical models of care etc.
- Support with workforce initiatives / cultural charter.
- Support in co-producing Maternity Governance Framework post deep dive findings.

It is the view of all stakeholders including the ICB Chief Nurse, the LMNS Senior Midwife, the MIAs, and Regional Chief Midwife/Obstetrician, that the criteria for leaving the programme have been met and oversight can now transfer over to the ICB, LMNS and Regional Teams. Therefore, the Trust seeks to exit the programme through this formal paper/sustainability plan. On approval at SFT Trust Board the same paper will subsequently be

presented via the following channels: LMNS ICB Board, Regional Perinatal Quality Surveillance Meeting & National Joint System Oversight Group. On approval through all channels the Trust will receive a formal letter outlining their successful exit from the MSSP.

3 The process for entering and exiting the MSSP.

3.1 Entry Criteria

Criteria for entry onto the MSSP in 2021, was based on the following criteria:

- An overall CQC rating of inadequate
- An overall CQC rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain.
- Been issued with a CQC warning notice.
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains.
- DHSC or NHS England request for a review of services or inquiry
- Been identified to CQC with concerns from MNSI.

3.2 Exit Criteria

In 2021, the criteria for exit from the MSSP was defined at the point of conclusion of the diagnostic, and at that time the exit criteria were agreed between Trust, MSSP, and Region. The exit criteria for SFT are further detailed below and has formed part of the bi-monthly progress reports & has been incorporated into the SFT MIP to ensure momentum of improvements upheld.

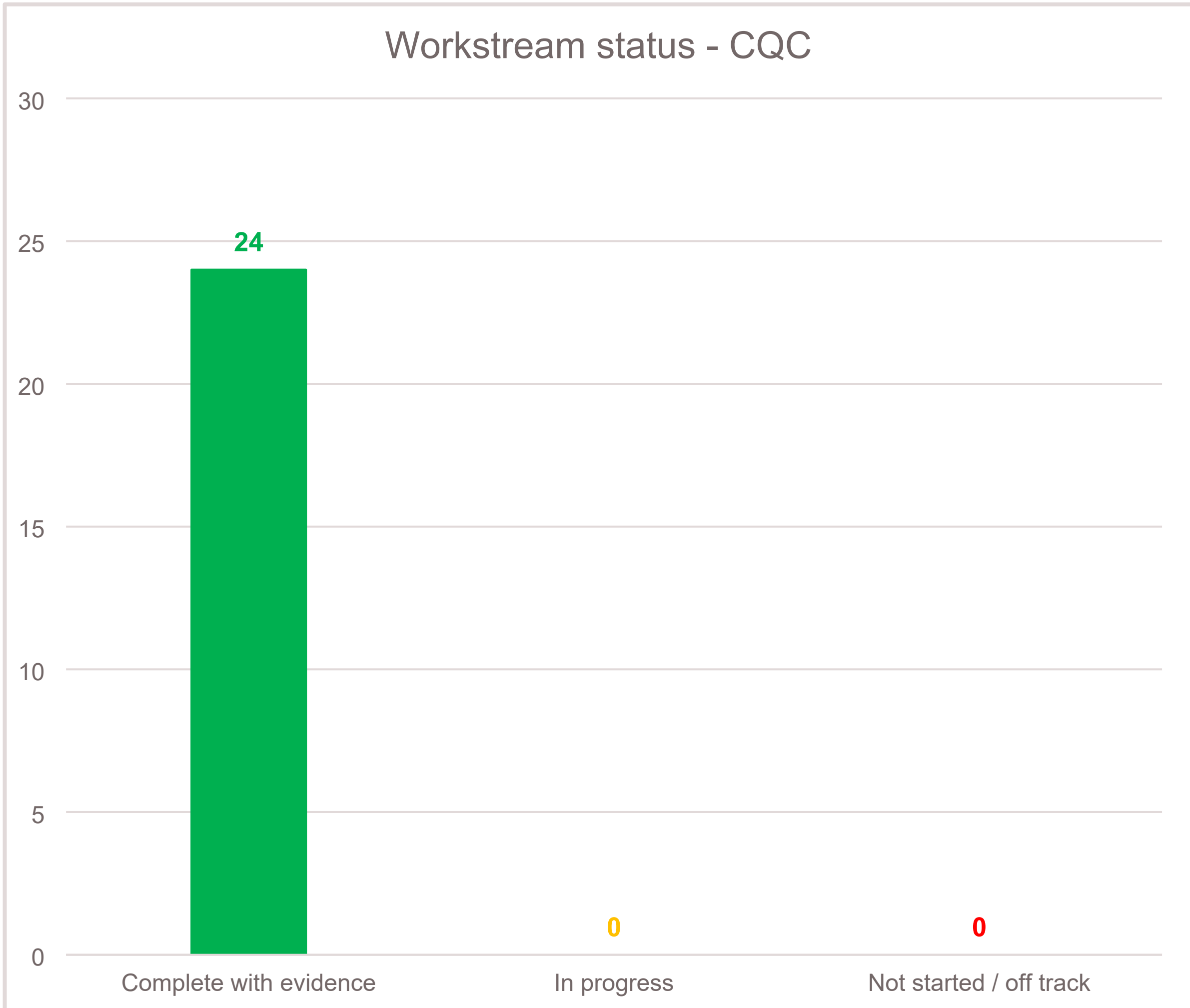
Issue Identified	Action	
Clinical Pathway		
No co-located MLU	Launch the MLU via a collaborative response with MNVP and with appropriate clinical leadership/oversight, via a consultant midwife and the clinical operational lead for the area.	
BSOTS loosely rolled out - not all staff trained & requires refresh as not working as per framework set out	Reset BSOTS triage pathway and ensure sustainable staffing model is embedded both medically and midwifery to align with BSOTS timeframe of reviews.	
Digital		
No strategic plan for revising maternity IT system	Develop local maternity digital strategy plan (in line with the national direction & local/regional needs)	
Education		
No TNA policy or forward plan aligned to Maternity and based on headcount	Develop a clearly defined TNA and forward audit plan (incorporating all Ockenden/CNST/SBLCB local & national benchmarks) – that will be revised and reviewed annually.	

Governance		
Recent changes with the Trust COM but no definitive plan re the long-term plan of the Division & whether it will remain as women's & neonates	Clearly defined plan regarding the clinical operating model for the trust and the direction of travel for the recently developed Women & Newborn Division ensuring appropriate ward to board oversight of women/neonates is maintained.	
A number of processes requiring formalisation to ensure ward to board oversight of maternity governance & support the division to have robust sustained processes to close the loop	Deep Dive and reset of the governance structure to ensure appropriate ward to board oversight is strengthened. To include: 1. Development & implementation of a maternity risk strategy (clearly defined ward to board oversight) 2. Refresh of the governance reporting processes feeding into the maternity risk strategy 3. Development of a CNST working Group with clearly defined ToR/Quorate membership 4. Divisional triumvirate presence at Trust Board & not at subcommittees 5. Revise & align the maternity safety champion pathway to national ask and assuring appropriate ward to board oversight (NHSEI Toolkit) 6. Thematic analysis exercise re SI lookback & cross-check process, as well as the shared learning/actions into practice	
No appropriate structure under DDO	Define and appoint the operational substructure for the directorate/division under the DDO to ensure safe and timely delivery of services is maintained.	
Leadership		
Reconfiguration of maternity/medical structure required to ensure sustained improvement and appropriate oversight/accountability (historical legacy of very lean & not appropriate structure)	Embed and sustain directorate leadership structure/roles in line with the RCM manifesto (substantive roles) & the National Maternity Self-Assessment Tool (To also include: Gynae Sister /Neonatal Charge Nurse – job matching to be complete).	
Workforce		
Lean medical leadership roles previously with risk of lost oversight & not appropriate accountability embedded	Complete the consultant job plan review and embed core obstetric/neonatal leadership roles with the right PA capacity in line with the NHSE maternity self-assessment tool.	
Team structure not robust for ensuring PMA & Screening delivery and model aligned with national picture	Reconfigure and embed the screening structure and PMA teams to support effective service delivery.	

3.3 Progress with actions since the 2021 CQC visit.

The wider SFT progress with improvements is detailed as per the overall improvement journey & as evidenced through the progress achieved with the MSSP Exit criteria as well as the CQC must & should do's.

The following depicts the completed actions relating to the CQC 2021 actions and what has helped shape part of the overarching MIP.



3.4 Compliance with CNST

In January 2022 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance in **4 of the 10** safety standards for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST). In January 2023 this increased to **5 out of 10**.

As of February 2024, following a sustained journey of improvement and progress Salisbury NHS Foundation Trust declared compliance with **9 out of 10** safety actions for submission for year 5 of the NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST) with a clear action plan regarding how the service would meet full compliance with CNST MIS. The safety standard that was not achieved in year 5 related to the Saving Babies Lives Care Bundle (SBLCB).

NHSR Maternity Incentive Scheme- Year 3, 4, 5 Submission

Are we well led?

	Description	Yr 3 Submission	Yr 4 Submission	Yr 5 Submission
1	Perinatal Mortality Review Tool using to required standard for all perinatal deaths	Non Compliant	Compliant	Compliant
2	Maternity Services Data Set submission to required standard	Compliant	Compliant	Compliant
3	Transitional Care Data Set minimise separation to mothers and babies	Non Compliant	Non Compliant	Compliant
4	Clinical Workforce Planning effective system	Non Compliant	Compliant	Compliant
5	Midwifery Workforce Planning	Compliant	Compliant	Compliant
6	Saving Babies Lives Care Bundle V3 compliance with all elements	Non Compliant	Non Compliant	Non Compliant
7	Service User Involvement and co-Production	Compliant	Compliant	Compliant
8	Multidisciplinary Training	Non Compliant	Non Compliant	Compliant
9	Board Assurance Board to Ward to Board	Non Compliant	Non Compliant	Compliant
10	HSIB and EN Reporting	Compliant	Non Compliant	Compliant

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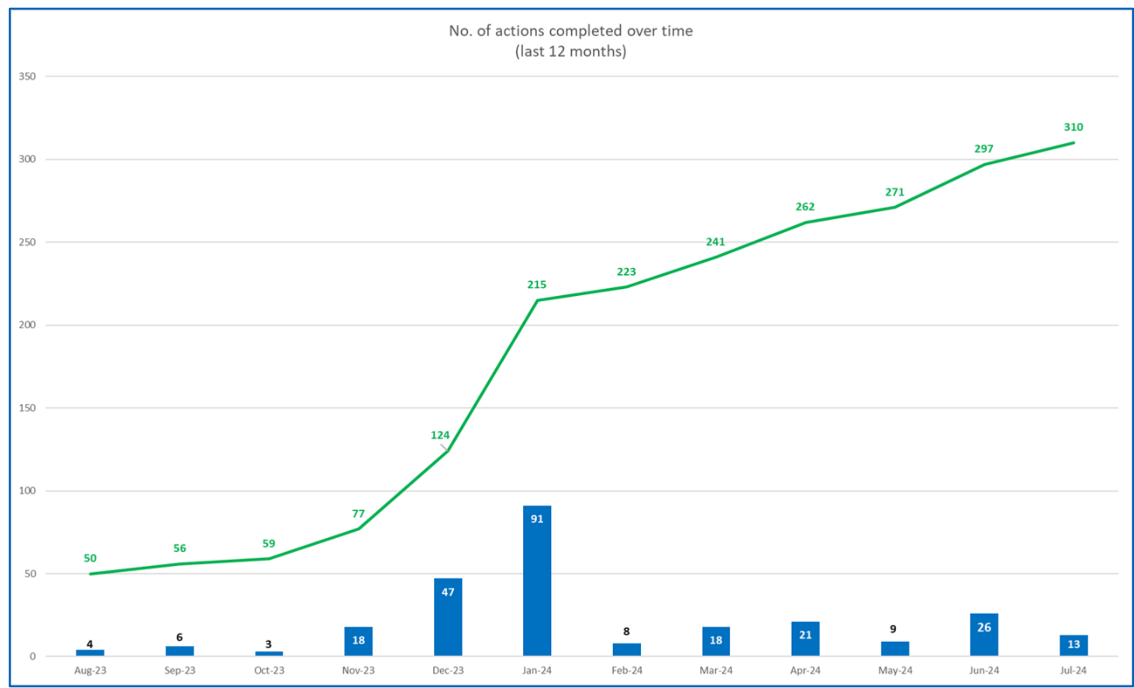
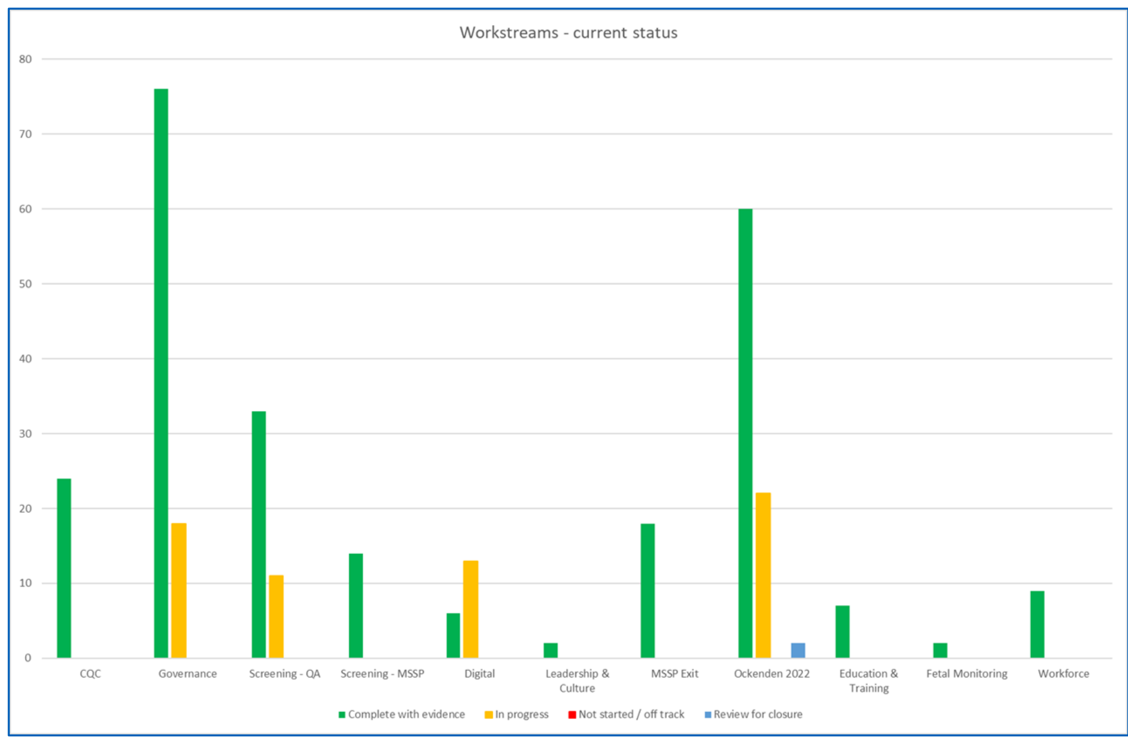
3.5 Progress with the MSSP Exit criteria.

As detailed above the exit criteria were mutually agreed at the point of conclusion of the MSSP diagnostic and these were added to the Maternity Improvement Plan to ensure appropriate oversight and momentum of change. The progress of the MSSP has been monitored regularly with consistent Exec oversight and system wide input.

The current progress (July 2024) is provided by the Trust in the following slides-





Person Centred & Safe
Professional
Responsive
Friendly
Progressive

3.6 Overall Improvement Journey

Over the last 3 years SFT have made significant changes to their leadership structures across both medical & midwifery disciplines and completed recruitment to all the substantive senior leadership roles and these individuals have become an embedded component with stable leadership across the Division. As part of the development of the structures, SFT have undertaken the national perinatal quadrumvirate leadership programme and worked closely with the Maternity Improvement Advisor.

In conjunction with the maternity improvement advisor and the support of the LMNS (Local Maternity and Neonatal System), ICB, regional and national teams, SFT have put their governance structures onto a much more solid foundation with the ratification & implementation of the maternity governance framework and in addition bolstered their Maternity Governance Resource.

In partnership with national, regional & system colleagues they have been actively engaged with the NHS England Maternity Safety Support Programme since 2021 and as part of this programme of improvement work, SFT have worked closely with the allocated maternity improvement advisor (MIA) and wider colleagues to develop a Salisbury Maternity Improvement Programme (MIP) which is monitored with System & Board oversight. The MIP & Maternity Improvement Group (MIG) demonstrates the improvement programme of work achieved to date or in train, and as per the performance MIP slide as detailed under the MSSP exit criteria progress above.

As part of the MIP programme of work; workstreams & task and finish groups have been set up to progress various aspects of improvement across the Maternity Services. As part of the ongoing MSSP support, SFT have had monthly touchpoint meetings with all stakeholders including Region, System, Trust & NHSE National colleagues. Through the monthly oversight it demonstrated the significant improvements SFT had achieved and collectively all stakeholders are in agreement that the Trust is ready to exit the programme.

3.7 Sustainability Plan and ongoing oversight

To give assurance regarding the sustainability of the MSSP improvements the following table summarises the sustainability plan for the MSSP exit criteria and other key actions.

SFT have very good oversight processes in place and a positive open relationship with all stakeholders. To ensure the oversight of the sustainability plan is safeguarded, this will be a collective responsibility to uphold between the Divisional Quadrumvirate, the LMNS ICB, and NHSE Regional team. This will be monitored at a minimum 6-12 monthly or as and when change is potentially required. If change is required outside the 6–12-month period, existing LMNS/ ICB reporting, and escalation processes will be followed, and the necessary action taken as per the Sustainability Plan.

Sustainability Action Plan

Action Ref	Sustainability Action Plan	Specific actions to ensure ongoing sustainability	Monitoring arrangements	Overall Action Owner	Date	
					Target	Complete
S01	Maintain the Division identity as developed through the MSSP journey & not look to devolve or separate Maternity & Neonates into a wider division	If change is required to the divisional structure/roles/responsibilities this should be collectively discussed with the Trust/LMNS/ICB with a clear outline of what mitigation will be in place to safeguard the current maternity and neonatal division resource. If change is being proposed - this should include a clear outline of the additional resource and governance /accountability arrangements to meet the demand of the scaled-up division.	6-12 monthly review , or as and when required, in collaboration with the Trust, ICB, and LMNS.	Divisional Tri / Exec body		
S02	Maintain the Maternity Leadership Structure & not look to devolve the Midwifery, Obstetric or Operational Leadership structures as a CIP – and Trust/Division to continue to align with the National Directives such as the RCM Manifesto & the key Medical Leadership role descriptor work	If change required to the maternity leadership structures this should be collectively discussed with the Trust/LMNS/ICB with a clear outline of what mitigation will be in place to safeguard the current maternity leadership structure. Any such change should include a clear outline of how the devolved role will be safely met through the wider maternity leadership structure with equitable MDT input.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS.	DoM / Divisional Tri		
S03	Division to develop a process with clear leadership regarding the ongoing coordination & oversight of the Maternity Improvement Group	Division to define the leadership responsibility to take over the co-ordination and management of the Maternity Improvement Plan/Maternity Improvement Group on departure of the Interim Transformation Project Manager to ensure ongoing sustainability of the MIG	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS.	Divisional Tri	Nov-24	
S04	Trust & Division to maintain assurance surrounding clear robust monitoring systems via the Maternity Governance Framework & update regularly. Ensuring the quality and safety of the service is sustained.	Division to ensure oversight of any change to a maternity quality and safety process is aligned to the maternity Governance Framework and corporate systems and processes. This may be outside of the normal governance arrangements for updating the framework.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS. As per the Governance requirements (expiry date)	Q&S Matron / Divisional Tri		

S05	Maintain & update the Divisional TNA / Audit Plan on an annual basis, ensuring both are aligned to the national directives / local outcomes & as per the CQC Must/Should	Division to ensure the TNA and Audit Plan are updated annually and inclusive of any national requirements / CQC Musts/Should, and that the overall compliance with each is reported as per the divisional governance systems and processes.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS. As per the Governance requirements (expiry date)	Q&S Matron / Divisional Tri		
S06	Maintain QUAD presence at Board to present maternity services performance and assurance	If change is required, or QUAD presence is proposed to be devolved to a sub-committee, this should be agreed with LMNS / ICB colleagues, and any required change should align to the CNST MIS standards. This may require a discussion with NHSR. However, it is deemed best practice that maternity QUAD presence is maintained at Trust Board.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS.	Divisional Tri / Exec body		
S07	Continue with the CNST MIS steering group to support achievement of full compliance & clear trajectory on meeting the CNST MIS 10 safety standards	Division to ensure the steering group is sighted in a timely way of any new release of annual CNST MIS guidance. If a change to the steering group is to be made, division to ensure ToR and Mat Gov Framework are updated to reflect the change and follows the necessary governance process. Division and Trust Board to continue to monitor compliance as per CNST requirements	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS.	Divisional Tri / Exec body		
S08	Ensure the maternity escalation policy is kept up to date & aligned to the wider Trust OPEL Framework. In addition, ensure all staff particularly, LW coordinators/new managers/medical colleagues are fully versed on the use of the escalation framework	Division to maintain oversight of any change to the maternity escalation policy and ensure all staff are fully versed on the use of the escalation policy. In addition, monitor outcomes to ensure timely escalation is maintained across the departments.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS. As per the Governance requirements (expiry date)	Divisional Tri		
S09	Benchmark against the National LW coordinator framework in conjunction with the LMNS	To work with the system to commence this piece of work and take the appropriate action to ensure all LW coordinators are equipped with the right skills to ensure Quality & Safety of services.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, and LMNS.	HoM / Inpatient Matron / LMNS		

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S10	Continue with the MIG workstreams & the MSSP deep dive actions that remain & continue to use the Maternity Improvement Plan for future improvement/national asks	Continue with monthly Maternity Improvement Group meetings with clear agendas, minutes, and escalations.	6-12 monthly review, or as and when required, in collaboration with the Trust, ICB, LMNS and MNVP	Divisional Tri		

4 Summary

4.1 In view of the significant maternity improvements achieved across SFT and as evidenced through this paper and the sustainability plan, it is requested that SFT is formally exited from the MSSP.

5 Recommendations

5.1 The committee are asked to approve the application for exit from the Maternity Safety Support Programme.

This report is prepared to demonstrate the progress and action taken as a Trust in line with the MSSP exit criteria.

This paper has been prepared in collaboration with Trust, NHSE Maternity Improvement Advisor, LMNS and Regional Leads.

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CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	5 September 2024		

Report title:	Final 2023/24 Annual Report and Accounts			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	Audit Committee – Approved on 20th June 2024			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Kylie Nye, Head of Corporate Governance			

Recommendation:

The Board is asked to note the Trust's final 2023/24 Annual Report and Accounts.

Executive Summary:

The Trust's Annual Report and Accounts was approved at the Audit Committee on 20th June 2024.

The report was laid before parliament in July and can therefore be published in the Trust's public Board papers and on the website.

The communications team is producing an 'Annual Review' which summarises the key highlights from the Annual Report and this will be shared with staff, governors and members prior to the Annual General Meeting on 30th September.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

Salisbury NHS Foundation Trust Annual Report and Accounts
1 April 2023 to 31 March 2024

NHS
Salisbury
NHS Foundation Trust

Salisbury NHS Foundation Trust

Annual Report and Accounts
2023 to 2024

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

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If you would like further copies of this report, need a copy in larger print, another language or audio format please contact the Chief Executive's Department.

Salisbury NHS Foundation Trust
Salisbury District Hospital
Odstock Road
Salisbury
Wiltshire
SP2 8BJ
01722 336262
www.salisbury.nhs.uk

PERFORMANCE REPORT

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Context and Overview of Performance

As we write this annual report it allows us to reflect on the difference our staff have made to many thousands of patients during this year. Whilst 2023-24 has been challenging in the NHS, Salisbury NHS Foundation Trust has a lot to be proud of. During the year the Trust saw over 277,525 people in outpatients, we treated 24,178 patients in our Day Case unit, 75,033 people attended our Emergency Department and 28,439 attended the hospital as an emergency admission.

We cannot escape the national context with industrial action, financial pressures and workforce challenges and we are very proud of the way our teams have continued to respond. Our colleagues have been resilient and resourceful in the face of pressure, they continue to find new and innovative ways to work around the challenges and offer expert and compassionate care to embody the spirit of *Improving Together*, the vision and values that underpin everything we do at the Trust.

We have asked a lot of our communities too as we continue to work to reduce the backlog of patients waiting for elective treatment. Our teams have worked tirelessly over the last year with colleagues, the independent sector and partners in Bath and Northeast Somerset, Swindon, and Wiltshire to use all available measures to reduce waiting times in line with national requirements. The Trust ended the year achieving zero patients waiting longer than 78 weeks for treatment. The Trust's target was to also minimise those waiting more than 65 weeks and, at the end of March 2024, there were just 9 patients in this category. It is recognised there is more work to do and this will continue and drive the Trust towards reducing the wait time for patients to less than 52 weeks by this time next year.

We have always been proud to deliver excellent care and experiences for our patients and in addition to improving our waiting times for planned care, we saw a positive drop in our overall length of stay as an organisation by one day, as a result of the changes in our Same Day Emergency Care (SDEC) and Acute Frailty services. The number of patients waiting for onwards care, known as No Criteria to Reside (NCTR), reduced by an average of 40 patients, allowing us to treat more planned patients. Additionally, our quality indicators show continued improvement with significant progress on the number of falls reducing as well as pressure ulcers.

2023-24 has also seen the development of our new state of the art Imber Ward with 24 additional beds. Imber will provide elderly care in a modern environment, supporting the Trust's elective recovery programme. Due to open in 2024-25, the ward marks a major milestone in the Trust's efforts to deliver the very best compassionate, effective care.

We have continued to develop our approach to continuous quality improvement as we build a culture and ways of working that allows everyone to flourish. Whilst there is more for us to do our colleagues are putting this into practice and delivering significant improvements for patients.

Our values – that we are *patient centred and safe, professional, responsive, progressive, and friendly* are at the heart of who we are and what we do at the Trust. Devised in collaboration with our staff we strive to be an inclusive, kind and welcoming organisation. More than 4,500 people work in our teams. We are a community where everyone plays a vital role in our organisation. We are passionate in ensuring that everyone is treated with dignity and respect and diversity and inclusion is celebrated.

We have fantastic colleagues, and their health and wellbeing continue to be a major focus in our recovery and reset, learning from measures and resources we have put in place to support them and empower them to deliver outstanding care for patients and their families. Listening and learning from them is crucial and as an organisation our staff survey results have been published showing the most improved organisation in England for 2023. I am delighted the investment in training and development, the move to reduce our vacancies, particularly in nursing, have shown a marked improvement.

As a key partner in the Bath and Northeast Somerset, Swindon, and Wiltshire' system (BSW), 2023-24 saw continued collaboration between partners to support and improve the quality of services and ensure resources are used effectively. We are also part of a provider collaborative, the Acute Hospital Alliance (AHA), with our acute Trust partners. We are working closely together to ensure patients have access to high quality, safe and sustainable services. A key success in the year has been the completion of a joint procurement process for a new shared Electronic Patient Record (EPR), with the implementation of this formally starting in 2024-25. This is an exciting step forward and will enable our clinical teams to work more effectively with each other.

This year has given us much to reflect on. There is no doubt it has tested us, but it has also brought opportunities for improvements to transform our services as we continue to deliver our strategy.

We are very grateful to our colleagues, our partners and would like to thank our partner charities Stars Appeal, Salisbury Hospice Charity, and the League of Friends for their ongoing support.

People are at the centre of everything we do at Salisbury NHS Foundation Trust. This includes colleagues, patients, families, carers and volunteers. Without them we would not have a hospital I know the Board and our local community are very proud of.

Ian Green OBE

Chair
27/06/2024
(on behalf of the Trust Board)

Lisa Thomas

Interim Chief Executive
27/06/2024

Purpose and Activities of the Trust

Introduction to Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust was formally established on 1 June 2006. The Trust delivers a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire which includes:

- Emergency and elective inpatient services
- Day Case services
- Outpatient services
- Diagnostic and therapeutic services

The Trust also provides Specialist services, such as burns, plastic surgery, cleft lip and palate and specialist rehabilitation which extends to a much wider population of more than three million people. The hospital includes the Duke of Cornwall Spinal Treatment Centre. This is a purpose built, 40 bedded unit which specialises in caring for people who have spinal cord injury and serves a population of 11 million covering an area across most of southern England.

The Trust has more than 4500 staff who deliver over 50 different clinical services, providing care to the local population and beyond, making SFT one of the biggest employers in South Wiltshire.

Integrated Care system (ICS)

Salisbury is part of Bath Swindon and Wiltshire (BSW) Integrated Care system (BSW ICS), the Trust works in partnership with local NHS organisations and the Local Authority to take collective responsibility for planning services, improving health, and reducing inequalities across the area.

The Trust works closely with partners at a local level to deliver more integrated care, effectively working with the health and care organisations in the immediate geography, Wiltshire Health and Care for Adult community services, Wiltshire Council for care services and many voluntary and third sector organisations for the benefit of the local population.

As part of the new Integrated Care System (ICS) arrangements nationally, provider organisations are being asked to step forward in formal collaboratives to better enable them to work together to continuously improve quality, efficiency, and outcomes for the populations they serve together. SFT is working with Great Western NHS Foundation Trust in Swindon and The Royal United Hospitals in Bath as part of an Acute Hospital Alliance (AHA) in the BSW ICS.

Throughout 2023-24 and into the next year a commissioning process is underway to appoint new providers of community services across BSW, this will greatly enable more integrated working for the benefit of our patients.

To continually improve the services that we run for our patients and carers, the ability to work with partner health and care agencies remains crucial. The Trust has many partners, many beyond the BSW ICS boundary, all of which remain pertinent to delivering outstanding care.

Acute Hospital Alliance (AHA)

As mentioned above we are part of the BSW Acute Hospital Alliance, working collaboratively alongside colleagues in Bath and Swindon to deliver the priorities set out in the Integrated Care Strategy.

NHS England now requires all NHS trusts to be working in at least one provider collaborative, with a focus on fully realising the benefits of working at scale, reducing unwarranted variation, and transforming services for the future.

Our collaborative (set up in 2018) pre-dates this requirement meaning we've had time to make some good progress with our collaborative working, relationship-building and governance arrangements.

Our three Trusts have long recognised there is much more we can do by working together to help and empower people, than by acting as individual organisations. In 2023-24 we were selected as the only South West collaborative to join the first wave of innovators in NHS England's new Provider Collaborative Innovators Scheme. This scheme recognises the role that providers play working with partners in systems to deliver better care.

Being part of the scheme is recognition of what we've done so far along with our potential to do much more in the future. This will help accelerate our development. Other achievements in 2023-24 include the following:

- Developing our joint clinical strategy, which considers how we can maximise the collective opportunities to strengthen clinical services, reduce variation, and scale up best practice.

- A focus on priority specialties; orthopaedics, dermatology, gastroenterology, and urology. As an example of some of the work we have done, we have created an improvement plan to tackle the rise in waiting lists for dermatology and are looking at ways to provide a more resilient and sustainable service for our population, including the expansion of tele-dermatology. The plan involves short-term measures to increase capacity, and longer terms plans to manage the demand upon this service.

- Introducing robotic surgery to BSW – our first robotic procedure took place at Great Western Hospital in May 2023 and since then surgical robots have been rolled out in Bath and Salisbury, helping surgeons to deliver operations with higher levels of precision and helping to improve recovery times and outcomes for patients. Robots are being used for general surgery, urology, and gynaecology and over time will be used for more specialities and more patients.

- Continuing to roll out Improving Together, our collective approach to empowering our teams to embed continuous improvement. This acts as the golden thread running through all that we do to make our three Trusts safer places to receive care and better places to work.

- Securing permission to build two additional modular theatres for elective operations at Sulis Hospital Bath, which will act as an NHS elective surgery hub for patients across the South West. The new facility will deliver 3,750 non-emergency, orthopaedic operations for NHS patients each year.

- Placing digital at the heart of what we do will enable us to maximise the benefits of new technology, meeting higher expectations on digital ways of working.

- Our focus on digital saw our plans to deliver a shared Electronic Patient Record in BSW approved by NHS England in March 2024. This will be a real shift in the way we work which will allow us to deliver real benefits including increased efficiency, better staff experience and improved patient care.

- We have carried out analysis of our staffing models in nursing, midwifery, Associated Healthcare Professionals, Healthcare Scientists, and our medical workforce, to help us better understand what the right model for staffing is in the future.

- A significant part of our work is also focused on collaboration between our corporate teams, and we launched a programme looking at how we can empower these teams to identify opportunities to work at scale where benefits can be realised. Teams currently involved in this work are People, Digital, Finance, Estates, Communications, Legal, Governance, and Research and Innovation.

- We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. But while these formal arrangements give us a structure to work within, the key to our success lies in how we collaborate and work together, and we have explored how we can realise our collective potential with joint coaching and development time for our executive directors and investing in our clinical leadership capacity.

More recently we have begun to work even more closely with the Integrated Care Board ensuring close strategic alignment in how work together to deliver the BSW Integrated Care Strategy.

Our Strategy 2022-26

The strategy is a key document for the hospital as the Trust sets out the future plans and priorities. It articulates the important commitments the Trust is making to the local communities over the next five years, and is underpinned by the vision:

To provide an outstanding experience for our patients, their families and the people who work for and with us.

The strategy confirms three priorities:
- Improving the health & wellbeing of the Population we serve
- Working through Partnerships to transform and integrate our services
- Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

These three priorities guide how the Trust works as part of an Integrated Care System. The August 2022 publication of the strategy was the first step in using these priorities to continuously improve the way the Trust works and focus on the things that are most important to the local community and staff.

As the 'Improving Together' system of operational excellence is embedded across the Trust, work will be prioritised through the identification of key short and long-term improvement projects and programmes:

- Strategic initiatives. These are 'must do, cannot fail' programmes of work that apply Trust-wide and are planned to deliver over 3-5 years. Because they are so important to the successful delivery of the strategy, they have dedicated delivery teams working to ensure they are delivered consistently with every SFT colleague. There are four strategic initiatives:

    1. Delivering digital care
    2. Delivering our people promise
    3. Improving health and reducing health inequalities
    4. Developing a culture of continuous improvement (Improving Together)

- Breakthrough objectives. These are operational in nature and where improvement efforts are focused for 12-18 months. They are reviewed each year and can evolve when the targets have been achieved for 6+ months.

As in 2022-23, in 2023-24 the breakthrough objectives below were aligned to the Trust's quality priorities and further detail on progress against the Trust's quality improvement plans can be found in the Quality Account, published annually on the Trust's website. These priorities represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience).

The continuous improvement approach applies to every aspect of our strategy and everyone in the Trust has a role to play in delivering it and making it the way we work at Salisbury.

Breakthrough Objectives 2023-2024

In 2023-24 the Trust chose the following four breakthrough objectives:

1. Reduction in falls to ≤7 per 1,000 bed days
2. Reduction in time to first outpatient appointment to an average of 87 days
3. Reducing bed occupancy to 96%
4. Reducing staff agency spend as a percentage of gross pay to 3.7%

Progress against the 2023-2024 breakthrough objectives

The falls breakthrough objective has delivered a 34.7% improvement in the last 12 months reducing falls from 8.99 (March 23) to 6.67 (March 24) below its target of 7 falls per 1,000 bed days. Improvements that have been introduced include 'bay watch' and improving multi-disciplinary working. The use of the improvement huddles that involve the whole team, encourages junior staff to have a say and make improvements. While the performance boards have helped teams better understand their performance and measure their successes.

This significant improvement has been sustained since June 23 and enables us to move to focusing on recognising and managing deteriorating patients well as one of the new breakthrough objectives for 2024/25.

The staff availability breakthrough objective has reduced agency spend against a percentage of gross pay in the last 12 months from 7.37% (April 23) to 3.77% (March

24). This equates to an improvement in agency spend from £1.3m in April 23 – to £683k in March 24. This improvement allows this breakthrough objective to move to focusing to the retention of additional healthcare staff in 2024/25.

The bed occupancy breakthrough objective has delivered a 12% improvement in bed occupancy in the last 12 months from 110% bed occupancy in March 23 down to 98% in March 24. This brings bed occupancy close to the local 96% target. Focused work will continue under the leadership of the Urgent and Emergency Care Board – supported by a number of corporate projects into 2024/25. A new breakthrough objective focusing on creating value for the patient through productivity improvements is being introduced for 24/25, which aligns to the organisational sustainability vision metric.

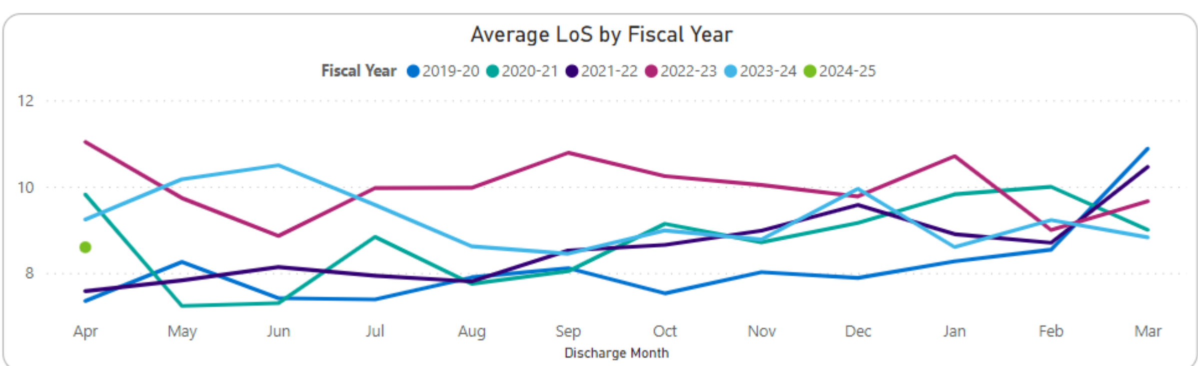
The time to first outpatient appointment breakthrough objective has seen a plateauing of the average time to first appointment and has not yet made the overall improvement expected of this area of focus. This will therefore continue into 2024/25 with refreshed cross-divisional focus through workshops and an outpatient's transformation group as a sub-set of Planned Care Board. Individual specialities such as Cardiology and Gastroenterology, however, have seen some good improvement particularly through the use of improvement huddles and tools introduced and supported by the Improvement and Transformation Team.

Improving Patient Flow & Reducing Bed Occupancy

The challenges with patient flow that were seen in 2022/23 continued to be a focus for improvement during 2023/24, with significant Improving Together work looking at how our medical Same Day Emergency care (SDEC) unit functions and the introduction of an Acute Frailty Unit (AFU). Electronic whiteboards have been relaunched, which has significantly improved data quality relating to patients who are experiencing delayed discharges.

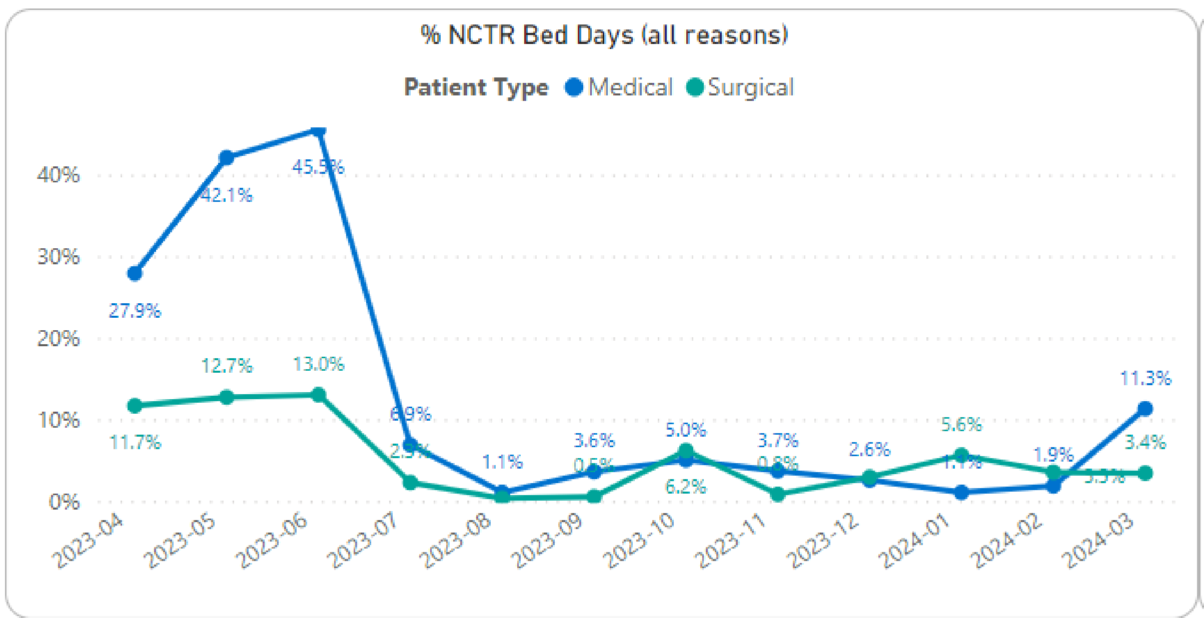
We also launched a local Urgent and Emergency Care and Flow Board (UECB) through which all the UEC improvement work reports and alignment with the strategic initiatives is overseen.

