

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







Salisbury NHS Foundation Trust

Annual Report and Accounts 2023 to 2024

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CONTENTS	PAGE
1. Performance Report	
1.1. <u>Performance overview from the Chief Executive</u>	5
1.2. <u>Performance Analysis</u>	18
2. Accountability Report	
2.1. <u>Directors' Report</u>	31
2.2. <u>Remuneration Report</u>	35
2.3. <u>Staff Report</u>	50
2.4. <u>NHS Foundation Trust Code of Governance</u>	67
2.5. <u>NHS Oversight Framework</u>	87
2.6. <u>Statement of Accounting Officer's Responsibilities</u>	88
2.7. <u>Annual Governance Statement</u>	90
3. Annual Accounts for the period 1 April 2023 to 31 March 2024	

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.

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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

A handwritten signature in black ink, appearing to read 'Ian Green'.

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

Lisa Thomas

A handwritten signature in black ink, appearing to read 'L. 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.

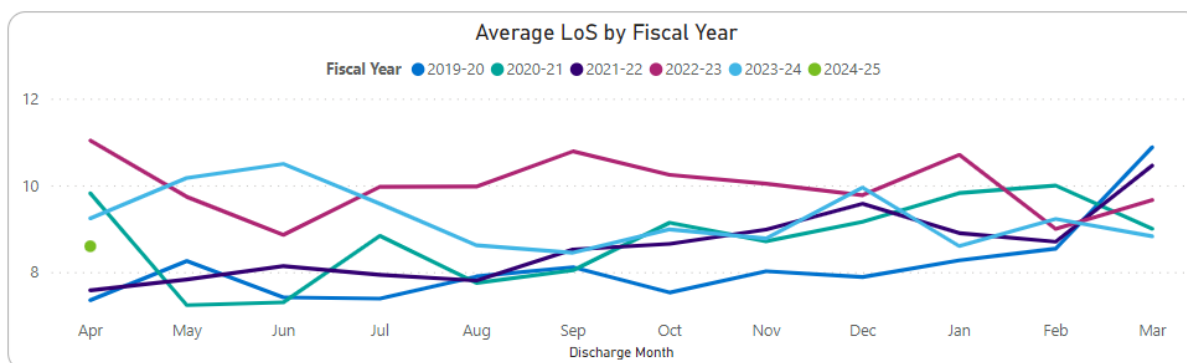
The time to first outpatient appointment breakthrough objective has seen a plateauing of the average time to first appointment and has not yet made the overall improvement expected of this area of focus. This will therefore continue into 2024/25 with refreshed cross-divisional focus through workshops 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.

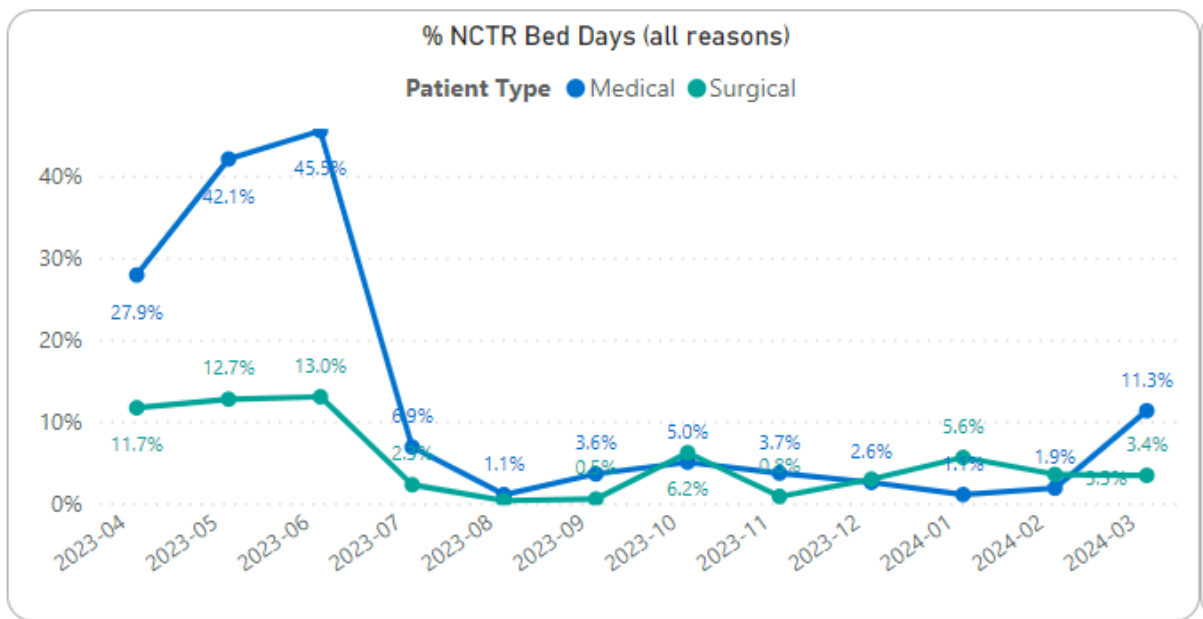
We also launched a local Urgent and Emergency Care and Flow Board (UECB) through which all the UEC improvement work reports and alignment with the strategic initiatives is overseen.

