



Salisbury NHS Foundation Trust Annual Report and
Accounts
1 April 2025 to 31 March 2026



Salisbury NHS Foundation Trust

Annual Report and Accounts 2025 to 2026

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

CONTENTS	PAGE
1. Performance Report	
1.1. <u>Performance overview from the Chief Executive</u>	7
1.2. <u>Performance Analysis</u>	18
2. Accountability Report	
2.1. <u>Directors' Report</u>	35
2.2. <u>Remuneration Report</u>	40
2.3. <u>Staff Report</u>	62
2.4. <u>NHS Foundation Trust Code of Governance</u>	76
2.5. <u>NHS Oversight Framework</u>	102
2.6. <u>Statement of Accounting Officer's Responsibilities</u>	103
2.7. <u>Annual Governance Statement</u>	105
3. Annual Accounts for the period 1 April 2025 to 31 March 2026	134

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

Throughout 2025-26 our staff have made an enormous impact to our population despite the many challenging headwinds facing the healthcare sector. This year Salisbury NHS Foundation Trust has a lot to be proud of. During the year the Trust saw over 318,032 people in outpatients, we treated 27,711 patients in our Day Case unit, 81,229 people attended our Emergency Department and 31,962 attended the hospital as an emergency admission.

With the publication of the Government's 10 Year Health Plan, the challenging financial pressures, and workforce challenges, we are very proud of the way our teams have continued to respond and drive improvement across our services. Our colleagues have been resilient, continue to find new ways to work around challenges, and offer expert and compassionate care to embody the spirit of *Improving Together*.

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 reduce waiting times in line with national requirements. The Trust ended the year achieving zero patients waiting longer than 65 weeks. It is recognised there is more work to do as strive to recover constitutional standards by the end of this parliament (2029) and we are on track to decrease the time patients wait after being referred even further.

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, as a result of the changes in our Same Day Emergency Care (SDEC) and Acute Frailty services. These will continue to expand in scope throughout 2026-27 as we work to realise the neighbourhood care ambitions set out in the 10 Year Health Plan.

While demographic shifts in our population continue to place pressure on acute and community providers, reducing hospital flow, our quality indicators show continued improvement with significant progress on sustaining a reduced number of falls as well as pressure ulcers. We continue to improve our management of patient deterioration and have seen reductions in ICU admissions as a result.

We have continued to embed our approach to continuous improvement as we build a culture and ways of working that champions those who know services best in the pursuit of improvement. 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 5,000 people work in our teams. We are a community where everyone plays a vital role in our organisation. We are passionate in ensuring all our staff belong and feel they belong.

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

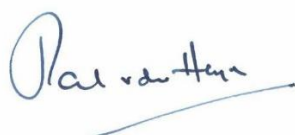
As a key partner in the Bath and Northeast Somerset, Swindon, and Wiltshire system (BSW), 2025-26 saw continued collaboration between partners to support and improve the quality of services and ensure resources are used effectively. We have formed BSW Hospitals Group, with our acute Trust partners in Bath and Swindon, and appointed a shared Chief Executive and executive leadership team. We are working closely together to ensure patients have access to high quality, safe and sustainable services.

We continue to make progress on our shared electronic patient record system (EPR), which is due to go live in 2027-28. This will be an exciting step forward and will enable our clinical teams to work more effectively with each other.

2025-26 has seen significant national and local change to decision makers, policy, and systems as the government embed their agenda and structural approach to the healthcare system. Our vision to provide outstanding experience for our patients, their families, and the people who work with and for us has given us a north star as we deliver our strategy and do the best possible for our population.

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, and where everyone matters.



Paul von der Heyde
Group Chair
26 June 2026
(on behalf of the Trust Board)



Cara Charles Barks
Group Chief Executive
26 June 2026

Purpose and Activities of the Trust

Salisbury NHS Foundation Trust was formally established on 1 June 2006. The Trust delivers a broad range of clinical care to approximately 300,000 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 our Spinal Treatment Centre. This specialises in caring for people who have a spinal cord injury and serves a population of 11 million covering an area across most of southern England.

The Trust has more than 5000 staff who deliver over 60 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), Somerset, and Dorset Integrated Care Board Cluster. The Trust works in partnership with local NHS organisations and the Local Authority to take collective responsibility for planning services, improving health, and reducing health 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, HCRG Care Group for Adult community services, Wiltshire Council for care services, Local GPs for primary care services, and many voluntary and third sector organisations for the benefit of the local population.

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, including those beyond the ICB cluster boundary such as University Hospital's Southampton and other Wessex geography organisations, all of which remain pertinent to delivering outstanding care.

BSW Hospitals Group in 2025-2026

In May 2025, Great Western Hospitals NHS Foundation Trust (GWH), Royal United Hospitals Bath NHS Foundation Trust (RUH) and Salisbury NHS Foundation Trust formed BSW Hospitals Group. Bringing together three NHS providers with a shared ambition to make a difference that really matters to colleagues, patients and their families, partners and wider communities across BSW and beyond.

With a combined workforce of over 17,600 colleagues and a budget of £1.6 billion, the partnership is united by a common purpose: to deliver the best possible care to over one million people. It aims to create a health and care system that works with people, not around them—reducing the differences people currently face in access, experience and outcomes, improving the experience of colleagues, and tackling shared challenges such as sustainability and financial pressures.

For the avoidance of doubt, this arrangement does not constitute a group for accounting purposes; the three statutory bodies remain separate legal entities, each responsible for its own statutory duties, financial management and reporting.

The five strategic initiatives the Group will focus on are:

- Transforming our models of care.
- Our people.
- Increasing sustainability.
- Delivering digital maturity.
- Developing our group.

The five priority programmes we will focus on to deliver our strategic initiatives over the next three years are:

- Transforming models of care: **Clinical services transformation** – focusing on patients and improving how healthcare services are delivered.
- Our people: **Corporate services transformation** – redesigning services around the needs of those who use them. Organisational Development and management of change programme.
- Increasing sustainability: **Recovery** – improving our performance and finances.
- Delivering digital maturity: **Implementing a single Electronic Patient Record** – bringing real time information together in one place to provide better, safer joined-up care for everyone.
- Developing our Group: getting **the right structure in place** to support us to work together effectively to truly serve our population.

This will help us to tackle the root causes of why our community doesn't always get the same quality of care or experience and means as a Group we can:

- Deliver care that is centred around patients, not organisations.
- Make sure our people and resources are focused where they can make the greatest difference.
- Create a solid foundation for the future where we can make the most of the opportunities available and be a strong voice for our community.