The improvement work across the organisation especially in medical Same Day Emergency Care (SDEC) and the Acute Frailty Unit (AFU) has improved our overall Length of Stay (LoS).



These improved lengths of stay have led to a reduction in bed occupancy and meant that as we closed the 24 beds at South Newton, we were able to manage all of our patients within the Trust footprint.

We continue to work with all our system partners and neighbouring systems (Dorset and Hampshire) to reduce the number of patients whose discharge is delayed (No Criteria To Reside). A local discharge/Flow hub went live in July 2023. This means that discussions regarding discharges of patients with complex needs take place with all partners in one room at the hospital site and as such can include patients and carers more readily. This combined with the improved data quality from the eWhiteboards, has resulted in a lower number of bed days lost in the last half of 2023 24.



All of these improvements have meant our patients will receive better quality care, in the right place at the right time; in so doing this means that they are staying in hospital for as short a time as is appropriate to each individual.

The improvement work in relation to flow improvement, including improvement of the ED 4 hour quality indicator and reducing delayed discharges with system partners will be a focus for 2024/25 and will be enhanced by the opening of a new ward and ward reconfiguration that will also support the increased elective programme.

Elective Recovery

We have continued to build upon the progress we made in reducing the time patients are waiting for planned care. Industrial Action has doubtlessly added to the existing challenges but despite this we reduced the number of patients waiting over 65 weeks for treatment to just 9 by the end of March 2024, and 84% of patients referred for a diagnostic test in 23/24 received it within six weeks – 10% higher than the national average.

Theatre productivity has remained above nationally recommended utilisation levels and recruitment remains on track to allow us to open additional theatre capacity in 24/25 as part of our three-year development plan for theatres.

We have developed a Community Diagnostic Centre within the Town Centre with CT and MRI scanning operational and plans to increase to Echocardiogram and Ophthalmology assessments.

Our most significant challenge continues to be access to inpatient beds due to the volume of beds required to support non-elective demand, and additionally theatre capacity. However, estate work has progressed throughout the year in building our new ward which will enable us to ring fence elective beds and is planned to open late Spring. This, along with the additional theatre capacity, will mean we can treat more patients and deliver shorter waiting times for our population requiring planned care.

We have not made as much progress as we would like in reducing waits to first outpatient appointments, in part due to this being the area that often saw the impact of reduced activity during periods of Industrial Action. There have been pockets of good improvement though, in particular Gastroenterology and Cardiology, which have provided learning opportunities for other specialties.

Improving our Maternity Services

The Maternity and Neonatal Services have continued work to improve Maternity and Neonatal services for women and families over the past year. They have actively engaged in the Maternity Services Support Programme, supported by NHSE, to improve and transform local services and successfully moved into the sustainability phase in March 2024, with anticipation to have exited the programme by the Summer of 2024.

The Improving Together methodology has been embraced within Maternity and Neonatal Services, and this methodology has supported improvements in compliance with Modified Early Obstetric Warning System (MEOWS) and Fluid balance audits aligning with the Trust’s focus on deterioration workstreams and embedding a culture of continuous improvement within the service. This year has also continued to see effective collaboration with the Maternity and Neonatal Voices Partnership to support an improvement in experiences for all and ensure that women and services users voices are heard, and services and changes are co-produced in collaboration with those who use them.

There has been further work in year to embed the governance structure within Maternity services, allowing even greater floor to Board transparency. This has been evidenced in continued presence and reporting at Trust Board and our Maternity Safety Champions meetings which continue to include a broad selection of staff from all roles and levels to ensure concerns from staff are heard at Executive level. In the same vein significant progress has also been made on staff communications to ensure everyone is informed of any developments or challenges with a number of focus groups and listening events held for all to encourage staff to influence decisions that are made within the service. This has meant a continued progression of the improvement in culture, leadership, and transformation within the service.

Midwifery recruitment has been really successful this year with the aim of being very close to full establishment by the end of the year. Our international midwives have been a really positive addition to our workforce, three of whom have now progressed into a Band 6 midwife position. We now have a midwifery apprenticeship programme for Maternity Care assistants which was launched in January 2024, in conjunction with the University of Worcester and have received excellent feedback from Band 5 preceptee midwives since the introduction of our ‘Gold standard’ preceptee programme. Recruitment into Middle Grade and Consultant positions has been variable through the last year, and this is recognised as a national challenge. There has been an expansion in obstetric leadership to meet national requirements and successful consultant recruitment to maintain clinical care. The midwifery

community teams are now working in 'Hubs' with work underway to improve the staffing model and service delivery now the midwifery vacancy rate is reducing at pace.

Responding to Staff Health and Wellbeing

The total number of days absence due to sickness rose in the period between April 2023 and March 2024 largely due to an increase in overall workforce size. The percentage of days lost as a proportion of all staff fell from 3.95% in 22/23 to 3.67% in this last year, continuing last year's trend of increased staff availability across the Trust. Lower rates of short-term absences are often an indicator of improved morale, and it is pleasing to see that short term absence trends fell this year, commensurate with increased morale scores in the staff survey results. The overall proportion of sickness absence remained slightly above the Trust target of 3%. The 2024-25 Forecast assumes a 1% growth in workforce and an average 3.5% absence rate, with improved actions to reduce long term sickness absences.

As part of the 'we are safe and healthy' element of the People Promise, several initiatives were delivered to support the wellbeing of our workforce. Our Trust Staff, Access, Learning, Information (SALi) intranet site has a dedicated portal which provides line managers and staff with a single-entry point to resources and guidance to improve physical and mental health and financial wellbeing.

This year, in response to data that shows Anxiety and Musculo-Skeletal injury as two of our biggest causes of sickness absence, we have increased the hours of our in-house physiotherapy services to cater for more staff appointments, and also increased the number of counselling sessions available to staff. A new, more streamlined process for seeking mental health support has been launched under a single application with responses triaged to provide the best options for the individual. With vacancies filled, our occupational health team has improved its service across all its functions including recruitment support and case referrals, where 96% of referrals were achieved within 2 working days. Adjustments to the Trust induction programme have been planned to incorporate changes which will see the introduction of a 'we are safe and healthy day' in the first week on site.

Our wellbeing lead delivered interventions to train line managers to enable skilful delivery of wellbeing conversations with their staff. These conversations are supported by several trained wellbeing champions who can provide further support and guidance by way of signposting and advice. Our staff continue to retain access to the onsite health and fitness centre, green spaces and walking routes. We will continue to routinely update information to include financial, legal, and other matters that may be underlying causes of stress.

National Staff Survey Results 2023

The NHS staff survey is conducted annually, with 2023 being the third year when the questions were aligned with the NHS People Promise to track progress against our ambition to make Salisbury Foundation Trust (SFT) workplace the 'best place to work'. The national Staff Survey reports against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

The 2023-24 response rate was higher than the previous year with 2265 members of staff responding compared to 1861 in 2022. This represents a positive increase in responses and marked a broader spread of staff groups involved in the survey. Details of the scores for

each indicator, together with the average, best and worst scores in the benchmarking group across the NHS can be found in the Staff Report or on the NHS Staff Survey website:
https://cms.nhsstaffsurveys.com/app/reports/2023/RNZ-benchmark-2023.pdf

In 2023, SFT was identified as the most improved scores across all seven elements, and we met all but one of the elements, 'Always Learning', where significant progress was made but the Trust did not reach its ambition. Our People Promise programme and the divisional action plans generated in response to staff survey results will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board. Further detail on our staff survey response can be found in the Staff Report.

Improving our digital capability

We continue on our journey to deliver the aims and objectives laid out in our five-year digital plan launched in 2022-23. Over the last year we have digitised a range of paper-based processes and pathways using our existing electronic patient record (EPR) system including completing the implementation of electronic prescribing and medicines administration (ePMA). Collaboratively with Royal United Hospitals Bath and Great Western Hospitals, we have completed a joint procurement for a new shared EPR with the implementation of this formally starting in 2024/25. Clinicians have started using the BSW integrated shared care record, which pulls together information about a person from a range of health and social care partners. We have successfully upgraded a range of systems and continue to progress the implementation of a new pathology laboratory management systems (LIMS) and new maternity EPR. Improving Digital Care remains a Strategic Initiative for the Trust over the next 5 years, with an initial focus on these projects and improved Business Intelligence and analytics tools.

We continue to improve digital access to our services for both patients and clinicians. We have embedded our virtual appointment technology for outpatients and are expanding other features including digital letter correspondence and questionnaires. Remote Advice and Guidance is also in place between our clinical partners to get specialist advice and support. We have aligned our plans to give patients access to key information about their care with the national NHS App programme, ensuring this becomes the entry point for people wherever possible.

Key operational and financial risks

In common with all NHS organisations, we face continual challenges balancing delivery of high-quality care with rising demand, the increasing acuity of our patients, and the pressing need to increase both productivity and efficiency. We recognise the important role that strategic and transformational change, both internally and across our Integrated Care System, will play as we address operational and financial risks. As the impact of the pandemic eased, we still faced significant and unique operational and strategic challenges for the Trust, most notably around the need to tackle growing waiting lists (elective recovery), manage the impact of ongoing industrial action, as well as the continued economic pressures due to a changing financial regime and constraints to capital funding.

In summary, the Trust's main priorities and risks for 2024/25 are the safe implementation of the new electronic patient health record, increasing levels of elective activity and operational

productivity, controlling finances and improving delivery of efficiencies and supporting the workforce. In addition to these, and critical to core business, is the continued delivery of quality care.

Going Concern

Our Board considered an assessment of the Trust as a going concern at its meeting on 2 May 2024. A number of risks to this position were identified including a planned deficit position for 2024-25 and the uncertainty of industrial action giving material financial risk.

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

Looking forward to 2024-25

In 2024-25 the Trust will continue to deliver its 2022-26 strategy. The annual plan and strategic planning framework are aligned to deliver reduced waiting times to first outpatient appointment, increasing staff retention, managing patient deterioration, and creating value for our patients. The Trust has made a commitment to make progress against our priorities of People, Population and Partnerships delivered through the drive for improvement through the Improving Together programme.

As we enter 2024-25, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and staffing availability, compounded by on-going strike action. The focus will be on the delivery of NHS England Operational Planning Priorities 2024-25. The key elements of the Trust's plan are delivered through the opening of Imber Ward, increasing elective capacity, improvements in outpatients and planned reductions in the number of No Criteria to Reside (NCTR) patients. Delivery of this plan is reliant on the interdependencies with system partners, particularly in relation to NCTR whilst we continue to work at pace to progress internal improvements around discharge.

We remain committed in developing our workforce, continuing to deliver improvements across the seven elements of the NHS People Promise. More specifically, there is a continued focus on supporting the health and wellbeing of staff with a number of wellbeing initiatives through wellbeing ambassadors, staff side representation and management input. Additionally, the Trust will work to deliver our newly refreshed long-term Equality, Diversity and Inclusion Plan (2024-27), incorporating its six high impact actions and also the South West region's 'Leading for Inclusion' framework.

Due to the Trust's deficit position and of the wider system going into next year, there will be significant external financial oversight during 2024-25. The most significant risk to our strategy is the financial sustainability of the organisation. Therefore, next year will see a heightened focus and work with system partners to develop a financial plan to enable sustainable delivery of services.

Whilst we move into a challenging year, the plan is based on a series of balances across finance, performance, workforce, and quality to enable us to deliver an outstanding experience for our patients, their families, and our colleagues.

Ian Green OBE	**Lisa Thomas**
[signature]	[signature]
Chair **27/06/2024** **(on behalf of the Trust Board)**	**Interim Chief Executive** **27/06/2024**

PERFORMANCE ANALYSIS

The Trust publishes a monthly Integrated Performance Report (IPR) which provides both the Board and the public with an overview of our performance. The report is structured around the strategic and enabling priorities identified by the Trust, Key Performance Indicators, and a range of watch metrics that provide oversight into the quality and timeliness of care received by patients. Areas of risk and mitigation in delivery of the standards are described in accompanying narrative within the IPR. The report evolves to reflect new areas of monitoring or national focus.

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

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

The IPR is presented at Board Committees, and then presented as one integrated document for scrutiny at Trust Board. The statistical process charts allow our Board and Committees to see trend analysis for the previous 24 months which provides more depth and understanding around our performance and emerging trends.

Performance overview

The Trust has made progress this year in delivering key priorities as part of the recovery and restoration of services following the pandemic. Unparalleled levels of Industrial Action and increases in non-elective demand have made the year a challenging one, but the progress has been meaningful.

National objectives influencing our plan for 2023-24 were to:

- improve ambulance response times and A&E waiting times.
- reduce elective long waits and cancer backlogs and improve performance against the core diagnostic standard.

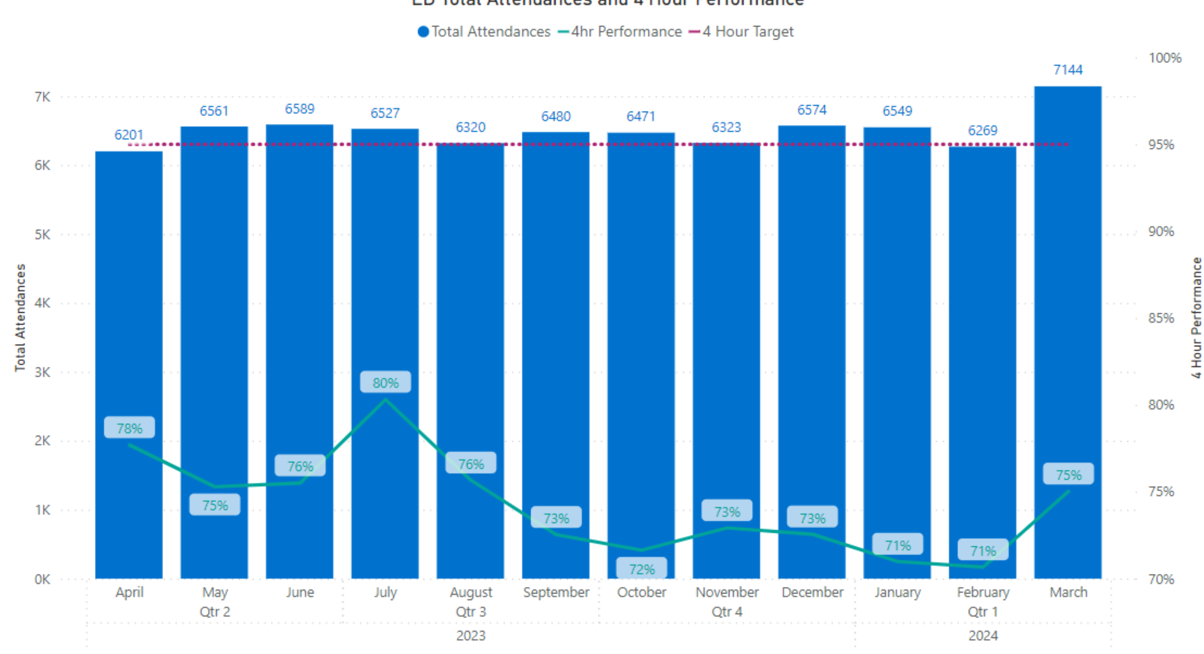
Our local plans included focusing on flow in terms of reducing bed occupancy and increasing productivity to reduce our waiting times.

Urgent and Emergency Care

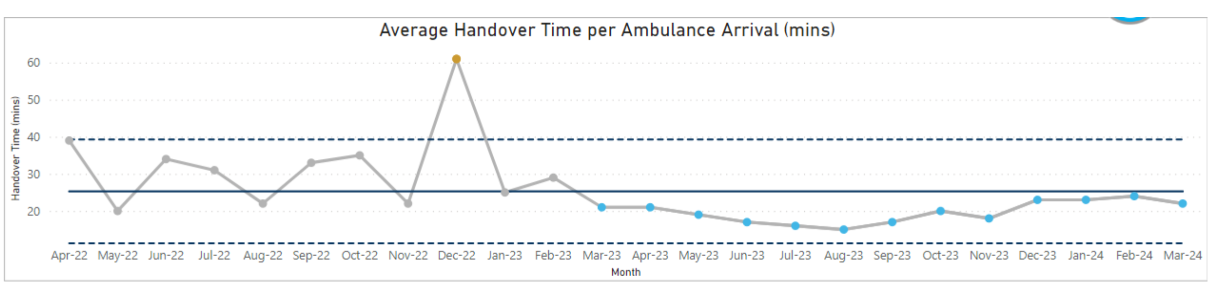
Demand for our Urgent and Emergency Care services have increased markedly this year, with Emergency Department attendances up by 4% in comparison to last year, and non-elective admissions up by around 6%. Bed occupancy levels remained high at around 97%. The number of patients no longer requiring acute care but waiting for services elsewhere peaked at an average of 125 (28% of occupied beds) in May 23, but efforts from the Trust and its partners to decrease this resulted in an average of 73 (18% of occupied beds) by March 24.

Over the course of the year average length of stay has reduced by around 1 day with the impact from this being a reduction in bed demand of 40 beds and balanced some of the increase in demand. Development of Same Day Emergency Care services has supported length of stay reductions and we plan to further expand these services in 2024/25.

Despite the pressure the Trust managed to achieve 74.2% of patients treated and admitted or discharged within 4 hours in the Emergency Department, up from 72.6% the previous year. Furthermore, the number of patients waiting longer than 12 hours to be admitted to the hospital from the Emergency Department reduced to 61 compared to 250 in 2022-23 despite increased activity.



An area of concentrated focus this year has been on reducing the time it takes for the ambulance service to handover patients to the Emergency Department. We recognise the wider impact to the local community and our partners when ambulances are unable to be released to respond when waiting for us. The Emergency Department developed a Rapid Assessment and Triage trial to support rapid response to ambulance arrivals and have regularly been amongst the top performing Trusts in the South West region for Ambulance handovers, testament to the absolute commitment by the Emergency Department and wider hospital inpatient teams to pursuing improvement to this standard.

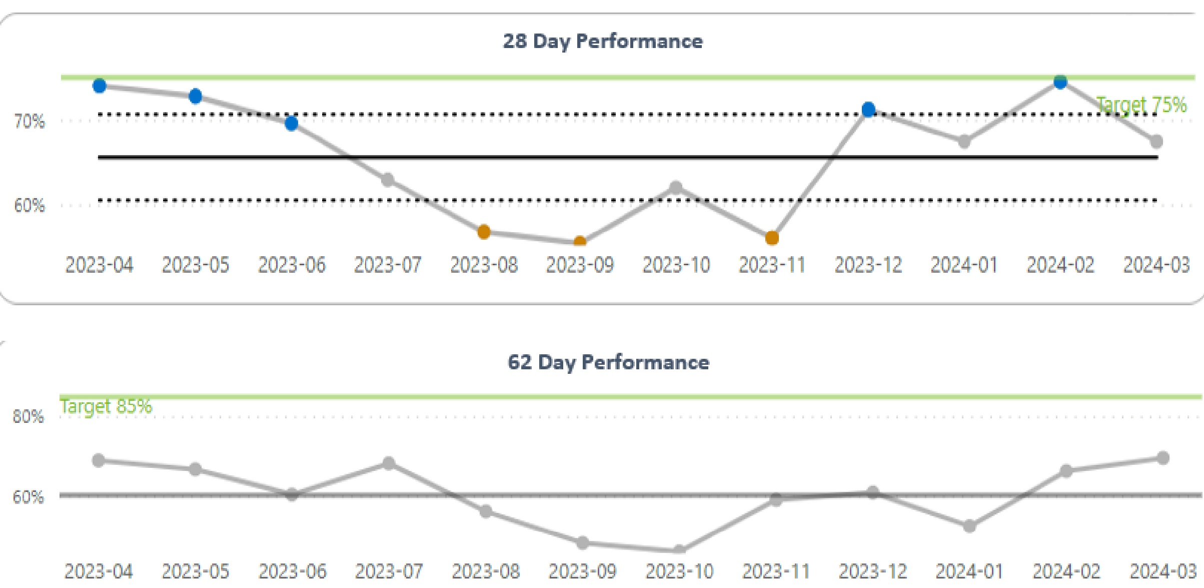


Elective Care

Cancer pathways

Referrals for patients with suspected cancer symptoms continued to increase with 7% more referrals overall than the previous year, with an increase of 9% in Skin, 13% in Breast, 15% in Gynaecology and 26% in Lung.

Increases in demand and capacity challenges meant that our performance against both the 28-day Faster Diagnosis Standard and the 62-day referral to treatment standard was influenced negatively. The biggest contributor was the high-volume Skin pathway, additional capacity was secured across quarters 3 and 4, with overall performance recovering up to 65% for the 28-day standard, and 72% for the 62-day standard by the end of the year. Complex pathways such as Colorectal and Prostate remain challenging, we have made progress in both this year, but remain focused on continuing this improvement in 2024/25.



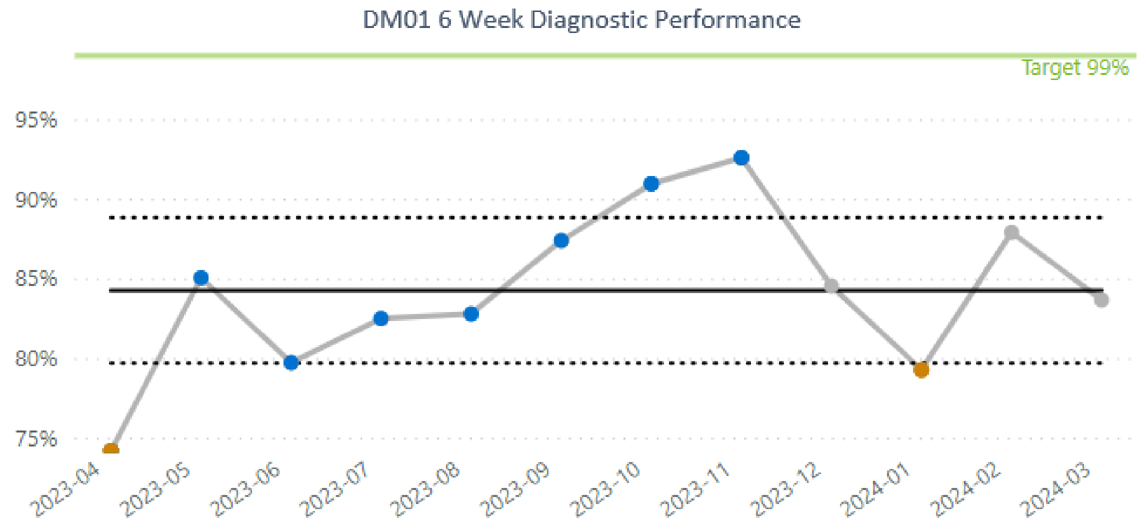
A consequence of lower performance for the 28 day and 62 day standards was an increased number of patients waiting longer that 62 days on a cancer pathway for treatment. This peaked at 167 patients in September 23, we reduced this to 91 by end of March 24 with increased capacity and support to the cancer pathway.

Improving cancer waiting times further is a key priority for the year ahead as we work to align pathways to the Best Practice models, reducing unnecessary waits for diagnostics and decision-making so that patients receive a non-cancer diagnosis or treatment as quickly as possible.

Diagnostics

We have continued to make good progress in ensuring our patients receive diagnostic interventions quickly with 84% of patients across the year waiting less than 6 weeks, around 10% higher than the national average. There continues to be areas of vulnerability such as Ultrasound with national staffing shortages and we will work with our partners more closely to explore innovative solutions to increase capacity in the year ahead. The expansion of Community Diagnostic Services in 2024/25 will give us greater opportunity to provide

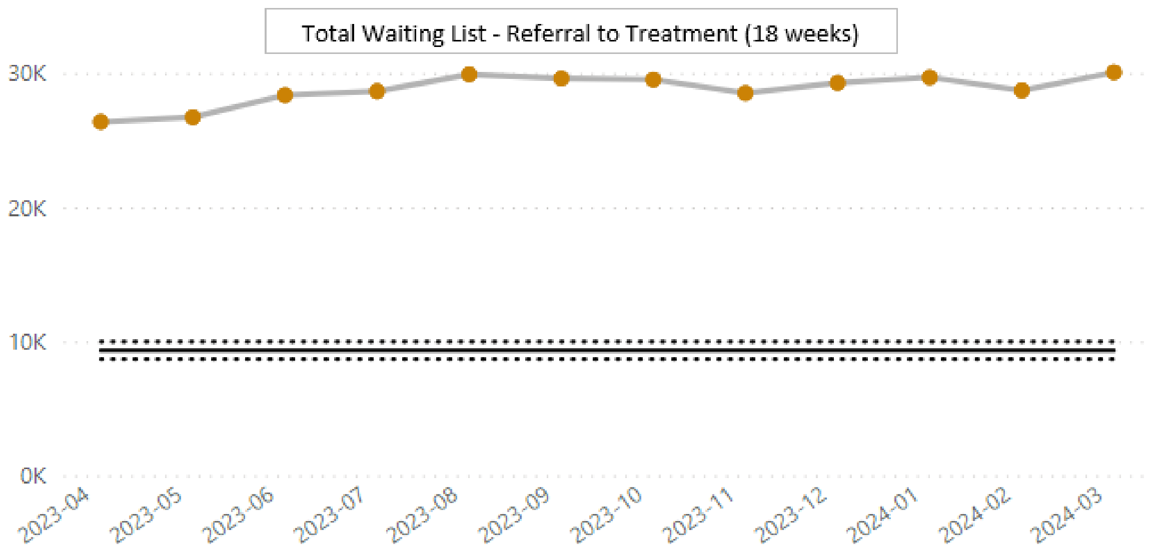
diagnostic services closer to our local population whilst also maintaining our progress in delivering low waiting times.



Referral to Treatment (18 weeks)

We started the year in a positive position having eliminated any waits over 78 weeks by March 2023 and our ambition was to eliminate all waits over 65 weeks by March 2024. The scale of disruption and loss of capacity triggered by the Industrial Action meant that by August we were off track and reporting a number of patients waiting over 78 and 104 weeks. Despite the challenges our staff worked relentlessly to find ways to reduce the longest waits, and by the end of the year there were zero patients waiting longer than 104 or 78 weeks, and just 9 waiting over 65 weeks.

The total waiting list size has increased further this year to 30,036 patients, growth of 12% since March 2023. Specialties with highest increases in waiting list size are Orthopaedics, Urology, Ophthalmology and Gynaecology. Referrals increased by 5% with the growth in waiting list size linked to elective and day case activity being constrained due to availability of beds and theatre capacity. Elective activity increased in the second half of the year, and



we have ambitious plans to increase this significantly in 24/25 with additional ward and theatre capacity coming online.

Overview of financial performance in 2023-24

In 2023-24 the NHS had a continued focus on the recovery of elective pathways and addressing waiting times combined with managing emergency pathways. Industrial action during the year constrained the elective programme and impacted on management capacity to improve productivity. The pressure on the emergency pathway manifested through increased costs and loss of elective capacity alongside the premium costs of bank and agency to cover vacancies and unavailability.

The Trust incurred material cost pressures in year related to Industrial Action, supernumerary cover for new and overseas staff, residual gaps on pay award funding and increases in bank and agency associated with pressures on the emergency care pathway and patient acuity and complexity.

The Group closed the year with a surplus of £3.1 million. Following required adjustments for national reporting, the Trust reported a position of £4.475m deficit.

Group Statement of Comprehensive Income	2023/24 £'000	2022/23 £'000
Income		
From clinical activities	332,928	316,728
Other operating income	51,908	44,826
Total Operating Income	384,836	361,554
Operating Expenses	(373,779)	(355,455)
Operating Surplus/(Deficit)	11,057	6,099
Finance income	1,565	1,082
Public Dividend Capital payable	(4,928)	(4,447)
Other finance costs	(5,425)	(2,218)
Net Finance Costs	(8,788)	(5,583)
Revaluation gains (+) / losses (-) on assets	895	(305)
Fair value gains (+) / losses (-) on investments	31	54
Transfers by absorption gains (+) / losses (-)		(329)
Corporation tax expense	(80)	
Total Retained Surplus / (Deficit)	3,115	(64)
Adjusted Surplus / (Deficit) SFT only	(4,475)	39

The Trust delivered £15.327m savings in year, which was in line with the plan, with the non-recurrent element of £3.755m achieved. Key workstreams underpinning the delivery included:

- Elective Productivity (£3.3m)
- Divisional CIPs (£3.0m)
- Non recurrent vacancies (£2.8m)
- Bed occupancy mainly delivered through the Acute Frailty scheme (£2.6m)

Capital Investment

The Trust invested £48.3m (including £3.4m Right of Use assets) in infrastructure and equipment during 2023-24 (£20.4m in 2022-23). This was funded internally through depreciation and cash, donations, IFRS16 leasing funds and additional Public Dividend Capital (PDC) from the Department of Health primarily for the Elective ward, EPR and Digital Pathology funding. The capital programme continues to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk and improving patient experience.

Significant in-year programmes included expenditure of:

- £13.3m on the works for the Imber ward and decant costs.
- £11.1m on the Salix grant for decarbonisation and energy conservation measures which included the installation of heat pumps and roof mounted Solar Photovoltaics (PVs), LED lighting and improvements to the Spinal unit and leisure centre.
- £6.9m on building and critical infrastructure schemes including the Whiteparish ward refurbishment, replacement of standby generators, Day surgery discharge scheme, automatic door replacements, fire and electrical compliance works, works to support the CT scanner installation and Helipad.
- £3.5m on the digital programme, including £1.3m investment in Network kit and £0.5m on PCs and mobile devices, £0.3m on the implementation of Electronic Prescribing and Medicines Administration and £0.3m on EPR optimisation.
- £3.0m on leased items including 2 CT scanners, Anaesthetics machines, fleet vehicles and accommodation.
- £2.7m on replacement and additional medical equipment, including Theatre lights, Theatre power tools, Theatre surgical instruments replacement, Phaco machine for ultrasonic cataract surgery, Patient monitoring replacement programme and Palliative Care syringe pumps.
- £2.1m on the EPR programme.
- £1.6m on schemes related to Digital Pathology and replacement of the Pathology Laboratory Information Management System; and
- £1.4m on the Surgical robot.

Tackling Health Inequalities

Health inequalities are unfair, avoidable, and systemic differences in health outcomes from different groups of people. On 27 November 2023 NHS England published a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006). The purpose of the statement is to help trusts and ICBs identify key data and information on health inequalities. This will be a key focus for the Trust in 2024/25 to collate, analyse and publish the data.

The **CORE20PLUS5** approach guides our work on health inequalities. The 'Core' references the 20% most deprived communities in England. In Wiltshire we have eight geographical areas in the poorest 20% nationally, and three of these are in Salisbury.

The **'PLUS'** represents defined groups that experience disparities in health outcomes within our local geography. In the case of BSW this is Gypsy, Roma, Traveller, and Boater communities, as well as routine and manual workers. Military populations are considered here too. For children there is a focus on mental health, and the children of Gypsy, Roma, Traveller, and Boater families.

The **'5'** represents the key clinical areas of focus – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. Smoking cessation is a theme through all five.

The Joint Strategic Needs Assessment (**JSNA)** is a document produced by all English local authorities; Wiltshire's can be found here: JSNA Wiltshire Intelligence. It provides high level data on our population and helps us take a data driven approach to defining our interventions for tackling health inequity.

To support our work at Salisbury NHS Foundation Trust, the Wiltshire Health Inequalities Group (WHIG) continue to meet monthly and there is an acute hospital focus at this meeting on a bi-monthly basis.

This year, approximately £860,000 was allocated to Wiltshire to help fund projects that will reduce health inequalities. This funding call opened in August 2023 and 14 projects were successful in their bids. These projects are aligned with the CORE20PLUS5 priorities and range from supporting under-5 health clubs to providing crisis support, with each helping to improve people's health where it is needed most. Working with our partners across Wiltshire on practical projects like this helps us to deliver on our vision to see people living longer, healthier lives.

In addition to the above, there are a range or projects being supported by our staff across the organisation. A sample of a few of these projects are highlighted below.

- The number of inpatients identified as current smokers and referred to our tobacco dependency service each month has almost doubled over the past year. We have also been using *Making Every Contact Count* (MECC) as a communication tool in clinics for parents/carers who smoke or vape.

- We have recently developed an 'Asthma Friendly Schools' package, which will enable wider recognition and signposting of children and young people with poorly controlled asthma.

- We have been rolling out an education programme across our wards to help optimise oral healthcare for our inpatients (which can be both a source and cause worsening of disease)

- We established a learning disability and autism operations group, which will support us to make reasonable adjustments for these patients and ensure that accessible information is being reviewed and produced with the support of the local learning disability advocacy group.

- Our cancer specialists have been helping to increase awareness of the early signs of cancer, particularly targeting vulnerable patient groups where access to healthcare may be more challenging.

- The Trust continues to offer a comprehensive staff health and wellbeing activities to support with both mental and physical health needs, offering counselling and wellbeing conversations for staff, access to financial support, improvement coaches, a health and fitness centre and pain management programme.

- Sustainability initiatives, such as promoting clean air and water, ensuring access to healthy food and green spaces, can contribute to reducing health inequalities by creating

healthier environments for all individuals. These have therefore all been areas of specific focus over the past year.

Plans are in place to host a partnership workshop in the summer of 2024 with specific focus on cardiovascular disease and health inequalities.

Environmental Sustainability Performance

Our Board approved Green Plan 2021-2024 (which can be found on the Trust's website www.salisbury.nhs.uk/about-us/sustainability/) aims to drive sustainable change and prepare us for transition to deliver net zero carbon healthcare within two decades.

The progression to carbon net zero through the development of our Green Plan does not aim to capture the full scope of the sustainability agenda, which would also extend to include biodiversity and the promotion and utilisation of green spaces to support health and wellbeing. Our Green Plan does not consider offsetting; but instead, focuses on efforts to tangibly reduce carbon emissions.

Targets

1. To measure our annual Carbon Footprint and set interim targets for reduction.
2. To be Net Zero by 2040 for our Carbon Footprint, with an ambition to reach an 80% reduction by 2028 to 2032.
3. To understand and further reduce our indirect scope 3 emissions within the NHS Carbon Footprint Plus.

Progress to Date

2023/2024 has seen continued momentum for delivery of Green Plan actions across the Trust. The Green Plan provides us with a framework to deliver sustainable healthcare and has complemented some of the clinical innovations seen this year. Such as the introduction of Electronic Prescribing and Medicines Administration (EPMA) and the continued roll out of 'Dr Doctor' virtual outpatient appointments, delivering sustainability co-benefits by reducing patient travel and unnecessary appointments.

We have a committed and engaged Sustainability Committee of Ambassadors, focused across 9 areas within our Green Plan. These areas align with NHS priorities and represent where we direct our efforts to reduce carbon emissions and improve sustainability and health outcomes. Highlights of this progress includes:

- EPMA project completed by Informatics with successful roll out across the Trust.
- Installation of UV sterile chamber to enable recycling of water in Hospital Swimming pools.
- Baselined our carbon footprint for Greenhouse Gases scopes 1 and 2, and now starting to baseline scope 3.
- Inclusion of a Net Zero e-learning course, completed by 2,285 staff thus far.
- Internal and external engagement and communications to highlight and promote the Sustainability agenda, including publication of the public-facing Green Plan.
- Launch of the staff sustainability engagement platform 'ACT' shared with RUH/GWH.
- Improvements in facilities and arrangements for active travel.

- Increased Cycle to Work scheme salary sacrifice to £3,000.
- Evergreen procurement framework for suppliers launched by Procurement.
- Introduction of branded reusable lunchboxes and cups for staff/visitors.
- Commencement of site air quality monitoring.
- Safer disposal of inhalers scheme launched in Childrens Outpatients.
- Acute Hospital Alliance (AHA) Sustainability Group formed.

Showcase Project 2023/2024

During the year the Trust successfully bid for £10.5m of funding through the Public Sector Decarbonisation Scheme (PSDS3b) for energy infrastructure investment to improve energy efficiency, reduce our carbon emissions, and lower energy bills.

Buildings in scope:

- Spinal Unit (heat building, domestic hot water, and pool water)
- Leisure Centre (heat building, domestic hot water, and pool water)
- SDH North, main hospital building (heat building, domestic hot water)

Project outline:

- End of life gas boilers replaced with air source heat pumps.
- Insulating building walls and roof spaces and replacing windows.
- Switch lighting to LED.
- New energy optimisation system (Open Blue) implemented to the Building Management System.
- New solar panel arrays which, based on 2021-2022 usage, will offset 13% of electricity imported to onsite generation.

Plans for a Geothermal renewable energy source onsite has also been prepared with a seismic study due to be undertaken in June 2024.

Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

The Board's oversight of climate-related issues

Our Board approved Green Plan identified a governance structure to support delivery, monitoring and reporting of progress (see figure 1). The Chief Finance Officer is the Trust Board nominated net zero lead, with responsibility for sustainability and the delivery and implementation of the Green Plan. The Head of Facilities is the Trust's Sustainability Lead and provides the Trust Management Committee (TMC) with annual progress reports against Green Plan objectives. The Sustainability Manager, working with subject matter leads, is leading the implementation of our Green Plan to ensure change happens as expected.

Sustainability is a key priority for the Trust and the Board considers climate-related issues when reviewing and developing organisational plans. Some examples of this are:

- Our Green Plan and commitment to net zero is an essential part of our Trust Strategy.
- The new Imber ward design and build is on track to be certified 'BREEAM Excellent' for its sustainability credentials, which puts it in the top 10% of UK new non-domestic buildings.
- The £10.5m Salix decarbonisation investment in 23/24 (and beyond) reflects the organisation's commitment and willingness to provide match funding to grant proposals.
- Campus redevelopment plan includes plans for climate adaptation, green technologies, and ensuring no impact on biodiversity.
- We've commissioned work to produce a risk assessment for an adaptation plan to build organisational resilience for the effects of climate change.
- Our Emergency Preparedness team has already considered national heat wave, cold weather and flood plans, which are reviewed and will feed into the climate change adaptation plan as necessary.

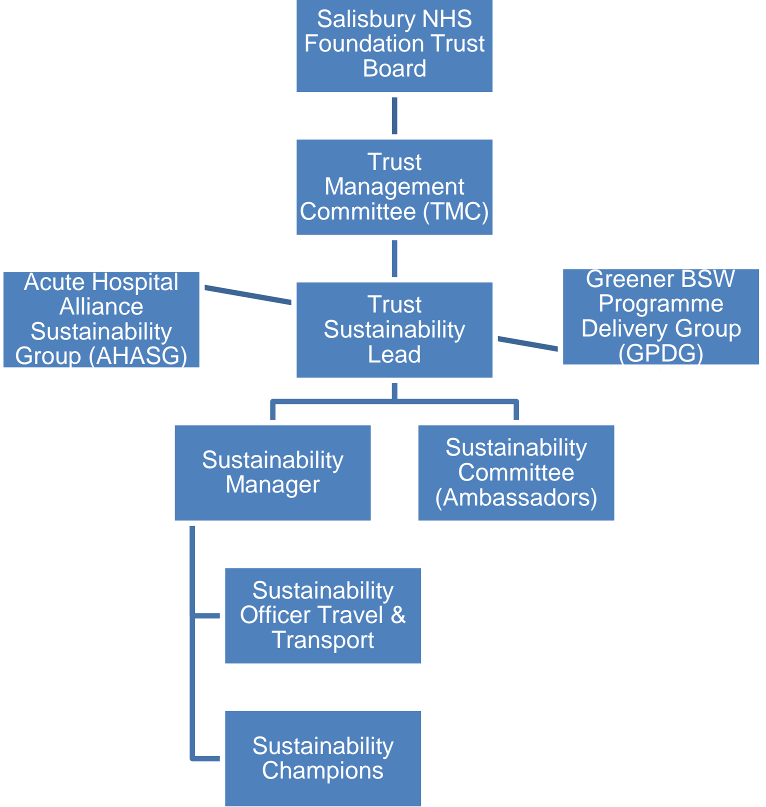


Figure 1. SFT Green Governance Structure

Management's role in assessing and managing climate-related issues

A Sustainability Committee of Green Plan Area of Focus subject matter experts, is monitoring progress through monthly meetings and the monitoring/maintenance of a detailed Green Plan Action tracker to ensure accountability for the delivery of objectives. They identify potential risks and opportunities related to climate change by various means, such as by conducting risk assessments, scenario planning, and trend analysis, to understand the potential impacts on our operations, supply chain and stakeholders, and through their expertise are developing adaptation and mitigation plans, are implementing sustainable practices, and are investing in renewable energy and other low-carbon technologies.