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 specialities.

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

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

Lisa Thomas

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.

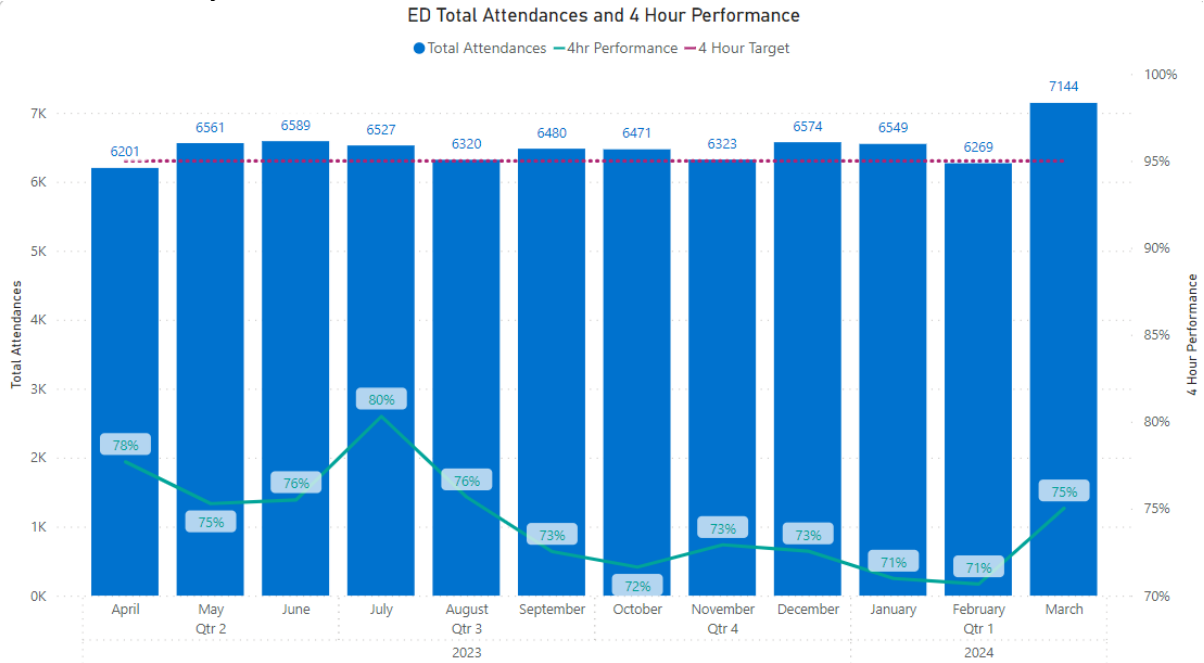
Our local plans included focusing on flow in terms of reducing bed occupancy and increasing productivity to reduce our waiting times.