Our Strategy 2022-26

2025-26 marked the final year in the deployment of our 2022-26 strategy. 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, and is underpinned by our vision:

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

The strategy confirms 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. Developing a sustainable workforce
 3. Designing services to meet population needs
 4. Embedding a culture of continuous improvement (Improving Together)
- Breakthrough objectives. These are operational in nature and where improvement efforts are focused for 18-24 months. They are reviewed each year and can evolve when the targets have been achieved for 6+ months.

As in 2023-24, 2024-25, and 2025-26 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 2025-26

In 2025-26 the Trust chose the following four breakthrough objectives:

1. Managing patient deterioration well
2. Reduction in time to first outpatient appointment
3. Increasing staff retention
4. Creating value for our patients.

Progress against the 2025-26 breakthrough objectives

Following sustained improvement in the 2023-24 'reducing falls' *breakthrough objective* we revisited reducing our overarching vision metric of reducing harm and determined that we needed to focus on better managing patient deterioration. This was measured through compliance with timely observations of each patient, thereby reducing their likelihood of coming to harm.

The time to first outpatient appointment breakthrough objective had seen a plateauing of the average time to first appointment throughout 2023-24. As such it was continued into 2024-25

and 2025-26 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. Further specialty level support has helped drive clear improvement in 2024-25 of 11%.

Following a 16% improvement in turnover amongst additional clinical service staff in 2024-25 and 2025-26 we pivoted late in the year to the issue of staff absence. As the job market has cooled, and with our efforts stabilising the retention position, we were able to turn to a new Breakthrough Objective around managing absence which is now live for 2026-27. At the close of 2025-26 this was still demonstrating fluctuating data with our interventions yet to start delivering sustained improvement.

A new breakthrough objective focusing on creating value for the patient through productivity improvements was introduced for 2024-25, which aligns to the organisational sustainability vision metric. This breakthrough objective has allowed us to deliver a more than 5% productivity gain across the organisation. Allowing us to make sure every pound of taxpayer funds go even further in the pursuit of outstanding care.

Improving Patient Flow

The challenges with patient flow that were first emerging as a significant issue for us in 2022-23 remain today, largely due to demographic pressure. We have leveraged our Improving Together methodology and Same Day Emergency Care (SDEC) unit functions (including the introduction of an Acute Frailty Unit) to drive an improvement in flow. We have been working with HCRG since their awarding in April 2025 of the BSW community services contract, to further improve flow and in the interface of acute, community, and primary care services.

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).

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, and further investment was made into therapy services in 2025. This means that discussions and preparatory clinical work regarding discharges of patients with complex needs take place with all partners. Following the commencement of the community services contract to HCRG Care Group in April 2025, and their transformation year following, there is now a single point of access (SPoA) across the system which is designed to further assist flow in and out of hospital.

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 everyone.

Elective Recovery

We have continued to build upon the progress we made in reducing the time patients are waiting for planned care. This has seen average waits falling across our specialties.

Theatre productivity has remained above nationally recommended utilisation levels and strong recruitment performance allowed us to open additional theatre capacity in 2024-25 as part of our three-year development plan for theatres. At the close of 2025-26 we continued to perform amongst the strongest in the region regarding theatre utilization and look forward to future investment in a new diagnostic and surgical hub on site. We have developed a Community Diagnostic Centre within the Town Centre with CT and MRI scanning operational and plans to expand the diagnostic offer in the hub in the years to come.

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, the opening of our new ward has helped to ease this pressure, and our long-term campus master planning is on track to further deliver right sized services for our population.

We recognise that despite steady improvement in waiting times for treatment against the 52-week standard, there is still much to do in our pursuit of 18 week wait performance and an outstanding experience for our patients and population. We will continue to drive improvement, and leverage opportunities as part of our Group in 2026-27.

Improving our Maternity Services

Over the past year, Salisbury's Maternity and Neonatal Services have continued to strengthen processes, culture, and governance, aligned with the national focus on quality and safety. Work across all national improvement programmes remains on track, with ongoing commitment to further progress.

In November 2024, the Salisbury Maternity Unit formally exited the National Maternity Safety Support Programme after meeting all required criteria. The service then entered the sustainability phase and, in March 2026, received full confirmation of its successful exit. Regional NHS England teams and the ICB commended the progress made, as well as the sustained improvements in quality and safety.

National reviews continue to highlight the importance of listening to women and families and shaping services around local needs. Salisbury has built strong, effective collaboration with the Maternity and Neonatal Voices Partnership (MNVP) and service users, ensuring co-production of services with those who use them, along with ensuring a patient voice at every level of the service. In recognition of this partnership and their contribution, the MNVP service lead won the Outstanding Partner Award of the Year Award at the 2025 Salisbury Hospital Staff Awards.

Throughout 2025-26, assurance and reporting processes were further strengthened to support transparency and oversight of Maternity and Neonatal Services. Improvements are now well embedded, including regular reporting to the Trust Board with the Director of Midwifery present, and active Maternity Safety Champions meetings involving staff from all roles and levels. This increased engagement ensures staff views and concerns are heard at Executive level and that leaders remain fully informed about service performance, family outcomes, and emerging challenges.

Culture and wellbeing were key priorities for 2025-26. The perinatal leadership team increased visibility and support to teams, holding regular staff listening and wellbeing events and ensuring feedback is acted upon with involvement from all levels.

Collaboration with GWH and RUH remains strong through the Local Maternity and Neonatal System (LMNS). These relationships across Maternity and Neonatal Services have been further reinforced by the move to the BSW group hospital model, supporting shared learning, benchmarking, and joint improvement across organisations at all levels.

Care Quality Commission (CQC) engagement

During 2025-26, the Trust was subject to a number of CQC inspections across Medical Services, Surgical Services and Nuclear Medicine (under IR(ME)R). These inspections provided a balanced assessment, highlighting strong patient care, positive staff culture, and effective multidisciplinary working, alongside areas where further improvement is required. Medical Services were rated Good overall, with inspectors recognising a strong safety culture and inclusive approach to improvement.

The Surgical Services inspection provided positive initial feedback on patient experience and clinical pathways. However, the final report, including the overall rating, had not yet been published at the year end. The IR(ME)R inspection confirmed compliance with the majority of regulatory requirements, with no enforcement action required.

Across the inspections, areas for improvement included consistency in infection prevention and control, aspects of the clinical environment and equipment management, workforce stability, and delivery against a number of national performance standards.

The Trust has incorporated all required actions into its quality improvement and governance arrangements, with progress monitored through established oversight structures. Further detail, including actions taken and ongoing assurance, is set out in the Annual Governance Statement.

National Staff Survey Results 2025

In 2025, the NHS Staff Survey remained aligned with the NHS People Promise. The Trust achieved a 53% response rate, which was lower than the previous year but continued to be above the benchmarking group average, providing confidence that the results are representative of staff experience.

The overall results mirrored the national picture, with a general decline across People Promise measures. Despite this, SFT continued to perform above the national average in seven of the nine People Promise areas, demonstrating resilience in staff experience during a challenging year.