Committee progress against Green Plan objectives will be formally reported to the TMC on an annual basis, and will consider:

1. The progress made and the ability to increase or accelerate agreed actions.
2. New initiatives generated by the community we serve, our staff, ICS colleagues or partner organisations.
3. Advancements in technology or other enablers.
4. The likely increase in ambition and breadth of national carbon reduction initiatives and targets.

Major in-year risks 2023/24 and in 2024/25

The Trust's Board Assurance Framework (BAF) details the principal strategic risks of the Trust's corporate objectives. This is received by the Board on a quarterly basis, alongside the Corporate Risk Register (CRR). The Board Committees have oversight of the BAF and CRR where the risk profile is reviewed and discussed in detail. Review of the risk profile is achieved through this quarterly oversight and review and therefore, the changes are continuous throughout the year resulting in a dynamic risk profile. The BAF records that the Trust has been managing 10 significant risks during the 2023-24, with 3 risks outside of the Board agreed risk appetite. For each BAF risk there is a detailed series of mitigations which will continue to be implemented throughout 2024-25.

Major in-year risks for 2023/24

Risks with potential to impact on achieving our strategic objectives were:

- The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.
- Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff.
- Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
- As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.
- Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.
- Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.
- An irreversible inability to reduce the scale of financial deficit.
- Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.
- Significant failure of supply chain which could result in substantial or prolonged disruption to services.

Key controls, assurances and actions on these risks include:

- Reconfiguration of services in collaboration within the BSW ICS and development of the Acute Hospital Alliance clinical strategy.
- Digital services review and approval of a Shared EPR business case.
- Categorisation and prioritisation of Trust capital. Review and prioritisation within the Trust framework (alongside digital, medical equipment etc)
- Investigations into strategic partnership models to allow development and investment of the estate.
- Analysis of patient experience, ward-level performance, incidents and complaints, monthly financial reporting and quality improvement activity.
- A comprehensive improvement programme against all 7 elements of the People Promise
- Recruitment campaigns.
- Strengthened workforce planning arrangements.

- Development and implementation of a Same Day Emergency care (SDEC) Unit and Acute Frailty Unit.
- Our performance management framework, including performance dashboards and monthly Integrated Performance Report.
- Supply chain monitoring through procurement systems.
- Quality assurance visits such as Board Safety Walks, including Non-Executive Directors.
- External regulatory and assessment body inspection and review reports.
- Assurances provided through the work of the Trust Clinical Governance Committee and executive sub-committees across quality, performance and risk.

The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committee of the Board. As we enter 2024-25, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and staffing availability, compounded by on-going strike action.

Major in-year risks for 2024/25

As with all NHS organisations, we face continual challenges in balancing the delivery of high-quality care with rising demand, rising acuity, rising rates of inflation and the need to increase both productivity and efficiency to meet challenging activity requirements. Successful implementation of the new electronic health record system will be critical in enabling the Trust to do this in the future. This remains an ongoing strategic priority for us and risks to delivering are reflected in our Board Assurance Framework to keep sight of our controls and assurance managing these. We recognise that strategic and transformational change internally and across our local health economy will be required to address any risks that we identify. These operational and programmatic demands may reduce focus on the development and delivery of our strategic ambitions. We will continue to monitor and manage the risks that arise from the changing health economy landscape and across our estate.

Risk management and internal control is provided in more detail in the Annual Governance Statement on page 90.

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

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

Directors of Salisbury NHS Foundation Trust during 2023-24

Ian Green	Chair
Stacey Hunter	Chief Executive (left January 2024)
Dr Peter Collins	Chief Medical Officer
Judy Dyos	Chief Nursing Officer
Mark Ellis	Interim Chief Finance Officer
Lisa Thomas	Interim Chief Operating Officer (from August 2022) Interim Chief Executive Officer (from February 2024)
Niall Prosser	Interim Chief Operating Officer (from February 2024)
Melanie Whitfield	Chief People Officer
Michael von Bertele CB, OBE	Non-Executive Director
Tania Baker	Non-Executive Director (Senior Independent Director to 31st August)
Margaret (Eiri) Jones	Non-Executive Director (Senior Independent Director from 1st Sept 2023)
Rakhee Aggarwal	Non-Executive Director
Dr David Buckle	Non-Executive Director
Debbie Beaven	Non-Executive Director
Richard Holmes	Non-Executive Director

Register of Directors' Interests

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

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

The Register of Declared Interests is made available to the public by contacting the Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ. This can also be found on the Trust website following the link below:

https://www.salisbury.nhs.uk/about-us/corporate-governance/

NHS Improvement's Well Led Framework

The Trust has considered NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality. For 2023/24, this was achieved through an external review.

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

During 2023-24, the Trust welcomed Niall Prosser, Interim Chief Operating Officer, to the Board and Lisa Thomas into her new role as Interim Chief Executive Officer.

An external well-led review started in April 2023 for a period of 3 months. This was a developmental review with the key aim to understand the Trust's strengths and also areas that require improvement from a well-led perspective. The outcomes of this report were shared with the Board and wider Trust and recommendations to take forward are underway. The findings reflected "an organisation with clear strategic ambition and commitment to lead for the benefit of the wider system. Operational and governance arrangements are in place and a key development challenge relates to the leadership attention needed to sustain and strengthen those foundations. Throughout the review it was clear that Improving Together is a pivotal focus in defining the organisational approach to improvement and development".

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

Other disclosures

Modern Slavery Act 2023-24 annual statement

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

Cost allocation and charging guidance issued by HM Treasury

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

Political Donations

The Trust has made no political donations of its own.

Better Payment Practice Code

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

Performance against the Code for 2023-24 is set out below:

Better payment practice 2023-24	Foundation Trust Number	Foundation Trust £'000
Non-NHS		
Total bills paid in the year	68,222	157,615
Total bills paid within target	64,102	144,576
Percentage of bills paid within target	94.0%	91.7%
NHS		
Total bills paid in the year	1,657	9,000
Total bills paid within target	1,407	8,020
Percentage of bills paid within target	84.9%	89.1%
Total		
Total bills paid in the year	69,879	166,615
Total bills paid within target	65,509	152,596
Percentage of bills paid within target	94.0%	91.6%

Performance against the Code for 2022-23 is set out below:

Better payment practice 2022-23	Foundation Trust Number	Foundation Trust £'000
Non-NHS		
Total bills paid in the year	65,144	128,795
Total bills paid within target	60,340	118,652
Percentage of bills paid within target	92.6%	92.1%
NHS		
Total bills paid in the year	1,476	6,944
Total bills paid within target	1,202	5,360
Percentage of bills paid within target	81.4%	77.2%
Total		
Total bills paid in the year	66,620	135,739
Total bills paid within target	61,542	113,292
Percentage of bills paid within target	92.0%	83.0%

Information on fees and charges

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

		2023-24	*2022-23*	*2021-22*
	Expected sign			
Income	+	*19,602*	*17,753*	*14,028*
Full cost	-	*15,239*	*15,561*	*12,787*
Surplus/Deficit	+/-	***4,363***	***2,192***	***1,241***

Income Disclosure

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff, and external bodies that generate income which cover the cost of the service. These services are self-funded with their own staff and do not distract from the core service of patient care. Surpluses generated from these income generating activities are used to enhance patient care. Services that generate income include payroll services, accommodation, catering, car parking, private patient treatment, pharmacy products. The total income from all these areas amounted to around £9.2 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £11.5 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £3.2 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.

L. Thomas.

Lisa Thomas
Chief Executive (Accounting Officer)
27 June 2024 (on behalf of the Trust Board)

REMUNERATION REPORT

Chair of the Remuneration Committee's Annual Statement on Remuneration

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

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

As the Chair of the Remuneration Committee, I am pleased to present our remuneration report for 2023-24.

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

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2023-24. Salaries are set in comparison with those given to holders of equivalent posts within the NHS. Advancement within the individual salary scales of Executive Directors is based on successful appraisal outcomes and this is the only performance-related element of the Executive Director's remuneration. The Remuneration Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chair advises the committee on the performance of the Chief Executive.

2023-24 major decisions on remuneration

During 2023-24, the Remuneration and Nominations Committee recognised the annual pay increase for Senior Managers as laid out in guidance shared from NHS England by 5% with effect from 1 April 2023. The interim Chief Finance Officer also received an uplift in pay during 2023-24 in consideration of national benchmarking and guidance.

The changes to the Trust's Executive team during 2023-24 were:

- Stacey Hunter left the Trust as Chief Executive Officer on 31st January 2024.
- Lisa Thomas commenced her position as Interim Chief Executive Officer in February 2024.
- Niall Prosser commenced a 6-month secondment as Interim Chief Operating Officer in February 2024.

Rakhee Aggarwal
Non-Executive Director / Remuneration Committee Chair

Senior Managers' Remuneration Policy

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

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

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

The Trust's overarching approach to remuneration is designed to ensure that senior managers' remuneration supports its strategy and business objectives. The approach has been developed to support the provision of high-quality services for patients through its strategic aim of delivering an outstanding experience for every patient, financial stability, and improved service performance. The Trust is mindful of a broad range of factors in setting this approach including reference to the Trust Equality and Diversity and Inclusion policy the aim of which is to foster a more equitable, diverse, and inclusive environment, enhancing the sense of belonging for all staff and empowering them to thrive at work and reach their full potential with dignity and respect.

There is particular mention of the Trust Board of Directors responsibilities for ensuring that the organisation complies with its legal and regulatory obligations under the Equality Act and the public sector equality duty.

This includes ensuring that the Trust:

- Provides equal opportunities for all employees and service users, regardless of their protected characteristics.
- Promotes diversity and inclusion in the workplace and in the delivery of services.
- Eliminates discrimination and harassment.

The Chief Executive Officer has ultimate responsibility for equality, diversity and inclusion, but this responsibility has been delegated to the Chief People Officer.

The Trust Board will receive for assurance and ratification, a range of equality, diversity and inclusion reports to ensure that the Trust is meeting its legal obligations and to identify any areas for improvement, these include the publication of annual NHS workforce race equality

standard (WRES) and workforce disability equality standard (WDES) and Gender pay reports in May and October respectively.

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

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

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: • Improving the health and wellbeing of the population we serve. • Working through partnerships to transform and	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March.

	integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work	benchmarked against the NHSI Guidance for pay for senior managers.	
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short- and long-term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic goals stated in the basic salary component.	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

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

The performance measures were chosen to reflect the Trust's adopted values and behaviours alongside its strategic goals which form the basis for Directors' performance objectives. Objectives for each Executive are agreed at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). The objectives / performance measures, alongside the refreshed national leadership competencies, are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of

sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-Executive Directors does have the authority to decide on whether any pay or remuneration increase should be awarded each year based on performance.

No Executive Directors have been released to undertake other paid work elsewhere.

Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSI guidance for pay for senior managers.

Remuneration of Non-Executive Directors

Element of pay (Component)	How component supports short- and long-term strategic objective of the Trust	Operation of the component	Performance metric used and time period
Basic salary	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of: • Improving the health and wellbeing of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work.	It is one single pay point based on research of NHS remuneration for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A
Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

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

Statement of consideration of employment conditions elsewhere in the Trust

While the Trust does not consult with employees on the remuneration policy regarding senior managers, it does consider the national pay and conditions of NHS employees.

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

Annual Report on Remuneration

Service contracts obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non- Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract, and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chair, Chief Executive and Non-Executive Directors. Guidance for VSM pay including for severance payments is noted in the NHS Employers: Guidance on pay for senior managers and Guidance for Making Severance payments. These guidance documents are referenced in the Trust Executive Pay framework.

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

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

Name	Role	Current term of office	Notice Period (months)
Ian Green	Chair	Commenced February 2023 (3 year term)	3
Rakhee Aggarwal	Non-Executive Director	Commenced January 2023 (3 year term)	3
Tania Baker	Non-Executive Director	Commenced May 2022 (2 year term)	3
Michael von Bertele	Non-Executive Director	Commenced October 2022 (2 year term)	3
David Buckle	Non-Executive Director	Commenced January 2023 (3 year term)	3
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2022 (3 year term)	3
Richard Holmes	Non-Executive Director	Commenced January 2023 (3 year term)	3
Debbie Beavan	Non-Executive Director	Commenced January 2023 (3 year term)	3
Peter Collins	Chief Medical Officer	Commenced October 2020	6
Judy Dyos	Chief Nursing Officer	Commenced June 2020	6
Mark Ellis	Interim Chief Finance Officer	Commenced August 2022	6
Lisa Thomas	Interim Chief Operating Officer Interim Chief Executive Officer	Commenced August 2022 Commenced February 2024	6
Niall Prosser	Interim Chief Operating Officer	Commenced February 2024	6
Melanie Whitfield	Chief People Officer	Commenced September 2021	6
Stacey Hunter	Chief Executive	Left January 2024	6

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

Remuneration Committee

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

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

Remuneration Committee Attendance		
Name	**Role**	**Attendance (out of 5 meetings)**
Ian Green	Chair	5
Rakhee Aggarwal	Non-Executive Director	5
Tania Baker	Non-Executive Director	3
Michael von Bertele	Non-Executive Director	4
David Buckle	Non-Executive Director	4
Margaret (Eiri) Jones	Non-Executive Director	3
Debbie Beaven	Non-Executive Director	4
Richard Holmes	Non-Executive Director	3

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

Disclosures in accordance with the Health and Social Care Act

Expenses for Senior Managers and Governors

Year	Number of Directors in Office	Number of Directors Reimbursed	Amount Reimbursed to Directors	Number of Elected Governors in Office	Number of Elected Governors Reimbursed	Amount Reimbursed to Elected Governors
2023/2024	15	5	£4,575	22	0	£0
2022/2023	14	2	£958	21	1	£27
Expenses incurred during the course of their duties relate to travel, accommodation and subsistence. Directors include those who were in post in an interim capacity during the year						

Salary and Pension Entitlement

Set out below is a table disclosing the single total figure of remuneration for each person occupying a director post. This includes all remuneration paid by the Trust to the individual in respect of their service for the Trust, including remuneration for duties that are not part of

their management role. There have been no payments made to directors relating to non-management roles in 2023-24.

Name and Title	Remuneration Year to 1 April 2023 - 31 March 2024					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ian Green - Chairman	45-50	0	0	0	0	45-50
Tania Baker - Non-Executive	10-15	0	0	0	0	10-15
Michael von Bertele - Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones - Non-Executive	15-20	0	0	0	0	15-20
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Richard Holmes - Non-Executive	10-15	0	0	0	0	10-15
Debbie Beavan - Non-Executive	10-15	0	0	0	0	10-15
Stacey Hunter - Chief Executive	165-170	0	0	0	0	165-170
Lisa Thomas - Interim Chief Operating Officer/ Interim Chief Executive	155-160	0	0	0	0	155-160
Peter Collins - Chief Medical Officer	195-200	0	0	0	0	195-200
Judy Dyos - Chief Nursing Officer	125-130	0	0	0	7.5-10	135-140
Mark Ellis - Interim Chief Finance Officer	115-120	0	0	0	0	115-120
Niall Prosser – Interim Chief Operating Officer	20-25	0	0	0	30-32.5	50-55

Name and Title	Remuneration Year to 1 April 2023 - 31 March 2024					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Melanie Whitfield - Chief People Officer	130-135	0	0	0	35-37.5	165-170

This table is subject to audit

- *Stacey Hunter left the Trust on 31st January 2024*
- *Lisa Thomas commenced as Interim Chief Executive Officer on 1st February 2024*
- *Niall Prosser commenced as Interim Chief Operating Officer on 5th February 2024*

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

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

Pension related benefits in 23/24 were affected by 'rollback' (see notes to remuneration tables).

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

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

Name and Title	Remuneration Year to 1 April 2022 - 31 March 2023					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Nick Marsden - Chairman	35-40	0	0	0	0	35-40
Ian Green - Chairman	5-10	0	0	0	0	5-10
Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20

Name and Title	Remuneration Year to 1 April 2022 - 31 March 2023					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Paul Miller - Non-Executive	0-5	0	0	0	0	0-5
Michael von Bertele – Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones - Non-Executive	10-15	0	0	0	0	10-15
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Richard Holmes - Non-Executive	0-5	0	0	0	0	0-5
Debbie Beaven - Non-Executive	0-5	0	0	0	0	0-5
Stacey Hunter - Chief Executive	185-190	0	0	0	102.5-105	290-295
Lisa Thomas - Interim Chief Operating Officer	140-145	0	0	0	7.5-10	150-155
Peter Collins - Chief Medical Officer	190-195	0	0	0	112.5-115	305-310
Judy Dyos - Chief Nursing Officer	120-125	0	0	0	50-52.5	170-175
Mark Ellis - Interim Chief Finance Officer	80-85	0	0	0	27.5-30	110-115
Melanie Whitfield - Chief People Officer	125-130	0	0	0	30-32.5	155-160
Andy Hyett - Chief Operating Officer	50-55	0	0	0	0	50-55

This table is subject to audit

- *Ian Green joined the Trust on 1 February 2023*
- *Richard Holmes and Debbie Beaven joined on 1 January 2023*

- *Mark Ellis was appointed as Interim Chief Finance Officer on 8 August 2022*
- *Lisa Thomas was appointed as Interim Chief Operating Officer on 22 August 2022, prior to this Lisa was the Chief Finance Officer*
- *Paul Miller left the Trust on 30 June 2022*
- *Andy Hyett left the Trust on 31 August 2022*
- *Nick Marsden left the Trust on 31 December 2022*
- *Paul Kemp left the Trust on 31 January 2023*
- *Lisa Thomas opted out of the NHS Pension Scheme on 1 December 2022.*

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

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

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

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

Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2024	Lump sum at pension age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 31 March 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2023	Employers Contribution to Stakeholder Pension
	(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000	To nearest £100
Stacey Hunter Chief Executive*	0	32.5-35	60-65	170-175	1,481	152	1,157	0
Peter Collins Chief Medical Officer*	0	37.5-40	65-70	180-185	1,564	184	1,230	0
Judy Dyos Chief Nursing Officer*	0	25-27.5	35-40	100-105	858	167	613	0
Lisa Thomas Interim Chief Operating Officer/ Interim CEO *	0	37.5-40	45-50	125-130	977	207	681	0
Niall Prosser	0-2.5	2.5-5	30-35	85-90	593	24	379	0

Interim Chief Operating Officer								
Melanie Whitfield Chief People Officer	2.5-5	0	15-20	0	270	49	184	0
Mark Ellis Interim Chief Finance Officer*	0	10-12.5	25-30	75-80	536	129	363	0

**Individual affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero (see further details below). This table is subject to audit.*

Notes to Remuneration and Pension Tables

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

The accounting policies for pensions and other retirement benefits and key management compensation are set out in the Note 1.6 to the accounts

Mark Ellis opted back into the NHS Pension Scheme on 1 November 2023.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called ‘rollback’.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of

pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Pay ratio information

This section is subject to audit

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

The banded remuneration of the highest-paid director in the organisation in the financial year 2023-24 was £195-200,000 (2022-23 £190-195,000). This is a change between years of +1.2%, due to a 5% pay award in 23-24 less the sale of annual leave entitlement for the year back to the Trust in 2022-23.

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

For employees of the Trust as a whole, the range of remuneration in 2023-24 was from £14,000 to £249,000 (2022-23 £14,000 to £264,000). 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 6.3% (2022-23 5.1%). Fifteen employees received remuneration more than the highest-paid director in 2023-24 (2022-23 nine employees).

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

2023/2024	25th percentile	Median	75th percentile
Salary component of pay	24,336	34,581	42,618
Total pay and benefits excluding pension benefits	25,839	36,242	48,865
Pay and benefits excluding pension: pay ratio for highest paid director	7.55	5.38	3.99

2022/2023	25th percentile	Median	75th percentile
Salary component of pay	23,177	32,934	40,588
Total pay and benefits excluding pension benefits	24,584	34,223	46,125
Pay and benefits excluding pension: pay ratio for highest paid director	7.85	5.65	4.19

The banded remuneration of the highest paid director was 5.65 times the median remuneration of the workforce in 2022-23. The Trust's median remuneration decreased in 2023-2024 compared with the previous year. This resulted from the highest paid director being in receipt of a Clinical Excellence Award in 2022-23 and the sale of annual leave entitlement for the year back to the Trust in addition to a 3.5% pay award.

Payments for loss of office

There were no payments made to senior managers for loss of office in 2023-24.

Payments to past senior managers

None to report in 2023-24.

The Remuneration Report has been approved by the Trust Board.

L. Thomas.

Lisa Thomas
Interim Chief Executive (Accounting Officer)
27/06/2024
(on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs

	Total 2023-24 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	182,588	181,861	727
Social security costs	18,250	18,250	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	21,129	21,129	0
Paid by NHSE on provider's behalf (6.3%)	9,148	9,148	0
Pension cost – other	28	28	0
Temporary staff/agency contract staff	12,014	0	12,014
Apprenticeship levy	922	922	0
TOTAL STAFF COSTS	244,079	231,338	12,741
Less: Costs capitalised as part of assets	2,363	2,363	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	**241,716**	**228,975**	**12,741**

Analysis of average staff numbers (subject to audit)

	Total 2023-24	Permanently employed 2023-24	Other 2023-24	Total 2022-23 (number restated)	Permanently employed 2022/ 2023 (number restated)	Other 2022/ 2023 (number restated)
Medical and Dental	654	358	297	473	463	10
Administration and Estates	1526	1294	233	1407	1329	78
Healthcare assistants and other support staff	843	675	169	685	677	8
Nursing, midwifery & health visiting staff	1261	1115	146	1095	1017	78
Scientific, therapeutic and technical staff	606	525	81	485	469	16
Total	4890	3965	925	4145	3955	190

The figure shown under the other column relates to other staff engaged on the objectives of the organisation such as, short term contract staff, agency/temporary staff, locally engaged staff overseas and inward secondments where the organisation is paying the whole or most of their costs.

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

The number of male and female directors, senior managers and employees 31 March 2024

Head Count	Female	Male	Total
Directors	3	3	6
***Senior managers**	11	6	17
All other staff	4179	1439	5618

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

Staff Turnover

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

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

Sickness Absence

Year April March	Overall absence days lost	% of total available days	% Short term <28 days	% Long term >28 days	Absence Recorded with No reason given
22/23	29,738	3.95%	1.95%	2.00%	3.00%
23/24	30,263	3.67%	1.3%	2.37%	0.41%
24/25 Forecast	*28,962*	*3.5%*	*1.25%*	*2.25%*	*0.40%*

The total number of days absence due to sickness rose in the period between April 2023 and March 2024 largely due to an increase in overall workforce size. The percentage of days lost as a proportion of all staff fell from 3.95% in 22/23 to 3.67% in this last year, continuing last year's trend of increased staff availability across the Trust. Lower rates of short-term absences are often an indicator of improved morale, and it is pleasing to see that short term absence trends fell this year, commensurate with increased morale scores in the staff survey results. The data for absence recorded with no reason fell dramatically (3.0% to 0.4%) reflecting an improved management system and greater confidence from Line

Managers in dealing with absence. The overall proportion of sickness absence remained slightly above the Trust target of 3%. The 24/25 Forecast assumes a 1% growth in workforce and an average 3.5% absence rate, with improved actions to reduce long term sickness absences.

Throughout the year, the proportion of long term (33%) and short-term sickness absences (66%) has been broadly consistent. Anxiety and other mental health related illnesses account for the largest proportion of both long and short-term absences at nearly 25% of the total days lost. Several complex circumstances often drive these absences and work is ongoing to better understand the background to enable improved interventions, although it is clear that not all of these absences are due to work related stress. Colds, coughs, and other infectious diseases are the next highest factor at c20%, rising further in the winter months. Finally, Musculo skeletal injuries make up the third highest contributing factor at c 9% of all absences, these often tend to be longer term problems, hence the numbers of staff are lower, but days lost generally higher.

The roll out of e-roster to all teams has enabled managers to quickly view team absence data and receive automated triggers identifying when policy thresholds have been triggered. In turn and combined with training on absence management policy at "All day breakfast clubs", our managers are better equipped to support staff who have had episodes of sickness absence, improving their wellbeing, and enabling appropriate return to work plans to be followed.

Under the 'we are safe and healthy' element of the People Promise, several initiatives have been delivered to support the wellbeing of our workforce. Our Trust Staff, Access, Learning, Information (SALi) intranet site has a dedicated portal which provides line managers and staff with a single-entry point to resources and guidance to improved physical and mental health and financial wellbeing. This year, in response to data that show Anxiety and Musculo-Skeletal injury as two of our biggest causes of sickness absence we have increased the hours of our in-house physiotherapy services to cater for more staff appointments, and also increased the number of counselling sessions available to staff. A new, more streamlined process for seeking mental health support has been launched under a single application with responses triaged to provide the best options for the individual. With vacancies filled, our occupational health team has improved its service across all its functions including recruitment support and case referrals, where 96% of referrals were achieved within 2 working days.

Adjustments to the Trust induction programme have been planned to incorporate changes which will see the introduction of a 'we are safe and healthy day' in the first week on site, this will bring together those elements of induction which signpost and support a safe and healthy hospital, including a session on our green plan aims – roll out of the new 90-day induction programme commenced in May 24.

Our wellbeing lead delivered interventions to train line managers to enable skilful delivery of wellbeing conversations with their staff. These conversations are supported by several trained wellbeing champions who can provide further support and guidance by way of signposting and advice. The Trust continues to monitor health intelligence through a series of quarterly meetings which enables the triangulation of data between stakeholders, including our Occupational Health team, Health and Safety Manager, Employee relations lead, Patient safety team and Freedom to Speak Up Guardian, which in turn supports the identification of improvement plans. These have included Breakfast Club sessions for line managers to better understand absence management, an improved understanding of the

process to enable reasonable adjustments in the workplace, increased funding for the staff hub, and the launch of the 'Beyond Blue Card' discount scheme for staff in Salisbury. Our staff continue to retain access to the onsite health and fitness centre, green spaces and walking routes. We will continue to routinely update information to include financial, legal and other matters that may be underlying causes of stress.

People Policies

Our people policies play an important part in ensuring that all staff are informed of both the guidelines and processes employed by the trust to support our workforce to perform effectively in their roles. Against our policy review workplan, we have continued to refresh and update our people policies in line with identified good practice, lessons identified from use and to ensure compliance with changing employment legislation and regulation. Key policies that have been introduced this year have included:

- **Carers Policy** – championed by our vibrant Staff Carer's network and meeting new legislation requirements, this policy supports our staff carer's in fulfilling their caring responsibilities, whilst maintaining work duties. It provides advice and guidance to support line managers who employ carers.

- **Armed Forces Policy** – As a Gold Award member of the Employer Recognition Scheme (ERS), this new policy draws together all those elements of policy which relate to Reservists, Cadet Force Adult Instructors and Veterans working in the trust.

- **Flexible Working and New Parent Policies** – these policies have been updated in line with legislative changes due for April 24.

- **Equality Diversity and Inclusion Policy –** this key policy has been refreshed to meet legislative changes, and to meet the needs of our staff, incorporating important feedback received from our network groups.

In addition to the refresh of our overarching EDI policy, in 2023/24 we applied a number of policies to support the improved recruitment and retention of disabled staff. These policies are included on our microguide, accessed through the Staff Intranet site SALI and include the Recruitment and Selection Policy which covers in general direction on equality of opportunity within the Trust recruitment. A specific policy 'Employment of People with Disabilities' provides direction on recruitment of personnel with disabilities ad return to work of staff who become disabled. Phase one of our work to address internal audit recommendations on recruitment has also identified and implemented the need for more diverse panels to support recruitment activity, specifically aimed at supporting staff with protected characteristics. Finally, our occupational health team have provided guidance and training for line managers to help with the implementation of reasonable adjustments for disabled staff.

In 2024/25 our focus will be on improving our restorative approach alongside streamlining our policies, making them easier for our workforce to pick up and easily find the information they require, in addition to providing our management teams with regular updates and briefings through breakfast clubs on how to utilise the policies to support their team's development and welfare. Examples of this is the current work include updating our Recruitment and Selection Policy which follows extensive work and roll-out of a Recruitment Toolkit helping teams improve the recruitment experience for all.

Continuous improvement and audit also help us shape our policies and work is already underway on reviewing our Disclosure and Barring Policy and the Control of Banding Policy following compliance reviews which have led to positive changes to our processes in line with legislative requirements and NHS standards.

Health and Safety (H&S)
Having introduced a formal Health and Safety (H&S) Management System in 2022, the past 12 months work has seen continued development of the system that includes implementing a formal H&S management plan, measuring agreed performance indicators, providing improved H&S reports to the Trust, the implementation of a scheduled audit program and a formal performance review to target specific H&S risks identified during the year.

Auditing, conducted by trained H&S auditors, identified several actions to improve the management of H&S, and reduce the risk of injury to staff. Examples of such actions include:

- Formalising local manual handling training for the Trust spinal unit.
- Improvements to the Trust's permit to work system.
- Completing additional risk assessments of manual handling within theatres, including the design of equipment to assist handling limbs during orthopaedic surgery.
- Implementing trust wide training to reduce violence and aggression associated with dementia, delirium and confusion, antisocial behaviour and mental health conditions.

The H&S team has been tasked with improving the response to reports of incidents and injuries, relating to violence and aggression on staff, with an expectation the H&S team contact those affected within 24 hours of all incident and injury reports. The aim is to improve the initial support to staff and then signpost staff to the available support services when necessary. Concurrently, the initiation of an investigation into underlying causes and determination if an injury has resulted in lost time will ensure there is an early and sustainable return to work.

Against baseline performance measures reported in FY22/23, this year the trust has seen an:

- 83% reduction in the number of days lost as a result of work-related injuries (from 1,296 to 218 days lost).
- 73% reduction in the number of lost time injuries reported (from 143 to 38).

It is difficult to qualify this significant reduction in injury rates, and time lost, over what is a relatively small space of time. Absences and time lost have been assessed against the trust incident database (Datix) to identify any discrepancies or errors, but none were readily identifiable. Possible indicators for these discrepancies may include:

- Absence due to infectious disease in 2021 and 2022 was significantly higher than 2023. It is likely absences due to covid accounted for significantly higher work-related injury absence in 2022. There is no evidence of work-related infectious disease absence being reported in 2023.

- Reports prior to 2023 did not utilise non-work-related absence data to triangulate data. The ability to dig deeper into injury reports and determine what is work-related and what is nor improves the accuracy of reporting where previously reports could reasonably have erred on the side of caution and over reported absences that were not work-related.

- The flip side to this is the potential under reporting of work-related injuries related to stress and anxiety. However, there have been not backdated Datix reports submitted for stress and anxiety where staff have been on long term leave and the number of reportable injuries to the health and Safety Executive are also down.

Notwithstanding, this considerable difference will require further trend analysis during the next financial year to determine if such results are an anomaly, in response to living with Covid or due to changes to safety and injury management.

Violence and aggression towards staff is the most reported incident and injury type this year. The Trust Violence Prevention and Reduction Committee, co-chaired by the Deputy Head of Nursing and H&S Manager, has developed a Trust wide strategy to reduce the risk of violence and aggression that includes, but is not limited to, finalising an awareness program titled ‘No Excuse for Abuse’, updating the Trust violence reduction policy and identifying initial steps on ways to adopt the Design Council’s ‘Reducing Violence and Aggression in A&E Through a Better Experience’ program. The Trust has also engaged with an external provider to undertake Positive Management of Violence and Aggression and Breakaway Training to reduce the risk of violence and aggression from patients with dementia, confusion, delirium and mental health conditions.

The H&S function remains supported by a Health and Safety Committee, chaired by the Chief People Officer which reports through the Trust Management Committee to the Trust Board. The Committee includes representatives from across the Trust’s management and staff side function and remains a point of escalation, assurance and alert for sub-committees such as fire, asbestos, water, electricity, security and radiation protection.

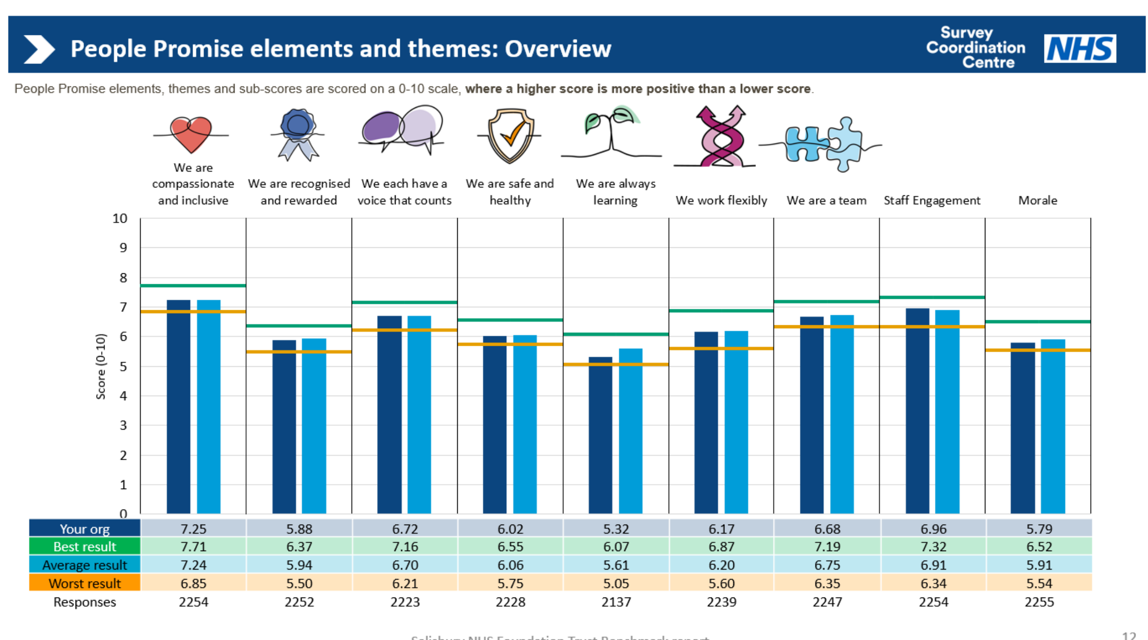
Staff Survey

Reporting year 2023 was the third year when the Annual NHS Staff Survey questions were aligned to the NHS People Promise seeking to track progress against our ambition to make Salisbury Foundation Trust (SFT) the ‘best place to work’. The 2023 Staff Survey reported against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

Our response rate for the 2023 survey was 54% (2265 responses) compared with 48% for the 2022 survey (1861) responses. By comparison the median response rate in 2023 for our benchmarking group (acute and acute and community trusts) was 45%. This represents a positive increase in responses, and it was pleasing to also see a broader spread of staff groups engaged with the survey, ensuring that results were more equitable across the trust.

We set clear ambitions about the scores we aspired to in the 2023 survey, progressing towards an ambition of reaching the upper quartile in the 2025 survey. In 2023 SFT was identified as the most improved scores across all seven elements, and we met all but one of the ambitions (aside from Always Learning where we made significant progress but did not reach our ambition).

Scores for each indicator together with the average, best and worst scores in the benchmarking group across the NHS are presented below for 2023:



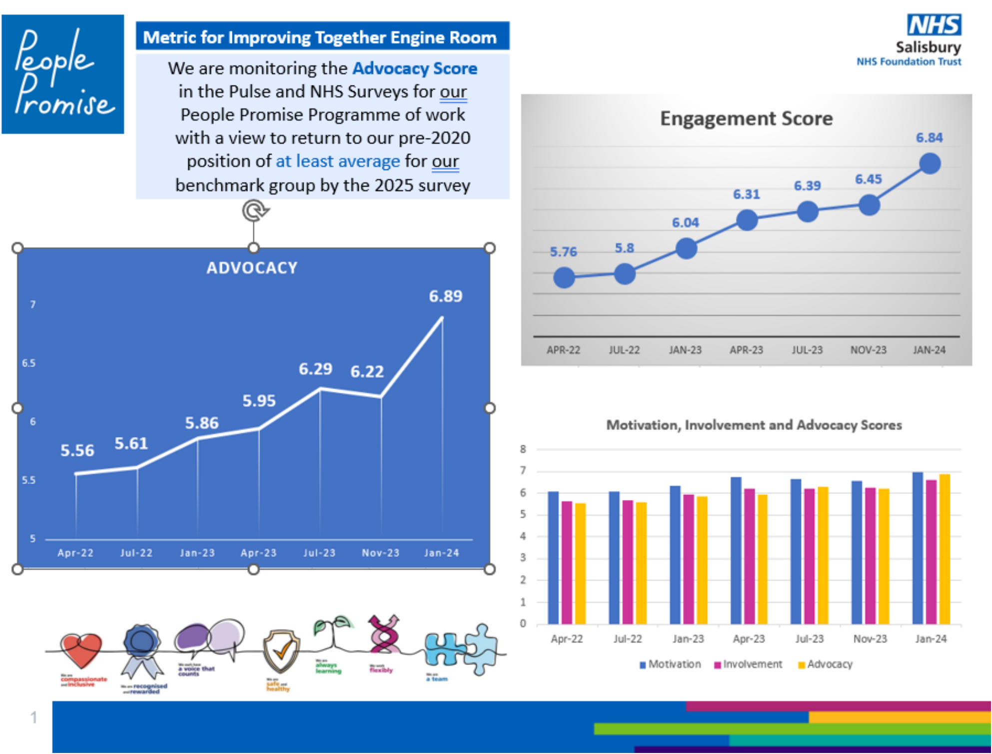
Comparisons between 2023-24, 2022-23 and 2021-22 are shown in the following table:

Indicators (People Promise elements and themes)	2023-24		2022-23		2021-22	
People Promise elements:	**Trust score**	**Benchmarking group score**	**Trust score**	**Benchmarking group score**	**Trust score**	**Benchmarking group score**
We are compassionate and inclusive	7.25	7.24	7.1	7.2	7.1	7.2
We are recognised and rewarded	5.88	5.94	5.6	5.7	5.6	5.8
We each have a voice that counts	6.72	6.70	6.6	6.6	6.6	6.7
We are safe and healthy	6.02	6.06	5.9	5.9	5.8	5.9
We are always learning	5.32	5.61	5.4	5.4	5.0	5.2
We work flexibly	6.17	6.20	6.0	6.0	5.7	5.9
We are a team	6.68	6.75	6.6	6.6	6.4	6.6
Theme: Staff engagement score	6.96	6.91	6.8	6.8	6.8	6.8
Theme: Morale	5.79	5.91	5.7	5.7	5.5	5.7

In the 2022 NHS Staff Survey, a particular concern was in relation to our scores for advocacy[1]. This year, using our Improving Together methodology, we selected advocacy as

[1] This score indicates whether people are keen to recommend the trust as a place to work or to be treated at and suffered a disappointing downward trajectory between 2019 and 2022 (from 7.26 above average down to 6.27 below average).

one of our watch metrics, using quarterly Pulse Survey data to monitor our progress, backed by proactive communication campaigns and a range of People Promise project activities that support culture change. Encouragingly the upward trajectory of the Pulse survey data was also reflected in the 2023 Staff Survey data, resulting in a score of 6.73 which has brought us back up to average. We aspire to continue watching and improving this metric through 2024.



Future priorities and targets

SFT was one of the first People Promise Exemplar Sites from 2022 to 2024. During the first two years of the programme, we developed a local People Plan that addressed all seven elements of the People Promise. By outlining clearly our long-term and in-year ambitions we used a series of projects and identified workstreams to improve the staff experience at SFT.

The People Promise is a retention programme. We aim to reduce numbers of staff leaving the Trust and to develop more coherent talent management plans to support the careers of those who stay with us. We are paying attention to the employee journey at every step from work experience, attraction, induction, recruitment, and promotion through to retirement and beyond. Of note this year has been the increase in skills and knowledge of our line managers and leadership teams. A range of programmes and training interventions have been designed to support them, in addition to bespoke HR interventions at ward level. These sessions have been well attended and staff have reported greater understanding of their role and an improvement in their confidence as a result.