Urgent and Emergency Care

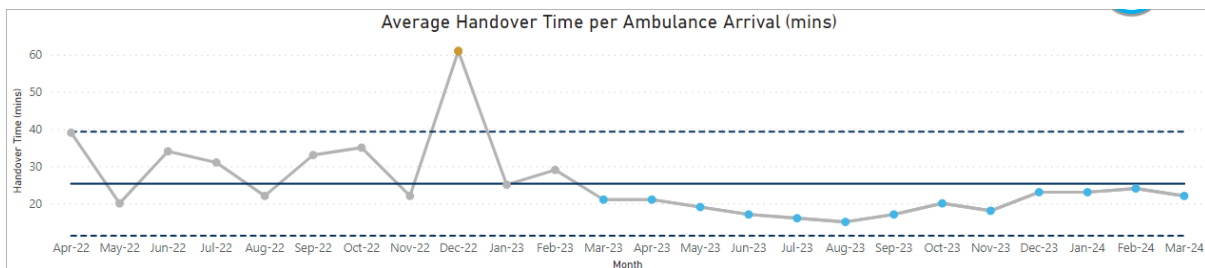
Demand for our Urgent and Emergency Care services have increased markedly this year, with Emergency Department attendances up by 4% in comparison to last year, and non-elective admissions up by around 6%. Bed occupancy levels remained high at around 97%. The number of patients no longer requiring acute 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.

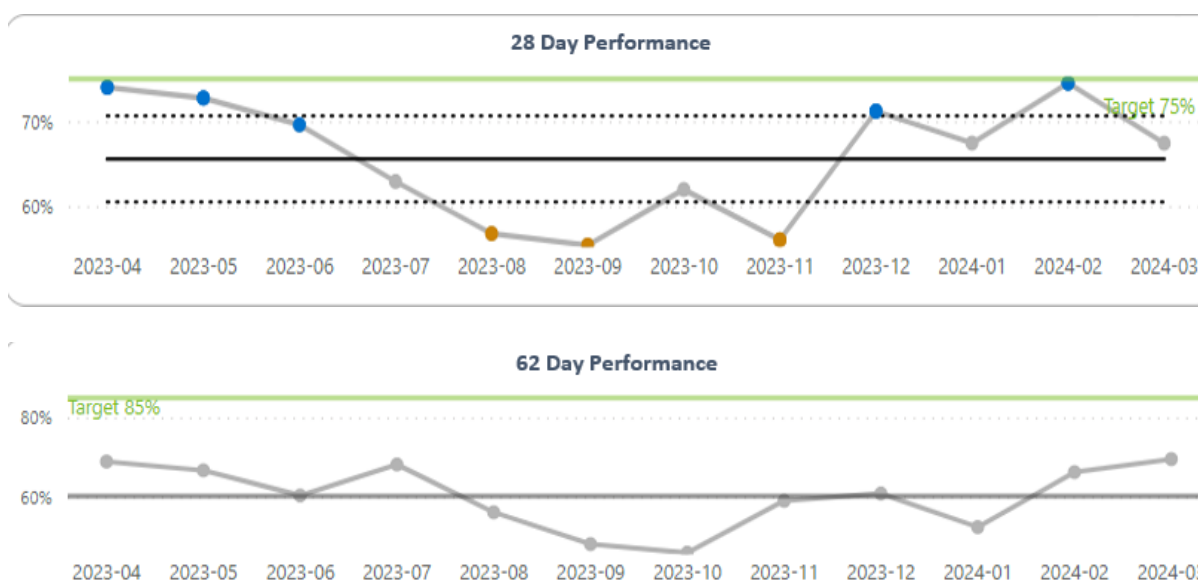


Elective Care

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.