The survey highlighted a number of areas for improvement, including:

- an increase in the number of staff considering leaving the organisation;
- reduced confidence in career development opportunities; and
- a decrease in the proportion of staff who would recommend SFT as a place to work.

Encouragingly, positive results were maintained in key areas, including:

- staff feeling involved in decisions affecting their work;
- colleagues continuing to look forward to coming to work; and

- the Trust's approach to making reasonable adjustments for staff with disabilities.

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: [2025 NHS Staff Survey Breakdown Report](#) Further detail on our staff survey response can be found in the Staff Report.

Improving our digital capability

We continue our journey to deliver the aims and objectives laid out in our five-year digital plan launched in 2022-23, with Improving Digital Care being a Strategic Initiative for the Trust. The programme to replace the Trust's main electronic patient record (EPR) has progressed through the design and configuration phases, focus now moved into testing and delivery preparedness. The new Shared EPR will be a single solution with Royal United Hospitals Bath and Great Western Hospitals and aims to go live in 2027-28.

Whilst the new core EPR is the focus, we have continued to mature the use of digital over the last year, including the replacement of our ageing Pathology laboratory management system with WinPath enterprise, delivering a single database network solution, shared across the Southern Counties Pathology Network.

There has also been focus on expanding the maternity electronic patient record (EPR) system to include digital CTG (Cardiotocography) monitoring and further work across many specialities and services to digitise patient and clinician correspondence and communication

Key operational and financial risks

In common with all NHS organisations, Salisbury NHS Foundation Trust continues to operate in a highly challenging environment. Rising and more complex demand, ongoing workforce pressures, and sustained financial constraints require careful balancing to ensure we continue to deliver safe, high-quality care while improving productivity and efficiency. These risks are heightened by demographic change, system-wide capacity constraints and increasing expectations for recovery of constitutional standards.

The Trust recognises that addressing these risks is dependent on effective strategic and transformational change, both within the organisation and through the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System and Hospitals Group. Collaboration at scale is critical to improving flow, tackling elective backlogs, strengthening service sustainability and delivering financial recovery.

Key operational challenges continue to include managing demand and capacity across urgent and emergency care, improving patient flow and discharge, and sustaining progress on elective recovery while maintaining quality and safety. The Trust also faces material risks associated with the delivery of major transformation programmes, particularly the safe and timely implementation of the shared Electronic Patient Record, critical infrastructure resilience, digital and cyber security, and the availability, wellbeing and retention of our workforce.

Financially, the Trust remains exposed to significant risk arising from a challenging funding regime, cost inflation, pay pressures and limits on capital investment. Delivery of ambitious cost improvement and productivity plans is essential to achieving sustainability, but these

plans are high-risk and reliant on continued system partnership working, particularly in reducing patients with no criteria to reside and mitigating demand growth.

In summary, the Trust's principal operational and financial risks for 2025–26 relate to:

- the safe implementation and realisation of benefits from the new EPR system.
- maintaining progress in elective recovery and operational productivity while managing demand for urgent and emergency care.
- delivering financial recovery and required efficiencies within a constrained funding envelope.
- ensuring service and workforce sustainability; and
- maintaining the delivery of high-quality, safe and compassionate care during a period of significant change.

These risks are actively overseen by the Board through the Board Assurance Framework and are subject to ongoing review, mitigation and escalation through established governance arrangements.

Going Concern

The Board considered an assessment of the Trust as a going concern at its meeting on 13 May 2025, during which a number of risks to this position were identified. This assessment was undertaken in line with the requirements of the Department of Health and Social Care Group Accounting Manual (GAM), including consideration of the Trust's financial position, liquidity, and exposure to operational and system risks.

After making appropriate enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be delivered by the public sector for the foreseeable future. On this basis, and in accordance with the definition of going concern set out in the GAM and HM Treasury's Financial Reporting Manual, the directors have adopted the going concern basis in the preparation of the accounts. Any identified risks have been considered in determining whether there are material uncertainties requiring disclosure, consistent with GAM expectations.

Looking forward to 2026-27

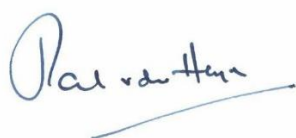
In 2026-27, BSW Hospitals Group will publish its overarching strategy and supporting three-year business plan. This will build on and align with the strategic initiatives and priority programmes already set out earlier in this report and does not represent a separate strategy; rather, it formalises and consolidates the Group's shared direction and ambitions.

As we enter 2026-27, the Trust remains focused on delivering its financial recovery plan while managing significant operational pressures. Priority will be given to delivering NHS England Operational Planning Priorities for 2026-27, alongside contributing to the delivery of the Group's agreed strategic initiatives through collaborative working.

Key areas of focus will include improving patient flow and reducing delays through strengthening our No Criteria to Reside (NCTR) position, working closely with system partners, and further developing Same Day Emergency Care (SDEC) services to reduce

pressure on inpatient capacity. Alongside this, there will be a continued emphasis on financial sustainability, recognising both the Trust's position and wider system challenges, with increased scrutiny and a need to deliver recurrent efficiencies.

The Trust's plans for 2026-27 are therefore consistent with, and supportive of, both its existing strategy and the emerging BSW Group strategic framework, with a continued focus on delivering high-quality, sustainable services for our population.



Paul von der Heyde
Chair
26 June 2026
(on behalf of the Trust Board)



Cara Charles Barks
Group Chief Executive
26 June 2026

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

National objectives influencing our plan for 2025-26 were to:

- reduce the time people wait for elective care through improving waits for elective and cancer treatment, and diagnostics.
- Reduce the number of patients waiting longer than 52 weeks for elective treatment.
- Improve A&E waiting times and ambulance response times

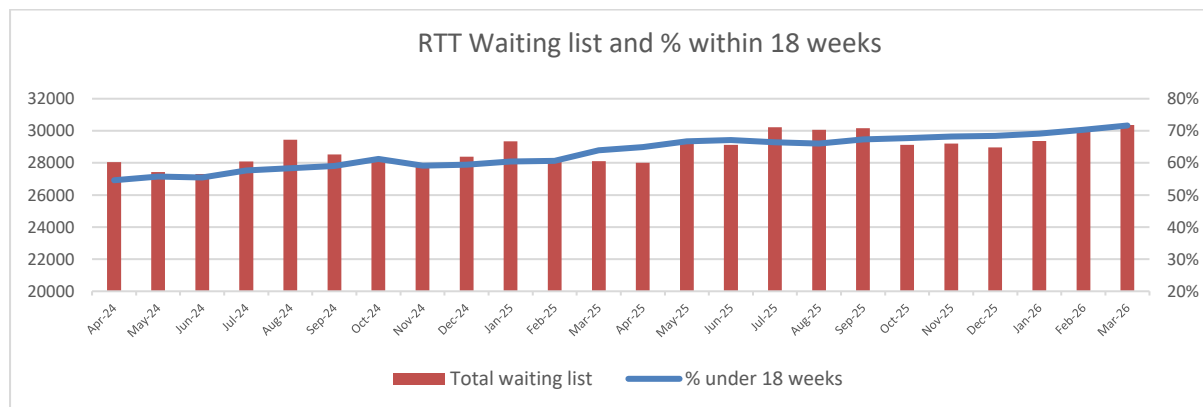
The Trust has made significant progress this year in delivering key elective priorities with improvements to elective and diagnostic waiting times. Demand increases in both urgent and cancer services have made the delivery of these services challenging but with progress in many areas.