We want to be recognised as an inclusive employer. There are still areas of our staff survey results relating to disability, race and violence and aggression that need further work in the coming year. Action plans are in place to support us to continue to improve our metrics including the 'no excuse for abuse' campaign and improved Cultural Awareness training, specific induction activities and support for internationally recruited staff as well as a more equitable recruitment process.

Following the launch of our listening events, including the 'Hearing It' sessions led by the CPO and CEO and the 100-day and one year anniversary events hosted by our CPO and OD and P senior team, we recognise the positive impact that listening has within the organisation. Sharing what we have heard, and the actions taken as a result has been very positive. A listening report will be launched in 2024.

Our People Promise programme and the divisional action plans generated in response to staff survey results will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board.

Staff engagement

Identified as a vision metric within the Improving Together methodology, Staff Engagement is a priority with the Trust aiming to achieve top quartile status against peer organisations in our staff survey results. We remain committed to engaging with staff at all levels through the 'We all have a voice that counts' element of the People Promise. Progress has been made in engagement, with the most recent staff survey indicating a score of 6.96, against the top quartile score of 7.19.

The Trust established a series of Listening events known as '*Hearing It'* that are hosted by the Chief Executive and Chief People Officer and open to all to attend. In addition, all staff are invited to provide feedback on their experience in the trust at their first 100 days and 1-year point after joining. We run the quarterly Pulse Survey, making good use of the local questions option. Board safety walks also continue to give Executive Directors the opportunity to engage directly with staff. These occur monthly and visit patient and non-patient facing areas, speaking to staff and listening to their concerns.

Our regular Cascade briefings give the Trust the opportunity to share information and to take views from staff on a wide range of topics. We have maintained our regular daily Bulletin, a weekly Chief Executive message and a line manager's round up every Friday via e-mail.

2023 saw the delivery of a 'first in a generation' Hospital Open Day. With 750 members of the community braving extreme weather to visit the hospital and meet staff and partner organisations. The year also saw the introduction of the hospital inaugural '*Tent Talks*', supported by the Stars Appeal, this is a two-day festival of learning, wellbeing and fun for staff, volunteers, and partner organisations, with family and friends invited to the comedy night.

The annual Staff Thank You Week included the staff awards, family fun day and staff party. Awards are presented covering a mix of categories from a Chair's award and the CEO Award to Best Team, Unsung Contribution and Sharing Outstanding Excellence (SOX) of the Year. In addition, we held a volunteer's lunch to recognise the contribution of our volunteers and we also held a Long Service Awards event. We continue to have regular peer to peer SOX Awards and SOX of the month that enable staff, patients and families to recognise the contributions made by their colleagues.

The trust podcast series '*The Cake with Joe & Jayne'* continues to explore all aspects of our people with the most recent series looking at why people do the jobs they do and how their career journey led them to work at the hospital. The series was a Finalist in the HSJ Awards and at the Communications Hero Awards.

2023 was an anniversary year for the hospital as well as for the NHS. To mark this a service was held at Salisbury Cathedral and new work was commissioned from poet Martin Figura exploring the hospital's history and from Saili Katebe recognising the diversity within the NHS workforce. Saili Katebe also produced a spoken word version of the annual review.

We are committed to being an active 'anchor' organisation within the Salisbury area. This requires our long-term sustainability to be aligned to the wellbeing of the population we serve. As such our Communications, Engagement and Community Relations team represents the Trust at the city Place Partnership (Chaired by John Glenn MP), are active within Experience Salisbury and are members of the city Cultural Pillar. It is this engagement with the community which has realised the 'beyond blue light' discount scheme now in place for our staff.

Equality, Diversity & Inclusion (EDI)

Over the past year, we've made significant strides toward our goal of creating an inclusive and equitable workplace for all staff. We are proud of our diverse workforce, representing over 85 countries, including a remarkable team of internationally educated nurses. This global perspective enriches the knowledge base of Salisbury District Hospital and enhances our ability to serve the local community. Our commitment to diversity is reflected in our workforce demographics. As of March 31st, 2024, our 5632 staff members included 3995 identifying as White, 1432 as Black and Minority Ethnic, and 205 with unknown ethnicity. A further 185 identified as disabled, with the disability status of 209 remaining unknown. These numbers outmatch the demography of our patient population in Wiltshire, providing a significant challenge to increasing the diversity of staff within the Trust, a barrier which is proving difficult to cross, without international staff recruitment.

We prioritise leading for inclusion and wellbeing in our leadership development programmes, cultivating empathy and collaboration. This commitment extends to our international nurses, with over 109 benefiting from dedicated cultural awareness workshops. These workshops enhance their cultural competency and positively impact the experiences of team members and patients alike.

Our six staff networks (Ability Confident, Armed Forces, Carers, Culture & Equity, LGBTQ+ Alliance, and Women's) provide vital support, fostering wellbeing and belonging. We promote the networks and areas of passion and interest with our comprehensive inclusion and wellbeing calendar, highlighting notable events and celebrations throughout the year. We recently hosted a hugely informative conference on neuro diversity, which provided a platform for shared knowledge and understanding across our staff of this complex area.

Our collaboration within the Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS) further demonstrates our dedication to inclusion. We have hosted successful joint events celebrating Black History Month, LGBT History Month, and Women's History Month, featuring inspiring speakers who overcame challenges and paved the way for others.

To reinforce our commitment, we have ratified a new EDI policy and refreshed our long-term EDI Plan. Our long-term EDI plan (2024/27) draws on the NHS EDI improvement plan, incorporating its 6 high impact actions and also the South West region's 'Leading for Inclusion' framework. The three pillars of Leadership, Culture and Policy and Accountability will be built through a series of projects and workstreams to attend to the key actions

identified in our WRES and WDES results as well as our Gender Pay Gap action plan to create a workplace where everyone feels valued, respected, and has a true sense of belonging. Data trends contained in the WRES/WDES and Gender Pay Gap reports are available on the Trust website (https://www.salisbury.nhs.uk/about-us/equality-diversity-and-inclusion/edi-reports/.)

Freedom to Speak Up

At SFT we continue to support and encourage our staff to speak up without fear of negative consequences. This year we have had stark reminders of why all efforts to improve the Speak Up culture in health, including the Freedom to Speak Up Guardian route, are so essential for patient safety. The Thirlwall inquiry, Ockenden review and Kirkup report all demonstrate the fundamental importance of a freedom to speak out culture.

Where concerns relate to fraud and corruption, the Trust supports staff to understand the processes and procedures for dealing with this through a comprehensive Fraud, Bribery and Corruption policy hosted on the microguide element of the Staff Intranet (SALI) site. This policy provides appendices highlighting procedures and a fraud referral flowchart to support staff in reporting this area of concern.

Our Freedom to speak up Guardian (FTSUG) has worked hard to implement lessons identified from previous staff survey results. This has included refreshing and publishing FTSU strategy and a policy refresh, delivery of a clear communications plan promoting our FTSU service, data triangulated to create thematic analysis to inform interventions, and work alongside staff networks to identify barriers to speaking up. Together, these actions have resulted in a positive increase of 2023 staff survey results in these areas.

The FTSUG also delivers training at the Aspiring and Transformational Leaders Course, focusing on how leadership behaviours influence the creation of psychological safety in order that colleagues can raise concerns with confidence and assurance that they will be listened to and acted upon.

	Themes	Cases Q1 (23/24)	Cases Q2 (23/24)	Cases Q3 (23/24)	Cases Q4 (23/24)
1	Element of Patient Safety/Quality	19	12	9	12
2	Worker Safety	5	9	10	10
3	Element of other inappropriate attitudes or behaviours	22	23	25	30
4	Bullying/Harassment	6	5	8	6
5	Disadvantageous and/or demeaning treatment (detriment as a result of raising concerns)	1	4	5	3

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

The Trust's Guardian has direct access to all senior leaders including the Chief Executive and all Board members. Themes and trends are reported quarterly to People and Culture Committee and through to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2023-24, 163 concerns have been raised to the Freedom to Speak Up Guardian, a 22% increase on the previous year. Of these,12 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

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

Education and Apprenticeships

The trust supports the aim of creating a highly skilled workforce through several approaches.

- Firstly, our mandatory, statutory, and additional valued core training is delivered via our on-line Managed Learning Environment (MLE).
- Core clinical skills and targeted situational clinical event management is delivered through our Practice Education Team and our clinical Simulation Team. It has been very pleasing to see our Practice Education team receive the National Preceptorship for Nursing quality mark this year, an excellent achievement and testament to the quality of our practice education programmes.
- Additional training for continued professional development (CPD) has this year been provided through two routes, coordinated by the Education Team. Firstly, the distribution of the NHSE CPD fund targeting Nurses, Midwives and Allied Health Professionals (AHPs), and secondly through an SFT provided fund aimed at other staff groups that traditionally have no access to the NHSE CPD funds.

Funding source	Amount distributed	Total Number of staff who accessed funds
NHSE CPD fund	£429,333.33	441
SFT Trust funded CPD	£99,000	65

The apprenticeship offer is a significant element of the NHS Long Term plan and also supports the growth of a sustainable workforce within the environs of Salisbury, supporting our role as an anchor institution. Apprenticeships combine practical training in an occupation with study, are accessed by all levels of staff within the Trust and depending on the apprenticeship, upon successful completion, apprentices may be eligible to apply for professional registration. The table below shows the uptake of apprenticeships and the monies provided to support our apprentices from the national levy.

	2021/2022	**2022-23**	**2023-24**
Total Number of apprentices	153	143	160
Current Funds	£1,481,729.00	£1,575,253	£1,788,691
Total Spent to Date	£1,265,125.39	£1,972,717.77	£2,513,451.77
Total Spend in Year	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations	£579,197.20 Of which £71,377.58 (12.32%) was transferred to other organisations	£608,083 Of which £67,349 (11.1%) was transferred to other organisations
Annual Expired Levy	£112,685.57	£136,370.30	£148,666

There are 160 apprentices, covering 29 different occupations working for their qualification at SFT. Occupations include Nursing Associate; Mortuary Technician; Occupational Therapist; Sustainability Manager; Project Manager; Health Play Technician; Carpentry & Joinery; Registered Nurse; Physiotherapist; Pharmacy Technician; Diagnostic Radiographer; Senior Healthcare Support Worker; Associate Project Manager; Business Administration; Clinical Coder; and more. We are very pleased that 20 of our staff successfully completed their apprenticeships in 2023-24.

The Apprenticeship Levy is used to pay the training providers who deliver training which makes up a minimum of 20% of the apprentices' time. SFT currently pays 0.5% (c. £82k) of its total pay bill into the Apprenticeship Levy per month, with a current total of £1.79 million available for us to access. Levy utilisation slightly increased this year compared to 2022-23. In 2023/4 the Trust spent £608,083, which is a 4.99% increase of spend compared to last year. Any Levy not utilised within 2 years of being paid into the fund will expire and we recognise the opportunity to encourage further take up.

In this last year we have appointed a full-time member of staff to support our widening participation agenda, specifically with development of new routes for apprentices into the Trust and options for local people to undertake graduate health care training opportunities.to support NHS long term workforce plan objectives. We have engaged in a partnership with Coventry University and Wiltshire College to deliver Nursing Associate Direct entry qualification from September 24 as a first step in this partnership.

Leadership and Development

The Organisational Development and Leadership (OD&L) team have designed and delivered two impactful leadership development programmes for both aspiring junior leaders and experienced middle to senior managers. These programmes are supporting our strategic ambition of being a compassionate and inclusive employer while supporting us to deliver on our People Plan vision of making Salisbury the 'Best place to work'.

Our hard work has already seen excellent impact through our Staff Survey results showing an upward trajectory in all areas aligned with our work. This has led to Salisbury NHS Trust being the best improved Trust nationally.
Our new Leadership Behaviours Framework, based around the Improving Together methodologies, and key NHS initiatives such as building a culture of Civility, Compassion, Inclusivity, has been embedded across the Trust. This has been achieved through socialisation sessions, seminars, and development programmes, as well as supporting teams in the creation of a team behavioural charter that has been designed around our new 8 behaviours model.

The OD&L team will continue to build its offer over the next 12 months with the introduction of our internal Clinical Leads programme, with wider support in design for Foundation Year 1-2 doctors (F1-2), Speciality and Specialist Grade Doctors (SAS), Locally Employed Doctors (LED) and more junior consultants. A new 2-day programme for more junior employees not yet in a leadership role, focuses on leading self and key elements such as our Trust values and behaviours. This is aimed at nurturing the right culture and language in all areas of our Trust.

2023-24 saw 144 leaders attend our internal programme with excellent feedback which has inspired us to increase places to 250 for 24/25. Our ambition to develop a coaching culture

has seen 411 delegates attending our coaching skills courses, the impact of this has been felt through our Staff Survey results and 4.9/5% positive feedback. SFT has invested in its coaching community by increasing the number of fully qualified coaches from 23 to 33 with another ILM 5 programme commissioned this year for a further 12, taking the community to 49.

We have piloted a new 360° feedback self-assessment tool with our Executive team, which is aligned to our new Leadership Behaviours Framework. This work will then support our Talent Management aspirations and drive our Talent and Succession Management strategy which again is a key contributor to our ambition of "*We Are Always Learning*".

The development of a suite of 13 management skills workshops have been designed to support current and future managers which is a key driver for our '*We are a Team*' People Promise strategy, aimed at making sure our employees are prepared for future responsibilities and challenges. 23/24 has seen 503 managers take advantage of our offer with more opportunities currently in design, including full access to NHS Elect where we have 100's of webinars and eLearning courses, offering a flexible way to learn for everyone.

Consultancy Expenditure Off Payroll Payments

Table 1: Highly paid off-payroll worker engagements as of 31 March 2021 earning £245 per day or greater	**23/24**	**22/23**	**21/22**
Number of existing engagements as of 31 March 2024	**44**	25	124
Of which:			
Number that has existed for less than one year at the time of reporting	**22**	6	114
Number that has existed for between one and two years at the time of reporting	**15**	13	2
Number that has existed for between 2 and 3 years at the time of reporting	**3**	3	3
Number that has existed for between 3 and 4 years at the time of reporting	**4**	2	3
Number that has existed for 4 or more years at the time of reporting	**0**	1	3
	44	25	125

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater.	**23/24**	**22/23**	**21/22**
Number of off-payroll workers engaged during the year ended 31 March 2024	**745**	692	466
Of which:			
Not subject to off-payroll legislation	**743**	682	16
No. assessed as caught by IR35	**0**	0	0
No. assessed as not caught by IR35	**2**	4	450
No. of engagements reassessed for consistency / assurance purposes during the year	**2**	0	16
No. of engagements that saw a change to IR35 status following the consistency review	**0**	0	0

Table 3: Off-payroll board member/senior official engagements for any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024	**23/24**	**22/23**	**21/22**
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	0	0	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	**15**	18	18

Staff Exit Packages

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2023-24 included in this table. The 2022-23 figure is in brackets.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Under £10,000	0(0)	3(6)	2(29)
£10,000 - £25,000	0(0)	1(1)	16(14)
£25,001 – £50,000	0(0)	0(0)	0(0)
£50,001 - £100,000	0(0)	0(0)	0(0)
£100,001 - £150,000	0(0)	0(0)	0(0)
£150,001 - £200,000	0(0)	0(0)	0(0)
Total number of exit packages by type	0(0)	4(7)	18(43)
Total resource cost	£0(£0)	£18,000(£43,000)	£18,000(£43,000)

This table is subject to audit.

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

Trade Union Facility Time Disclosures

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

Table 1 - Relevant Union Officials

Number of employees who were union reps	22
FTE union reps	20.3

Table 2 Percentage of time spent on facility time

Percentage of time	%
0%	8
0-50%	14
51-99%	0
100%	0

Table 3 Percentage of pay bill spent on facility time

Percentage of pay bill on facility time	
Total cost of facility time	£27,071.21
Total pay bill	£231,643,052.12
Percentage facility time	0.01%

Paid Union Activities	
Time spent	0

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

Salisbury NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently updated in April 2023 replaces the version revised and published in 2014.

The Board considers that for the 2023-24 year the Trust has been fully compliant with the provisions of the Code.

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

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

Council of Governors Public Constituency

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

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

The Council has been placed into groups to consider various topics over which they can have an influence. In 2023-24 these covered:

- Membership and Communications Committee
- Performance Committee (Chair and Non-Executive Directors)
- The Trust's Annual Plan prior to submission to the regulator
- Nominations Committee
- Staff Governors Committee
- Self-assessment Committee

- Patient Experience Group
- Volunteers

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

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

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

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

The Council of Governors hold four meetings a year, in addition to the Annual General Meeting (AGM). The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. Salisbury City held their constituency meeting in June 2023. However, membership engagement has been highlighted as a priority in the Membership Strategy and more meetings will be scheduled to take place in 2024-25.

Elected Governors - Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
Kevin Arnold	Salisbury City	June 2020	Three years	3 / 6
Lucinda Herklots (Deputy Lead)	Salisbury City	May 2018	Three years	5 / 6
Joanna Bennett[1]	Salisbury City	June 2020	Three years	1 / 1
Frances Owen	Salisbury City	June 2023	Three years	3 / 5
Frank Cunnane	South Wiltshire Rural	June 2023	Three years	4 / 5
William Holmes	South Wiltshire Rural	June 2023	Three years	5 / 5
Dr James Robertson[2]	South Wiltshire Rural	June 2020	Three years	0 / 1
Anthony Pryor-Jones	South Wiltshire Rural	June 2020	Three years	5 / 6
Angela Milne	South Wiltshire Rural	June 2021	Three years	5 / 6
Andrew Rhind-Tutt	South Wiltshire Rural	June 2021	Three years	2 / 6
Peter Russell	South Wiltshire Rural	June 2021	Three years	5 / 6
John Parker	North Dorset	June 2021	Three years	5 / 6
Matthew Swift	North Dorset	June 2023	Three years	5 / 5
Barry Bull	East Dorset	June 2023	Three years	3 / 5
John Mangan	New Forest	June 2021	Three years	5 / 6
Peter Kosminsky	Kennet	June 2020	Three years	2 / 6
Mary Clunie	Rest of England	June 2021	Three years	3 / 6

[1] Joanna Bennett completed her first term but was not re-elected.
[2] James Robertson finished his third term in June 2023.

Elected Governors - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
Paul Russell	Clerical, Administrative and Managerial	June 2020	Three years	4 / 6
Jane Podkolinski	Volunteers	June 2021	Three years	6 / 6
Anisa Nazeer[1]	Medical & Dental	June 2021	Three years	4 / 5
Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	6 / 6
Jayne Sheppard	Nurses & Midwives (Lead Governor)	June 2021	Three years	5 / 6

[1] Anisa Nazeer resigned her post February 2023

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance
Cllr Richard Rogers	Wiltshire Council	9 March 2022	Three Years	0/6
Vacant*	Wessex Community Action	N/A	N/A	N/A
Vacant*	Dorset Integrated Care Board (ICB)	N/A	N/A	N/A
Vacant*	Bath and Northeast Somerset, Swindon, and Wiltshire ICB	N/A	N/A	N/A
James House[1]	Hampshire and Isle of Wight ICB	July 2021	Three years	0 / 3
Sarah Walker[2]	Military	July 2021	Three years	3 / 6
Jason Goodchild	Military	March 2024	Three years	0/0

[1] James House resigned his post in September 2023
[2] Sarah Walker resigned from her post March 2024 and was replaced by Jason Goodchild on 5 March 2024
* Vacant positions were acknowledged by the Council during the year. Work to review the nominated governor category is ongoing and will be completed during 2024-25

During the year our executive team have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chair of the Trust and these meetings are attended by the Chief Executive, who is there to provide clarifications on the Integrated Performance Report (IPR); and the Chief Nursing Officer who presents the Patient Experience Reports. There is an opportunity for Governors to express their views and raise any other issues, so that members of the Board, including Non-Executive Directors can respond.

There have been no formal requests for Director attendance at the Council of Governors meetings, but it has been standard practice for the Chief Executive to attend. Other executives attend as and when required dependent on the topics raised as part of the agenda.

An informal meeting is normally held between the Governors and the Non-Executive Directors a week after a public board meeting approximately four times a year.

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

In 2023-24, the Trust Board met regularly in public and, as part of its commitment to openness, Governors and members are invited by the Chair to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board.

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

The Trust Board has invited Governor observers to attend the meetings of the Board's Finance and Performance Committee, its Clinical Governance Committee and its People and Culture Committee.

Register of Governor Interests

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

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

Dispute Resolution

There are several mechanisms in place that allow an issue or concern to be discussed and escalated. Informally, there are meetings between the Lead Governor and the Chair. There are also regular meetings between the Governors and the Non-Executive Directors. A formal procedure is in place (see point 51, Dispute Resolution in the Trust's Constitution) should there be a dispute between the Council of Governors and Trust Board. There have been no disputes during 2023-24.

The Board of Directors

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

The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust.

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

During 2023-24, the Trust commenced a Non-Executive Director recruitment process to replace three positions who are due to leave during 2024-25. The process was rigorous and independently assessed by recruitment consultants, Odgers Berndtson. The recruitment process has continued into 2024-25 and all new Non-Executive Directors appointed in line with Fit and Proper Person guidance and the Trust.

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

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

During 2023-24, the Trust was of an external well-led assessment review, undertaken by Advancing Quality Alliance (Aqua). The outcome of this review was reported to the Board in July 2023. The Executive Directors reviewed the outcome of the review prior to a Board workshop in October 2023 which focussed on agreement of the key areas for improvement. Further details on the outcome of this review are provided in the Annual Governance Statement (AGS).

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

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

Trust Board Members

Non-Executive Directors

Ian Green OBE– Chair (Independent)

Ian Green joined the Trust as Chair in February 2023 for his first three-year term. Ian has held Non-Executive Director posts within the NHS over the past 15 years, including Non-Executive Director of South-Central Ambulance Trust Board. This broad experience has provided Ian with an excellent grasp of the challenges of healthcare delivery and of those specific to Salisbury. He is committed to ensuring services are delivered in accordance with best possible practice and emphasises the importance of working with partners to ensure

population health needs are met, in a safe and effective environment. Most recently Ian has been Chief Executive of the Terrence Higgins Trust.

Rakhee Aggarwal – Non-Executive Director (Independent)

Rakhee Aggarwal joined the Trust in January 2020. Rakhee has been a mental health nurse since 1999; She has a BSc in Behavioural Studies (Psychology); and a Master's in teaching and Learning for Health Professionals. She has worked for the University of the West of England for the past 15 years as a Senior Lecturer; Associate Head of Nursing and Midwifery - Mental Health and Learning Disability Nursing; Associate Head of Nursing and Midwifery - Adult Nursing; and as Associate Head of Nursing and Midwifery - Continuing Professional Development. Rakhee is leading and developing the CPD Education provision for the NHS and private and voluntary sectors. In addition to her work at the University she has been a Non-Executive Director with the South-Western Ambulance Trust since 2017. Rakhee was appointed for her second term of office of three years in December 2022.

Tania Baker - Non-Executive Director (Independent)

Tania Baker joined the Trust in June 2016 for a three-year period. Her term of office was extended for a further two years in February 2019. She was Chief Executive Officer at health analytics company, Dr Foster where she was involved in developing the business nationally and internationally. Before this Tania held senior appointments in private healthcare and was Commercial Director at Aviva Health insurance. Tania was the Senior Independent Director (SID) until September 2023. She was appointed for her third term of office, for two years, in May 2022.

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

Michael joined the Trust in November 2016 for a three-year period. His term of office was extended for a further three years in October 2019. As an army junior doctor, he trained in occupational and environmental medicine, and became a consultant in 1992. Michael has served in the UN Protection Force in Croatia, was chief medical planner in the Ministry of Defence and was Director General of the Army Medical Services. He retired in 2012 and worked for Save the Children International until 2015. Michael was appointed for his third term of office, for two years in October 2022.

Dr David Buckle – Non-Executive Director (Independent)

Dr David Buckle joined the Trust in January 2020. He is MB BS, DRCOG and MRCGP qualified and is a Fellow of the Royal College of General Practitioners. He was a practising GP until 2017 whilst latterly working part-time (until May 2018) as the Medical Director for Herts Valley Clinical Commissioning Group, where he was the Director of General Practice development. He has previously held other roles comprising various positions within Berkshire East and Berkshire West Primary Care Trusts and with NHS Berkshire West Primary Care Trust. David currently has a portfolio of non-Executive appointments, as the President of the Society for Assistance of Medical Families, Non-Executive Director with Berkshire Healthcare NHS Foundation Trust, Non-Executive Director with East and North Hertfordshire NHS Hospitals Trust; and Vice Chair (clinical) of the Stroke Association. David became a voting member of the Board in May 2020. David was appointed for his second term of three years in January 2023.

Debbie Beaven– Non-Executive Director (Independent)

Debbie Beaven joined the Trust in January 2023 for her first three-year term as Non-Executive Director. Debbie is a qualified accountant and experienced executive and board director. She has a career spanning 25 years in financial leadership, from which she brings sound financial expertise around good governance, financial improvement plans and long-term financial modelling. Debbie also works as a Non-Executive Director at Isle of Wight NHS Trust, chairing their finance committee and working with the board to help evolve their health and care plans and trust strategy.

Richard Holmes– Non-Executive Director (Independent)

Richard Holmes joined the Trust in January 2023 for his first three-year term as Non-Executive Director. Richard has had a wide range of senior appointments with responsibility for business services, including IT, HR, estates, and infrastructure. However, Richard's fundamental background is in finance and assurance as finance director and chief operating officer, and corporate governance as Company Secretary. Richard has long experience of serving on and chairing audit committees for large complex organisations and is also currently appointed to the audit committee of a charity that supports people to access higher education. He has been instrumental in improving organisational systems of control and assurance in organisations across many sectors ranging from both large corporate organisations to small charities, from public to private, and from education to manufacturing and construction.

Margaret (Eiri) Jones – Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019. Eiri is a registered adult and children's Nurse, has an MA in Professional Development and is a Quality Service Improvement and Redesign (QSIR) Practitioner. She has clinical, managerial, and executive leadership knowledge and skills gained during a career spanning over 40 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her last UK Executive role was as the Director of Nursing for the United Lincolnshire Hospitals NHS Trust (2012 – 2014). Since then, she has held roles as an interim Quality Manager at NHS Crawley CCG; interim Director of Quality Governance at Barts Health NHS Trust; Implementation Director of GIRFT in the Southwest of England and most recently as a Quality Programme Director for Cwm Taf Morgannwg Health Board. Eiri is also Non-Executive Director at Dorset County Hospital and sits on Allocate's Advisory Board. Eiri became Senior Independent Director (SID) in September 2023.

Executive Directors

Lisa Thomas – Interim Chief Executive

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

Lisa joined Salisbury in 2017 as Chief Finance Officer. In August 2022, she took on the role as Interim Chief Operating Officer on a secondment basis. Following the resignation of Stacey Hunter in late 2023, Lisa was appointed as Interim Chief Executive Officer and started on 1st February 2024.

Dr Peter Collins – Chief Medical Officer

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

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

Judy Dyos – Chief Nursing Officer

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

Mark Ellis – Interim Chief Finance Officer

Mark has worked in the Trust as Deputy Chief Finance Officer was appointed as Interim Chief Finance Officer in August 2022, responsible for the Trust's Finance, Payroll, and Procurement departments.

Mark has over 18 years' NHS finance experience, working in senior finance positions at a number of NHS Trusts across Hampshire and Berkshire until joining the Trust in late 2017. Mark has an undergraduate master's degree in engineering science from the University of Oxford and obtained Chartered Management Accountant status as part of the NHS Graduate Training Scheme.

Melanie Whitfield – Chief People Officer

Melanie is an accomplished HR leader and coach with many years' experience leading on significant programmes of change and people strategy in both the private and public sector. With years of organisational HR experience, including Board level experience within private equity and public charity sectors, Melanie joined the national team at NHS England and Improvement as one of the founding authors of the People Plan.

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

Niall Prosser – Interim Chief Operating Officer

Niall Prosser joined the Trust in February 2024 on a 6-month secondment basis from Royal United Hospitals Bath NHS Foundation Trust. He has over 16 years of NHS operational management experience working within the Bath, Swindon and Wiltshire and Bristol systems. Over the last three years this has included undertaking the Interim Chief Operating Officer and Deputy Chief Operating Officer roles at the Royal United Hospital in Bath. Prior to working within Bath, he has also undertaken senior transformation, commissioning, and divisional director roles. Niall has a strong track record of helping services to innovate through clinically led service developments.

Directors that left the Trust during 2023-24

Stacey Hunter – Chief Executive
Stacey joined the Trust in September 2020 as Chief Executive with over 35 years' experience working in the NHS. Stacey worked in Salisbury for over three years and in January 2024 left the Trust to join North Tees and Hartlepool NHS Foundation Trust and South Tees Hospital NHS Foundation Trust as Group Chief Executive Officer.

Board of Directors' Attendance (Members' attendance only) 2023-24

	Appointment Date							
	From	To	Trust Board (8 meetings)	Audit Committee (5 meetings)	Remuneration Committee* (5 meetings)	Finance & Performance (10 meetings)	Clinical Governance Committee (9 Meetings)	People and Culture Committee (9 meetings)
Rakhee Aggarwal Non-Executive	01/01/20	-	7	-	5	-	-	9
Tania Baker Non-Executive	01/06/16	-	8	5	2	-	-	7
Debbie Beaven Non-Executive	01/01/23		8	-	4	10	9	-
Michael Von Bertele Non-Executive	01/11/16	-	8	4	3	-	-	7
Dr David Buckle Non-Executive	27/01/20	-	8	-	4	-	7	-
Peter Collins Medical Director	05/10/20	-	8	-	-	-	6	7
Judy Dyos Director of Nursing	15/06/20	-	8	-	-	-	8	5
Mark Ellis Interim Chief Finance Officer	08/08/22	-	8	5	-	9	-	1
Ian Green Chair	01/02/23	-	7	-	5	-	-	-
Richard Holmes Non-Executive	01/01/23	-	7	5	2	9	-	-
Stacey Hunter Chief Executive	01/09/20	31/01/2024	7	-	-	4	1	-
Margaret (Eiri) Jones Non-Executive	11/11/19	-	8	-	3	9	8	6
Niall Prosser Interim Chief Operating Officer	05/02/2024	-	1	-	-	2	2	-
Lisa Thomas Interim Chief Operating Officer / Interim Chief Executive Officer	03/07/17	-	7	-	-	10	9	-
Melanie Whitfield Chief People Officer	06/09/21	-	8	-	-	1	-	9

[1] Stacey Hunter left the Trust in January 2024.
[2] Niall began his role as Interim Chief Operating Officer in February 2024.

[3] Lisa began her role as Interim Chief Executive Officer in February 2024.
[*] During the year there were changes to the membership of Remuneration Committee. However, this was reversed in Jan 2024 with an approved proposal to include all Non-Executive Directors in Committee membership.

Register of Director's Attendance* – Public Council of Governors 2023-24

	22 May 23	24 Jul 23	27 Nov 23	4 Mar 24	Attendance rate
Ian Green	✓	✓	✓	✓	4/4
Tania Baker	✓		✓	✓	3/4
Michael von Bertele	✓	✓	✓		3/4
Rakhee Aggarwal		✓			1/4
Debbie Beaven	✓	✓		✓	3/4
Richard Holmes				✓	1/4
Stacey Hunter	✓	✓	✓		3/3
Peter Collins					0/4
Lisa Thomas				✓	1/4
Judy Dyos		✓		✓	2/4
Melanie Whitfield					0/4
Margaret (Eiri) Jones	✓	✓		✓	3/4
David Buckle	✓			✓	2/4
Mark Ellis	✓				1/4
Niall Prosser					0/1

Extraordinary meetings held on 9th August and 20th December 2023 were held in private. The first to appoint the Trust's external auditors and the December meeting was to discuss arrangements in relation to CEO recruitment.
* Executive Directors will attend in rotation based on papers reporting to the meeting.

The Audit Committee

Name	Committee Role	Attendance
Richard Holmes	Chair	5/5
Michael von Bertele	Non- Executive Director	4/5
Tania Baker	Non- Executive Director	5/5

The Work of the Audit Committee in Discharging its Responsibilities

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

The committee is supported by the Appointed Auditor, Deloitte, who took office from November 2023. In August 2023 the Council of Governors approved the appointment of Deloitte as the Trust's external auditor for the next three years.

During 2023-24, the internal audit service was provided by PwC UK until KPMG were appointed as the Trust's internal auditors and counter fraud specialists during the year.

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

The Audit Committee has been chaired by Richard Holmes, Non-Executive Director since 1st January 2023. The Audit Committee is responsible for:

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

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

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

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

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

The committee reviewed the draft financial statements and governance statements for the 2022-23 annual report and recommended their adoption to the Board. The Audit Committee signed off the Annual Accounts on 8th June 2023, acting on the delegated authority of the Board.

During 2023-24, Internal Audit conducted eight internal audits. The finalised reports have resulted in the identification of 2 high (4 for 22/23), 24 medium (14 for 22/23) and 19 low risk (11 for 22/23) findings to improve weaknesses in the design of controls and/or operating effectiveness. Further information can be found within the Annual Governance Statement.

The newly appointed Local Counter Fraud Officer (LCFO) has worked with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter Fraud Functional Standard Return, with 9 components achieving green rating and 3 achieving an amber rating. These include policy and response plan, reporting routes for staff, contractors and the public, and policies and registers for gifts, hospitality, and conflicts of interest.

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. The committee reviews the effectiveness of the audit process including verifying compliance with statutory requirements

and deadlines, communication with key senior management personnel, satisfactory planning processes, and confirmation that the provision of staff to carry out work for the Trust are those named and qualified.

Deloitte has not provided any non-audit services for the Trust in 2023-24.

Membership of the Audit Committee

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

Financial Audit

The external auditors for the Trust are Deloitte. During the 2023-24 period, the Trust has incurred the following costs on external audit:

- Audit services: £223,000
- Other services: Nil

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

The Trust has an internal audit function which was delivered under contract by PwC for part of 2023-24 until KPMG were appointed. The work programme is reviewed and approved by the Audit Committee. Senior representatives of KPMG report to the audit committee and a working protocol is in place with Deloitte, the Trust's appointed auditor. The delivery of the contract with KPMG is overseen by the Chief Finance Officer and the internal audit fee for 2023-24 was £97.3k with counter fraud fees at £30.8k.

Revaluation of Property and Land

The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. The five-yearly revaluations are carried out by a professional qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. The last full revaluation occurred at 31 December 2023. Fair values are determined as follows:

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

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

Recognition of Income

Of the Trust's income, 86% is received from other NHS organisations, with the majority being receivable from NHS Bath and North-East Somerset, Swindon, and Wiltshire ICB. The Trust participates in the Department of Health and Social Care's agreement of balances

exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivable balances that arise from Whole Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA payable and receivable balances are appropriately recorded. The Trust's external auditors will review the outcome of the exercise and report their findings to the Audit Committee.

Directors' Responsibilities for Preparing the Annual Report and Accounts

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

REMUNERATION AND NOMINATIONS COMMITTEE

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

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

As highlighted in the Trust's recently refreshed Equality, Diversity and Inclusion Policy and Recruitment and Selection Policy, the Trust is committed to promoting equality of opportunity and treatment of any individual engaged in the recruitment and selection process and ensuring that there is no unlawful discriminatory practice on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, and sexual orientation.

During 2023-24 the Board reflected on its diversity in relation to indicator 9 in the NHS Workforce Race Equality Standard. Whilst it was acknowledged that Board diversity somewhat reflects the local community in terms of ethnic diversity, this is not the case when compared to those from ethnic minority backgrounds within our workforce.

The Remuneration and Nominations Committee welcomes applicants who bring diversity to the Board profile and understand how that diversity can bring added value to the Board. The terms of reference outline the committee's responsibilities to regularly review the composition of the Board, including skills, knowledge, experience, and diversity. Additional responsibilities also include succession planning for the Chief Executive and other Executive Directors considering the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

In 2023-24 the Trust was part of an external well-led assessment. In relation to Board stability, composition, skills and experience, the outcome of the assessment noted that whilst there had been executive changes, this reflected the progression and nurturing of internal

talent. Overall, it was felt that there is a good balance of skills with particular strength of clinical representation.

FOUNDATION TRUST MEMBERSHIP

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

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

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

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

During the year the Trust sought to broadly maintain membership. The membership for Salisbury NHS Foundation Trust at 31st March 2024 is:

Public Constituency	Number
Salisbury City	2,349
South Wiltshire Rural	4,241
Kennet	1,134
North Dorset	1,253
East Dorset	539
New Forest	958
Rest of England	1,077
Staff Constituency	1,858
Total	**13,409**

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

The Trust's Membership Strategy was revised by the governor-led Membership and Communications Committee and approved by the Council of Governors in February 2023. The Trust should continually seek to communicate with its members, through a variety of effective means, i.e., governor newsletters, Medicine for Members meetings, constituency meetings, public Council of Governor meetings, the Annual General Meeting and through local and social media.

With an updated Membership Strategy, the Membership and Communications Committee is focusing on different methods of recruitment, including using the Trust's social media platforms. Furthermore, it is hoped that an updated membership page on the Trust's website

and the continuation of constituency meetings and other events, for example, 'Medicine for Members' will attract a more representative membership and is a focus for 2023-24. This year, the Trust continued to publish a digital summary of the Annual Review to enable a wider reach to the local population. This document was published on the Trust website, promoted to our members. This document provides a succinct and informative summary of the year's events, including our ambitions for the year ahead.

During 2023-24 Governors continued to join their committee's and groups in person and virtually to enable flexibility for those who are not always able to travel to the Trust. They have been focusing on their statutory duties and have also been involved in the development of the Trust's Annual Plan and Quality Account. Governors have been able to participate on Trust-led working groups, such as Food and Nutrition and the Transport Strategy. Governors have had the opportunity to be involved in the 'patient experience', including Real Time Feedback and PLACE assessments.

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

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

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

Part of Schedule A	***Code* section**	**Summary of requirement**	**Annual Report Location**
Required disclosures			
Disclose	A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency, and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Performance Report (page 5) / Annual Governance Statement (page 90)
Disclose	A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Staff Report (page 50)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Performance Report (page 5) / Code of Governance (page 67)
Disclose	B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. • Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Code of Governance (page 67)
Disclose	B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Code of Governance (page 67)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Code of Governance (page 67)
Disclose	C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors (in relation to Executive or Non-Executive recruitment).	Code of Governance (page 67)
Disclose	C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Code of Governance (page 67)
Disclose	C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise, and experience.	Code of Governance (page 67)
Disclose	C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Code of Governance (page 67) / Annual Governance Statement (page 90)
Disclose	C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition	Code of Governance (page 67)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
		• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	
Disclose	C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Code of Governance (page 67)
Disclose	D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit. • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Code of Governance (page 67) / Annual Governance Statement (page 90)
Disclose	D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Performance Report (page 5)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Governance Statement (page 90)
Disclose	D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement (page 90)
Disclose	D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Annual Accounts
Disclose	E 2.3	Where a trust releases an executive director, e.g., to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Remuneration Report (page 35)
Disclose	Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Code of Governance (page 67)
Disclose	Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Code of Governance (page 67)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g., through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Code of Governance (page 67)
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Code of Governance (page 67) 'Council of Governors'. No issues identified in the reporting year.

NHS OVERSIGHT FRAMEWORK

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

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

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

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

Segmentation
The Trust is currently segmented at 3. The specific areas under review are

- Quality (Maternity Safety Support Programme)
- Workforce (Safety Culture and Leaver Rates)
- Cancer (62-day backlog)
- Finance (Efficiency, Stability and Agency Spend)

As part of this process the Trust is required to have Enhanced Oversight Meetings chaired by the Integrated Care Board. With the exception of 'Finance – Stability' significant progress has been made during 2023-24 across each of the areas under review, with regular reports of assurance received at the Finance and Performance Committee. The Trust's ability to achieve financial sustainability is highlighted as a major risk going into 2024-25. Further detail on mitigations and controls in relation to this can be found in the Annual Governance Statement (AGS)

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

Statement of the Accounting Officer's Responsibilities

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

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Salisbury NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Salisbury NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care*

Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

- ensure that the use of public funds complies with the relevant legislation, delegated authorities, and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

This confirmation is given and should be interpreted in accordance with the provisions of s418 of the Companies Act 2006.