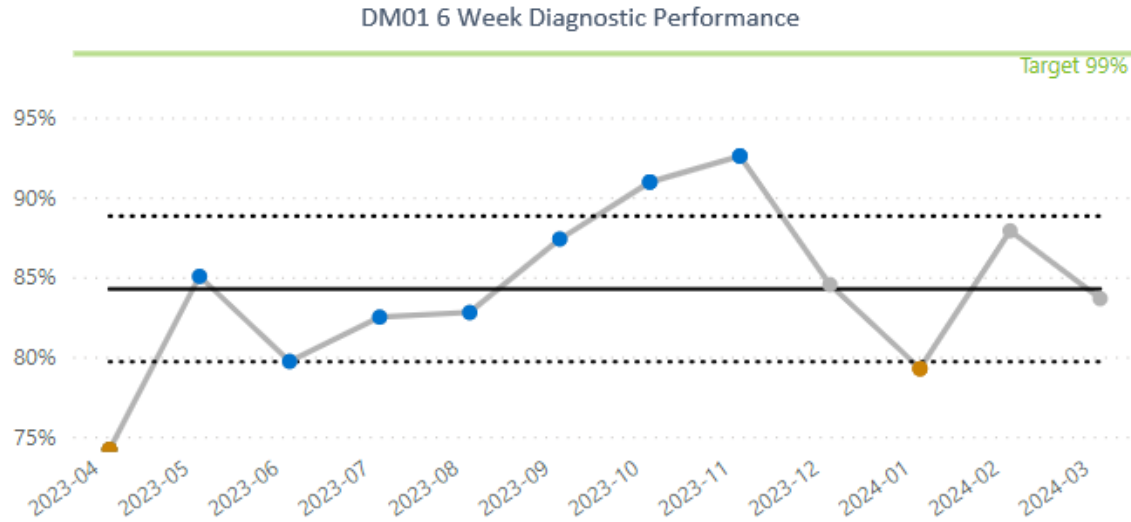
A consequence of lower performance for the 28 day and 62 day standards was an increased number of patients waiting longer than 62 days on a cancer pathway for treatment. This peaked at 167 patients in September 23, we reduced this to 91 by end of March 24 with increased capacity and support to the cancer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

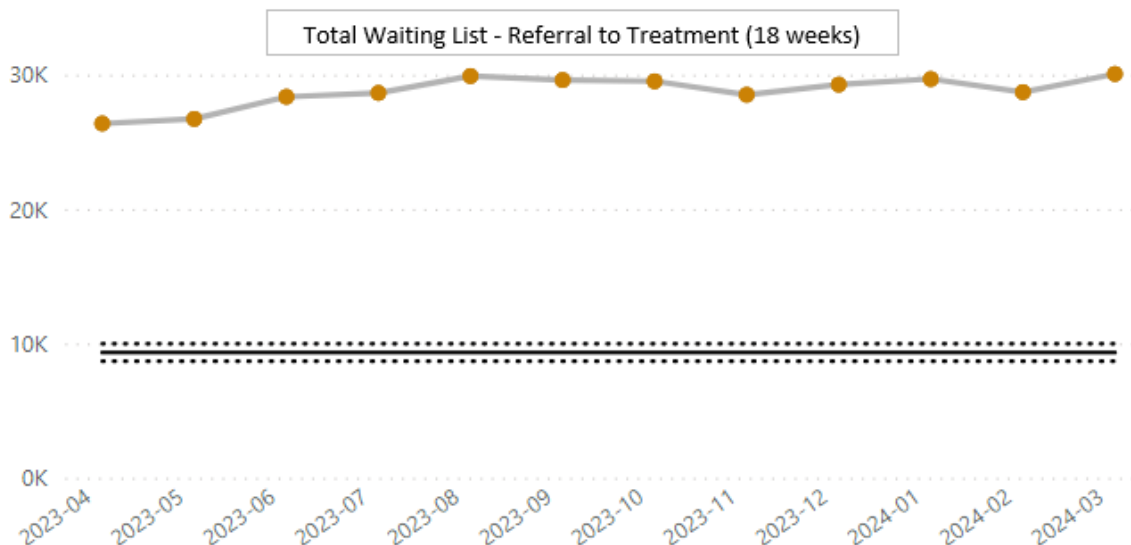
diagnostic services closer to our local population whilst also maintaining our progress in delivering low waiting times.



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 of 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.