Elective Care

Referral to Treatment (18 weeks)

We made excellent progress throughout 2025–26 in reducing waiting times for elective treatment and have continued to build on this over the course of the year. From June through to September 2025, and continuing into early 2026, we saw sustained improvement in performance. By March 2026, the percentage of patients waiting less than 18 weeks had increased to 71%, significantly exceeding our plan of 65%. This made us one of the most improved Trusts in the South West region and represents an increase of 17% over the last two years, an achievement we are proud of.

We also made reductions to our longest waits – we started the year with nearly 600 patients waiting longer than 52 weeks and by March 26 this was just 26, we aim to eliminate all by Q2 of 2026-27.



We were able to deliver these improvements by focusing on;

- Time to first outpatient – reduced from 143 days two years ago to 111 days by March 26, delivered by using the Improving Together methodology.
- Continued focused operational management and oversight of actions to deliver reducing wait times
- Productivity – focusing on maximising our capacity and treating as many patients as possible within our existing sessions

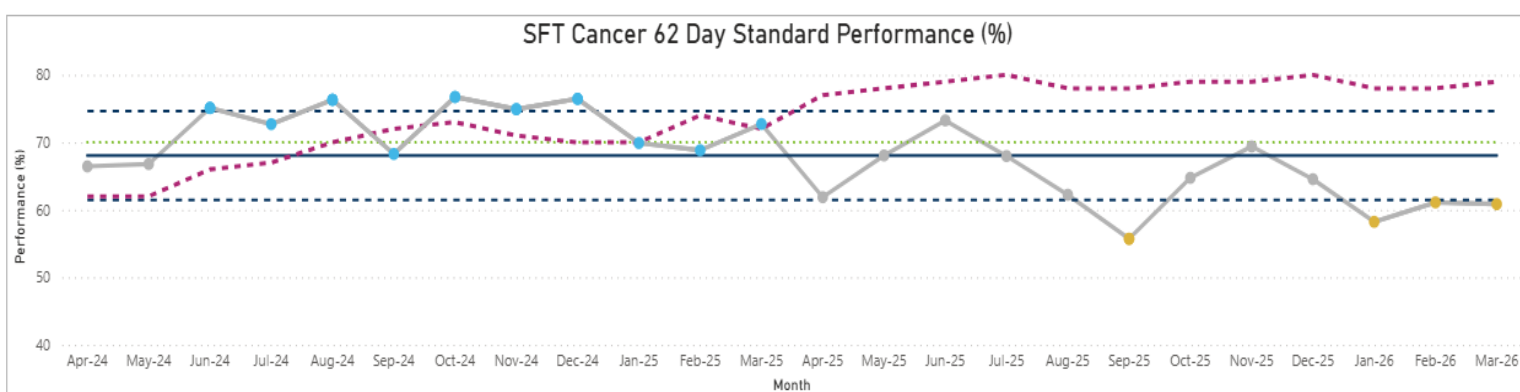
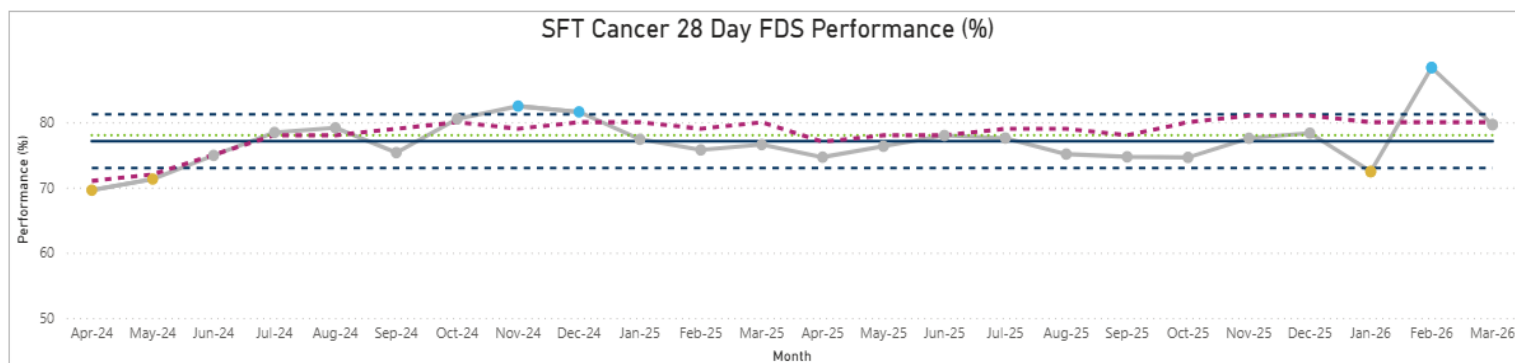
The waiting list size has grown by 8% over the year; reducing this growth and decreasing the waiting list size will be required as we work towards returning to achieving the constitutional standard of 92% percentage of patients waiting less than 18 weeks for elective treatment over the next 3 years.

Cancer pathways

We achieved an average of 75% across the year against the 28-day standard, rising to almost 80% by the end of the year. Exceptionally high demand to our skin cancer services has made this really challenging – referrals increased by 25% in comparison to the previous year. Skin is the biggest single tumour site and accounts for around a quarter of all suspected cancer referrals.