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

L. Thomas.

Lisa Thomas
Interim Chief Executive (Accounting Officer)
27/06/2024
(on behalf of the Trust Board)

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

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

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Salisbury NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Salisbury NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Salisbury Hospitals NHS Foundation Trust is committed to a Risk Management Strategy which minimises risk to all of its stakeholders through a comprehensive system of internal controls. The understanding of risk involves the interplay of risk processes affecting staff, patients and the environment.

Trust Board

The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors. The Board recognise that risk management is an integral part of good management practice and to be most effective should be embedded within the Trust's culture. This is embodied within the Strategy and Policy as this documents the Board's risk appetite and the processes applied across the Trust which see the oversight of the Trust's corporate and strategic risks assigned to a Board Committee and each risk has a named Executive Lead. The Board is committed to ensuring that risk management is embedded across all functions and is not seen or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

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

Board Committees

The Audit Committee has overall responsibility for ensuring there is effective risk management process employed across the Trust. The Audit Committee receive information annually from the Trust's internal auditors through their work which supports the Board Assurance Framework and through this work the Committee supports the Board to be assured over the robustness of the Trust's application of sound internal control processes.

The other key Board Committees of Clinical Governance, Finance and Performance and People and Culture receive and consider the strength of assurance of actions being taken to manage key corporate and strategic risks outside of the Board's stated risk appetite and request further assurance in the form of deep dives or specific reports where necessary.

Non-Executive Directors

All Committees are chaired by a nominated Non-Executive Director. The Audit Committee which plays a pivotal role in providing assurance on the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Directors, together with the Non-Executive Audit Committee chair, they all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit Committee and Board supports the effectiveness of the Trust's systems of internal control.

Executive Directors

The Chief Executive has overall responsibility for risk management within the Trust.

The day-to-day oversight has been delegated to the Chief Nursing Officer who is responsible for the strategic development and implementation of organisational risk management systems and processes and for ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) registration and legal requirements. The Chief Nursing Officer is also responsible for patient safety, patient experience and medical legal matters.

The Chief Finance Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud. The Chief Finance Officer attends the Trust's Audit Committee and liaises with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk-based approach.

The Trust's Senior Leadership Team Committee, chaired by the Chief Executive Officer, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified.

There is a process of escalation to Executive Directors through Divisional Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

Divisional Governance committees introduced to further strengthen the governance arrangements are now embedded in the risk management structure and have responsibility for the oversight of divisional governance and risk processes.

The Head of Risk Management supports the Executive Lead and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments and teams directly.

The Risk and Control Framework

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises, and managing finances will always involve an inherent degree of risk. Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve. The Trust considers risk management to be an intrinsic part of our governance and quality frameworks; it is an essential element of the entire management process and not a separate entity.

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

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

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

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

Each Division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments, or the division, are recorded within the

Divisional risk register whilst individual departments/specialties maintain departmental risk registers containing risk to the achievement of individual department's objectives. The escalation process between these risk registers is monitored via the divisional management team with oversight through the Divisional Governance Committees. Escalation of Divisional risks to the Corporate Risk Register is via the Divisional Performance Reviews.

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

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

The Trust's counter fraud work plan and Local Counter Fraud Specialist also play a key role in assisting the Trust to anticipate and manage risk, and regular reporting to each Audit Committee meeting ensures the Board is frequently appraised of counter fraud prevention and detection activity, and any necessary improvements required to the Trust's controls. Together with the internal audit plan the recommendations and learning identified from such reviews are taken forward in an action plan, to support improvements and the embedding of risk management in the Trust. Internal Audit reports relating to quality processes, also get reported to the Clinical Governance Committee to seek assurance on delivery of actions.

The Clinical Effectiveness Steering Group, reporting to the Clinical Management Board consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives. The Clinical effectiveness agenda is overseen by the Chief Medical Officer.

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

The BAF records that the Trust has been managing 10 significant risks during the year. Two risks relating to availability of the workforce moved within tolerance in January 2024, leaving 3 risks outside of the Board-agreed risk appetite. This compares to 8 risks reported last year

which demonstrates active management of strategic risks throughout the year. These relate to

- Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.
- Financial sustainability.
- Critical plant and building infrastructure within limited capital funding.

The remaining risks within tolerance relate to:
- Sustainability of sub-specialised services.
- Capability and capacity to deliver the digital strategy.
- Staff availability.
- Partnership working across BSW.
- Supply chain disruption.
- Deterioration across key performance metrics.

For each of the BAF risks, there is a detailed series of mitigations which will continue to be implemented throughout 2024/25. The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committee of the Board.

The Trust established controls or implemented actions to manage these risks as summarised below:
- Delivery of a joint Acute Hospital Alliance (AHA) Clinical Strategy and reconfiguration of services across BSW.
- New urgent care transformation programme including SDEC, ED and Elderly Care.
- A comprehensive improvement programme against all 7 elements of the People Promise.
- Increased focus on financial controls, emphasising best value decisions.
- Implementation of the digital strategy and continued focus on development of the infrastructure and controls.
- Robust capital prioritisation processes to ensure resources are deployed effectively.

Major risks 2024/25

As we enter 2024/2025, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and staffing availability, compounded by on-going strike action. The focus will be on the delivery of NHS England Operational Planning Priorities 2024/25.
- Supporting the health and wellbeing of staff.
- Accelerate the restoration of elective and cancer care and reduce waiting times.
- Working with partners to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on the system priorities.
- Ability to achieve financial sustainability at pace.

Key risks include:
- Scale of the transformation required to achieve both urgent and planned care requirements.

- No control over external factors such as on-going industrial action and/or infection control outbreaks.
- Financial constraints to deliver the transformation required.
- A sustainable workforce to deliver the Trust priorities.
- Reliance on whole system change to enact plans.

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

Our underlying financial position remains a significant challenge, with a planned deficit of £17m and a liquidity challenge leading to a reliance of the NHS revenue support PDC, subject to approval by DHSC. The financial context for the NHS as a whole in 2024-25 is as challenging as has been seen in recent years. We will continue to operate under a national tariff (i.e. payment by number of patients treated) for a significant proportion of planned activity but fixed income for other care, we must therefore manage internally the expenditure risk associated with growth in demand for emergency pathways. We have a great opportunity in 2024-25 to significant increase the number of patients we are treating on planned pathways as the opening of Imber ward facilitates the utilisation of more theatre capacity. As a healthcare system, financial sustainability is also a priority; For our own part, SFT will be seeking to reduce our underlying deficit through a significant £21m savings plan, delivery of which is underpinned by the 'Creating value for the patient' Breakthrough Objective, while BSW ICS is developing plans to address the system deficit where Salisbury will play a significant role.

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

Quality Governance

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

The Trust has a robust Quality Governance reporting structure in place through an established Clinical Governance Committee. The Quality Governance arrangements are described in the Integrated Governance and Accountability Framework which is reviewed on an annual basis. The framework was presented for approval at the Trust Board in May 2024. This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Governance and Accountability Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will

flourish. The Quality Account published alongside this Annual Report and Accounts describes quality improvements and quality governance in more detail.

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

Improving Together is the operational management system we share across the Acute Hospital Alliance in BSW. It aligns with the five components of NHS Impact and links improvement tools and routines with the behaviours needed for a culture of continuous improvement. It is founded on the development of a coaching approach, which enables every member of staff to improve the services they work in and contribute to achieving our strategy.

Evidence shows that Trusts that have a continuous improvement approach like this provide better patient care, and colleagues working in these Trusts have greater job satisfaction.

Ultimately Improving Together is about improving the quality-of-care provision. By focusing our efforts where they will have the most positive impact on our services, we will improve the way we work and our quality of care. It covers the following main areas:

- Alignment of priorities – using the strategic planning framework from board to ward we focus on linked priorities, helping us achieve our goals more effectively.
- Empowerment – colleagues will know they are empowered to make changes in their team. Every member of SFT will be supported to develop and improve their skills to be able to identify and adopt improved ways of working.
- Developing our culture – by empowering each and every member of staff to have a voice and supporting our leaders to adopt compassionate and enabling leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to better understand and continually improve the services we offer.
- Stopping doing things that do not add value to our people, population and partners.

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

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The quality impact assessment (QIA) process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality. This process has been reviewed and was refreshed for 2023-24. The Clinical Management Board, jointly chaired by the Chief Nursing Officer and Chief Medical Officer, now has oversight of and responsibility for approving all QIA's.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2023-24 and the quality priorities selected for 2024-25. Progress of the priorities is monitored via the

Clinical Management Board and Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators.

The Integrated Performance Report (IPR) is aligned to our key areas of focus within the strategic planning framework. It comprises of detailed reports on quality, operational performance, finance and workforce, has been received by the Board monthly and is considered in detail. Our divisions follow the same approach via the Executive Performance Reviews, which feed into the IPR.

Dedicated data quality teams pro-actively manage elements of data quality within key Trust systems and provide appropriate training and guidance to service colleagues across the Trust. The Trust has an internally developed data quality dashboard held in PowerBI where key performance indicators are monitored each month at Divisional and Specialty/Ward level. Independent assurance regarding data quality is provided using published NHS England dashboards, ad hoc internal audits which review internal processes and the annual Data Security and Protection Toolkit self-assessment audit review. The Trust's Data Quality Manager attends regional Data Quality network forums across the South West where key challenges are discussed and ideas for improvement are shared amongst acute providers.

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

Data Security and Cyber Security risks are invariably treated as Trustwide risks overseen by the Informatics Directorate and assured through Digital Steering Group up to Finance and Performance Committee. A range of data protection and security risks are identified on the risk register and progress to reduce the risks are reviewed monthly through the Informatics Divisional Management Committee. A range of technologies are in place to protect the Trust from threats which are maintained by the Informatics technical teams. The Trust's compliance with the Data Security and Protection Toolkit (DSPT) and the underpinning external audit provides assurance that the Trust has the expected minimum level of controls and protections in place, recognising that that there is always an element of risk tolerance required. The Trust's risk appetite for data security has been agreed at the Board. A rolling awareness programme on key areas such as phishing is also in place to help educate staff on data protection and security, with the annual IG training a mandatory training requirement.

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

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

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken. The ICS quality leads are an integral part of the Trust quality governance arrangements and attend key quality committees. The Trust works in partnership with our commissioners to share learning and improvement actions.

The Trust launched the new National Patient Safety Incident Response Framework (PSIRF) on the 8th January 2024. The framework sets out a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is a significant change to how staff work and respond to patient safety incidents and the Trust is still learning and adapting documentation and training to support effective implementation. The Trust has a well-established process of review for all incidents graded moderate or severe together with compliance with Duty of Candour on a weekly basis through the Patient Safety Summit chaired by the Chief Nursing Officer or Chief Medical Officer.

The National Reporting Learning System has also been replaced with the Learning From Patient Safety Events (LFPSE) system. The Trust has actively engaged with this transition.

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

- Regular oversight by the Board of the Board Assurance Framework and application of the Board approved risk appetite and risk tolerances which has enabled a focus on risks outside of tolerance.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Service level deep dive reviews through the Clinical Governance Committee receiving assurance on the quality-of-service provision and areas for improvement.
- Reviewing a significant proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group. A new audit management and tracking (AMaT) system was introduced this year and an electronic module for mortality developed within this, to support with our learning from deaths processes. Specific consideration has been given to how we monitor and capture patient safety risks (ensuring close alignment to our PSIRF processes) and our policies for both audit/effectiveness and mortality were updated accordingly. The Board also requested an external mortality insight visit this year to help us understand the areas for further improvement and to support our overall approach to learning from deaths.
- Preparations for the community Medical Examiner roll-out have been continued to progress, and our medical examiners are now operating within the majority of our local GP surgeries. We are still awaiting formal notification of when the community medical examiner roll-out will become statutory (anticipated for September 2024).
- The Trust's Mortality Surveillance Group (MSG) continue to meet every two months, providing assurances that the Trust has a robust process for overseeing mortality.
- Weekly review of all reported incidents graded moderate and above to agree the appropriate level of investigation and identify any immediate actions to mitigate identified risk.

- Ensuring that learning from incidents is maximised and disseminated via the Patient Safety Steering Group, Clinical Risk Group, Clinical Management Board and Divisional Governance Committees.
- Weekly oversight of compliance for any notifiable safety incident where unintended or unexpected moderate or above harm occurred to service users. The Trust is implementing Divisional Learning Forums to further strengthen learning from quality intelligence.
- Our Risk Management System, Datix, provides a range of quantitative data to support analysis across services and wards to provide assurance that we have effective systems for the monitoring of incidents.
- Transition to the new NHS Patient Safety Incident Response Framework (PSIRF) in January 2024. The PSIRF places emphasis on reviewing incidents thematically to increase the amount of potential learning.

The Trust continues to demonstrate a clear commitment to person centred care and acknowledges that this correlates with good patient engagement. The Trust has focused through Improving Together methodology, measures to demonstrate an overall engagement score and problem solve barriers to achieving this. The Patient Engagement Score covers an array of elements including Patient Stories, Patient Focus Groups and Panels, Complaints and Concerns, Real-time feedback and Friends and Family Tests. The Trust completes an annual engagement report, outlining this progress, which is reported to Trust Board.

Patient Stories continue to be a highly valued part of our commitment to ensuring the voices of our patients and services users are heard. So far this year, we have filmed 3 stories with the following themes:

Elle's Story – Supporting Birth Choices. This has been used as a staff educational video to raise awareness of the importance of informed decision making and supporting the choices of expectant mothers.

Poppy's Story – My Organ Transplant Journey. This was used to promote the importance of the organ donation conversation and showcase the impact this has on the lives of recipients. This was used in various campaigns during Organ Donation Week.

Helen's Story – An Inpatient Experience as a British Sign Language (BSL) user. This is our most recent production aimed to educate staff about BSL as a requirement under the Equality Act. This story will be used in staff training and used to bolster other initiatives such as the Trust's Hard of Hearing Project launching in the Spring and promote related national campaigns such as British Sign Language and Deaf Awareness Week.

In addition, we have also heard several in-person stories at both our Patient Experience Steering Group and Trust Board meetings. These have been poignant and powerful, with a mixture of positive and negative experiences covering a range of journeys; from chemotherapy and prostate cancer to carers as well as reflections on our evolving patient-led panels. These are now beginning to embed into our departmental and divisional governance groups as we continue to explore different methods and approaches to presenting these stories in order to ensure their maximum impact and reflection.

In April 2023 we launched our first fully patient-led service improvement panel for Spinal Services. There are 3 active projects, all selected based on the common experiences of the group; improving patient information, maximising opportunities for self-rehabilitation and experience of facilities. The group now also provides patient representation for the regional oversight group for Spinal Services. In August 2023, the Trust launched its second speciality patient panel for Cancer Services. To date the group has developed an action plan and terms of reference and have workstreams selected based on common experiences of its members, including communication and information, facilities and environment and contacting the hospital.

The effectiveness of these collaborations is actively being showcased across the Trust and this is driving appetites amongst specialities to replicate similar engagement opportunities locally. This continues to be an area of focus and development for the Trust.

This year we have continued to develop a pool of service user engagement volunteers. This database was an initial point of reference for recruitment of the Trust's new Patient Safety Partner roles and continues to be a resource for any new engagement activities that emerge. We now have a highly active readership group, reviewing patient facing material on a weekly basis. This triggered a need to recognise this valued input and reviewed material now carry an identifiable "patient reviewed" stamp.

There continues to be various opportunities for patients to engage with the Trust and commitment levels vary from one-off projects such as those undertaken for Stoma, Colostomy and Breast Care to high level commitments such as our Inpatient Spinal Group and Patient Safety Partners.

In the Autumn of 2022, the Trust embarked on a co-produced complaints process review project in partnership with Healthwatch Wiltshire. The learnings taken from this project have been implemented over the past 12 months, culminating in an updated complaints policy and new PALS information leaflet. The complaints process continues to be monitored through our quality and governance processes, with focus on quality of response and response within timescale being continued priorities going into 2024/25.

The Trust is continuing to invest in the digitisation and extraction of data insights from our Friends and Family Test (FFT) surveys, to help shape service improvements. Response rates and overall experience ratings are nationally reported currently, but it is recognised the additional value this data could provide if we were able to robustly theme and analyse feedback received through this mechanism. Implementation of a new digital solution was delayed this year due to resourcing challenges, however implementation recommenced in December 2023 and is set for Go Live in Spring 2024. The anticipated benefits of this solution include increased accessibility and options for inclusivity, robust analysis of data for insight and meaningful comparison and benchmarking through a real-time dashboard and opportunity to triangulate feedback themes with complaints, incidents, compliments, RTF and national surveys.

Real-time feedback (RTF) was re-launched in February 2023 and continues to go from strength to strength. To date 239 surveys have been conducted by the patient's bedside. The aim of the feedback is to give a "real-time" view of a patient's perspective of their care.

The survey mirrors the focuses of the National Inpatient survey and includes questions to measure the patient's perspective of the following areas; admission to hospital, the ward environment, doctors & nurses, care, & treatment, operations & procedures, leaving hospital and respect & dignity. This is summarised with an overall experience rating. This feedback continues to develop and is being used to triangulate themes being seen though complaints, FFT and National Surveys.

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

The Trust has assessed compliance with the NHS provider licence section 4 (governance). The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

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

There is no requirement for 2023/24 to submit a Corporate Governance Statement as per previous years.

As a Trust, the following approaches and mechanisms are used to ensure that short, medium and long-term workforce strategies support staffing systems to ensure that staff processes are safe sustainable and effective.

- The Trust's Strategic workforce plan identifies the workforce requirement for the next 5 years by staff group and specialist area for medical, clinical and non-clinical staff. This plan is reviewed annually against the operational plan baseline to ensure the 5-year outlook is maintained. The plan takes into account analysis of population demographics for our service catchment areas, any adjustment to NHS operational direction and priorities, system plans and Trust strategy. The plan is then cohered against at the Divisional level, and against operational and financial priorities at the Trust level. The Strategic Workforce Plan enables a long-term view of workforce requirements, which supports the generation of retention and recruitments plans across the Trust.
- The OD&P Business Partners and workforce planning team work collaboratively with Divisional Management Teams to provide guidance and support in both organisational design and organisational development to ensure effective establishments are designed which meet safe staffing guidance.
- The annual review of the operational plan is informed by the strategic workforce plan and developed at Divisional Level to ensure clinical outcomes can be met, within the agreed financial envelope and that safe staffing levels are met in accordance with Developing Workforce Safeguards and local Trust guidance. Resourcing the plan is a collaborative venture between service leads and the OD&P team who support attraction campaigns with a focus on hard to recruit posts for both clinical and non-clinical roles. Positions currently subject to

high turnover, such as Health Care Assistants remain as active campaigns with a regular timeframe to ensure that these pipelines are maintained with trained staff.

- In year, where there is an identified review and or requirement to modify the workforce plan, a system is in place which provides scrutiny at Divisional Management Team level, and then at Trust level through the Workforce Control Panel to ensure changes are within the financial envelope, provide no risk to patient or staff safety and are necessary to deliver trust outcomes safely and effectively.
- An established process for proposed changes to clinical staffing profiles to undergo Quality Impact Assessment in accordance with national guidance by the Chief Medical and Nursing Officers.
- The nursing establishment and skills mix on wards is assessed bi-annually and reported to the Trust Board through the Clinical Governance Committee, in accordance with National Quality Board guidance.
- Workforce risks are identified and monitored in the Board Assurance Framework and divisional risk registers.
- Staff wellbeing is monitored in two ways. For Junior Doctors, our Guardian for Safe Working ensures that the health, wellbeing, and safety of junior doctors is maintained through routine engagement with clinical and educational leads and monthly forums with the Junior Doctors, which drives a monthly reporting process. An escalation and assurance report is then provided at the end of each academic term to the People and Culture Committee. More widely, health and wellbeing issues for staff are monitored by wellbeing conversations between line managers and staff and issues raised through the Wellbeing committee, which monitors the effectiveness of a number of wellbeing initiatives through wellbeing ambassadors, staff side representation and management input.

Our Board is provided with assurance of these mechanisms and processes in the following ways.

- E-Roster is used to capture and collate staffing numbers and skills mix for nursing staff. The system also enables routine capture of staff absence through illness, providing a trigger for line managers to monitor their staff and offer the correct support. A project is in place to roll out E-Roster to all medical staff to support this element of the workforce. Routine reports from the E-Roster system are raised through the Strategic Workforce Systems Steering Group into OD&P Management Board for action and assurance.
- A suite of Power BI dashboards are now available to support data management and assurance of safe staffing and workforce requirements.
- Integrated performance reports articulate safe staffing levels and bank/agency usage on a monthly basis.
- Divisional Performance Review meetings consider staffing issues with escalation of any concerns to Execs monthly.
- The OD&P Management Board provides oversight of all workforce plans concerns and takes an escalation report from the safe staffing group to enable triangulation of workforce capacity and safety concerns. The OD&P Management Board raises issues for escalation to the Trust Management Committee, and to the People Committee for assurance, thus providing assurance for the Trust Board. The Trust board also receives regular updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes, which includes skills mix and care hours per patient day.

- Safe staffing reviews for nursing and midwifery are provided to Board through the Clinical Governance Committee bi- annually. Routine Safe Staffing concerns are escalated to OD&P Management Board for resolution.
- The Trust's BAF reflects increased the risk to sustainable staffing against our strategic vison of a sustainable workforce in the 5-year period.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Maternity Service has been on the NHSEI Maternity Safety Support programme (MSSP) since 2022 and, in response to the improvements and progress made, transitioned into the sustainability phase of the MSSP at the end of March 2024. There have been no inspections since 2021 and scheduled engagement with the CQC has continued.

The CQC's new approach to monitoring and regulation

CQC has been developing its new approach to regulation. It has been working with providers, stakeholders and members of the public to co-create, test and pilot aspects of that new approach, and in November 2023 it formally launched its new Single Assessment Framework.

The new framework, which is designed to apply to providers, systems and local authorities, promises a more granular and transparent assessment, greater focus on what matters to people using services, and more scope for providers to benchmark themselves against others and to follow their own progress within a rating category. Under CQC's new approach, the five key questions of safe, effective, caring, responsive and well-led and the ratings of outstanding, good, requires improvement and inadequate remain the same. A set of new quality statements replace key lines of enquiry and six new evidence categories that underpin them will be scored to arrive at an overall rating for each key question, core service and location.

With an improved provider portal and increased reliance on data and technology, CQC has suggested it will be better able to review new evidence and will be able to update core service and provider ratings more quickly, without the need to wait for a full-scale re-inspection, providing greater objectivity and a more 'live' picture of quality.

At the Trust, work began socialising the new approach and framework into the organisation in Spring 2023, with momentum gathering in preparation for the transition.

External Well-led Developmental Review

In Quarter 4, 2022/23 a successful system wide procurement process was undertaken across the 3 BSW Acute Trusts to secure an external company to undertake a well-led developmental review. The Trust review commenced in April 2023 for a three-month period, concluding in June. To gain a breadth of understanding of the organisation, in addition to a documentary review, the team interviewed 41 internal stakeholders, 13 external stakeholders and observed five committees. The report was received in July 2023. The Executive Directors reviewed the outcome of the review prior to a Board workshop in October 2023 which focussed on agreement of the key areas for improvement.

The review reflected "an organisation with clear strategic ambition and commitment to lead for the benefit of the wider system. Operational and governance arrangements are in place and a key development challenge relates to the leadership attention needed to sustain and strengthen those foundations. Throughout the review it was clear that Improving Together is a pivotal focus in defining the organisational approach to improvement and development. Whilst recognising that this is still at a formative stage, aligned to more recent changes to board leadership there is now a platform for resetting some of the core foundations of good governance. Regulatory peer reviews continue to have a strong bias in their focus upon these features.

Priorities in the next phase of the Trust's well-led development are:

- to develop the strength and consistency of the board's line of sight across the organisation. Key to this is the continuing maturity of the divisions in terms of accountability, autonomy, visibility with the board, and increased awareness of wider corporate issues. This recognises the challenges such as those faced through the National Maternity Support Programme.
- to have a collective leadership narrative to the staff survey results which remain an area of significant focus for regulators with an increasing attention being given to Freedom to Speak up, equality, diversity, and inclusion".

The Trust has aligned the key areas for improvement to existing programmes of work to ensure this has oversight through existing governance arrangements.

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

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

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

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

The trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust has identified a strategic risk in respect of financial sustainability. The Trust's external auditor has reported a 'significant weakness' in the Trust's arrangements to secure financial sustainability. This relates to the unplanned deficit in 2023/24 and a planned deficit for 2024/25, underpinned by a significant cost improvement programme. The Trust has taken a series of actions to mitigate the risks to the delivery of the plan, including developing a £21m savings and efficiency programme; it should be noted that non-delivery, or late delivery, of the savings programme would result in the Trust needing to seek further support through the NHS revenue support PDC process, which would require approval from DHSC. We believe our internal controls have allowed us to monitor accurately our financial position and in 2023/24 the Trust delivered the full amount of planned CIP savings. Whilst we recognise the underlying deficit we face due to structural factors such as the profile of patients we treat and the cost of maintaining our estate, we do not believe this finding represents a significant weakness in our internal control.

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

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

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

Arrangements to operate efficiently, economically, and effectively are formally reviewed by external audit. Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and facilitated by the deployment of the 'Improving Together' operating management system. In addition, for the duration of 2023/24 the Trust have been holding a monthly Financial Recovery Group meeting, acting as escalation from the Divisional Performance Reviews and reporting into Finance and Performance Committee. This will continue to be taken forward as a key part of financial governance and controls.

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

Information Governance

The Trust recognises the importance, value and risk that comes with processing large volumes of personal, sensitive and corporate data. The Trust is committed to proactively managing the confidentiality, integrity, availability and resilience of this data through clear

leadership and accountability, which is underpinned by the Trust's values and behaviours through awareness and education.

The Chief Medical Officer (Caldicott Guardian) and Chief Digital Officer (Senior Information Risk Owner (SIRO)), oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively balances a data protection by design and default approach while ensuring that the right data is available at the right time to ensure excellent care can be provided.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) is an annual assessment which demonstrates that organisations can meet the required standards in relation to confidentiality, security and resilience of personal information. The Trust met the standards of this assessment in 2022/23 and is on course to meet the standards again in 2023/24. The Trust's assessment is subject to an independent audit and the results are published, to provide transparency and increase public confidence. The DSPT reporting year runs from the 1st July to the 30th June. In line with the NHS England guidance, the Trust confirms it will submit the 2023/2024 DSPT assessment on or before the 30th June 2024.

Since July 2023, the Trust reported one data security incident to the Information Commissioner's Office. The incident related to the inappropriate behaviour of a third-party contractor working on behalf of the Trust. The incident was notified to the contractor's employer as part of the process. The ICO has not yet provided an outcome for this incident.

During the year, work has continued to align processes with ICS partners, and in particular, Great Western Hospitals NHS Foundation Trust, as there is joint digital leadership across the two Trusts. This has included sharing knowledge and resources, aligning best practice and collaborating on programmes of work to improve consistency for patients and service users, such as implementing shared policies and achieving a successful DSPT assessment.

Data Quality and Governance

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

The Trust has an up-to-date Data Quality Policy that was last refreshed in January 2024. The policy outlines a comprehensive approach to data quality, focussing on the following key areas:

- Raising awareness of the importance of high-quality data.
- Assisting all staff in understanding their role and responsibility in maintaining high quality data.
- Assisting staff in getting data quality 'Right First Time' through supporting staff to implement and maintain working practices and processes that enable high data quality at the first time of input.
- Minimising risks arising from poor data quality.

- Monitoring the quality of data used by the Trust via various dashboards and reports, and where needed, to highlight where data is inaccurate and needs to be checked and improved.
- Establishing a framework within which data quality issues can be raised and actioned.

The Trust's Information Standards Group (ISG), chaired by the Head of Information, oversees implementation of the Data Quality Policy. This includes the routine assessment of data quality maturity (DQMI) for all metrics used in core external returns and internal monitoring by Trust committees. Monitoring of all DQMI data helps the Trust identify Key Performance Indicators (KPIs) which are monitored via ISG. Where potential improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process.

The Trust is an active participant in system wide Business Intelligence analytical Forums (one focusing on Elective Care and one on Urgent Care) which seek to standardise the approach to regular reporting, ensuring best practice methodologies are followed and building a shared pool of expert resource across the system in the use of tools such as Power BI and demand and capacity. The system wide Business Intelligence strategy developed in 2021-22 sets a clear direction towards convergence on cloud-based technology for our underpinning business intelligence infrastructure in the coming years. This will enable improved collaborative working, reduced duplication of reporting and increased ability to support detailed interpretation and predictive analysis on areas such as population health management.

All data used for quality reporting is derived from operational clinical systems which are well known and reviewed by the staff using them. The weekly division-led Delivery Performance Group regularly reviews performance data, including patient level information, especially on elective waiting times.

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

One of the Data Quality Policy's activities is to increase awareness of Data Quality in the Trust. The Trust's own Data Quality Dashboard was published in 2024, and now allows all users to easily monitor their ward/departments' compliance with KPIs, ADT (Admissions, Discharges and Transfers) and raised DATIX incidents relating to DQ.

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

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

The Improvement Group also feeds up any persistent DQ issues to the Information Standards Group with further escalation to the Digital Steering Group which meets monthly. This is an opportunity to reflect current performance to senior Executive staff.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection and these are underpinned by the Improving Together methodology.

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

The Trust changed Internal Audit, Counter Fraud and External Audit providers within the year. The new arrangements are working well, and audit activity continued to be delivered as per the audit plans.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for the period 1 April 2023 to 31 March 2024 is that 'Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

During 2023-24, Internal Audit conducted eight internal audits. The finalised reports have resulted in the identification of 2 high (4 for 22/23), 24 medium (14 for 22/23) and 19 low risk (11 for 22/23) findings to improve weaknesses in the design of controls and/or operating effectiveness.

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

- Cancer pathway data accuracy – sample testing of patients from the 28-Day faster Diagnosis Standard found that data had been recorded incorrectly in the Somerset Cancer Register used for National cancer wait time submissions. 3 actions completed within deadline. Further action with deadline 31 July 2024 relating to regular auditing.
- Divisional oversight of service risks – divisional oversight of department/specialty risk registers varied across the four Divisions. Action deadline: 31 July 2024.

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

The Trust is focused on action plans to address the identified risks reported in 2023-24 which have been approved by the Trust Audit Committee. The Trust utilises an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. The success of this has been sustained and is demonstrated by quarterly reports to Audit Committee.

Conclusion

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

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

L. Thomas.

Lisa Thomas
Interim Chief Executive (Accounting Officer)
27/06/2024
(on behalf of the Trust Board)

NHS
Salisbury
NHS Foundation Trust

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2024

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2024 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:

L. Thomas.

Lisa Thomas - Interim Chief Executive

Date: 28 June 2024

Independent auditor's report to the board of governors and board of directors of Salisbury NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

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

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

We have audited the financial statements which comprise:

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

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

Basis for opinion

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

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor’s responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

We discussed among the audit engagement regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- determination of whether expenditure is capital in nature, and for major projects the value of work completed at 31 March 2024, is subjective and therefore vulnerable to manipulation: we tested a sample of expenditure to assess whether it met the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correct accounting period.

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

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

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

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

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

On 20 June 2024 we reported to the foundation trust a significant weakness in the foundation trust's arrangements to secure financial sustainability. The significant weakness reported was in how the Trust plans to bridge its funding gaps, identified achievable savings and plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities. Our recommendations for improvement included that the Trust build on the measures already taken to accelerate its efforts to identify and realise specific opportunities from those areas of potential efficiency savings identified to deliver its plan, including continued focus on its governance arrangements over the cost improvements programme and related implementation plans. Management should continue to closely monitor the liquidity position and ensure that robust plans are in place to manage any liquidity shortfalls, keeping open dialogue with the Department of Health and Social Care and considering whether other sources of short-term finance are available and suitable to meet the Trust's needs. On a longer-term basis the Trust should work with the Integrated Care System to develop a more sustainable financial settlement.

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

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

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

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

Annual Governance Statement and compilation of financial statements

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

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

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate of completion of the audit

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

Use of our report

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

Chris Randall

Chris Randall (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Appointed Auditor
Reading, United Kingdom
28 June 2024

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2024

		Group		Trust	
		2023/24	2022/23	**2023/24**	2022/23
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**332,928**	316,728	**332,928**	316,728
Other operating revenue	4	**51,908**	44,826	**38,999**	31,206
Operating expenses	6	**(373,779)**	(355,455)	**(360,604)**	(340,321)
OPERATING SURPLUS		**11,057**	6,099	**11,323**	7,613
FINANCE COSTS					
Finance income	11	**1,565**	1,082	**1,417**	1,012
Finance expense	12	**(5,425)**	(2,218)	**(5,359)**	(2,159)
PDC Dividends payable		**(4,928)**	(4,447)	**(4,928)**	(4,447)
NET FINANCE COSTS		**(8,788)**	(5,583)	**(8,870)**	(5,594)
Losses on disposal of assets	15	**(198)**	(5)	**(192)**	(5)
Share of profit of associates/ joint ventures	33	**31**	54	**31**	54
Movement in fair value of other investments	17	**1,093**	(300)	**-**	-
(Losses) from transfers by absorption	39	**-**	(329)	**-**	(329)
Corporation tax expense		**(80)**	-	**-**	-
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**3,115**	(64)	**2,292**	1,739
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations	7	**(4,278)**	8,869	**(4,278)**	8,949
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(1,163)**	8,805	**(1,986)**	10,688
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Non-controlling interest, and		**46**	10	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**3,069**	(74)	**2,292**	1,739
TOTAL		**3,115**	(64)	**2,292**	1,739
(b) Total comprehensive (expense)/ income for the year attributable to:					
(i) Non-controlling interest, and		**46**	10	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(1,209)**	8,795	**(1,986)**	10,688
TOTAL		**(1,163)**	8,805	**(1,986)**	10,688

The notes on pages 5 to 59 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2024

	Note	Group 31 March 2024 £000	Group 31 March 2023 £000	Trust 31 March 2024 £000	Trust 31 March 2023 £000
NON-CURRENT ASSETS					
Intangible assets	14	**7,762**	6,967	**7,762**	6,967
Property, plant and equipment	15	**205,630**	181,572	**204,873**	179,333
Right of use assets	16	**6,382**	4,805	**4,375**	2,587
Investments in joint ventures	33	**331**	300	**331**	300
Other investments	17	**9,143**	8,245	**500**	500
Other financial assets	18	**2,907**	2,658	**3,577**	3,900
Receivables	21	**324**	402	**324**	402
Total non-current assets		**232,479**	204,949	**221,742**	193,989
CURRENT ASSETS					
Inventories	20	**8,628**	7,955	**6,477**	6,098
Receivables	21	**33,179**	23,607	**32,872**	21,445
Investments	17	**460**	123	**-**	-
Other financial assets	18	**-**	-	**537**	654
Non-current assets held for sale	19	**1,415**	-	**-**	
Cash and cash equivalents	22	**16,963**	33,179	**10,638**	27,455
Total current assets		**60,645**	64,864	**50,524**	55,652
Total assets		**293,124**	269,813	**272,266**	249,641
CURRENT LIABILITIES					
Trade and other payables	23	**(51,796)**	(56,668)	**(49,338)**	(54,258)
Borrowings	24	**(8,168)**	(2,000)	**(7,486)**	(1,488)
Provisions	25	**(444)**	(475)	**(444)**	(475)
Total current liabilities		**(60,408)**	(59,143)	**(57,268)**	(56,221)
Total assets less current liabilities		**232,716**	210,670	**214,998**	193,420
NON-CURRENT LIABILITIES					
Borrowings	24	**(30,102)**	(17,668)	**(29,064)**	(16,275)
Provisions	25	**(490)**	(594)	**(490)**	(594)
Total non-current liabilities		**(30,592)**	(18,262)	**(29,554)**	(16,869)
TOTAL ASSETS EMPLOYED		**202,124**	192,408	**185,444**	176,551
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	34	**120,382**	99,600	**120,382**	99,600
Revaluation reserve		**80,451**	84,729	**80,451**	84,729
Income and expenditure reserve		**(14,174)**	(6,173)	**(15,389)**	(7,778)
Charitable fund reserves	35	**15,329**	14,162	**-**	-
OTHERS' EQUITY					
Minority Interest		**136**	90	**-**	-
TOTAL TAXPAYERS' AND OTHERS' EQUITY		**202,124**	192,408	**185,444**	176,551

The notes on pages 5 to 59 form an integral part of these financial statements.
The financial statements on pages 1 to 59 were approved by the Board on 28 June 2024 and signed on its behalf by:

Signed:

L. Thomas.

Lisa Thomas - Interim Chief Executive

STATEMENT OF CHANGES IN EQUITY

		Trust				Subsidiary		Charitable Fund	Group
	Note	Public dividend capital (PDC) £000	Income and expenditure reserve £000	Revaluation reserve £000	Trust Reserves £000	Income & expenditure Reserves £000	Minority interest £000	Charitable Funds reserve £000	Total taxpayers' equity £000
Taxpayers' and Others' Equity at 1 April 2022		94,826	(10,673)	75,780	159,933	1,434	80	16,226	177,673
Changes in equity for 2022/23									
Implementation of IFRS 16 on leases (excl. PFI) at 1 April 2022		-	1,156	-	**1,156**	-	-	-	**1,156**
Retained surplus/(deficit) for the year		-	1,739	-	**1,739**	171	10	(1,984)	**(64)**
Net gain/(loss) on revaluation of property plant and equipment	15.2	-	-	8,949	**8,949**	-	-	-	**8,949**
Revaluations and impairments - charitable fund assets	15.2	-	-	-	**-**	-	-	(80)	**(80)**
Public dividend capital received in year	34	4,774	-	-	**4,774**	-	-	-	**4,774**
Balance at 31 March 2023		**99,600**	**(7,778)**	**84,729**	**176,551**	**1,605**	**90**	**14,162**	**192,408**
Changes in equity for 2023/24									
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	29.7	-	(9,903)	-	**(9,903)**	-	-	-	**(9,903)**
Retained surplus/(deficit) for the year		-	2,292	-	**2,292**	(390)	46	1,167	**3,115**
Impairment of property plant and equipment	7	-	-	(4,441)	**(4,441)**	-	-	-	**(4,441)**
Net gain/(loss) on revaluation of property plant and equipment	15.1	-	-	163	**163**	-	-	-	**163**
Public dividend capital received in year	34	20,782	-	-	**20,782**	-	-	**-**	**20,782**
Balance at 31 March 2024		**120,382**	**(15,389)**	**80,451**	**185,444**	**1,215**	**136**	**15,329**	**202,124**

The notes on pages 5 to 59 form an integral part of these financial statements.

STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2024

	Note	Group 2024 £000	Group 2023 £000	Trust 2024 £000	Trust 2023 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus		**11,057**	6,099	**11,323**	7,613
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	6	**14,955**	14,553	**14,274**	13,759
Impairments	6	**669**	-	**669**	-
Income recognised in respect of capital donations - NHS Charity		**(828)**	(2,308)	**(828)**	(2,308)
Income recognised in respect of capital donations - Other		**(10,326)**	(1,116)	**(10,326)**	(1,116)
(Increase) in trade and other receivables	21	**(9,315)**	(9,324)	**(11,080)**	(8,057)
(Increase)/ decrease in inventories	20	**(673)**	(16)	**(379)**	213
(Decrease)/ increase in trade and other payables	23	**(12,802)**	14,430	**(12,818)**	13,333
(Decrease) in provisions	25	**(139)**	(1,058)	**(139)**	(1,058)
Movements in charitable fund working capital		**8**	209	**-**	-
Net cash (outflow)/ inflow from operating activities		**(7,394)**	21,469	**(9,304)**	22,379
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**1,058**	752	**1,130**	802
Payments to acquire property, plant and equipment	15	**(32,539)**	(24,210)	**(32,502)**	(24,109)
Receipt of cash donations to purchase capital assets		**10,326**	-	**10,326**	-
Payments to acquire intangible assets	14	**(3,673)**	-	**(3,673)**	-
NHS charitable funds - net cash flows from investing activities		**111**	58	**-**	-
Net cash (outflow) from investing activities		**(24,717)**	(23,400)	**(24,719)**	(23,307)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	**20,782**	4,774	**20,782**	4,774
Loans received	24	**5,011**	-	**5,011**	-
Loan repayment received		**-**	-	**689**	1,053
Movement in loans from the Department of Health and Social Care		**(631)**	(631)	**(631)**	(631)
Capital element of lease liability repayments		**(805)**	(1,030)	**(249)**	(382)
Capital element of Private Finance Initiative obligations	29	**(1,296)**	(612)	**(1,296)**	(612)
Interest paid		**(24)**	(34)	**(24)**	(34)
Interest element of lease liability repayments		**(87)**	(64)	**(21)**	(5)
Interest element of Private Finance Initiative obligations	29	**(1,892)**	(2,126)	**(1,892)**	(2,126)
PDC dividend paid		**(5,163)**	(4,473)	**(5,163)**	(4,473)
Net cash inflow/ (outflow) from financing		**15,895**	(4,196)	**17,206**	(2,436)
(Decrease) in cash and cash equivalents		**(16,216)**	(6,127)	**(16,817)**	(3,364)
Cash and cash equivalents at the beginning of the financial year		**33,179**	39,306	**27,455**	30,819
Cash and cash equivalents at the end of the financial year	22	**16,963**	33,179	**10,638**	27,455

The notes on pages 5 to 59 form an integral part of these financial statements.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

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

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Going concern

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

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

1.3 Critical accounting estimates and judgements

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Basis of Consolidation

1.4.1 NHS Charitable Fund

The Trust is the Corporate Trustee to Salisbury District Hospital Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

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

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

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

1.4.2 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

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

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

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

1.4.3 Associates

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

1.4.4 Joint ventures

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

Joint ventures are accounted for using the equity method.