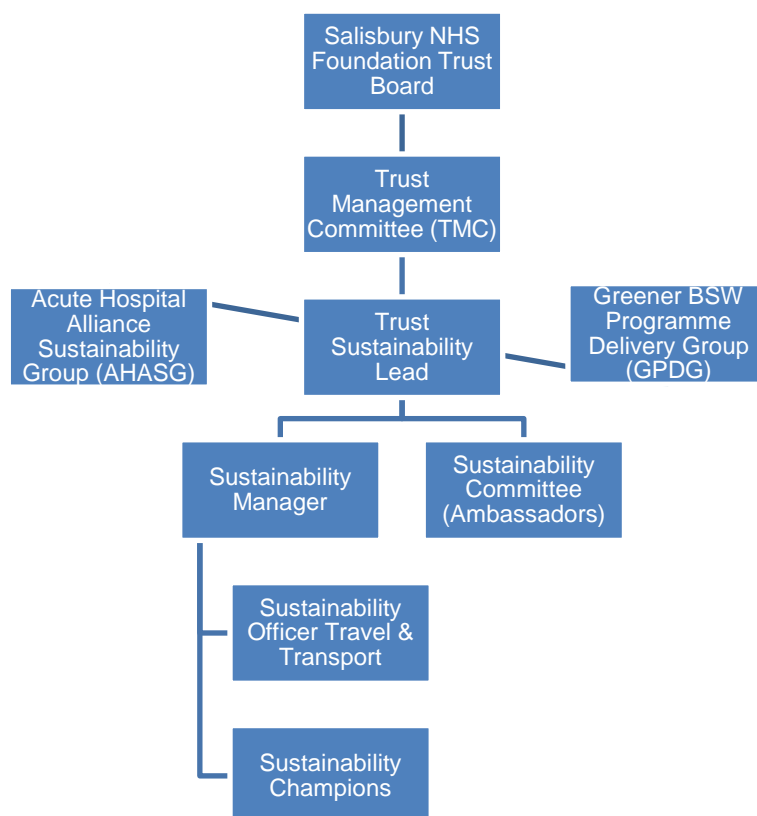


Figure 1. SFT Green Governance Structure

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 31 st August)
Margaret (Eiri) Jones	Non-Executive Director (Senior Independent Director from 1 st 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	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Improving the health and wellbeing of the population we serve. • Working through partnerships to transform and 	<p>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.</p> <p>Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration.</p> <p>Initial positioning on this pay band is based on experience and</p>	<p>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.</p>

	<p>integrate our services.</p> <ul style="list-style-type: none"> 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	<p>Provides a solid basis for recruitment and retention of top leaders in sector.</p> <p>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.</p>	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	<p>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.</p> <p>Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of:</p> <ul style="list-style-type: none"> 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.

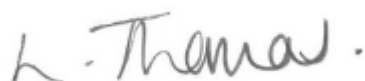
Payments for loss of office

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.



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 and 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 not 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.

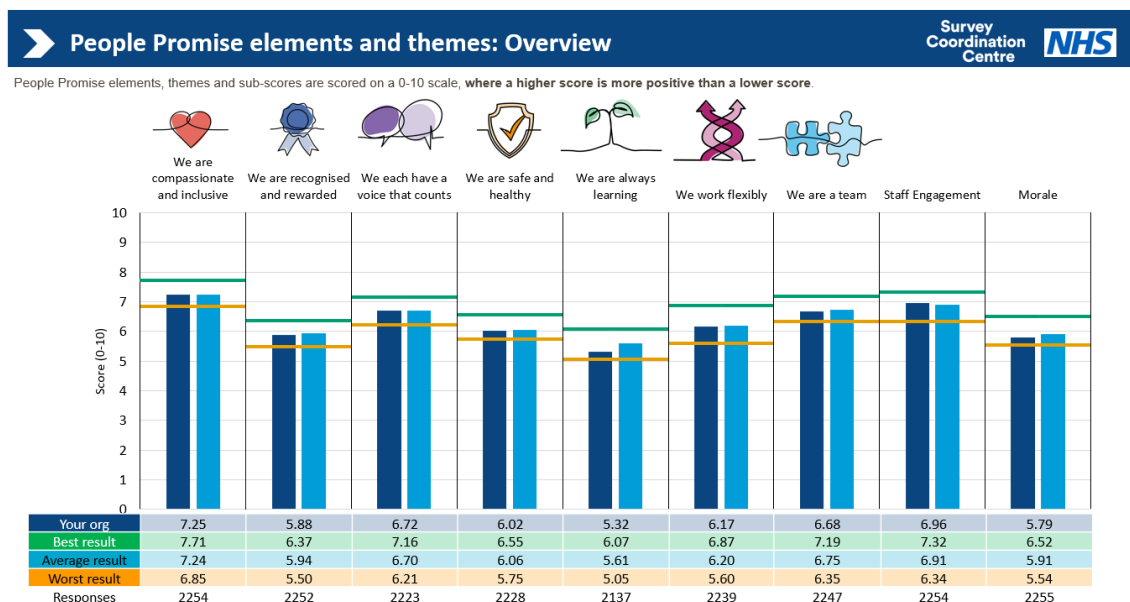
Staff Survey

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:



Salisbury NHS Foundation Trust Benchmark report

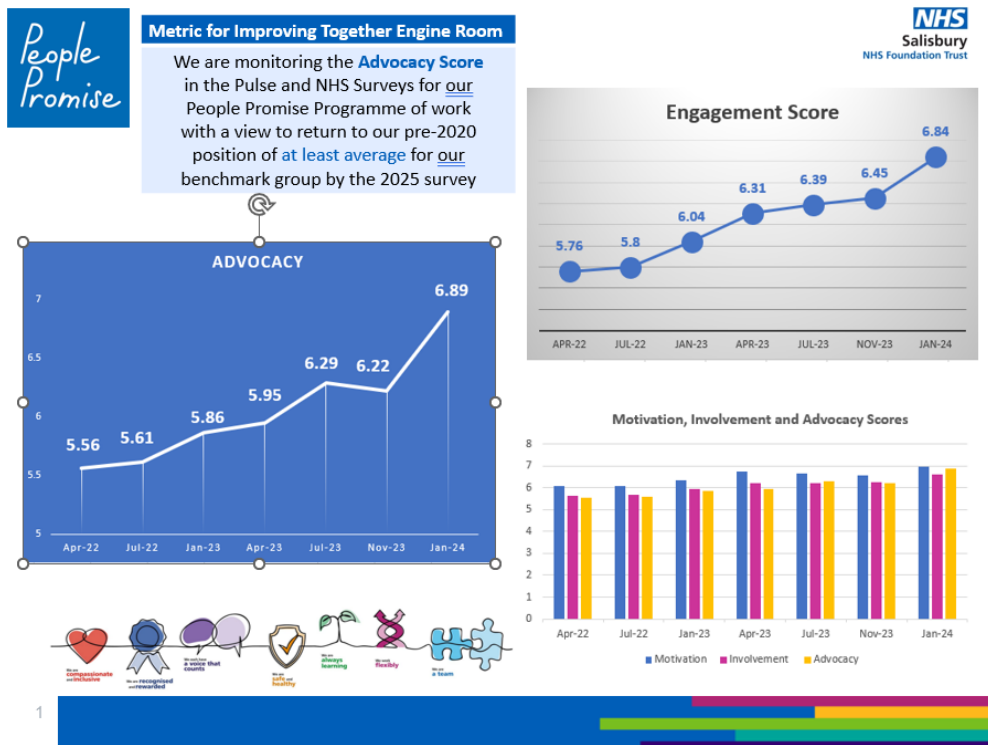
Comparisons between 2023-24, 2022-23 and 2021-22 are shown in the following table:

Indicators (People Promise elements and themes)	2023-24		2022-23		2021-22	
	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 advocacy¹. 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/.](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 MRCP 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		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)
	From	To						
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	<p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> 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			
		<ul style="list-style-type: none"> 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	<p>The annual report should include:</p> <ul style="list-style-type: none"> 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	<p>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.</p> <p>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.</p> <p>* 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).</p> <p>** As inserted by section 151 (6) of the Health and Social Care Act 2012)</p>	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*.



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 significantly 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 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 through 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 vision 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.



Lisa Thomas
Interim Chief Executive (Accounting Officer)
27/06/2024
(on behalf of the Trust Board)



SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2024

INDEX

	Page
FOREWORD TO THE ACCOUNTS	(i)
INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS	(ii - v)
STATEMENTS OF COMPREHENSIVE INCOME	1
STATEMENTS OF FINANCIAL POSITION	2
CONSOLIDATED STATEMENTS OF CHANGES IN TAXPAYERS EQUITY	3
CONSOLIDATED STATEMENTS OF CASH FLOWS	4
NOTES TO THE ACCOUNTS	5 - 59

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:

A handwritten signature in black ink that reads "L. Thomas." The signature is written in a cursive, slightly slanted style.

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.

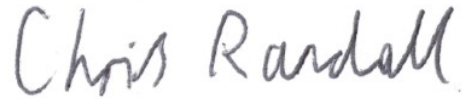
We have nothing to report in respect of these matters.