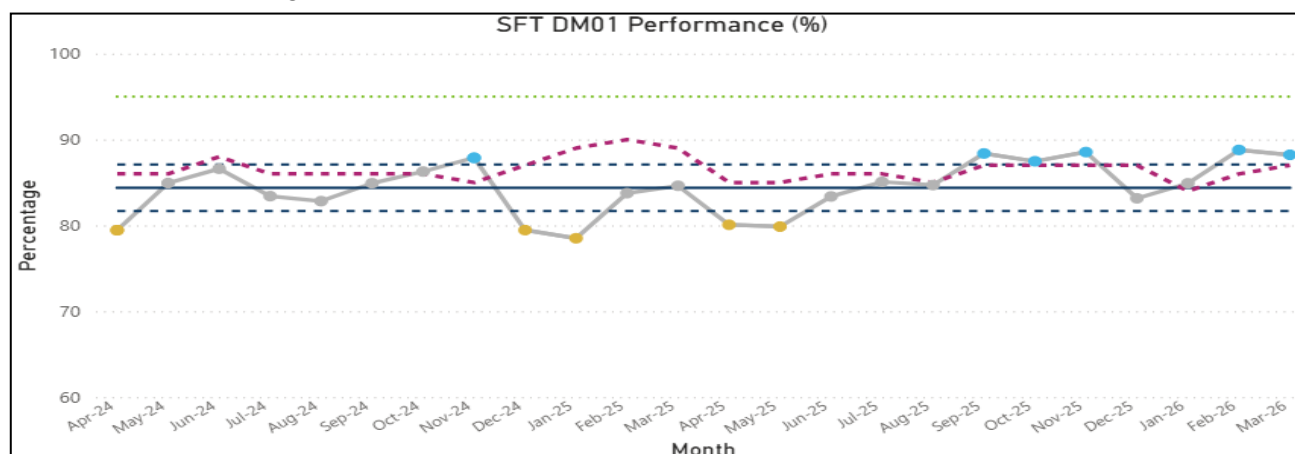
The 62-day standard has been more complex with some challenge across a number of tumour sites including Skin, Urology, Colorectal and Breast. Our performance dipped below 60% in September and is not yet consistently above this. Cancer remains a priority for us and we continue to focus on the actions required to improve up to the target of 75% and beyond. To support improvements in timeliness, a new cancer governance structure was

implemented in Q4 2025–26, alongside a recovery plan identifying targeted actions to further reduce cancer pathway times.



Diagnostics

Prompt access to diagnostics is key for us to be able to deliver all our access standards for elective and non-elective pathways. We have steadily improved against the 6-week standard throughout the year, ending at 88% in March 26, above the plan we set at the start of the year. We continue to benchmark above the England average. In the next three years we will focus in increasing this further to achieve the constitutional standard of 99%.



Urgent and Emergency Care

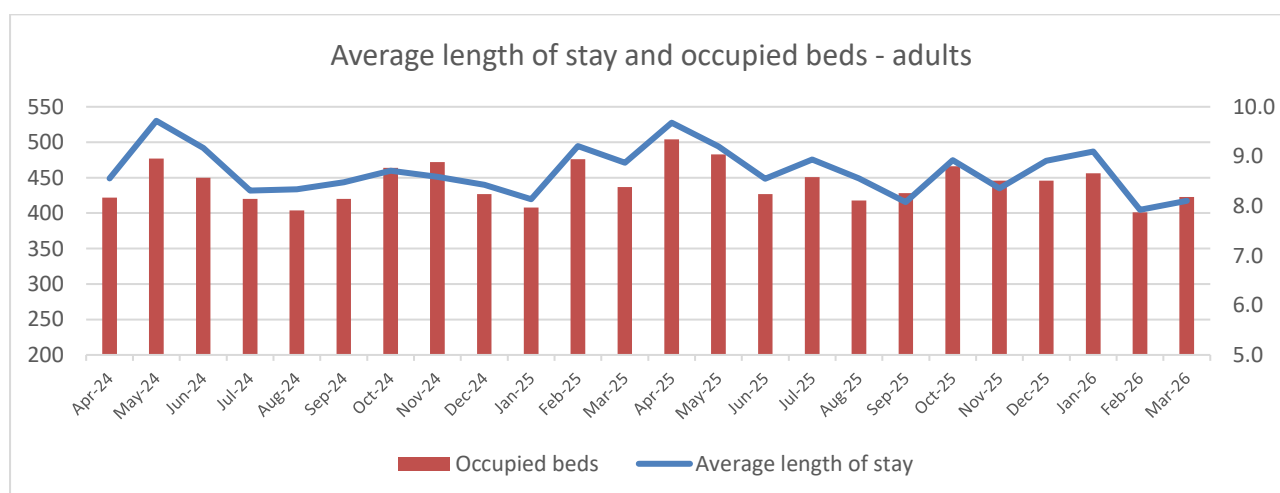
In a continuation of the trend over the past few years, the Trust again experienced high demand for urgent and emergency care services. The number of patients presenting to the Emergency Department increased by 3%, and the number of non-elective admissions to the Trust increased by 4%, both of which were above the agreed plan with commissioners.

Flow into the hospital continues to remain a challenge, affecting our ability to treat and admit or discharge patients within 4 hours. Our plans relied on the number of beds that were occupied by patients no longer meeting the criteria to reside reducing from 90 (the level in March 25) to 40. With our partners we delivered some solid improvement and by March the number had reduced to 59 which was the lowest monthly average since we started recording this metric in May 23. The average across the year was 82. Providing the right capacity for patients requiring further care remains a difficult and complex issue, and despite the clear challenges there have been examples of excellent collaborative working across the system to try and tackle this significant issue.

The high demand into the Trust and delays in being able to discharge patients meant the Trust did not meet the planned level (78%) of performance against the 4-hour standard. Despite the challenges we have maintained performance against the 4-hour standard at an average of 71% across the year.

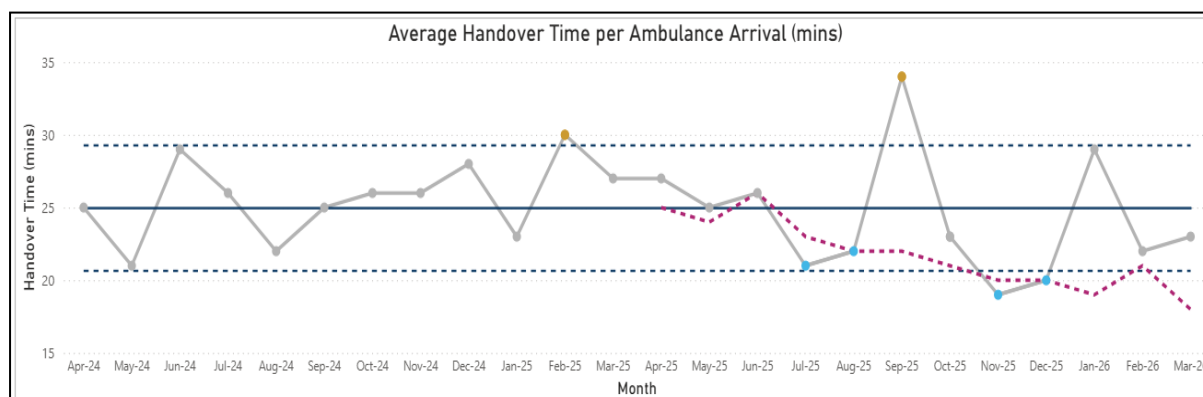
To help mitigate the growth in demand we have expanded our Same Day Emergency Care (SDEC) which has reduced our average length of stay from 9.7 in April 25 to 8.1 in March 26, treating more patients in the same bed base, and importantly, allowing more patients to receive care and return home on the same day.