1.4.5 Joint operations

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition

1.5.1 Revenue from contracts with customers

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

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

Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

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

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

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

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

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

1.5.2 Other forms of income

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Expenditure on employee benefits

1.6.1 Short-term employee benefits

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

1.6.2 Pension costs

NHS Pension Scheme

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

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

National Employment Savings Trust (NEST)

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

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

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

Subsidiary pension scheme

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

These schemes comply with legislative requirements.

1.7 Expenditure on goods and services

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.8 Intangible assets

1.8.1 Recognition

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

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

Software

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

1.8.2 Measurement

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

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

Amortisation

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

Useful lives of intangible assets

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

Software 1 - 7 Years

1.9 Property, plant and equipment

1.9.1 Recognition

Property, plant and equipment is capitalised where:

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

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

1.9.2 Measurement

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

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

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

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

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Depreciation

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

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

Useful lives of property, plant and equipment

Items of property, plant and equipment are depreciated in a straight line over their remaining useful lives, as follows:

Buildings (excluding dwellings)	4 - 68 years
Dwellings	6 - 57 years
Plant and Machinery	1 - 15 years
Transport equipment	3 - 10 years
Information Technology	1 - 10 years
Furniture and Fittings	5 - 15 years

Revaluation gains and losses

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

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

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

Impairments

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

1.9.3 De-recognition

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

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

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

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

1.9.4 Donated, government grant and other grant funded assets

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

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

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

1.9.5 Private Finance Initiative (PFI) transactions

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

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

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment.

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Initial application of IFRS16 liability measurement principles to PFI liabilities

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

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

Lifecycle replacement

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

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

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

Assets contributed by the Trust to the operator for use in the scheme

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

Other assets contributed by the Trust to the operator

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

1.10 Investments

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

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

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Inventories

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

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

1.13 Cash and cash equivalents

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

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

1.14 Financial assets and financial liabilities

1.14.1 Recognition

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

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

1.14.2 Classification and measurement

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

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

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

Financial liabilities are classified as subsequently measured at amortised cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14.3 Financial assets and financial liabilities at amortised cost

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

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

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

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

1.14.4 Impairment of financial assets

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

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

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

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

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

1.14.5 De-recognition

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases

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

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

1.15.1 The Trust as lessee

Initial recognition and measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust’s incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.721% to new leases commencing in 2024.

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

Subsequent measurement

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases (continued)

1.15.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

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

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

1.15.3 Initial application of IFRS 16 in 2022/23

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

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

The Trust as lessee
For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

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

The Trust as lessor
Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Provisions

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

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

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are 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 2024:

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

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

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

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

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

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

A Contingent liability is disclosed unless the probability of a transfer of economic benefits is remote.

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

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Public dividend capital

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

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

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

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

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

1.19 Value Added Tax

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

1.20 Corporation Tax

The Trust does not have a corporation tax liability for the year 2023/24 (2022/23 £nil). Tax may be payable by the Trust on activities described below:

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

The Trust's subsidiary companies have made a modest profit leading to a corporation tax liability of £80k (2022/23: £34k).

1.21 Climate change levy

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

1.22 Foreign exchange

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

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

• monetary items are translated at the spot exchange rate on 31 March

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.22 Foreign exchange (continued)

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

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

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

1.23 Third party assets

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

1.24 Losses and Special Payments

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

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

1.25 Gifts

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

1.26 Transfers of functions to other NHS bodies

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

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

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

NOTES TO THE ACCOUNTS

1.27 Early adoption of standards, amendments and interpretations

IFRS 17 Insurance Contracts - Applies to accounting periods beginning on or after January 2021. The standard is not yet adopted by the FReM which is expected from April 2025.

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.

Neither standard is expected to have a material impact on the accounts.

2. Segmental Analysis

Group and Trust

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

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities

3.1 Revenue by Nature

	Group and Trust	
	2023/24	2022/23
	£000	£000
Income from commissioners under API contracts - fixed and variable elements*	**253,981**	257,252
High cost drugs income from commissioners	**24,397**	23,908
Other NHS clinical income	**29,895**	5,007
Total revenue at full tariff	**308,273**	286,167
Private patient revenue	**2,607**	2,583
Elective recovery fund	**-**	7,919
Agenda for change pay award central funding**	**174**	6,740
Additional pension contribution central funding***	**9,148**	8,062
Other clinical income	**12,726**	5,257
Total income from patient care activities	**332,928**	316,728

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 National tariff payments system documentation.
https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

Other types of activity revenue above includes amounts due for specialist services such as community and hospice services.

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

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

3.2 Revenue by Source

	Group and Trust	
	2023/24	2022/23
	£000	£000
NHS England	**66,833**	68,745
Clinical commissioning groups	**-**	51,231
Integrated Care Boards	**250,384**	182,987
Department of Health and Social Care	**51**	39
Other NHS providers	**6,395**	5,007
NHS other	**585**	592
Local authorities	**1,630**	1,724
Non NHS:		
- Private patients	**2,607**	2,451
- Overseas patients (chargeable to patient)	**349**	132
- NHS Injury cost recovery scheme	**751**	906
- Other	**3,343**	2,914
	332,928	316,728

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 23.07% (2023: 24.86%) to reflect expected rates of collection. The doubtful debt provision is included in the allowance for impaired contract receivables included in note 21.3.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities (continued)

3.3 Commissioner requested services

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

	Group and Trust	
	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	**316,248**	293,874
Income from services not designated as commissioner requested services	**16,680**	22,854
	332,928	316,728

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

	Group and Trust	
	2023/24	2022/23
	£000	£000
Income recognised this year	**349**	132
Cash payments received in-year	**162**	75
Amounts added to provision for impairment of receivables	**-**	-
Amounts written off in-year	**97**	3

3.5 Additional information on contract revenue (IFRS 15) recognised in the period

	Group and Trust	
	2023/24	2022/23
	£000	£000
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**240**	161

3.6 Transaction price allocated to remaining performance obligations

	Group and Trust	
	2023/24	2022/23
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	**1,334**	1,334
after one year, not later than five years	**2,668**	4,002
after five years	**-**	-
Total revenue allocated to remaining performance obligations	**4,002**	5,336

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

NOTES TO THE ACCOUNTS

4. Other operating revenue

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Reimbursement and top up funding	**-**	1,229	**-**	1,229
Research and development	**870**	862	**870**	862
Education and training	**11,320**	10,400	**11,320**	10,400
Non-patient care services to other bodies	**4,226**	4,855	**4,226**	4,855
Received from other bodies- donated assets	**10,326**	184	**10,326**	184
Received from NHS charities - donated assets	**-**	-	**828**	2,308
Contributions to expenditure - from other bodies	**152**	-	**152**	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**169**	619	**169**	619
Peppercorn leased assets recognised	**-**	932	**-**	932
Revenue from laundry services	**10,493**	11,954	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**1,581**	1,803	**-**	-
Odstock Medical Limited	**3,185**	2,632	**-**	-
Accommodation	**1,559**	1,383	**1,559**	1,383
Administrative services provided to Sterile Supplies Limited	**313**	198	**313**	198
Car Parking	**1,682**	792	**1,682**	792
Catering	**868**	693	**868**	693
Payroll services provided to other organisations	**2,443**	2,180	**2,443**	2,180
Other	**2,721**	4,110	**4,243**	4,571
	51,908	44,826	**38,999**	31,206

Included within 'Other' revenue above are: Covid mass vaccination centre income £223k (2022/23: £1,750k), Royalty Income £106k (2022/23: £475k), procurement framework income re: apprenticeships £1,424k (2022/23: £475k), Leisure Centre income £172k (2022/23: £148k), income from the rent and hire of rooms £144k (2022/23: £118k), cancer transformation £26k (2022/23: £606k) and overseas recruitment £526k (2022/23: £468k).

Donated asset income received from other bodies includes a £10.0m grant from Salix Finance (a non-departmental public body, wholly owned by the UK government) for a decarbonisation project at the hospital and a £0.3m donation from The HELP Appeal, a charity registered in England and Wales, to make improvements to the hospital helicopter landing pad. All donated assets are recognised as capital additions in note 15.

5. Operating lease income

5.1 As lessor

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

5.2 Receipts recognised as income

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**119**	113	**283**	277

NOTES TO THE ACCOUNTS

5. Operating lease income (continued)

5.3 Total future lease income

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
Future minimum lease receipts due at 31 March:	**£000**	£000	**£000**	£000
- not later than one year	**136**	105	**170**	213
- later than one year and not later than two years	**145**	120	**187**	170
- later than two years and not later than three years	**145**	137	**145**	187
- later than three years and not later than four years	**145**	145	**145**	145
- later than four years and not later than five years	**145**	145	**145**	145
- later than five years	**230**	367	**222**	367
Total	**946**	1,019	**1,014**	1,227

6. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**4,457**	4,225	**4,457**	4,225
Purchase of healthcare from non-NHS and non-DHSC bodies	**5,080**	3,569	**5,080**	3,569
Staff and executive directors costs	**242,038**	226,936	**234,506**	218,532
Non-executive directors	**168**	156	**168**	156
Supplies and services – clinical (excluding drugs costs)	**26,998**	29,508	**25,632**	28,244
Supplies and services - general	**4,441**	4,512	**2,907**	3,124
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**32,087**	29,305	**32,087**	29,305
Inventories written down	**66**	-	**66**	-
Consultancy costs	**126**	280	**126**	280
Establishment	**5,482**	5,490	**5,482**	5,490
Premises	**21,191**	21,364	**20,502**	19,725
Transport	**2,119**	1,872	**1,627**	1,356
Depreciation on property, plant and equipment and right of use assets	**12,077**	11,629	**11,396**	10,835
Amortisation on intangible assets	**2,878**	2,924	**2,878**	2,924
Impairments net of (reversals)	**669**	-	**669**	-
Movement in credit loss allowance: contract receivables / contract assets	**17**	342	**17**	342
Provisions arising /(released) in year	**17**	84	**17**	84
Change in provisions discount rate(s)	**(5)**	(27)	**(5)**	(27)
Audit fees payable to the external auditor				
audit services- statutory audit	**223**	150	**223**	150
Internal audit costs	**188**	126	**188**	126
Clinical negligence	**7,038**	6,756	**7,038**	6,756
Legal fees	**200**	25	**200**	25
Insurance	**413**	213	**413**	213
Research and development	**36**	76	**36**	76
Education and training	**2,685**	2,665	**2,685**	2,665
Charges to operating expenditure for on-SoFP PFI scheme	**1,290**	1,166	**1,290**	1,166
Other NHS charitable fund resources expended	**593**	1,052	**-**	-
Other	**1,207**	1,057	**919**	980
	373,779	355,455	**360,604**	340,321

The total employer's pension contributions are disclosed in note 8.1

There were no Redundancy payments in either 2024 or 2023.

There is a limitation on the Auditor's liability of £1.0m (2022/23: £2.0m). The fees payable to auditors for the statutory audit and additional services above are quoted gross of VAT at 20%, reflecting the Trust's inability to reclaim VAT on this type of expenditure.

Other expenses include professional fees associated with the hospital site development £0.2m (2022/23: £0.1m) and professional accounting and VAT advisers £0.2m (2022/23: £0.3m)

NOTES TO THE ACCOUNTS

7. Impairment of assets

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Net impairments charged to operating surplus / deficit resulting from:				
Other	**669**	-	**669**	-
Total net impairments charged to operating surplus / deficit	**669**	-	**669**	-
Impairments charged to the revaluation reserve	**4,441**	-	**4,441**	
Total net impairments	**5,110**	-	**5,110**	-

Other impairments relates to the write down to depreciated replacement cost of a refurbished building brought into use following its first professional valuation after completion of the work.

8. Employee benefits

8.1 Staff costs

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Salaries and wages	**182,910**	169,646	**176,036**	163,028
Social security costs	**18,250**	17,013	**18,250**	17,013
Apprenticeship levy	**922**	789	**922**	789
Employer's contributions to NHS pensions	**30,277**	26,684	**30,277**	26,564
Pension cost - other	**28**	42	**28**	42
Temporary staff (including agency)	**12,014**	13,666	**11,356**	12,000
Total gross staff costs	**244,401**	227,840	**236,869**	219,436
Of which				
Costs capitalised as part of assets	**2,363**	904	**2,363**	904

NOTES TO THE ACCOUNTS

8. Employee benefits (continued)

8.2 Directors' remuneration

	Group and Trust	
	2023/24	2022/23
	£000	£000
Salaries and wages	**1,063**	1,038
Social Security Costs	**130**	134
Employer contributions to Pension Schemes	**173**	168
	1,366	1,340

The total number of Directors accruing benefits under pension schemes is 6 (2022/23: 6). The Directors Remuneration only relates to the Group.

9. Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution schemes for Odstock Medical Limited and Salisbury Trading Limited was £21.1m (2022/23: £18.6m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf (6.3%), as at 31 March 2024 (and 2023), contributions of £3.05m (2022/23: £2.90m) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

9.1 NHS Pension Schemes

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

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

a) Accounting valuation

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

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

NOTES TO THE ACCOUNTS

9. Pension costs (continued)

b) Full actuarial (funding) valuation

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

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

10. Retirements due to ill-health

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

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

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

During the year to 31 March 2024 there was 1 (2022/23: 6) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £42k (2022/23: £477k). The cost of the 2023/24 ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

NOTES TO THE ACCOUNTS

11. Finance income

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Interest on bank accounts	**1,064**	756	**1,064**	756
Interest on other investments / financial assets	**248**	162	**353**	256
NHS charitable fund investment income	**253**	164	**-**	-
	1,565	1,082	**1,417**	1,012

12. Finance expenditure

	Group		Trust	
	2023/24	2022/23	**2023/24**	2022/23
	£000	£000	**£000**	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	**20**	30	**20**	30
Interest on lease obligations	**87**	64	**21**	5
Finance costs on PFI obligations:				
Main finance costs on PFI obligations	**1,892**	1,061	**1,892**	1,061
Contingent finance costs on PFI obligations	**-**	1,065	**-**	1,065
Remeasurement of the liability resulting from change in index or rate*	**3,422**	-	**3,422**	-
Total interest expense	**5,421**	2,220	**5,355**	2,161
Unwinding of discounts on provisions	**4**	(2)	**4**	(2)
Total finance costs	**5,425**	2,218	**5,359**	2,159

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 29.

13. Losses and special payments

	Group and Trust			
	2023/24		2022/23	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Cash losses	**-**	**-**	1	1
Bad debts and claims abandoned	**94**	**133**	140	26
Stores losses	**-**	**-**	4	1
	94	**133**	145	28
Special payments				
Ex-gratia payments	**18**	**7**	40	45
	18	**7**	40	45
Total losses and special payments	**112**	**140**	185	73

There were no case payments that exceeded £0.1m.

NOTES TO THE ACCOUNTS

14. Intangible Assets

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

Group and Trust

	Assets under Construction £000	Software Licences £000	Total £000
Cost or valuation			
At 1 April 2023	2,254	18,704	20,958
Additions - purchased	3,673	-	3,673
Reclassifications	(235)	235	-
At 31 March 2024	**5,692**	**18,939**	**24,631**
Amortisation			
At 1 April 2023	-	13,991	13,991
Provided during the period	-	2,878	2,878
Amortisation at 31 March 2024	**-**	**16,869**	**16,869**
Net book value at 31 March 2024			
- Purchased at 31 March 2024	5,692	2,070	7,762
Total at 31 March 2024	**5,692**	**2,070**	**7,762**
Cost or valuation			
At 1 April 2022	3,306	17,869	21,175
Reclassifications	(1,052)	1,052	-
Disposals	-	(217)	(217)
At 31 March 2023	**2,254**	**18,704**	**20,958**
Amortisation			
At 1 April 2022	-	11,279	11,279
Provided during the period	-	2,924	2,924
Disposals	-	(212)	(212)
Amortisation at 31 March 2023	**-**	**13,991**	**13,991**
Net book value at 31 March 2023			
- Purchased at 31 March 2023	2,254	4,713	6,967
Total at 31 March 2023	**2,254**	**4,713**	**6,967**

NOTES TO THE ACCOUNTS

15. Property, plant and equipment

Group

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2023	2,420	124,245	7,864	16,660	49,062	110	14,692	3,453	218,506
Additions - purchased	-	-	-	30,111	-	-	-	-	30,111
Additions - donated	-	-	-	11,154	-	-	-	-	11,154
Impairments	-	(669)	-	-	-	-	-	-	(669)
Reclassifications	-	10,269	279	(17,629)	5,156	-	1,735	190	-
Revaluation	210	(9,134)	(266)	-	-	-	-	-	(9,190)
Transfer to assets held for sale	(559)	-	(873)	-	-	-	-	-	(1,432)
Disposals	-	-	-	-	(1,392)	-	(36)	(25)	(1,453)
At 31 March 2024	**2,071**	**124,711**	**7,004**	**40,296**	**52,826**	**110**	**16,391**	**3,618**	**247,027**
Accumulated depreciation									
At 1 April 2023	-	-	-	-	26,038	50	8,259	2,587	36,934
Provided during the period	-	4,693	236	-	3,640	11	1,826	248	10,654
Revaluation	-	(4,693)	(219)	-	-	-	-	-	(4,912)
Transfer to assets held for sale	-	-	(17)	-	-	-	-	-	(17)
Disposals	-	-	-	-	(1,204)	-	(36)	(22)	(1,262)
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**28,474**	**61**	**10,049**	**2,813**	**41,397**
Net book value at 31 March 2023									
Owned	2,420	101,080	7,864	16,660	22,347	60	6,433	866	157,730
On balance sheet PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	-	-	-	677	-	-	-	677
Total at 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**23,024**	**60**	**6,433**	**866**	**181,572**
Net book value at 31 March 2024									
Owned	2,071	101,577	7,004	29,970	23,749	49	6,342	805	171,567
On-SoFP PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	-	-	10,326	603	-	-	-	10,929
Total at 31 March 2024	**2,071**	**124,711**	**7,004**	**40,296**	**24,352**	**49**	**6,342**	**805**	**205,630**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a full revaluation at 31 December 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £669k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £4,278k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Group

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2022	2,401	116,709	7,938	6,007	48,530	110	13,351	3,369	198,415
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(1,782)	-	(1,943)	-	(3,725)
Transfers by absorption	-	-	-	-	(952)	-	(206)	-	(1,158)
Additions - purchased	-	-	-	20,376	-	-	-	-	20,376
Additions - donated	-	-	-	-	2,492	-	-	-	2,492
Reclassifications	-	3,284	8	(9,723)	2,857	-	3,490	84	-
Revaluation	19	4,252	(82)	-	-	-	-	-	4,189
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
At 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**49,062**	**110**	**14,692**	**3,453**	**218,506**
Accumulated depreciation									
At 1 April 2022	-	220	-	-	25,098	39	8,292	2,347	35,996
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(108)	-	(1,263)	-	(1,371)
Transfers by absorption	-	-	-	-	(637)	-	(197)	-	(834)
Provided during the period	-	4,224	236	-	3,768	11	1,427	240	9,906
Revaluation	-	(4,444)	(236)	-	-	-	-	-	(4,680)
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**26,038**	**50**	**8,259**	**2,587**	**36,934**
Net book value at 31 March 2022									
Owned	2,401	94,593	7,938	6,007	21,592	71	4,379	1,022	138,003
Finance leased	-	-	-	-	1,286	-	680	-	1,966
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	-	-	-	554	-	-	-	554
Total at 31 March 2022	**2,401**	**116,489**	**7,938**	**6,007**	**23,432**	**71**	**5,059**	**1,022**	**162,419**
Net book value at 31 March 2023									
Owned	2,420	101,080	7,864	16,660	22,347	60	6,433	866	157,730
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	-	-	-	677	-	-	-	677
Total at 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**23,024**	**60**	**6,433**	**866**	**181,572**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a destop valuation using indices of the Trust's land and buildings as at 31 March 2023. The valuation was carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The net revaluation movement was £8,869k. Of this £8,949k has been credited to the revaluation reserve and £80k charged to the charitable funds reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2023	1,460	124,245	6,991	16,561	46,753	110	14,692	3,453	214,265
Additions - purchased	-	-	-	30,074	-	-	-	-	30,074
Additions - donated	-	-	-	11,154	-	-	-	-	11,154
Impairments	-	(669)	-	-	-	-	-	-	(669)
Reclassifications	-	10,269	279	(17,592)	5,119	-	1,735	190	-
Revaluation	210	(9,134)	(266)	-	-	-	-	-	(9,190)
Disposals	-	-	-	-	(1,382)	-	(36)	(25)	(1,443)
At 31 March 2024	**1,670**	**124,711**	**7,004**	**40,197**	**50,490**	**110**	**16,391**	**3,618**	**244,191**
Accumulated depreciation									
At 1 April 2023	-	-	-	-	24,046	50	8,259	2,587	34,942
Provided during the period	-	4,693	219	-	3,553	11	1,826	248	10,550
Revaluation	-	(4,693)	(219)	-	-	-	-	-	(4,912)
Disposals	-	-	-	-	(1,204)	-	(36)	(22)	(1,262)
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**26,395**	**61**	**10,049**	**2,813**	**39,318**
Net book value at 31 March 2023									
Owned	1,460	95,360	6,991	16,561	22,717	60	6,433	866	150,448
On balance sheet PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	5,720	-	-	-	-	-	-	5,720
Total at 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**22,717**	**60**	**6,433**	**866**	**179,333**
Net book value at 31 March 2024									
Owned	1,670	95,952	7,004	29,871	23,492	49	6,342	805	165,185
On-SoFP PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	5,625	-	10,326	603	-	-	-	16,554
Total at 31 March 2024	**1,670**	**124,711**	**7,004**	**40,197**	**24,095**	**49**	**6,342**	**805**	**204,873**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a full revaluation at 31 December 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £669k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £4,278k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2022	1,460	116,709	6,941	6,007	44,677	110	13,351	3,369	192,624
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(228)	-	(1,943)	-	(2,171)
Transfers by absorption	-	-	-	-	(952)	-	(206)	-	(1,158)
Additions - purchased	-	-	-	20,267	-	-	-	-	20,267
Additions - donated	-	-	-	-	2,492	-	-	-	2,492
Reclassifications	-	3,284	8	(9,713)	2,847	-	3,490	84	-
Revaluation	-	4,252	42	-	-	-	-	-	4,294
Disposals	-	-	-	-	(2,073)	-	-	-	(2,073)
At 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**46,763**	**110**	**14,692**	**3,453**	**214,275**
Accumulated depreciation									
At 1 April 2022	-	220	-	-	23,204	39	8,292	2,347	34,102
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(108)	-	(1,263)	-	(1,371)
Transfers by absorption	-	-	-	-	(637)	-	(197)	-	(834)
Provided during the period	-	4,224	211	-	3,670	11	1,427	240	9,783
Revaluation	-	(4,444)	(211)	-	-	-	-	-	(4,655)
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**24,046**	**50**	**8,259**	**2,587**	**34,942**
Net book value at 31 March 2022									
Owned	1,460	89,049	6,941	6,007	18,792	71	4,358	804	127,482
Finance leased	-	-	-	-	120	-	680	-	800
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	5,544	-	-	2,571	-	21	218	8,354
Total at 31 March 2022	**1,460**	**116,489**	**6,941**	**6,007**	**21,483**	**71**	**5,059**	**1,022**	**158,532**
Net book value at 31 March 2023									
Owned	1,460	95,360	6,991	16,561	22,717	60	6,433	866	150,448
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	5,720	-	-	-	-	-	-	5,720
Total at 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**22,717**	**60**	**6,433**	**866**	**179,333**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a destop valuation using indices of the Trust's land and buildings as at 31 March 2023. The valuation was carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The net revaluation movement of £8,949k has been credited to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity).

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases rooms in medical centres/ practices to provide outreach clinics closer to the population it serves, vehicles for staff visiting these sites as well as patients in their own homes, commercial vehicles for site management, a computer server environment and medical equipment provided as part of managed service agreements. The subsidiary company, Salisbury Trading Limited, is purchasing through a leasing arrangement new laundry equipment as well as the hire of commercial premises for production and storage of laundered items and vehicles for delivery.

16.1 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 1 April 2023	1,067	3,897	992	1,943	-	7,899	-
							-
Additions - leases	362	2,537	515	-	-	3,414	25
Disposals / derecognition	-	-	(546)	-	-	(546)	-
At 31 March 2024	**1,429**	**6,434**	**961**	**1,943**	**-**	**10,767**	**25**
Accumulated depreciation							
At 1 April 2023	301	853	288	1,652	-	3,094	-
							-
Provided during the year	260	631	241	291	-	1,423	2
Disposals / derecognition	-	-	(132)	-	-	(132)	-
Accumulated depreciation at 31 March 2024	**561**	**1,484**	**397**	**1,943**	**-**	**4,385**	**2**
Net book value at 31 March 2024	**868**	**4,950**	**564**	**-**	**-**	**6,382**	**23**

NOTES TO THE ACCOUNTS

16.2 Right of use assets - 2022/23

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	1,782	-	1,943	-	3,725	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	947	1,166	390	-	-	2,503	-
Additions - leases	120	17	602	-	-	739	-
Additions - peppercorn leases	-	932	-	-	-	932	-
At 31 March 2023	**1,067**	**3,897**	**992**	**1,943**	**-**	**7,899**	**-**
Accumulated depreciation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	108	-	1,263	-	1,371	-
Provided during the year	301	745	288	389	-	1,723	-
Accumulated depreciation at 31 March 2023	**301**	**853**	**288**	**1,652**	**-**	**3,094**	**-**
Net book value at 31 March 2023	**766**	**3,044**	**704**	**291**	**-**	**4,805**	**-**

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.3 Right of use assets - 2023/24

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 1 April 2023	595	2,335	138	1,943	-	5,011	-
Additions - leases	90	2,528	17	-	-	2,635	25
At 31 March 2024	**685**	**4,863**	**155**	**1,943**	**-**	**7,646**	**25**
Accumulated depreciation							
At 1 April 2023	88	630	54	1,652	-	2,424	-
Provided during the year	105	407	44	291	-	847	2
Accumulated depreciation at 31 March 2024	**193**	**1,037**	**98**	**1,943**	**-**	**3,271**	**2**
Net book value at 31 March 2024	**492**	**3,826**	**57**	**-**	**-**	**4,375**	**23**

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.4 Right of use assets - 2022/23

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	228	-	1,943	-	2,171	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	475	1,158	129	-	-	1,762	-
Additions - leases	120	17	9	-	-	146	-
Additions - peppercorn leases	-	932	-	-	-	932	-
At 31 March 2023	**595**	**2,335**	**138**	**1,943**	**-**	**5,011**	**-**
Accumulated depreciation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	108	-	1,263	-	1,371	-
Provided during the year	88	522	54	389	-	1,053	-
Accumulated depreciation at 31 March 2023	**88**	**630**	**54**	**1,652**	**-**	**2,424**	**-**
Net book value at 31 March 2023	**507**	**1,705**	**84**	**291**	**-**	**2,587**	**-**

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.5 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.

	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£'000	£'000	**£'000**	£'000
Carrying value at 1 April	**2,513**	1,457	**608**	291
IFRS 16 implementation - adjustments for existing operating leases	**-**	1,347	**-**	613
Lease additions	**3,414**	739	**2,635**	145
Interest charge arising in year	**87**	64	**21**	5
Early terminations	**(408)**	-	**-**	-
Lease payments (cash outflows)	**(892)**	(1,094)	**(270)**	(446)
Carrying value at 31 March	**4,714**	**2,513**	**2,994**	**608**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

16.6 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Undiscounted future lease payments payable in:				
- not later than one year;	**1,101**	728	582	138
- later than one year and not later than five years;	**3,296**	1,538	1,918	221
- later than five years.	**1,163**	508	1,182	297
Total gross future lease payments	**5,560**	2,774	**3,682**	656
Finance charges allocated to future periods	**(846)**	(261)	(688)	(48)
Net lease liabilities at 31 March	**4,714**	2,513	**2,994**	608
Of which:				
- Leased from other NHS providers	**-**	**-**	-	-
- Leased from other DHSC group bodies	**23**	**-**	23	-

NOTES TO THE ACCOUNTS

17. Investments

Non-current	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Carrying value at 1 April	**8,245**	8,225	500	-
Additions	**4,674**	3,160	-	500
Fair value gains/ (losses) taken to I & E	**1,093**	(300)	-	-
Disposals	**(4,869)**	(2,840)	-	-
Carrying value at 31 March	**9,143**	8,245	**500**	500
Current				
Financial assets designated at amortised cost	**460**	123	**-**	-

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

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

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also note 18.

Fair value measurement of investments

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

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

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

NOTES TO THE ACCOUNTS

18. Other financial assets

Non-current	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,658**	2,497	**3,900**	4,006
Transfer (to)/ from current assets	**-**	-	**117**	1,286
Amortisation at the effective interest rate	**249**	161	**249**	161
Loan converted to share capital	**-**	-	**-**	(500)
Repayments in year	**-**	-	**(689)**	(1,053)
Carrying value at 31 March	**2,907**	2,658	**3,577**	3,900

Current				
Carrying value at 1 April	**-**	-	**654**	1,940
Transfer from/ (to) non-current assets	**-**	-	**(117)**	(1,286)
Carrying value at 31 March	**-**	-	**537**	654

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

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

Details of the loans to Salisbury Trading Limited are as follows:

1. £1.3m to purchase the laundry stock.
2. £2.0m to purchase the laundry equipment.
3. £0.5m to purchase laundry stocks.
4. £0.7m to purchase laundry stock.
5. £0.5m to purchase laundry stock to assist with the Covid 19 pandemic.

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

The remaining fifth loan of £0.5m at 31 March 2022 was converted into ordinary shares in Salisbury Trading Limited during 2022-23.

NOTES TO THE ACCOUNTS

18. Other financial assets (continued)

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

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

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

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

During 2023-24 Odstock Medical Limited repaid the loan and interest in full.

19. Non-current assets for sale and assets in disposal groups

	Group		**Trust**	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Net Book Value of non-current assets for sale				
Carrying value at 1 April	**-**	-	**-**	-
Assets classified as available for sale in the year	**1,415**	-	**-**	-
Carrying value at 31 March	**1,415**	-	**-**	-

The Charitable Trustees, following a review of core operations, have placed the Charity's residential properties up for sale.

NOTES TO THE ACCOUNTS

20. Inventories

	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Drugs	**2,598**	1,933	**2,598**	1,933
Consumables	**3,784**	3,784	**3,784**	3,784
Laundry and other subsidiary stock	**2,151**	1,857	**-**	-
Other	**95**	381	**95**	381
	8,628	7,955	**6,477**	6,098
Inventories recognised as an expense in the period	**62,663**	60,007	**59,778**	58,814

In response to the Covid pandemic, The Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During the year the Trust received £169k (2022/23: £619k) items free of charge.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

21. Receivables

21.1 Non-current

	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Clinician pension tax provision reimbursement funding from NHSE	**324**	402	**324**	402
	324	402	**324**	402
Of which receivables from NHS and DHSC group	**324**	402	**324**	402

21.2 Current

	Group		Trust	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Contract receivables	**28,471**	20,619	**28,022**	18,409
Allowance for impaired contract receivables / assets	**(1,151)**	(1,270)	**(1,151)**	(1,270)
Prepayments (non-PFI)	**3,731**	2,880	**3,738**	2,928
PDC dividend receivable	**292**	57	**292**	57
VAT receivable	**1,422**	1,136	**1,422**	1,136
Clinician pension tax provision reimbursement funding from NHSE	**10**	16	**10**	16
Other receivables	**404**	169	**539**	169
	33,179	23,607	**32,872**	21,445
Of which receivables from NHS and DHSC group	**19,633**	11,315	**19,633**	11,315

NOTES TO THE ACCOUNTS

21. Receivables (continued)

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

The average credit period taken on sale of goods is 33 days (2022/23: 24 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2024		31 March 2023	
	receivables and contract assets	**All other receivables**	receivables and contract assets	All other receivables
	£000	**£000**	£000	£000
Allowance for credit losses at 1 April - brought forward	**1,270**	**-**	954	-
New allowances arising	**90**	**-**	342	-
Changes in the calculation of existing allowances	**(73)**	**-**	-	-
Utilisation of allowances (write offs)	**(136)**	**-**	(26)	-
Balance at 31 March	**1,151**	**-**	1,270	-

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

22. Cash and cash equivalents

	Group		**Trust**	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Balance at beginning of year	**33,179**	39,306	**27,455**	30,819
Net change in year	**(16,216)**	(6,127)	**(16,817)**	(3,364)
Balance at end of year	**16,963**	33,179	**10,638**	27,455
Made up of:				
Cash with Government Banking Service	**10,374**	27,240	**10,374**	27,240
Cash at commercial banks and in hand	**6,589**	5,939	**264**	215
Cash and cash equivalents as in balance sheet	**16,963**	33,179	**10,638**	27,455
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**16,963**	33,179	**10,638**	27,455

NOTES TO THE ACCOUNTS

23. Trade and other payables

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
Current:				
Trade payables	**25,543**	28,342	**23,083**	25,902
Capital payable	**13,353**	5,455	**13,353**	5,455
Accruals	**1,310**	2,357	**1,310**	2,357
Receipts in advance	**2,023**	1,456	**2,023**	1,456
Social security and other taxes payable	**4,892**	4,559	**4,892**	4,559
Pay creditor re: agenda for change pay offer	**-**	7,101	**-**	7,101
Pay and pensions related	**4,169**	5,280	**4,169**	5,280
Other	**506**	2,118	**508**	2,148
	51,796	56,668	**49,338**	54,258
Of which payables from NHS and DHSC group bodies:	**9,795**	3,731	**9,795**	3,731

All Trade and other payables are current liabilities.

24. Borrowings

Group	Current		Non-current	
	31 March 2024 £000	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
Lease liabilities	**1,101**	660	**3,613**	1,853
Amounts due under PFI (note 30.7) *	**1,419**	699	**26,170**	14,865
Loans from Department of Health and Social Care (DHSC)	**637**	641	**319**	950
Other loans	**5,011**	-	**-**	-
	8,168	2,000	**30,102**	17,668

Trust	Current		Non-current	
	31 March 2024 £000	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
Lease liabilities	**419**	148	**2,575**	460
Amounts due under PFI (note 30.7) *	**1,419**	699	**26,170**	14,865
Loans from Department of Health and Social Care (DHSC)	**637**	641	**319**	950
Other loans	**5,011**	-	**-**	-
	7,486	1,488	**29,064**	16,275

* The Trust has applied IFRS 16 to PFI arrangements within these accounts from 1 April 2023 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

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

Other loans represents an interest free advance from NHS Bath and North East Somerset, Swindon and Wiltshire ICB that was repaid in the first quarter of 2024-25.

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2023/24	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	**1,591**	**-**	**2,513**	**15,564**	**19,668**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	5,011	(805)	(1,296)	**2,279**
Financing cash flows - payments of interest	(24)	-	(87)	(1,896)	**(2,007)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	-	9,903	**9,903**
Additions	-	-	3,414	-	**3,414**
Remeasurement of PFI liability resulting from change in index or rate	-	-	-	3,422	**3,422**
Application of effective interest rate	20	-	87	1,892	**1,999**
Early terminations	-	-	(408)	-	**(408)**
Carrying value at 31 March 2024	**956**	**5,011**	**4,714**	**27,589**	**38,270**

Group - 2022/23	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	**2,226**	**-**	**1,457**	**16,176**	**19,859**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(1,030)	(612)	**(2,273)**
Financing cash flows - payments of interest	(34)	-	(64)	(1,061)	**(1,159)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	1,347	-	**1,347**
Additions	-	-	739	-	**739**
Application of effective interest rate	30	-	64	1,061	**1,155**
Carrying value at 31 March 2023	**1,591**	**-**	**2,513**	**15,564**	**19,668**

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.2 Reconciliation of liabilities arising from financing activities (Trust)

Trust - 2023/24	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	**1,591**	**-**	**608**	**15,564**	**17,763**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	5,011	(249)	(1,296)	**2,835**
Financing cash flows - payments of interest	(24)	-	(21)	(1,896)	**(1,941)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	-	9,903	**9,903**
Additions	-	-	2,635	-	**2,635**
Remeasurement of PFI liability resulting from change in index or rate	-	-	-	3,422	**3,422**
Application of effective interest rate	20	-	21	1,892	**1,933**
Carrying value at 31 March 2024	**956**	**5,011**	**2,994**	**27,589**	**36,550**

Trust - 2022/23	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	**2,226**	**-**	**291**	**16,176**	**18,693**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(441)	(612)	**(1,684)**
Financing cash flows - payments of interest	(34)	-	(5)	(1,061)	**(1,100)**
Non-cash movements:					
	-	-	613	-	**613**
Additions	-	-	145	-	**145**
Application of effective interest rate	30	-	5	1,061	**1,096**
Carrying value at 31 March 2023	**1,591**	**-**	**608**	**15,564**	**17,763**

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Pensions - early departure costs	**14**	14	**12**	26
Pensions - injury benefits	**27**	25	**154**	166
Legal claims	**348**	375	**-**	-
Clinician pension tax reimbursement	**10**	16	**324**	402
Other	**45**	45	**-**	-
	444	475	**490**	594

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2023	40	191	375	418	45	**1,069**
Change in the discount rate	-	(5)	-	(72)	-	**(77)**
Arising during the year	-	17	-	-	-	**17**
Utilised during the year	(15)	(25)	(27)	(12)	-	**(79)**
Reversed unused	-	-	-	(22)	-	**(22)**
Unwinding of discount	1	3	-	22	-	**26**
At 31 March 2024	**26**	**181**	**348**	**334**	**45**	**934**
Expected timing of cash flows:						
Within 1 year	14	27	348	10	45	**444**
1 - 5 years	12	87	-	17	-	**116**
5+ years	-	67	-	307	-	**374**
	26	**181**	**348**	**334**	**45**	**934**

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2022	38	238	973	665	215	**2,129**
Change in the discount rate	-	(27)	-	(368)	-	**(395)**
Arising during the year	16	6	182	133	-	**337**
Utilised during the year	(14)	(24)	(35)	(20)	-	**(93)**
Reversed unused	-	-	(745)	-	(170)	**(915)**
Unwinding of discount	-	(2)	-	8	-	**6**
At 31 March 2023	**40**	**191**	**375**	**418**	**45**	**1,069**
Expected timing of cash flows:						
Within 1 year	14	25	375	16	45	**475**
1 - 5 years	26	88	-	19	-	**133**
5+ years	-	78	-	383	-	**461**
	40	**191**	**375**	**418**	**45**	**1,069**

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

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

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges (continued)

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

Other provisions relate to an additional tax liability following revised guidance by HMRC.

£82.1 m is included in the provisions of NHS Resolution at 31 March 2024 in respect of clinical negligence liabilities of the Trust (2022/23: £88.1 m).

26. Capital and other commitments

Capital commitments - Group and Trust

	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	1,988	3,684
Intangible assets	23	593
Total	**2,011**	4,277

27. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £0.5m (2023: £0.5m).

28. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year ended 31 March 2024 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities include Clinical Commissioning Groups, NHS England, Health Education England, NHS Resolution and other Trusts and Foundation Trusts.