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 (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	
	Note	2023/24 £000	2022/23 £000	2023/24 £000	2022/23 £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		Trust	
		31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	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:



Lisa Thomas - Interim Chief Executive

STATEMENT OF CHANGES IN EQUITY

	Trust				Subsidiary		Charitable Fund	Group
	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		Trust	
		2024 £000	2023 £000	2024 £000	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.

Initial Recognition

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

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
	<u>332,928</u>	<u>316,728</u>

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	<u>4,002</u>	<u>5,336</u>

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 £000	2022/23 £000	2023/24 £000	2022/23 £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 £000	2022/23 £000	2023/24 £000	2022/23 £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 £000	2022/23 £000	2023/24 £000	2022/23 £000
Future minimum lease receipts due at 31 March:				
- 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 £000	2022/23 £000	2023/24 £000	2022/23 £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
	<u>1,366</u>	<u>1,340</u>

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 £000	2022/23 £000	2023/24 £000	2022/23 £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	-	-
	<u>1,565</u>	<u>1,082</u>	<u>1,417</u>	<u>1,012</u>

12. Finance expenditure

	Group		Trust	
	2023/24 £000	2022/23 £000	2023/24 £000	2022/23 £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	<u>5,421</u>	<u>2,220</u>	<u>5,355</u>	<u>2,161</u>
Unwinding of discounts on provisions	4	(2)	4	(2)
Total finance costs	<u>5,425</u>	<u>2,218</u>	<u>5,359</u>	<u>2,159</u>

* 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 £000	Number	Value £000
Losses				
Cash losses	-	-	1	1
Bad debts and claims abandoned	94	133	140	26
Stores losses	-	-	4	1
	<u>94</u>	<u>133</u>	<u>145</u>	<u>28</u>
Special payments				
Ex-gratia payments	18	7	40	45
	<u>18</u>	<u>7</u>	<u>40</u>	<u>45</u>
Total losses and special payments	<u>112</u>	<u>140</u>	<u>185</u>	<u>73</u>

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 desktop 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 desktop 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 £'000	31 March 2023 £'000	31 March 2024 £'000	31 March 2023 £'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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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:

- 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
- Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.
- Odstock Medical Limited to assist with working capital requirements

Non-current other financial assets represent loans made to:

- 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
- Sterile Supplies Limited to re-develop a new production facility with a third party.
- Odstock Medical Limited to assist with working capital requirements

Details of the loans to Salisbury Trading Limited are as follows:

- £1.3m to purchase the laundry stock.
- £2.0m to purchase the laundry equipment.
- £0.5m to purchase laundry stocks.
- £0.7m to purchase laundry stock.
- £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	All other receivables £000	receivables and contract assets £000	All other receivables £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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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

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:					
Additions	-	-	613	-	613
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 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £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 £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax £000	Other £000	Total £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 £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax £000	Other £000	Total £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	<u>2,011</u>	<u>4,277</u>

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
Vyair 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	<u>4,910</u>	<u>4,329</u>

29.3 Annual commitments under Private Finance Transactions - On Statement of Financial Position

	2024	2023
	£000	£000
The Trust is committed to make the following service payments on the PFI:		
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	<u>40,792</u>	<u>23,696</u>
Finance charges allocated to future periods	(13,203)	(8,132)
Net PFI liabilities	<u>27,589</u>	<u>15,564</u>
- 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	<u>70,109</u>	<u>73,244</u>
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	<u>70,109</u>	<u>73,244</u>

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)
	<u>4,910</u>	<u>4,910</u>	<u>-</u>

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	<u>(12,332)</u>

	£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)	<u>(2,429)</u>

	£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	<u>(12,332)</u>

	£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	<u>-</u>

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
<u>Fixed rate</u>									
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
<u>Floating rate</u>									
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
<u>Fixed rate</u>									
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
<u>Floating rate</u>									
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.

Shares at cost	Trust 31 March 2024 £'000	Trust 31 March 2023 £'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	<u>500</u>	<u>500</u>

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	<u>31</u>	<u>51</u>
Carrying value of investment at 31 March	<u>168</u>	<u>137</u>

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	<u>-</u>	<u>3</u>
Carrying value of investment at 31 March	<u>163</u>	<u>163</u>

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	<u>120,382</u>	<u>99,600</u>

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	-	-
	<u>15,329</u>	<u>14,162</u>

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.