Length of stay and occupied beds



Regardless of the pressures in flow from the Emergency Department, we have continued to focus and improve our average handover time for ambulance arrivals, recognising the

important role we play in releasing ambulances to be able to respond to our community. We continue to benchmark highly with an average handover time over the year of 24 minutes.



Overview of financial performance in 2025-26

In 2025-26 the NHS had a continued focus on the recovery of elective pathways and addressing waiting times combined with managing emergency pathways. Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, impacted length of stay reductions.

The Trust incurred material cost pressures in year driven by pay and non-pay pressures largely driven by non-elective activity volumes and pathways resulting in an increased bed base, additional backfill requirements and medical agency costs plus drugs and clinical supplies costs.

The Group, encompassing Charity, Subsidiaries and Trust before adjustments for Annually Managed Expenditure (AME) Impairments and Capital donations, closed the year with a deficit of £11.899m (£13.215m 24/25). Following required adjustments for national reporting, the Trust reported a position of £13.424m deficit (£5.513m 24/25). The position considers that the Trust was unable to access the national element of the deficit support funding in Quarter 4 of £3.5m.

Group Statement of Comprehensive Income	2025/26 £'000	2024/25 £'000
Income		
From clinical activities	395,805	373,347
Other operating income	40,128	43,530
Total Operating Income	435,933	416,877
Operating Expenses	(442,737)	(422,613)
Operating Surplus/(Deficit)	(6,804)	(5,736)
Finance Income	2,007	1,635
Public Dividend Capital payable	(5,095)	(5,242)
Other finance costs	(3,116)	(3,586)
Net Finance Costs	(6,204)	(7,193)
Revaluation gains (+) / losses (-) on assets	1,210	126
Fair value gains (+) / losses (-) on investments		(168)
Discontinued operations gains (+)/ losses (-)		(163)
Corporation tax expense	(101)	(81)
Total Retained Surplus / (Deficit)	(11,899)	(13,215)
Adjusted Surplus/(Deficit) SFT only	(13,424)	(5,513)

Group Statement of Comprehensive Income	2025/26 £'000	2024/25 £'000
Total Retained Surplus / (Deficit)	(11,899)	(13,215)
Remove loss on disposal of discontinued operations		(163)
Remove impact of consolidating NHS Charitable fund	(2,515)	(637)
Remove net impairment not scoring to Department expenditure limit	574	8,097
Remove impact of capital grants and donations	491	67
Remove impact of PFI revenue costs on IFRS16 basis	(75)	338
Remove net impact of DHSC centrally procured inventories		
Adjusted Surplus / (Deficit) SFT Only	(13,424)	(5,513)

The Trust delivered £13.4 m savings in year (£18.6m 24/25), which was £7.5m below plan, with the non-recurrent element of £6.1m achieved (£7.9m 24/25). Key workstreams underpinning the delivery included:

- Elective productivity including Outpatients (£4.9m)
- Bed rationalisation (£2.2m)
- Agency, Bank and Workforce controls including Non recurrent vacancies (£1.8m)
- Better Buying/Procurement (£1.3m)
- Staffing Infrastructure review (1.0m)

Capital Investment

The Trust invested £44.6m (including £4.0m Right of Use assets) in infrastructure and equipment during 2025-26 (£26.0m in 2024-25). The most significant projects were the

continuation of the Electronic Patient Record project (£2.7m), the completion of Tisbury ward refurbishment (£1.4m), Vehicles leases (£0.8m) and Pathology LIMS (£0.5m).

The £44.6m was funded internally through depreciation and cash, donations, IFRS16 leasing funds and additional Public Dividend Capital (PDC) from the Department of Health of £28.5m primarily for Estates Safety, Urgent Treatment Centre, Community Diagnostics Centre and EPR. 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:

- £7.4m on Estates safety schemes, including £2.5m Tisbury ward refurbishment, £0.8m lifts, £0.8m Main theatres Electrical safety, £0.6m main chimney flues and £0.5m hot water system for North block
- £7.0m on the Urgent Treatment Centre
- £6.4m on the Community Diagnostic Centre
- £5.9m on the EPR programme
- £4.9m on building and critical infrastructure schemes including the conclusion of the Tisbury ward, Fluoroscopy installation schemes, Energy efficiency and lift repairs.
- £4.0m on leased items including replacement vehicles and the covenant on the car park; and
- £3.3m on the digital programme, including £0.8m on the Pathology Laboratory Information Management System, £0.7m investment in Network kit, £0.7m on Mobile devices, £0.3m implementation of the Badgernet (Maternity IT) system and £0.3m Windows 11 upgrade rollout.

Tackling Health Inequalities

Health inequalities are unfair, avoidable, and systemic differences in health outcomes from different groups of people. The CORE20PLUS5 approach continues to guide 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 in adults. 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. There was a refresh of this data in 2025, and this

data is helping us to define the local priorities for 2026-27 that will benefit our local population and ensure that the services we provide are fair and equitable.

Our vision at Salisbury NHS Foundation Trust (SFT) is to ensure that our population are treated fairly and that health inequalities become part of everyone's business. As part of our Trust strategy, health inequalities feature within our strategic framework ('vision metric'), and this ensures there is a high level of focus on this work with Executive oversight. To support this wider agenda, the Wiltshire Health Inequalities Group (WHIG) continue to meet monthly, and this group is co-chaired by a Public Health Consultant from Wiltshire Council and the Health Inequalities Lead at SFT. A new BSW inequalities strategy is expected to be published this year, and work has already begun to ensure that our local priorities are aligned and to see whether there may be further opportunities to work together across the local acute hospitals within BSW on shared programmes of work. There is likely to be a greater focus on supporting our military population and their families this year as part of the new strategy.

During 2026-27 we intend to:

- Co-host a workshop with Wiltshire Council Public Health Department to review the latest data and launch of the new local strategy to set priorities for 2026-27
- Run a health inequalities awareness week with RUH and GWH hospitals in the Summer of 2026
- Refresh our local priorities (using the A3 Improving Together methodology); to specifically include programmes of work to:
- Increase staff awareness of health inequalities
- Standardise our approach for considering health inequalities – for instance by:
- reviewing existing/new data sources and ensuring that fairness of services is routinely considered by staff and managers when designing new services or making changes to existing services or clinical pathways.

The above will be achieved through furthering our partnership with Wiltshire Council and the Wiltshire Health Inequalities Group (WHIG) and working even more closely with the health inequality leads at the other BSW acute hospitals.