Salisbury NHS Foundation Trust also has the following transactions listed below with its subsidiary companies, joint ventures, charitable funds (for which it is the Corporate Trustee) and other organisations identified as related parties by DHSC:

	Income	**Expenditure**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**
Year ending 31 March 2024				
Salisbury Trading Limited	**200**	**1,027**	**2,127**	**90**
Odstock Medical Limited	**214**	**-**	**64**	**1**
Salisbury District Hospital Charitable Fund	**867**	**39**	**144**	**-**
Sterile Supplies Limited	**313**	**2,313**	**50**	**1**
Wiltshire Health and Care LLP	**615**	**987**	**139**	**815**
Locums Nest Limited	**-**	**72**	**-**	**-**
NHS Confederation	**-**	**14**	**-**	**3**
Vyaire UK 236 Limited	**-**	**6**	**-**	**-**
Year ending 31 March 2023				
Salisbury Trading Limited	206	997	1,081	128
Odstock Medical Limited	214	-	63	1
Salisbury District Hospital Charitable Fund	1,089	39	470	-
Sterile Supplies Limited	263	2,123	1	222
Wiltshire Health and Care LLP	591	224	140	24
Locums Nest Limited	-	64	-	-

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI)

29.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services
At the end of the contract term the hospital buildings revert back to the Trust
There were no changes to the terms and conditions of the PFI agreement

Terms of the Arrangement - the unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a service fee which is subject to indexation based upon 'the Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

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

	Group and Trust	
	2024	2023
	£000	£000
Interest	**1,892**	1,061
Repayment of finance lease liability	**1,296**	612
Service element	**1,290**	1,166
Capital lifecycle maintenance	**432**	425
Contingent rent	**-**	1,065
Unitary payment payable to service concession operator	**4,910**	4,329

29.3 Annual commitments under Private Finance Transactions - On Statement of Financial Position

The Trust is committed to make the following service payments on the PFI:	**2024**	2023
	£000	£000
Due within one year	**3,223**	1,718
Due within 2 to 5 years	**13,021**	6,976
Due after 5 years	**24,548**	15,002
Gross PFI liabilities	**40,792**	23,696
Finance charges allocated to future periods	**(13,203)**	(8,132)
Net PFI liabilities	**27,589**	15,564
- not later than one year;	**1,419**	699
- later than one year and not later than five years;	**6,835**	3,413
- later than five years.	**19,335**	11,452

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

29.4 Total future payments committed in respect of PFI

Total future commitments under these on-SoFP schemes are as follows:

	2024	2023
	£000	£000
Total	**70,109**	73,244
of which due:		
Within one year	**5,164**	4,910
Within 2 to 5 years	**21,979**	20,900
Due thereafter	**42,966**	47,434
Total	**70,109**	73,244

NOTES TO THE ACCOUNTS

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

29.5 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

29.6 Impact of change in accounting policy on the allocation of unitary payment (Group and Trust)

	IFRS 16 basis (new basis) 2023/24 £000	IAS 17 basis (old basis) 2023/24 £000	Impact of change 2023/24 £000
Unitary payment payable to service concession operator			
Interest charge	1,892	1,019	873
Repayment of balance sheet obligation	1,296	699	597
Service element	1,290	1,290	-
Lifecycle maintenance	432	432	-
Contingent rent	-	1,470	(1,470)
	4,910	**4,910**	**-**

29.7 Impact of change in accounting policy on primary statements (Group and Trust)

	£000
Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:	
Increase in PFI / LIFT and other service concession liabilities	(12,728)
Decrease in PDC dividend payable / increase in PDC dividend receivable	396
Increase in cash and cash equivalents (impact of PDC dividend only)	-
Impact on net assets as at 31 March 2024	**(12,332)**

	£000
Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:	
PFI liability remeasurement charged to finance costs	(3,422)
Increase in interest arising on PFI liability	(873)
Reduction in contingent rent	1,470
Reduction in PDC dividend charge	396
Net impact on surplus / (deficit)	**(2,429)**

	£000
Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:	
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(9,903)
Net impact on 2023/24 surplus / deficit	(2,429)
Impact on equity as at 31 March 2024	**(12,332)**

	£000
Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:	
Increase in cash outflows for capital element of PFI / LIFT	(597)
Decrease in cash outflows for financing element of PFI / LIFT	597
Decrease in cash outflows for PDC dividend	-
Net impact on cash flows from financing activities	**-**

NOTES TO THE ACCOUNTS

30. Financial instruments

IFRS 7 and IFRS 9 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

30.1 Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations although the charity holds a small number of investments denominated in United States dollars and Euros, these are immaterial and, as a result, the Group has low exposure to currency fluctuations.

30.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

30.3 Interest-rate risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

30.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2024

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Fixed rate									
Finance lease obligations	**0.95 - 7.16**	**91**	**181**	**816**	**1,092**	**2,183**	**1,177**	**(826)**	**4,714**
PFI obligations	**6.5**	**269**	**537**	**2,417**	**3,397**	**9,624**	**24,548**	**(13,203)**	**27,589**
DHSC capital loan	**1.64**	**-**	**323**	**321**	**322**	**-**	**-**	**(10)**	**956**
Floating rate									
Trade and other payables	**-**	**40,206**	**-**	**-**	**-**	**-**	**-**	**-**	**40,206**
Other borrowings	**-**	**5,011**	**-**	**-**	**-**	**-**	**-**	**-**	**5,011**

As at 31 March 2023

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Fixed rate									
Finance lease obligations	3.4 - 5.1	61	121	546	385	1,153	508	(261)	2,513
PFI obligations	6.5	139	278	1,301	1,718	5,258	15,002	(8,132)	15,564
DHSC capital loan	1.64	-	328	326	644	322	-	(29)	1,591
Floating rate									
Trade and other payables	-	36,154	-	-	-	-	-	-	36,154

NOTES TO THE ACCOUNTS

30. Financial instruments (continued)

30.5 Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2024 are in receivables from customers, as disclosed in note 21.

30.6 Carrying values of financial assets

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2024				
Trade and other receivables excluding non financial assets	**27,923**	**-**	-	**27,923**
Other investments / financial assets	**2,907**	**-**	-	**2,907**
Cash and cash equivalents	**13,044**	**-**	-	**13,044**
Consolidated NHS Charitable fund financial assets	**4,514**	**9,143**	**-**	**13,657**
Total at 31 March 2024	**48,388**	**9,143**	**-**	**57,531**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2023				
Trade and other receivables excluding non financial assets	19,745	-	-	19,745
Other investments / financial assets	2,658	-	-	2,658
Cash and cash equivalents	28,891	-	-	28,891
Consolidated NHS Charitable fund financial assets	4,602	8,245	-	12,847
Total at 31 March 2023	55,896	8,245	-	64,141

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2024				
Trade and other receivables excluding non financial assets	**27,607**	-	-	**27,607**
Other investments / financial assets	**4,945**	-	-	**4,945**
Cash and cash equivalents	**10,638**	-	-	**10,638**
Total at 31 March 2024	**43,190**	**-**	**-**	**43,190**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2023				
Trade and other receivables excluding non financial assets	17,324	-	-	17,324
Other investments / financial assets	3,962	-	-	3,962
Cash and cash equivalents	24,091	-	-	24,091
Total at 31 March 2023	45,377	-	-	45,377

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

30.7 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2024			
Loans from the Department of Health and Social Care	**956**	-	**956**
Other borrowings excluding lease and PFI liabilities	**5,011**	-	**5,011**
Obligations under leases	**4,714**	-	**4,714**
Obligations under PFI, LIFT and other service concession contracts	**27,589**	-	**27,589**
Trade and other payables excluding non financial liabilities	**44,272**	-	**44,272**
Provisions under contract	**779**	-	**779**
Total at 31 March 2024	**83,321**	**-**	**83,321**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2023			
Loans from the Department of Health and Social Care	1,591	-	1,591
Obligations under finance leases	2,513	-	2,513
Obligations under PFI, LIFT and other service concession contracts	15,564	-	15,564
Trade and other payables excluding non financial liabilities	50,605	-	50,605
Provisions under contract	903	-	903
Total at 31 March 2023	71,176	-	71,176

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2024			
Loans from the Department of Health and Social Care	**956**	**-**	**956**
Other borrowings excluding lease and PFI liabilities	**5,011**	-	**5,011**
Obligations under finance leases	**2,994**	**-**	**2,994**
Obligations under PFI, LIFT and other service concession contracts	**27,589**	**-**	**27,589**
Trade and other payables excluding non financial liabilities	**42,012**	**-**	**42,012**
Provisions under contract	**779**	**-**	**779**
Total at 31 March 2024	**79,341**	**-**	**79,341**

Unless otherwise stated above, carrying value is considered to be a reasonable approximation of fair value.

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2023			
Loans from the Department of Health and Social Care	1,591	-	1,591
Obligations under finance leases	608	-	608
Obligations under PFI, LIFT and other service concession contracts	15,564	-	15,564
Trade and other payables excluding non financial liabilities	48,243	-	48,243
Provisions under contract	903	-	903
Total at 31 March 2023	66,909	-	66,909

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
In one year or less	**54,574**	54,784	**51,210**	52,421
In more than one year but not more than five years	**16,754**	9,613	**16,754**	9,613
In more than five years	**26,085**	15,971	**26,085**	15,971
Total	**97,413**	80,368	**94,049**	78,005

31. Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2024 (2022/23: £nil) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Investment in subsidiary

32.1 Odstock Medical Limited

Salisbury NHS Foundation Trust established, following Department of Health approval, a subsidiary company, Odstock Medical Limited (registered in England), to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 70% of Odstock Medical Limited.

	Trust 31 March 2024	Trust 31 March 2023
Shares at cost	**£'000**	£'000
At 31 March	**-**	-

The Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

The Trust's charity, Salisbury District Hospital Charitable Fund, owns a further 18% of Odstock Medical Limited.

NOTES TO THE ACCOUNTS

32. Investment in subsidiary (continued)

32.2 Salisbury Trading Limited

Salisbury NHS Foundation Trust established a subsidiary company, Salisbury Trading Limited (registered in England), to market and deliver laundry and linen services. The company commenced trading on 1 October 2013. Salisbury NHS Foundation Trust owns 100% of Salisbury Trading Limited. The company has experienced steady growth since commencing to trade by winning new linen contracts. It has increased operational capacity through arrangements involving the management of another NHS laundry facility, which will provide an additional base for future expansion.

	2024	2023
Shares at cost	**£000**	£000
At 31 March 2024 and 31 March 2023	**500**	500

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also notes 17. and 18.

33. Investment in Joint Ventures

33.1 Sterile Supplies Limited

Salisbury NHS Foundation Trust owns 50% of the issued share capital of Sterile Supplies Limited, a company registered in England. The remaining 50% is owned by Synergy Health (UK) Limited, a company registered in England. The Board structure and voting rights are such that the Trust is not able to exert overall control of Sterile Supplies Limited, the Trust therefore recognises the company as a joint venture. The joint venture is re-developing a new production facility, from which it will market and deliver sterilisation services. The joint venture currently trades from the Trust's existing sterilisation and disinfection unit.

Group and Trust	**2024**	2023
	£000	£000
Carrying value of investment at 1 April	**137**	86
Share of profit/ (loss) in the period	**31**	51
Carrying value of investment at 31 March	**168**	**137**

33.2 Wiltshire Health and Care

The Trust is a one third partner in Wiltshire Health and Care LLP, a limited liability partnership registered in England. The other equal partners being Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. Wiltshire Health and Care is focused solely on delivering improved community services in Wiltshire and enabling people to live independent and fulfilling lives for as long as possible.

Salisbury NHS Foundation Trust has not invested any capital sum in this partnership.

Group and Trust	**2024**	2023
	£000	£000
Carrying value of investment at 1 April	**163**	160
Share of surplus in the period	**-**	3
Carrying value of investment at 31 March	**163**	**163**

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	**2024**	2023
	£000	£000
Public Dividend Capital at 1 April	**99,600**	94,826
New public dividend capital received	**20,782**	4,774
Public dividend capital repaid	**-**	-
Public Dividend Capital at 31 March	**120,382**	99,600

The new public dividend capital received in the year relates to additional funding to purchase capital items of £16,485k (2022/23: £4,774k) and £4,297k revenue support (2022/23 :£Nil).

35. Charitable fund balances

Group only	**2024**	2023
	£000	£000
Restricted funds	**4,162**	4,162
Unrestricted funds	**11,167**	10,000
Endowment funds	**-**	-
	15,329	14,162

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

During 2022-23 the Charity Trustees performed a review of funds resulting in endowment funds being converted into distributable funds.

36. Critical accounting judgements

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

Valuation basis

Department of Health and Social Care guidance specifies that the Trust’s land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as “the cost of a modern replacement asset that has the same productive capacity as the property being valued.” Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The current site forms the basis in determining the MEA, but the Trust has to make assumptions that are practically achievable, but is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the catchment area for patients using the services, and transport infrastructure has been taken into account when deciding on an appropriate alternative site.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for the administrative buildings occupied by Salisbury District Hospital would be a multi storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

NOTES TO THE ACCOUNTS

37. Critical accounting estimates

In the application of the Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

Property Valuations

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.

Property, plant and equipment were valued using an index from Gerald Eve as at 31 March 2024. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health. Property valuation techniques include an inherent element of estimation; in particular specialised assets that have no active market require valuation based on assessing the likely replacement cost of an asset. Future property values will be influenced by factors such as construction costs and developments in healthcare technology and any recognised impairments. Future asset values will inevitably fluctuate but the Trust mitigates against material correcting adjustments by commissioning regular professional asset valuation reviews.

Depreciation and Amortisation

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.

The useful economic life of each category of fixed asset is assessed when acquired by the Foundation Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

38. Reserves

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

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

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

Minority interest
Minority interest relates to the ownership stake in the subsidiary companies which is under 50% of the total shares in terms of voting rights and hence doesn't exercise control of the company.

39. Transfers by absorption

During 2022-23 the Genetics service provided by the Trust was transferred to University Hospital Southampton Foundation Trust. This included the transfer of equipment with a net book value of £329k. This was transferred by absorption in accordance with DHSC GAM, with no payment received, resulting in a loss on disposal.

Meeting of Board of Directors

Report Summary Sheet

Report Title	Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust.			Agenda item			
Date of meeting	22nd July 2024						
Purpose	Note		Agree X		Inform		Assure	
Authors, contact for enquiries	• Ian Green, Chair SFT, Chair AHA Committees in Common • Liam Coleman, Chair GWH, Chair AHA EPR Joint Committee • Alison Ryan, Chair, RUH, Chair AHA-BSW Communities Together Programme • Lisa Thomas, Interim Chief Executive, SFT • Jon Westbrook, Interim Chief Executive, GWH • Cara Charles-Barks, Chief Executive, RUH, AHA SRO • Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	• *Appendix 1: Draft Joint Committee Terms of Reference*							
This report was reviewed by	• AHA Committees in Common							
Executive summary	Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities, and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position. In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.							

	Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this. We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June. With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group'. The report describes: • The case for collaboration and change • Proposed group leadership & governance, developments • Eight Recommendations The realisation of the significant benefits identified in the *Case for Collaboration* will require development in leadership and governance arrangements. Our proposed areas of change in the collaborative leadership, governance, and development of the Trusts are included in the recommendations set out below. • We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. • We will establish a Joint Committee, from September, to enable joint decision-making across GWH, RUH and SFT. This Joint Committee will oversee the plan for realising the case for collaboration, the subsequent delivery programme, and development of the proposed Group model. • In-year priorities and an associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and

	align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan. What does this mean for our organisations? • These changes are designed to accelerate successful delivery of transformed sustainable excellent clinical services, in service of the BSW population. We believe that a joint leadership model will improve the delivery of care to local communities. • In establishing a Group, we will maintain three Trusts with their own Governors, Boards and Non-Executive Directors. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve. • GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care. • We are not recommending a merger or change in legal structure, as we do not think such a change would offer value for money or be in the best interests of our populations. The following timeline is proposed and will see vital involvement of Governors and Trust teams in helping shape our next steps: • July. Progress Initial recommendations. Remuneration Committees to convene to confirm process for appointment of Joint-Chief Executive. August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding move to Joint Chair. Develop delivery plan for in-year priorities. • September-January. Joint Development Phase. Trusts develop target operating model, and strategic framework. Begin delivery of in-year priorities. Appointment of Joint-Chair. • January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework • Q4 – Q1 Implementation of agreed Operating Model.
Equality Impact Assessment	An Equality Impact Assessment of proposed changes been completed.
Recommendation(s)	Boards are invited to approve the following eight recommendations: • *Recommendation 1.* We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Trust will retain its own board and this change would not represent a merger of the trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and

timetable. We would like our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter of 2025.

- *Recommendation 2.* In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.
- *Recommendation 3.* We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1, initial Joint Committee Terms of Reference.
- *Recommendation 4* We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, stabilisation of the services we deliver and our financial position,* so in coming months we will bring executives and non-executives together to identify collective opportunities to work more efficiently and eliminate unnecessary duplication. An associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan.
- *Recommendation 5.* Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement & innovation, embracing standardisation, all in an effective and agile governance environment.
- *Recommendation 6.* We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services.
- *Recommendation 7.* We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively at place or neighbourhood and those where partnership working across BSW delivers added benefits to the populations we serve.
- *Recommendation 8.* We recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help

<table>
<tr><td></td><td colspan="8">shape our future together; Organisational Development support for coming years will be secured.</td></tr>
<tr><td>Risk (associated with the proposal / recommendation)</td><td>High</td><td></td><td>Medium</td><td></td><td>Low
x</td><td></td><td>N/A</td><td></td></tr>
<tr><td>Key risks</td><td colspan="8">The development of our BSW provider collaborative is in line with national policy and strategic direction on provider collaboration. The eight recommendations in this proposal are designed to address the following risks:
• Quality of and access to planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery.
• Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery.
• Performance & oversight environment. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support.
• Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities.

Risk of proceeding with proposed recommendations:
• Uncertainty for our staff. Changes may create uncertainty for some staff. Mitigation and Management: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required.
• Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. Mitigation: Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.</td></tr>
<tr><td>Impact on quality</td><td colspan="8">The developments proposed are designed to enhance the quality and resilience of health services for the population in BSW.</td></tr>
<tr><td>Resource implications</td><td colspan="8">Establishment of a group will better enable GWH, RUH and SFT to deliver the benefits identified in the Case for Collaboration, thereby supporting the three</td></tr>
</table>

	Trusts to improve the efficiency and value for money of our services. During the proposed *Joint Development Phase* - Q2 and Q3 2024-25 - a group operating model, with detailed resource implications will be developed by Trust leads, for consideration by Boards.
Conflicts of interest	None known.
This report supports the delivery of the following BSW Integrated Care Strategy Objectives:	☒ Focus on Prevention and Early Intervention ☒ Fairer Health and Wellbeing Outcomes ☒ Excellent Health and Care Services

Title: Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust:

1. Introduction and Context

Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position.

In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.

Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this.

We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June.

With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group' (refer sections 3-6 below). The report describes:

- The Case for Collaboration
- Proposed Group Leadership and Governance Developments
- Proposed Timeline, Risks and Eight Recommendations.

National Context

The Health and Care Act (2022)

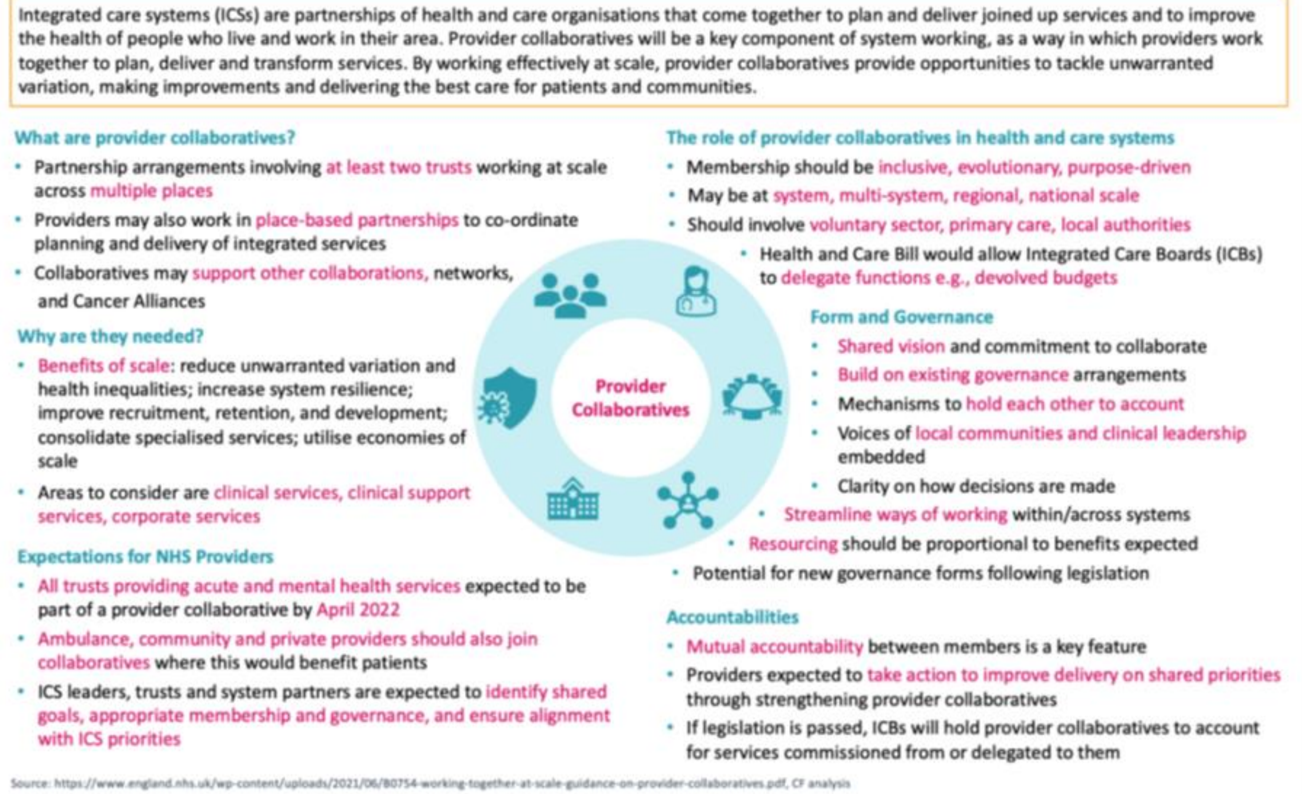
The 2022 Health and Care Act created Integrated Care Boards (ICBs) as statutory bodies and established a new legislative framework to enable greater collaboration between health and care system partners, including NHS trusts. Provider collaboratives are core to the development of Integrated Care Systems (ICSs), particularly in terms of delivering the quadruple aim duties:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience, and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Working Together at Scale: Guidance on Provider Collaboratives (2021)

Prior to the broader legislative framework coming into effect, guidance on provider collaboratives was published by NHS England in 2021. The guidance outlines the expectation of how providers should work together as provider collaboratives, principles to help support local decision-making, and function and form options that systems may consider in support of quadruple aim duties. NHS trusts were required to be part of at least one provider collaborative by April 2022. A high-level summary of the guidance is provided in Figure 1

Figure 1 Overview of NHS Provider Collaboratives



The developments we propose below are in the context of this increased drive for collaboration nationally.

2. The Case for Collaboration and Change to Support Delivery

We know that 2024-2025-2026 need to be years of action, delivered well and at pace with a focus on a small number of high impact changes. We are conscious of our system's financial position and must use collective opportunities to work more efficiently.

In this context a range of stakeholders from each of the three Trusts and wider system partners joined a series of corporate services and clinical services workshops designed to identify collaborative opportunities. These sessions led to ten areas for deeper collective work being identified as the *case for collaboration*; these are outlined in Figure 2. The areas identified can be broadly grouped as clinical and non-clinical opportunities, and centre on significantly improving quality and access for the people of BSW, achieving efficiencies and effectiveness in operations, and enhancing opportunities for staff.

Figure 2. Ten Areas: Our Case for Collaboration

Our *case for collaboration* report illustrates the challenges and potential impact across these ten opportunity areas, establishing a call to action to focus on clinical and operational performance to improve outcomes for people in BSW.

3. Proposed Provider Group Development

The realisation of the significant benefits identified in the *Case for Collaboration* will require development in our leadership and governance arrangements. Our review identified these areas as a critical requirement for success. Eight proposed developments are described here.

Recommendation 1. We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter 2025 [January-March].

Recommendation 2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.

Recommendation 3. We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to help oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1 initial Joint Committee Terms of Reference.

Recommendation 4 We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position,* so in September we will bring executives and non-executives together to identify collective opportunities and clear plan to work more efficiently and eliminate unnecessary duplication. The Joint Committee will hold Executives accountable for the delivery of this plan.

Recommendation 5. Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement, & innovation, embracing standardisation, all in an effective and agile governance environment.

Recommendation 6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services.

Recommendation 7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively locally and those where partnership working across BSW delivers added benefits to the populations we serve.

Recommendation 8. Finally, and perhaps most importantly, we recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help shape our future together; Organisational Development support for coming years will be secured.

What do these proposed changes mean for our organisations?

- The *changes described are designed to accelerate successful delivery* of transformed sustainable, and excellent clinical services. They are a natural next step in the interests of the BSW population, patients, and our workforce. GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care.

- We are *not recommending a merger or change in legal structure*; it is considered that such a change would be highly disruptive and would not offer value for money for our system. In establishing a

Group, we will maintain three Trusts with their own Boards and NEDs. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve.

- *Subsidiarity*. Our agreed operating model will describe how the subsidiarity principle will be applied. Subsidiarity will see decisions being made at the lowest practical level, embedding local decision-making, and making decisions at group level only when it is considered beneficial to do so.
- *Long-term impact*. The anticipated impact over three+ years will be related to the ten clinical and corporate services areas set-out in the *case for collaboration*.
- *In the short-term*, change will be more limited. Staff and patients should not notice significant change in day-to-day operation and management of services. A joint-chief executive, with their team including the site deputy chief executives will lead an evolutionary process, developing an operating model, identifying priority areas for transformation. After these initial steps, the Joint Chief Executive with Deputy Chief Executives will support the Trusts to accelerate sharing of best practice, reduce duplication, enhancing resilience of our services while creating career structures and opportunities for many of our services that cannot currently benefit from working at scale. Again, in the short-term significant change in delivery and strategy is not anticipated, but teams will come together to develop and deliver collaborative plans, creating excellent sustainable services for our population.
- *Cost of new model*. Costs and return on investment will be defined in detail as part of the operating model proposal – due to be developed between August and December 2024, in readiness for Board review in January 2025.

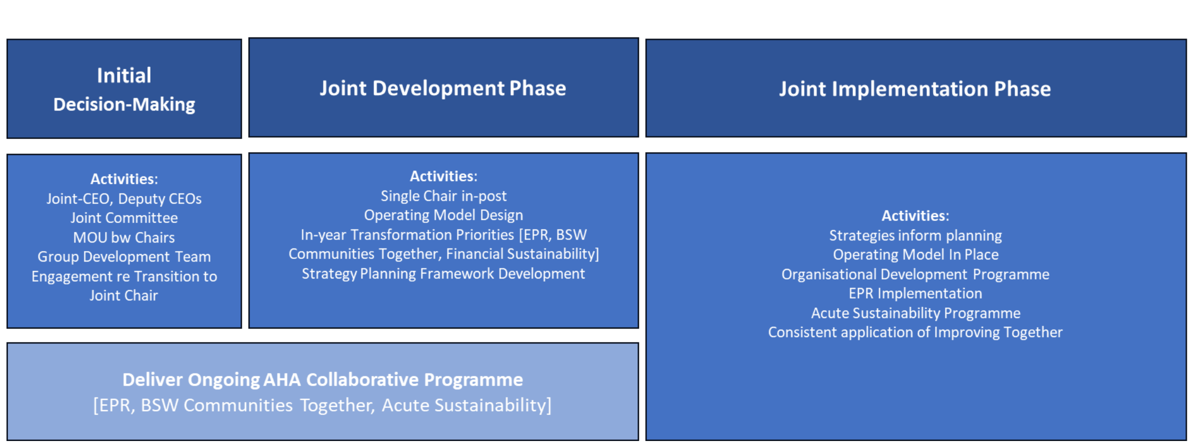
4. Proposed Timeline

The timeline proposed is set out *in figure 3 below*. Learning from successful collaborative transformation schemes, other groups and collaboratives, we should not seek an off-the-shelf example or model. Rather, we should develop our BSW Providers model together. A three-phased approach is proposed, whereby an *initial phase* will be followed by a central *Joint Development Phase* leading to Board decision-making gateways before a *Joint Implementation Phase*.

- Progress Initial recommendations.
    - July. Remuneration Committees to convene to confirm process and timeline for appointment of Joint-Chief Executive.
    - August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding Joint Chair. Develop delivery plan for in-year priorities.
- Joint Development Phase
    - September – January. Trusts develop target operating model, strategic framework. Begin delivery of in-year priorities.
    - January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework

- Joint Implementation Phase. Q4 Onwards, 2025-2026-2027. Operating Model Implementation and delivery of Case for Collaboration.

Figure 3. Proposed Collaborative Development Timeline



5. Risks

The eight recommendations in this proposal will support us to address the following risks:

- Quality of and access to the planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. We will work within a clear framework that maintains responsiveness to the needs of the local populations and enables local innovation.
- Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery.
- Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities *Mitigation*: We have begun, and in a group model should make standard practice, modelling different ways of deploying our senior leaders. Leading on behalf of others will become common, with local hospital leaders also having group-level leadership responsibilities – working in a matrix environment.
- Timeframes for Development. A drawn-out phased approach to development may create uncertainty. Staff need to be able to focus on local operational delivery. *Mitigation*: Our decision-making timetable should be pragmatic, but with sufficient pace to reduce uncertainty.
- Oversight. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support.

Risk/s associated with pursuing this proposal:

- Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. *Mitigation:* Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.
- Uncertainty for our staff. Changes may create uncertainty for some staff. *Mitigation and Management*: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required. Additionally, the programme will see development of Group operating model over coming months - allowing for senior staff to be actively involved in development through co-creation.

6. Summary of Recommendations

Our recommendations are summarised in figure 4 below.

Figure 4. Our Eight Recommendations

1. We will identify a Joint Chief Executive and Joint Chair for our Trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role January-March 2025.
2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.
3. We will create a Joint Committee, from September, to help oversee our work together. [Refer draft Terms of Reference in Appendix 1].
4. By the end of September, we will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position.*
5. We will develop a Group Operating Model, in 2024 that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January 2025, mobilising in 2025-2026.   Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work.
6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with joint clinical strategy and associated workforce and digital strategies, we will confirm our transformation programmes for clinical and corporate services.
7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*.
8. We will invest in Organisational Development support to enable the scale of required change.

Close

Draft 1.0.

Ben Irvine. 10th July 2024 with IG, LC, AR, CCB, LT, JW.

Appendix 1. Joint Committee Terms of Reference [see accompanying document]

Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust.

Appendix 1: Draft Joint Committee Terms of Reference

DRAFT [BSW AHA Group [Name TBC]]

Joint Committee - Terms of Reference

1. **Status of the Committee**

1.1 Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust (the "**Trusts**") are parties to a long standing strategic collaboration known as the "**BSW AHA Group [NAME TBC]**", referred to hereinafter as "**the Group**".

1.2 To facilitate joint working across the Group's priorities and programmes, the Trusts have agreed to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 with these terms of reference (the "**Terms of Reference**"), to be known as the "**BSW AHA Group Joint Committee**" (the "**Committee**").

1.3 These Terms of Reference set out the membership, remit and delegation, responsibilities and reporting arrangements of the Committee.

1.4 The Committee is a committee of the boards of each of the Trusts and therefore its decisions are binding on each Trust. The Committee is authorised by the Trust boards to carry out the functions set out in these Terms of Reference to ensure the Committee can fulfil its purpose.

1.5 The Committee replaces the former Acute Hospitals Alliance/AHA committees-in-common arrangement.

1.6 Capitalised terms have the meanings given to them in these Terms of Reference or in the memorandum of understanding for the Group which the Trusts entered into on [insert x] ("**Group MoU**"). The Annex means the annex to these Terms of Reference.

2. **Purpose**

2.1 The purpose of the Committee is to ensure appropriate governance arrangements are in place to enable joint decision making in relation to the functions described in these Terms of Refence and the Annex which the Trusts have agreed to exercise jointly.

2.2 The Committee will be responsible for:

2.2.1 Oversight of the development and delivery of the Group Programme and the workstreams in accordance with the Principles of Collaboration; and

2.2.2 setting the overall strategic direction in order to deliver the Group Programme.

2.3 The Group Programme agreed by the Trusts for the years [insert financial years 2024-2028] includes:

2.3.1 the design and implementation of a group model for the Trusts (the **"Group Operating Model**");

2.3.2 the 10 agreed areas for collaboration ("**10 Areas for Collaboration"**), including annually agreed priorities for collaboration;

2.3.3 the response to the BSW integrated community health care services procurement exercise; and

2.3.4 oversight of governance over the joint EPR Programme,

all described in more detail in the Annex.

3. General Responsibilities

3.1 The general responsibilities of the Committee are to:

3.1.1 provide overall strategic oversight of and direction to the development of the Group Programme;

3.1.2 ensure the agreement of each of the Trusts to the vision and strategy underpinning the Group Programme;

3.1.3 formally recommend the final form of the Group Programme, including determining roles and responsibilities within the workstreams;

3.1.4 review and scrutinise the Group Programme key deliverables and ensure adherence to the required timescales;

3.1.5 obtain assurance that Group Programme workstreams have been subject to robust equality impact assessments;

3.1.6 review the risks associated with the performance of any of the Trusts in terms of the impact to the Group Programme and recommend remedial and mitigating actions across the system;

3.1.7 obtain assurance that risks associated with the Group Programme are being identified, managed and mitigated;

3.1.8 promote and encourage commitment to the Principles of Collaboration;

3.1.9 formulate, agree and implement strategies for delivery of the Group Programme;

3.1.10 determine or resolve any matter referred to it by the Group Programme Executive or any individual Trust and any dispute in accordance with the Group MoU;

3.1.11 approve the appointment, removal or replacement of Group Programme personnel;

3.1.12 review and approve the terms of reference of the Group Executive; and

3.1.13 agree the overall Group Programme budget, financial contribution and use of resources.

3.2 The Committee has the specific responsibilities set out in the Annex to these Terms of Reference.

4. Membership

4.1 The Committee will initially comprise the chair (representing the non-executive membership) of each of the Trusts, the Group Chief Executive and Deputy Chief Executive (representing the executive membership) of each of the Trusts. Once a chair is jointly appointed across all 3 Trusts, each of the Trusts shall nominate a non-executive director ("**NED**") to serve on the Committee. There will initially be 7

members on the Committee, 3 of whom are NEDs, and once a chair is jointly appointed there will be 8 individuals on the Committee, 4 of whom are NEDs. Each individual is hereinafter referred to as a **"Member"**.

4.2 Each Trust will nominate two deputy members (one from the non-executive membership of the Trust's board and one from the executive membership) (**"Nominated Deputy"**) to attend meetings of the Committee in the event that their Chair (or NED) and/or Chief Executive is unable to attend. The Nominated Deputy must be a voting board member of the respective Trust. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the Member is not personally present and do all the things which the appointing Member is entitled to do.

4.3 Each Member will have one vote.

4.4 At the first meeting of the Committee, the Committee will select a chair ("**Committee Chair**") from amongst the Members who are Trust chairs. Once a joint chair for the Trusts is appointed, he or she shall become the Committee Chair and the incumbent Committee Chair (if not the joint chair) shall immediately hand over.

4.5 In the absence of the Committee Chair at any meeting for reasons of conflict or otherwise, the Members present shall nominate one of the other NED Members to chair the meeting.

4.6 The Trusts will ensure that, except for urgent or unavoidable reasons, their respective Members (or their Nominated Deputy) attends and fully participates in the meetings of the Committee.

4.7 Meetings of the Committee will be regularly attended by the [Group Programme Director [and insert other regular attendees] on an advisory basis only. They will receive advance copies of the notice, agenda and papers for meetings. They may be invited, at the discretion of the Committee Chair, to ask questions and address the meeting but may not vote.

4.8 With the consent of the Committee Chair, other persons may be invited to attend and contribute to meetings of the Committee but not take part in making decisions.

5. Framework for Decision Making

5.1 The Committee (and each Member or Nominated Deputy) shall at all times act in accordance with these Terms of Reference and the internal governance arrangements of the individual Trusts including the Trusts' constitutions and standing orders insofar as these Terms of Reference do not provide otherwise. In the event of any inconsistency between the Trust's standing orders, the Committee Chair shall determine whose standing orders will prevail.

5.2 The following decisions may only be taken where the Members present and voting at a meeting vote unanimously in favour of it:

5.2.1 any decision relating to the design of the Group Operating Model – see the Annex;

5.2.2 [insert any other types of decisions which require unanimous approval].

5.3 Functions not delegated to the Committee in accordance with these Terms of Reference are retained by the Trust boards or other Trust committees. Matters specifically reserved to the Trusts, acting individually, include without limitation:

5.3.1 the approval of the design of the Group Operating Model;

5.3.2 a decision to enter into contracts following the Trusts' response to the BSW integrated community health care services procurement exercise;

5.3.3 [insert other matters reserved].

5.4 The Committee may not:

5.4.1 form sub-committees or delegate its functions to any individual Member;

5.4.2 pool budgets or establish any risk-gain share arrangements;

5.4.3 commit a Trust to any spend, loan or investment (including capital investment) or acquire or dispose of Trust property;

5.4.4 commit a Trust to enter into a contract, other than in relation to the Group Operating Model provided for in the Annex; or

5.4.5 carry out any function which is governed by a statutory process or reserved in law to a statutory committee of a Trust, including constitutional amendments and board appointments, or which may not be exercised jointly according to law or NHS England guidance.

5.5 In carrying out its functions, the Committee will abide by the Seven Principles of Public Life (Nolan Principles) and shall have regard to NHS England's statutory guidance for joint exercise of statutory functions and joint committees issued from time to time.

6. **Decision making**

6.1 The Committee must comply with the above framework for making decisions and have regard to the principles specified in paragraph 6.2.

6.2 When making decisions, the Members shall, recognising that some decisions may not be of obvious benefit to or impact directly upon all Trusts, nevertheless:

6.2.1 enable each Member to have an equal say in discussions;

6.2.2 work together in good faith and in an open, cooperative and collaborative manner for the benefit of one or more Trusts;

6.2.3 take collective responsibility for decisions whether impacting on one or more Trusts;

6.2.4 communicate openly about major concerns, issues or opportunities; and

6.2.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs.

6.3 The Committee will seek to make decisions on a consensus basis.

6.4 Any questions needing to be put to a vote at a meeting shall, save for the matters set out in paragraph 5.2 (matters requiring unanimous decision), be determined by a majority of the votes of the Members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chair of the meeting shall have a second or casting vote.

6.5 With the consent of the Committee Chair, urgent decisions or decisions required outside of scheduled meetings may be taken outside of a formal meeting by written resolution (including email). This is subject to the quorum of the Committee endorsing

the required decision. Any decisions taken in accordance with this section shall be reported to the next formal meeting.

7. **Proceedings of the Committee**

7.1 Subject to the provisions of this paragraph, the Committee may regulate its proceedings as it sees fit.

7.2 The Committee will meet [monthly], or more frequently if so required.

7.3 Meetings of the Committee are anticipated to take place in private as this is appropriate to facilitate discussion and decision making on matters deemed to be commercially sensitive or confidential.

7.4 For meetings to be quorate each of the Trusts must be represented by both its chair and chief executive, or their Nominated Deputies. No decision may be taken at any meeting unless a quorum is present.

7.5 No decision may be taken at a meeting unless a quorum is present.

7.6 Declarations and notifications of interests in relation to an item of scheduled or likely business must be made at the beginning of each meeting, and the provisions of the "Protocol for Managing Conflicts of Interest" (Schedule 4 of the Group MoU) applies.

7.7 Meetings may take place in person or remotely by telephone or video conference, or a hybrid, provided that each Member participating is able to speak to each of the others, and to be heard by each of the others simultaneously.

7.8 The Committee is authorised by the Trust boards to obtain independent legal or other professional advice and to secure the attendance of such persons with relevant experience or expertise at any meeting of the Committee.

8. **Administration of the Committee**

8.1 The administration of meetings, including the provision of governance advice, maintaining the register of interests and the preparation of minutes, will be provided by the Group Programme Office.