Last year, a total of £863,195 was also allocated to Wiltshire (from BSW ICB) to help fund projects that will reduce health inequalities. As a result of this, SFT were successfully awarded funding to support two specific projects which will be continuing to work over 2026-27 to:

- Reduce low uptake of screening and late cancer presentation.
- Enable equality of access for children and young people to secondary care and CAMHS services in Salisbury.

Ethnicity Data Completeness

As part of the annual report, the Trust is now required to report on the completeness of ethnicity data this year. This data is shown in the table below.

Months	% of pt records with a completed and valid Ethnicity	% of pt records with Not Known (NULL) Ethnicity	% of pt records with Not Stated Ethnicity
Mar-25	100.0%		
Apr-25	100.0%		
May-25	91.5%	1.89%	6.59%
Jun-25	92.5%		7.55%
Jul-25	94.7%	1.99%	3.31%
Aug-25	91.1%	1.75%	7.15%
Sep-25	91.9%	1.49%	6.63%
Oct-25	91.7%	1.83%	6.50%
Nov-25	91.9%	1.60%	6.49%
Dec-25	91.4%	1.99%	6.59%
Jan-26	91.9%	1.94%	6.18%
Feb-26	90.7%	2.43%	6.86%

Note: The 100% figures for March/April 2025 are assumed accurate but represent a smaller sample size due to the timing of data refresh.

As part of the work to improve our ethnicity recording several actions are being taken:

- Staff at SFT will be attending the South West Ethnicity Recording Improvement Group to learn about the opportunities to improve our ethnicity recording.
- We are looking to seek improvements in data collection and quality, patient confidence, and staff capability, with the aim of reducing invalid ethnicity codes and increasing consistency across datasets.
- The ethnicity recording data will be reviewed at the Trust Inequality Operations Group.

It is likely to become easier to align and standardize our processes for ethnicity recording once the new shared electronic patient record (EPR) across the BSW hospitals group has been launched.

Environmental Sustainability Performance

Introduction

Salisbury NHS Foundation Trust continues to recognise that environmental sustainability is fundamental to the delivery of safe, high-quality patient care, long-term financial resilience, and organisational stability. During 2025-26, the Trust progressed delivery of its Green Plan priorities, focusing on measurable carbon reduction, responsible use of resources, and strengthening resilience to climate-related risks. This work supports the NHS commitment to achieve Net Zero for the NHS Carbon Footprint by 2040 and the NHS Carbon Footprint Plus by 2045, while ensuring services remain reliable and responsive to future challenges.

The Trust's refreshed Green Plan (2025–2028) builds on the foundations of earlier work, maintaining a focus on actions that deliver tangible carbon and operational benefits. While estate-based decarbonisation remains a key priority, increasing emphasis is now placed on

clinical engagement, procurement, travel, and system working to address the growing influence of Scope 3 emissions.

Progress During 2025-26

Progress during the year reflects continued investment in estate decarbonisation alongside broader organisational engagement. Confirmed carbon footprint data for 2024/25 demonstrates that SFT's total NHS Carbon Footprint (Direct Boundary) reduced to 10,543.23 tCO₂e, representing a 0.33% reduction compared with 2023/24. Scope 1 and 2 (Direct and Energy) emissions reduced to 8,282.41 tCO₂e, a 2.0% year-on-year reduction, indicating early benefits from infrastructure upgrades including renewable energy generation, energy efficiency measures and heat decarbonisation projects. These investments represent an important step in reshaping the Trust's emissions profile and improving long-term energy resilience. However, the relatively modest reduction in overall emissions highlights the importance of addressing emissions beyond estates and energy, reinforcing the need for continued action across wider organisational activities and the supply chain. The 2025/26 carbon footprint data is provided by NHS England and has not yet been received.

However, total emissions reductions remain modest. This highlights the increasing importance of addressing emissions beyond estates and energy, particularly those associated with clinical activity, procurement, and travel. In response, the Trust has continued to strengthen clinical engagement through sustainability working groups and the planned establishment of a Clinical Sustainability Group to support consistent, high-impact action across services.

Resource efficiency initiatives, waste reduction programmes, and digital transformation have continued to deliver environmental and financial benefits. These activities support both carbon reduction and wider organisational priorities, including cost efficiency, staff engagement, and improved patient experience.

Climate Adaptation and Resilience

Alongside mitigation activity, the Trust has taken a significant step forward in its approach to climate adaptation. During 2025-26, Salisbury NHS Foundation Trust, working in partnership with other providers within the Bath and North East Somerset, Swindon and Wiltshire (BSW) Hospitals Group, completed and approved a Climate Change Adaptation Plan. This plan provides a structured assessment of climate risks and vulnerabilities, drawing on recognised evidence sources including UK Climate Projections, flood risk mapping, and site-specific assessments.

The Adaptation Plan identifies priority physical climate risks, including heatwaves, flooding, extreme weather events, and water stress, and sets out actions to protect patient safety, staff wellbeing, infrastructure, and service continuity. During the year, work progressed to integrate higher-scoring climate risks into the Trust's risk management processes, including corporate risk registers and business continuity planning.

This work represents a shift from understanding climate risks to actively managing them, ensuring resilience is increasingly embedded within business-as-usual processes rather than treated as a standalone activity.

Challenges and Looking Ahead

While progress has been made, the Trust recognises that significant challenges remain. The pace of emissions reduction required to meet NHS Net Zero targets will require accelerated action, particularly in addressing Scope 3 emissions and supporting clinical transformation. Data availability and maturity continue to constrain the ability to fully quantify some impacts, especially in relation to adaptation and supply chain emissions.

Over the coming year, the Trust will focus on:

- fully realising the benefits of recent estate decarbonisation investments.
- strengthening Scope 3 emissions management through procurement, clinical engagement, and travel initiatives.
- progressing priority actions from the BSW Climate Change Adaptation Plan; and
- improving data quality to support more robust sustainability and climate-related reporting.

Taskforce on Climate-related Financial Disclosures

Salisbury NHS Foundation Trust has prepared climate-related financial disclosures in accordance with HM Treasury's Taskforce on Climate-related Financial Disclosures (TCFD)-aligned requirements, on a comply or explain basis, for the 2025–26 reporting period. NHS England has implemented a phased approach to TCFD adoption up to 2025–26, and this represents year three of reporting for the Trust.

During this reporting year, the Trust has reached Year 3 of TCFD implementation, with disclosures covering all four recommended pillars:

- Governance
- Strategy
- Risk Management
- Metrics and Targets

Governance

The Trust's governance structure for climate-related risks and opportunities remains unchanged from the previous reporting year. Oversight continues to be provided by the Trust Board, which retains overall accountability for sustainability and climate-related matters. Executive responsibility is assigned at Board level, with delivery and monitoring supported through established sustainability governance arrangements, including the Sustainability Committee and reporting through the Trust Management Committee (see Figure 1).