8.2 Agendas for meetings will be determined jointly by the Committee Chair and Group Chief Executive.

8.3 Papers for each meeting will be sent from the Group Programme Office to Members no later than five working days prior to the meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4 The draft minutes of each meeting, together with a summary report from the [Group Chief Executive], will be circulated promptly to all Members as soon as reasonably practical after the date of the meeting to ensure their inclusion in the private agenda of each of the Trust's board meetings. The Committee Chair (or chair of the meeting) will be responsible for approving the first draft set of minutes for circulation to members. The Group Programme Director will provide a summary of the meeting for sharing in the public domain.

8.5 The Committee will prepare an annual report for the Trust boards on its performance against its annual work plan.

9. **Review**

9.1 It is anticipated that these Terms of Reference will be updated to reflect strategic developments in BSW. The Committee will review these Terms of Reference at least annually. Amendments to the Terms of Reference must be approved by the Trust boards.

Approved by the boards of:
Great Western Hospitals NHS Foundation Trust
Salisbury NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust

[date] 2024

ANNEX – Specific Responsibilities

1. The Committee will:

   1.1 mobilise, oversee and assure successful delivery programmes in relation to the following Group Programme initiatives:

      1.1.1 the design of the future Group Operating Model;

      1.1.2 the "case for collaboration" as set out in [insert document which describes the case for collaboration] which identifies the 10 Areas for Collaboration (summarised in paragraph 2 below), including formulating and implementing key strategies for delivery, with a focus on improving quality and access for the people within the BSW integrated care system, achieving efficiencies and effectiveness in operations and enhancing opportunities for staff; and

      1.1.3 the Trusts' response to the BSW integrated community health care services procurement exercise;

   1.2 in respect of each of the areas in paragraph 1.1 above:

      1.2.1 review and scrutinise key deliverables of such programmes and ensure adherence to the required timescales;

      1.2.2 review significant risks to such programmes and obtain assurance that risks are being identified, managed and mitigated;

      1.2.3 hold relevant teams to account for delivery of workstreams; and

      1.2.4 agree communications strategies and stakeholder management strategies.

   1.3 in relation to the design and/or implementation of the Group Operating Model, have authority to award contracts for consultancy and other services with individual values of up to [£1,000,000 (one million pounds sterling)] subject to procurement law and principles. When awarding contracts, the Committee shall also decide which Trust is to hold the contract and other related matters.

   1.4 ensure that effective governance arrangements are in place for successful delivery of the EPR programme (overseen by a separate EPR joint committee).

2. The 10 Areas for Collaboration are:

Area 1	Tackling the challenges from chronic illness in the ageing population in the areas of the BSW integrated care system
Area 2	Aligning around transformation in Urgent and Emergency Care to better manage acute demand
Area 3	Delivering clinically sustainable services for the future
Area 4	Improving access, effectiveness and value for money of planned care
Area 5	Tackling increasing prevalence and performance challenges in cancer
Area 6	Aligning research and innovation to accelerate delivery of shared clinical priorities
Area 7	Developing a resilient workforce for the future, drawing on talents of the local population

Area 8	Creating efficiencies in the use of data and adoption of digital innovations
Area 9	Building resilience across finance
Area 10	Supporting corporate efficiency and cost reduction

Report to:	Trust Board	Agenda item:	6.2
Date of meeting:	5th September 2024		

Report tile:	Freedom to Speak Up Annual Report 2023-24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Paper reviewed and approved at People and Culture Committee 27th June 2024			
Prepared by:	Elizabeth Swift – Freedom to Speak Up Guardian (presenting)			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:
Discuss and note the Freedom to Speak Up Annual Report. Support on-going work to ensure an open and transparent culture of speaking up in the organisation. Support the work underway to ensure Black and ethnically diverse colleagues can safely report concerns. Note the improvements in the numbers of colleagues speaking up (22% increase from 2022/23)

Executive Summary:

For information:

- Of the 15 areas of Guardian activity, ranging from the promotion of learning and training to compliance, 11 have shown positive indicators of improvement, specifically in the staff survey results around responding to concerns raised.
- The National Guardian's Office (NGO) will be looking to strengthen the Guardian role in the wake of the Letby verdict. This may include mandating all levels of FTSU online training, additional powers for the NGO to escalate if appropriate action has not been taken and further compliance levers to ensure FTSU has been implemented according to national guidance.
- Triangulation of data as part of We are Safe and Healthy is at an early stage but is beginning to highlight areas of concern that may need additional support to improve staff experience.
- SFT data shows the attention given to ensuring that all colleagues especially from diverse backgrounds, know how to speak up. This puts SFT in a strong position with the NGO focus for 2024-25 being Inclusion.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	✓
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	✓
Other (please describe):	

1 Purpose

1.1 To present an overview of the work of the Freedom to Speak Up (FTSU) Guardian over the year including high level details of the number of cases raised, a thematic analysis and any learning from these cases.

2 Background

2.1 The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up (FTSU) Guardian. FTSU Guardians are now employed across the health and care sector, including in primary care, health charities, independent providers and arms' length bodies including health regulators. The FTSU Guardian's role is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FTSU Guardian also provides support to staff raise concerns and supports the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan.

2.2 In addition, while the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, the broader strategy is to effect cultural change.

2.3 Salisbury NHS Foundation Trust is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong speaking up culture throughout the Trust.

2.4 The network of Freedom to Speak Up Guardians continues to grow, with over 1,000 Guardians in place supporting healthcare workers in England to speak up about anything which impacts on their ability to do their job. The National Guardian's Office has strengthened the training and support it gives Freedom to Speak Up guardians in order to ensure that they meet the needs of the workforce in this complex and wide-ranging role.

People want to work for high performing organisations. Fostering a Speak Up, Listen Up, Follow Up culture promotes excellence and increases staff engagement, boosting morale and performance.

3 National Guardian's Office

Our vision: that speaking up is business as usual in the healthcare sector in England.

On Tuesday 21st May2024, Jayne Chidgey-Clark, National Guardian for the NHS, gave evidence to the Health and Social Care Select Committee in the House of Commons, for their inquiry into NHS leadership, performance and patient safety. The committee examined the fear and futility of speaking up in the NHS, and how the healthcare system needs to learn lessons quicker from the multiple reviews that take place.

Ensuring Freedom to Speak Up guardians are fully supported to deliver the role was discussed alongside embedding a more consistent approach to the implementation of the guardian role.

Jayne has been quoted in an article in The Independent saying "I very worryingly have heard of accounts from some guardians where they feel that when they're delivering messages around themes

that are hard for organisations to hear, that they feel they suffer detriment themselves, which is clearly unacceptable". Below is a link to the article in the Independent.

https://www.independent.co.uk/news/uk/nhs-mps-infected-blood-inquiry-robert-francis-whitehall-b2548749.html
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What is Freedom to Speak Up?

In healthcare, Freedom to Speak Up is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviours or attitudes at work, or an idea which could improve processes or make things even better.

In response to the publication of Too Hot to Handle: why concerns about racism are not heard or acted upon, the NGO has incorporated equity, diversity and belonging into the mandatory refresher training for all FTSU Guardians to give all guardians an understanding of discrimination. The report includes the better use of FTSU Guardians, who as part of their role have a focus on encouraging their organisations to remove the barriers which workers face in speaking up, particularly black and minoritized workers.

A Speak Up Review is being initiated by the NGO over the next 12 months to understand the speaking up experiences of overseas trained workers. The National Guardian for the NHS is becoming increasingly concerned that the voices of overseas trained workers are not always being heard, and in some cases are being silenced. It is vital that these workers are listened to. Our aim is to develop actionable recommendations out of this Review to improve policies and practices, fostering a more inclusive and supportive Speak Up culture throughout healthcare.

Other highlights over the 2023/24 period include:

- This year, Freedom to Speak Up guardians supported more workers than ever before. Over 25,000 cases were raised to them; that is 25,000 opportunities for leaders to learn what is getting in the way of people doing a great job; 25,000 opportunities for improvement. In a system which is stretched and under pressure, leaders need to take heed. Listening could make the difference to patient safety, worker wellbeing, staff retention, organisational risk and reputation.
  Progress continues to be made to improve the speak up culture across a range of organisations. There are now more than 1000 Freedom to Speak Up Guardians in over 500 organisations who have handled over 100,000 speak up cases since data records began in 2017 to date, allowing workers to speak up who might otherwise not be heard. 625 concerns have been raised at SFT since 2017.
  Support and development have improved for FTSU Guardians including revised training for new Guardians, a new Strategy for the NGO, to which the Guardian at SFT was invited to contribute towards.
  A new Mentor role has been introduced to support success of FTSU services. The FTSU Guardian from SFT has been selected to be one of these mentors and is actively supporting other Guardians from different organisations.
  There is a new National Speaking up Policy. The SFT policy has adopted and published the new Speaking Up Policy.

4 National Guardian's Office Update on actions being taken in the wake of Lucy Letby verdict:

The National Guardian met with the Secretary of State to discuss the implications of the investigations into the Countess of Chester. After their discussion, Jayne followed up with a letter recommending the Secretary of State consider four priorities:

1. Leadership – including increased investment in training and mandating the Speak Up, Listen Up, Follow Up training
2. Compliance levers, and concerns that there is a lack of assurance or enforcement, on a routine basis, regarding Freedom to Speak Up and the implementation of guardians.
3. Escalation routes and individual investigations, including the power of the NGO to escalate concerns and further escalation if it does not feel appropriate action has been taken, escalation routes for guardians and enhanced guidance on external investigations.
4. Strengthening the role of the National Guardian's Office and Freedom to Speak Up Guardians, including a review of the job description and funding for research to explore the impact of the role. She also requested a review of support and protection for Freedom to Speak Up Guardians who feel threatened for doing their jobs.

5 Freedom to Speak Up Guardian Activity

5.1 **National Work –** The FTSUG has continued to actively engage with the National Guardian's Office, including responding to surveys, timely submission of quarterly data returns and putting forwards ideas for future development of the Guardian role.

FTSUG was invited to a Mentor Meeting at the NGO head office in London to look at the NGO strategy and discuss the FTSU job role for the future to provide more consistency across organisations. FTSUG has mentored over 20 new Guardians.

In response to the Speak Up Review of Ambulance Trusts - The National Guardian Jayne Chidgey-Clark says 'within the last 12 months, there have been several other reviews, reports and recommendations examining aspects of culture within ambulance trusts. Recognising the work of our partners, I am calling for Ministerial oversight of an independent cultural review. This will bring together all these pieces of work in a collaborative way to facilitate shared learning. This cultural review should act as a catalyst to accelerate the pace of meaningful change, to support the ambulance sector in making the improvements it wants and needs to make'. SFT meets in full the recommendations set out in this review.

Following the successful visit to the Tent Talks at SFT in July 2023, The National Guardian Jayne Chidgey-Clark commented on the positive engagement that the Board had with FTSU and the desire to improve, reflect and learn from concerns raised. She was also satisfied with the quality, content and governance of FTSU Reports, and in particular the attention given to ensuring that all colleagues especially from diverse backgrounds, do speak up. This puts SFT in a strong position with the NGO focus for 2024-25 being Inclusion.

5.2 **Regional Work -** The FTSUG attends Regional Network meetings and actively participates in driving the FTSU agenda forward. As the health landscape continues to evolve with the development of integrated care systems (ICS), Regional Integration Plans have been produced to describe actions going forwards and how to measure progress and uptake. The National Guardian's Office is working with primary care organisations to show how this can work at system level consultancy.

The FTSUG is in regular contact with the Guardians at Royal United Hospitals Bath. This relationship is key for peer support, benchmarking and working together to push the Speaking Up agenda forwards as

part of the BSW partnership. The FTSU service is inconsistent across the BSW and the FTSUG at SFT plans to offer enhanced support to our BSW partners.

Comparisons in current cases:

RUH Bath	Salisbury NHSFT	Great Western Hospitals
Q1-Q4 148	Q1-Q4 163	Q1-Q4 15

FTSUG provides ongoing mentorship to new and existing Guardians in the South West region.

5.3 **Local work –**

- **Triangulating Feedback – We are safe and healthy** - Throughout 2023/24 leads from Health and Safety, Employee Relations, Occupational Health, Wellbeing, EDI and Freedom to Speak up have been exploring ways to compare data sets in an attempt to triangulate these to better understand if there were opportunities to improve both patient and staff experiences.

  Meetings will continue each quarter and we aim to produce an annual summary of our findings. When necessary, any notable themes that may require escalation will need to have a clear and defined route of escalation.

  - **Care Quality Commission (CQC) –** More emphasis is being put on raising, responding and learning from concerns in the Well-Led element of the CQC single assessment framework. The FTSUG continues to engage with the local CQC team providing information and assurance when needed.
  - **Policy –** the new universal Speak Up Policy was ratified and launched in January 2024, supported by the Board Self-Reflection Toolkit and FTSU Strategy which is due for revision in June 2025.
  - **Training** - The National Guardian's Office has launched, with Health Education England, training for all workers, and plan training for managers and leaders – with the view that everyone needs to take personal responsibility for their actions. In response to this, the Trust has agreed that this basic training 'Speak Up' became mandatory from 1st April 2021. From 1st April 2023 to 31st March 2024, 1497 staff have completed this module. 'Listen Up' is the next training package which is being delivered as part of the Leadership and Management offer which targets staff with line management responsibilities. In response to our own Maternity Services Review and the Ockenden Report, the Trust's Guardian presents at Midwives Study Days, Preceptee Study Days and meets regularly with the Director of Women and Newborn and divisional team. Raising Concerns is also part of the Foundation Doctors training programme and the FTSUG delivers this training. Including Trust Induction, over 1,300 staff have had face to face training with the FTSUG.
  - **Organisational Development** - In the period 2023-24, 123 delegates had FTSU and Civility and Respect training as part of the Transformational and Aspiring Leadership Programme delivered by Organisational Development. A further 250 delegates are due to have this training during the 2024-25 period.
  - **Civility and Respect –** FTSUG supported Theatres Management Team to develop Behaviour Charter

- **Induction – My First 90 Days -**This event has been reviewed and re-styled with more emphasis on staff support and well-being. The FTSUG presents regularly at this event, supporting the Trust's aim to enable a compassionate and open culture.
- **SEQOHS (Safe, Effective, Quality Occupational Health Service)**– FTSUG met with the SEQOHS Inspector with Head of Occupational Health. Feedback is that they are impressed with how within the boundaries of our roles we are working together to support the Trust and the positive effects of this on our staff and ultimately on the patients.
- **Education Review** – FTSUG is invited to meet medical trainees at all levels with the Director of Medical Education. These sessions have been implemented on the back of the annual GMC survey results, to ensure that doctors in training are having the best possible education experience during their time at Salisbury.
- **Promoting FTSU** – Contact details for Freedom to Speak Up support is in the daily trust wide bulletins, and new posters have been produced and are placed in prominent places across the entire estate. The CEO and CPO do approximately 6 focussed FTSU bulletins throughout the year. Every new member of staff is given a credit size card with contact details of the FTSU service. Speaking up leaflets aimed specifically at Student Nurses developed and distributed. FTSUG has taken 2 staff stories to Board to share the experiences of speaking up and the learning that occurred as a result.
- **100 day and 1 year Anniversary Listening events** - The FTSUG attends these listening events with the Chief People Officer to gain valuable insight into the experiences of our new starters. The feedback we have received has shown that there are inconsistencies across the organisation regarding induction in different departments and process issues in all parts of the recruitment process. These insights have given us the opportunity to rectify issues and improve the experiences of our new colleagues, influencing the My First 90 Days Project that has been launched in May 2024.
- **On call Listening Clinics with Chief People Officer** – FTSUG and CPO facilitate out of hours listening clinics to enable staff to share their experiences of working at SFT. These clinics are a useful way of gaining additional insight into what works well in terms of a good working environment and where additional attention may be needed and being able to reach colleagues who may not work in usual office hours. These clinics will continue into the 2024-25 period.
- **Key relationships** – the FTSUG continues to collaborate with many teams to support speaking up despite the challenges of staff shortages and turnover. Regular meetings are held with People Business Partners, Divisional Management Teams, People Advisors, Risk, PALS, Occupational Health, Litigation, Clinical Psychology, Staff Side, Chaplaincy, Guardian of Safe Working, Chief Resident, Executives and Non-Executives and protected groups such as the Multicultural Staff Network and the Disability Network. FTSUG has also contributed to The People Promise Exemplar Site project and supports line managers and leaders to develop a heathy speaking up culture. The FTSUG has access to the CEO, Chairman and CPO as Executive Lead as and when required, as well as having monthly 1:1's
- **PSIRF (Patient Safety Incident Response Framework)-** The FTSUG attended the implementation group to contribute to the aspects regarding what is being done to support the development of a just culture. This group has now ceased as PSIRF is now in place. FTSUG was part of the recruitment process for the 2 Learning Response Leads and meet with the Leads bi-monthly.
- **FTSU Ambassadors** –The Ambassadors come from a variety of clinical and non-clinical backgrounds, including a Consultant, providing a gateway to hard-to-reach groups. In addition, they raise the profile of the speak up culture in the Trust and uphold the Trust values. SFT is

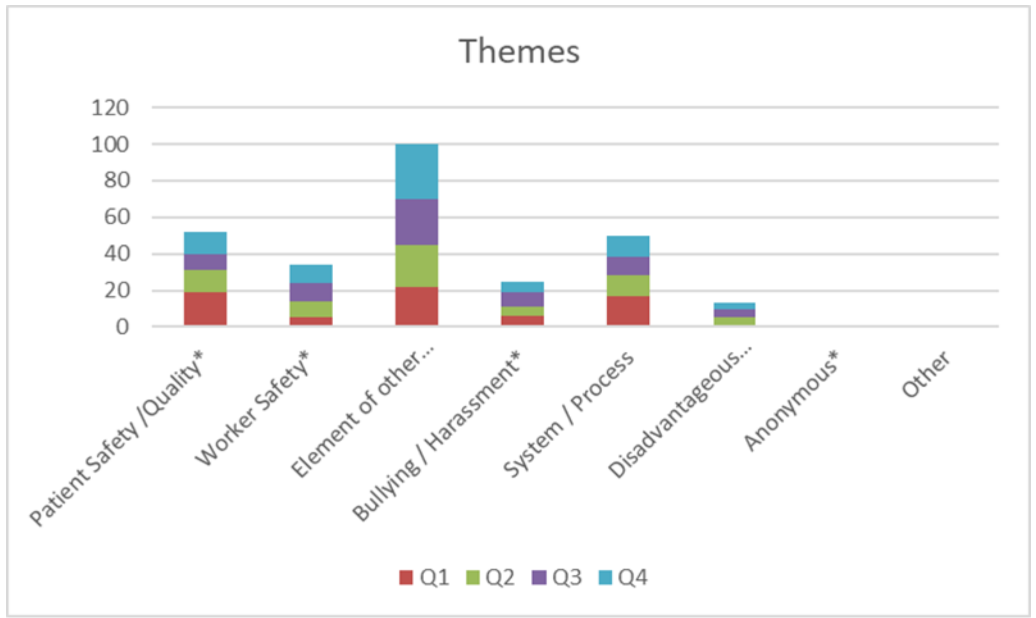
fully compliant with the NGO's guidance on developing and maintaining ambassador networks, including ring fenced time for Ambassadors to support speaking up.

- **Cases** – 163 concerns were raised to the FTSUG during 2023-24, an increase of 22% from the previous year. Where issues are complex external investigations commissioned by the Executive Team have taken place. Approximately 11% of staff who raised concerns have left the organisation, which is a decrease from 15% the previous year.

6. Summary of Concerns 2023-24

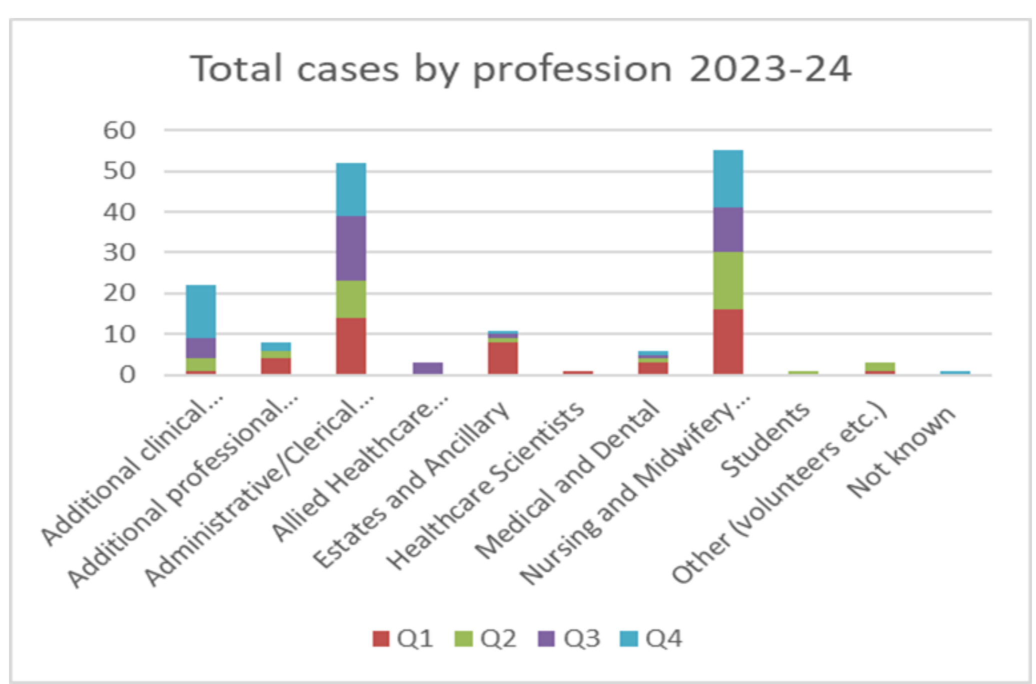
6.1 Annual data - summary of issues raised 1st April 2023 – 31st March 2024

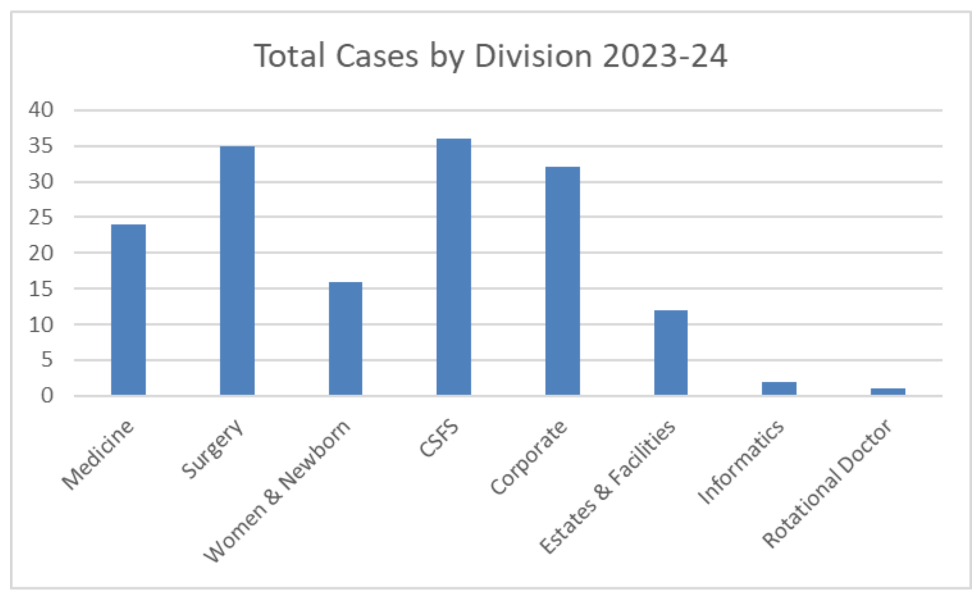
During this period 163 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes and trends.



*Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive





As we can see from the data, there are varying amounts of concerns being raised in the clinical divisions, with the CSFS Division being the highest and Medicine the lowest.

Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

Below are some examples of anonymised staff concerns capturing the complexities of some of the issues staff are raising:

Cases with an element of worker safety	• Staff safety concerns connected to sexual harassment • Staff reporting concerns about fear in relation to speaking up
Examples of patient safety concerns	• Staff feeling inadequately trained to treat patients with confidence • Poor working relationships having impact on patient care
Examples of bullying & harassment concerns	• Staff member had racial slur in front of entire team at meeting • Staff reporting public humiliation
Examples of system & process concerns	• Lack of clarity regarding fixed term contract, felt unfairly treated • Inappropriate redeployment with no regard for disclosed disability
Examples of cases with inappropriate attitudes or behaviours	• Lack of confidentiality in relation to personal details being inappropriately shared • After long career at SFT, now being made feel surplus to requirements

WRES data – during this period at SFT approximately 27% of the 5632 including bank staff, were from a Black, Asian or Minority Ethnic background. Of the 163 concerns raised, 21% were raised by staff from a Black, Asian or Minority Ethnic background which is a proportional representation of the BAME workforce. The FTSUG works closely with the Multicultural Staff Network to ensure that speaking up is promoted and barriers that this particular staff group may face are discussed and addressed.

Of note, disability issues were connected to 12% of staff who raised concerns, with several staff mentioning caring responsibilities that were having an impact on their role. The amount of staff who disclose a disability is around 3% showing that disabled colleagues are having a less good experience at work. The reinvigorated staff networks and wellbeing offers that have been introduced will give more support and guidance in the future.

Total amount of concerns raised having an element of poor line managers competency or behaviours or both is 103. Additionally, out of 34 managers who raised a concern, 17 of them were raising concerns about their line managers. There were also 33 concerns raised that could have been resolved through Human Resources/Employee Relations/Payroll or Counter fraud. In many cases they had tried but had no response.

7. Benchmarking

7.1 The national data is summarised below for 2017/18, 2018/19, 2019/20,2020/2021 and 2021/2022. There has been a delay due to staff shortages for the reconciliation and publication of the data for 2023/24 from the National Guardian's Office. Patient safety and worker safety have now been separated into two categories.

	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Total cases	7,087	12,244	16,199	20,388	20,362	25,382	32,167
Element of Patient Safety/Quality	2,267	3,523	3,732	3,668	3,838	4,898	6,006

Worker Safety	No data	No data	No data	No data	2,757	6,953	6,955
Element of Bullying & Harassment	3,189	4,969	5,831	6,131	6,471	5,506	6,369
Inappropriate attitudes/behaviours	No data	No data	No data	No data	No data	7,621	12,389
Suffered Detriment	361	564	544	632	856	1,000	1,285
Anonymous	1,254	1,491	2,037	2,379	2,120	2,373	3,046

SFT data for the same period:

	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Total cases	28	21	85	105	89	134	163
Element of Patient Safety/Quality	16	11	44	43	36	37	52
Worker Safety	No data	No data	No data	No data	14	25	34
Inappropriate attitudes or behaviours						80	100
Element of Bullying & Harassment	9	12	60	49	37	24	25
Suffered Detriment	No data	No data	16	11	8	5	13
Anonymous	1	0	1	1	1	2	1

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, particularly the increase in the number concerns, reflects the picture seen nationally.
- Nurses and midwives continue to be the staff group who raise the most concerns both nationally and locally closely followed by Administrative and Clerical.
- The Guardian has only received one anonymous concern.
- Inappropriate attitudes or behaviours is significantly higher than other themes.
- SFT reported 13 cases where there was a perception of negative treatment for speaking up.

Anonymous reporting is highlighted by the NGO as an indicator of staff potentially feeling a lack of trust in the organisation and a fear of detriment. SFT appears to be consistently reporting low numbers of anonymous FTSU concerns which indicates a level of trust in the FTSU service.

Comparisons in current cases:

RUH Bath	Salisbury NHSFT	Great Western Hospitals
148	163	15

7.2 **Feedback -** A feedback form is sent to all staff who raise a concern, which asks if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 20% of staff returned the form and the FTSUG also seeks verbal feedback when appropriate. There have been positive and negative experiences from staff who have raised concerns, below are a few examples: -

"Thank you for all your perseverance and support, it has been a long journey but I can now put the past to rest"

"I am very grateful for the advice and support I have received, without which I don't think we would have seen such positive progress with my case. I felt that the FTSUG really listened to me to understand all the issues I was facing. It is so helpful to have someone with whom you can speak openly and in confidence. I would really recommend that anyone experiencing problems in the workplace contact the FTSUG. I wouldn't hesitate to contact the FTSUG in future if I experience any more issues - although I hope I won't need to!"

"I felt supported by FTSUG but did not feel listened to by the senior manager who couldn't believe what they were hearing. I have had no option but to resign and move departments."

"Thank you for making me feel welcome to express my concerns to you. No one wants to feel left out and as an ethnic minority there is an expectation for us to be 'extraordinary' in what we do but in reality we shouldn't be. We should be treated the same way as everyone."

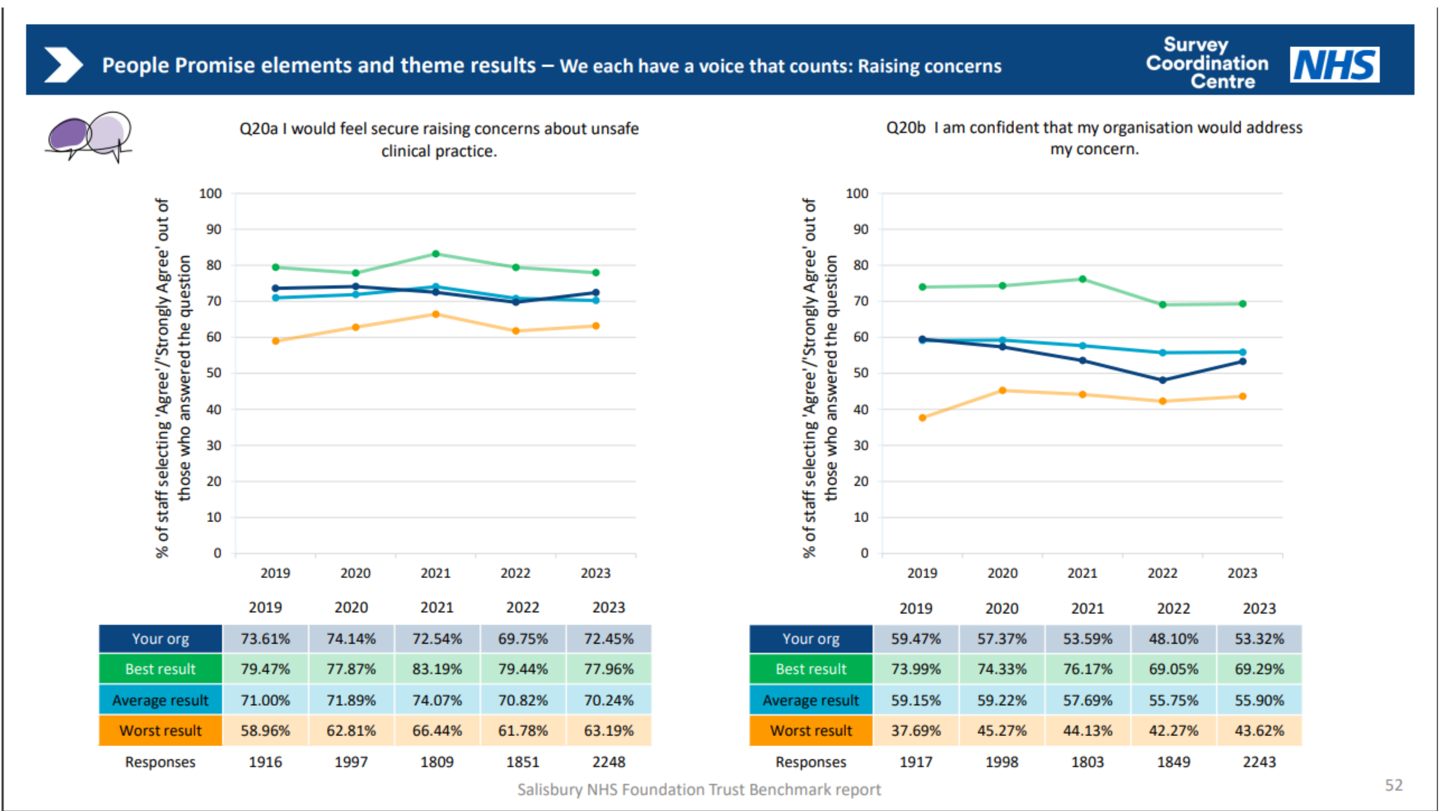
"Would definitely speak up again, felt very supported and happy with the outcome".

"Would definitely speak up again. Good to get an independent view of the situation".

For those who feel they have suffered detriment after raising a concern, the FTSUG flags this to the Chief People Officer and those who have been involved in managing the concern. Development of clear guidance and protocol when detriment is identified needs to be a priority to create the psychological safety for colleagues to raise concerns.

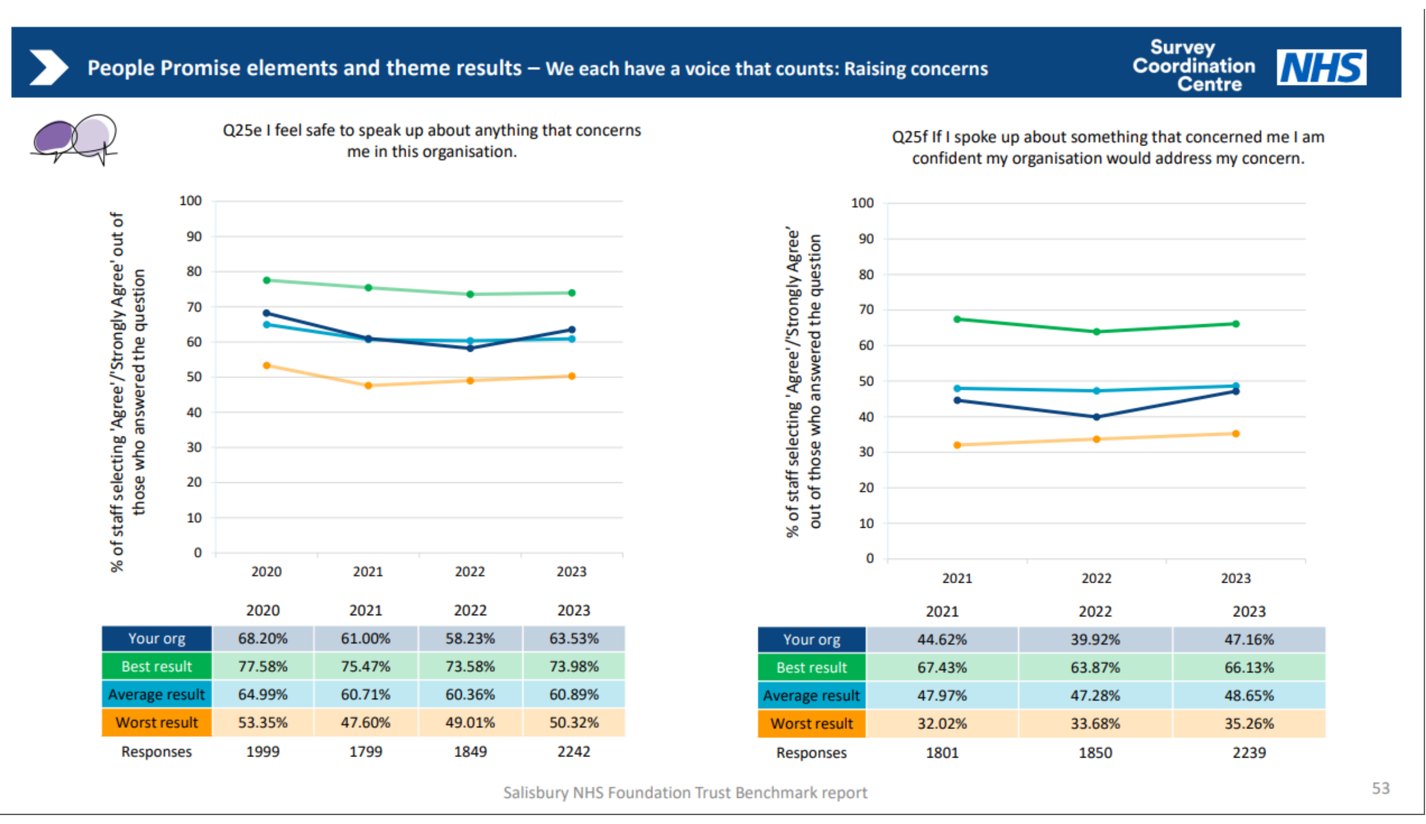
7.3 NHS Staff Survey – SFT Results

The staff survey results reflect the increase in staff feeling safe to raise concerns at SFT. There is also an increase in staff feeling that concerns are being addressed when raised.



	2019	2020	2021	2022	2023
Your org	73.61%	74.14%	72.54%	69.75%	72.45%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	1916	1997	1809	1851	2248

	2019	2020	2021	2022	2023
Your org	59.47%	57.37%	53.59%	48.10%	53.32%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	1917	1998	1803	1849	2243



	2020	2021	2022	2023
Your org	68.20%	61.00%	58.23%	63.53%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	1999	1799	1849	2242

	2021	2022	2023
Your org	44.62%	39.92%	47.16%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	1801	1850	2239

7.4 NHS People Promise – We each have a voice that counts.

The response of the staff survey results reflects the work the FTSUG with the wider OD&P team has done to deliver this particular aspect of the People Promise. Actions included refreshing and publishing FTSU Policy and Strategy, clear communications plan promoting FTSU service, expert data triangulated to create thematic analysis to inform interventions and work alongside staff networks to identify barriers to speaking up. All these aspects have been attended to resulting in significant positive staff survey results.

The FTSUG also delivers training at the Aspiring and Transformational Leaders Course, focusing on how leadership behaviours influence the creation of psychological safety in order that colleagues can raise concerns with confidence and assurance that they will be listened to and acted upon.

8.0 Summary of Learning from Speaking Up

The majority of the concerns raised have resulted in learning for the Trust. A summary of this learning is described below:

- Focus groups arranged for staff to have a safe place to talk openly with feedback themed and anonymised for line managers to reflect on and action plans put in place.
- Identified support for colleagues who are struggling to find accommodation in the local are which is vital to retain skilled workforce.
- Flexible working policy to be better socialised around service need and reasonable working patterns.
- Clarity and clear role expectations put in place for Ward Assistants.
- Additional support and training given to new Maternity Nurses with safe care being delivered to patients

- Challenged poor behaviours to include openness and visibility of managers, disciplinary action taken where appropriate.
- Cultural review to take place by Organisational Development to assess employee experience and wellbeing within a department where recurrent concerns have been raised.
- OSCE nurses now enjoying a much higher pass rate since training has been bought back in-house.
- Discriminatory behaviour has been addressed by appropriate training given to the individuals concerned with support put in place for those who spoke up.
- Work Experience and Volunteer engagement process has been reviewed and focus put on equity to all potential work experience students which has not always been the case.
- Maternity Leave Policy reviewed and changed after a concern raised about financial loss due to pregnancy in relation to advancement in pay award after completion of training.
- Patients are no longer being discharged directly from recovery, which is against protocol.
- FTSUG works with the Divisions looking at themes and trends of concerns raised. Action plans are developed in response.
- Poor recruitment practice on ward, managers have been supported and retrained in fair and equitable recruitment. Staff affected have been supported.

All these improvements will help our staff deliver an outstanding experience every time for our patients.

Speaking up is about anything that gets in the way of delivering high quality care.

9.0 Summary

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report and recent guidance from NHSI/E and the CQC: This paper provides the Committee with assurance that best employment practice for FTSUG has been adopted at Salisbury NHS Foundation Trust.

10 Recommendations

10.1 The Board is asked to note the Freedom to Speak Up Annual Report 2023/24 and consider appropriate actions for improvement going forwards.

It is recognised that improved leadership and management across the Trust will drive improvements in staff experience and wellbeing – this has been clear in our most recent Staff Survey and in ongoing conversations identified within this report.

The Board to consider mandating Speak Up, Listen Up and Follow Up FTSU online training all of which are available on MLE.

It is the Trust Board's responsibility to support the Chief People Officer and FTSU Guardian to complete the Board Self Reflection Toolkit which needs to be reviewed and refreshed by April 2025.

Detriment to be identified and appropriately managed. This includes input from the Executive and Non-Executive Leads, expectations for those managing a concern, and whether a concern is raised through FTSU or not. My recommendation would be that FTSU to work with Employee Relation Team and HR

Business Partners to come up with a clear protocol which can be embedded into our Leadership Development Programme and relevant people policies.

The author wishes to thank the Board for the continued support, scrutiny and awareness of our plans and their critical support in addressing the cultural changes and that appropriate resource is in place to enable.

Elizabeth Swift
Freedom to Speak Up Guardian