During 2025-26, the Trust supported the development and approval of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Hospitals Group Climate Change Adaptation Plan. The Plan provides an assessment of climate-related risks and sets out priority actions relevant to the Trust and the wider provider group.

Management activity relating to climate-related risks and opportunities is progressed through existing governance and reporting arrangements, including sustainability reporting, risk management processes, and collaboration between Sustainability and Emergency Preparedness, Resilience and Response (EPRR) functions. These arrangements support the identification, escalation, and monitoring of climate-related issues within established organisational frameworks.

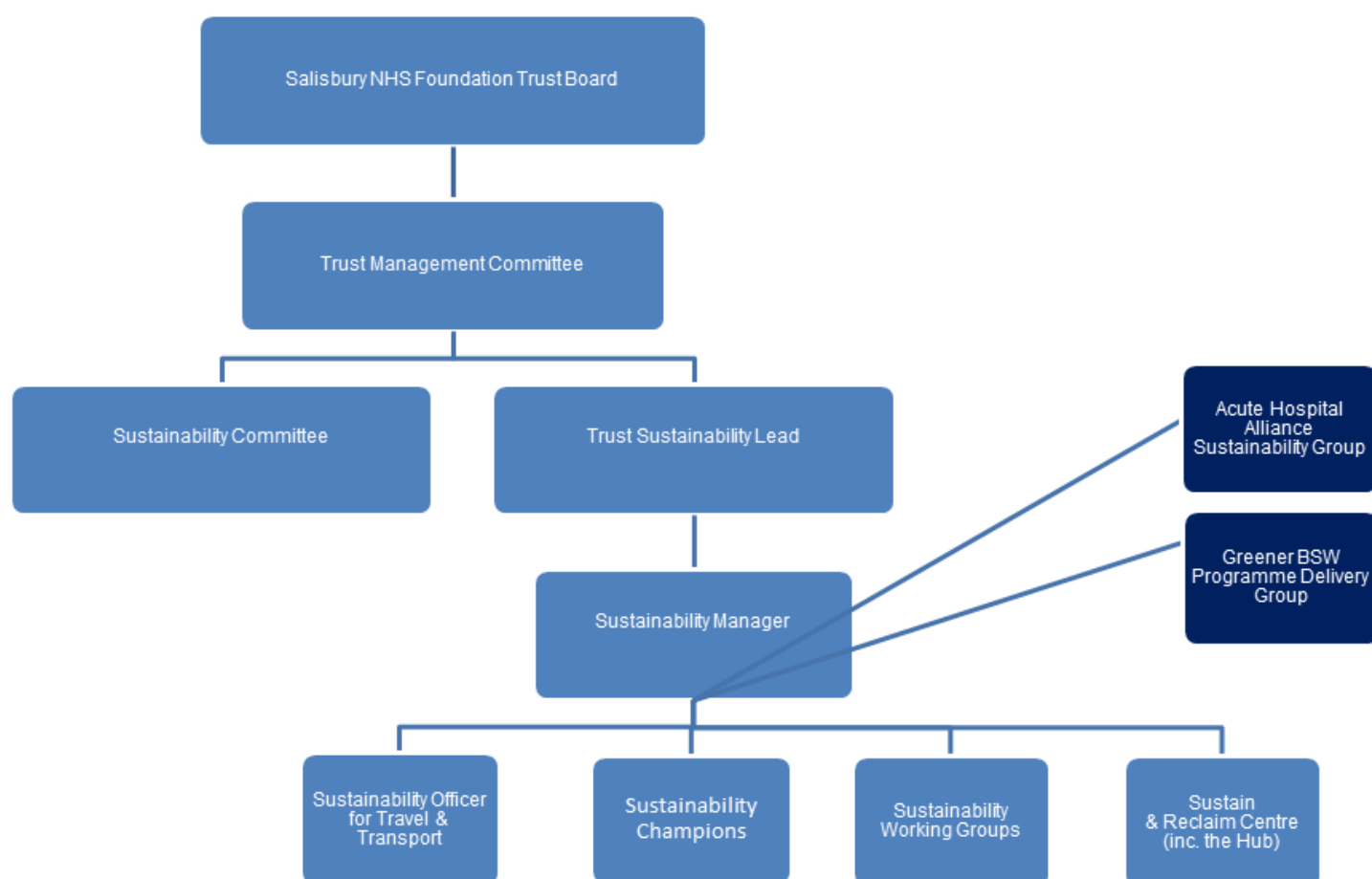


Figure 1. Sustainability and Climate Governance Structure (unchanged from 2024/25).

Strategy

The Trust has considered the actual and potential impacts of climate-related risks and opportunities over the short, medium, and long term. Climate-related evidence is used to inform estates strategy, resilience planning, and the identification and prioritisation of

adaptation actions. This evidence is increasingly considered within capital planning and strategic discussions, particularly where decisions relate to infrastructure, energy, and service resilience.

During 2025-26, this approach was strengthened through the development and approval of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Hospitals Group Climate Change Adaptation Plan. The Plan provides a structured assessment of physical climate risks, including heatwaves, flooding, extreme weather events, and water stress, and identifies priority actions to protect patient safety, staff wellbeing, infrastructure, and service continuity.

While detailed quantitative climate scenario analysis is not yet embedded within financial modelling or investment appraisal, the Trust applies a proportionate approach to the use of available evidence, consistent with current data maturity and NHS guidance. Further work is planned to strengthen the integration of climate risk considerations into long-term strategic planning and decision-making.

Risk Management

Climate-related risks are identified and assessed through Salisbury NHS Foundation Trust participated in the development of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Hospitals Group Climate Change Adaptation Plan, which provides an assessment of physical climate risks relevant to Trust sites and services. The Plan draws on evidence including UK Climate Projections, flood risk mapping, and vulnerability assessments.

The Adaptation Plan identifies a range of climate-related risks, including those associated with heatwaves, flooding, extreme weather events, and water stress, and sets out priority actions for consideration at Trust and group level. These risks relate to potential impacts on patient safety, staff wellbeing, infrastructure, and service continuity.

During the reporting year, work progressed to integrate climate-related risks into existing risk management processes. This includes collaboration between Sustainability and Emergency Preparedness, Resilience and Response (EPRR) functions, and planned inclusion of higher-scoring climate risks within the Trust's corporate risk register. Climate-related risks are therefore managed through established organisational risk management and assurance arrangements, rather than through a separate or standalone process.

Metrics and Targets

The Trust monitors greenhouse gas emissions in line with Greener NHS guidance, reporting emissions associated with Scope 1 and Scope 2, and selected Scope 3 sources within the NHS Carbon Footprint (Direct Boundary). Confirmed carbon footprint data for 2024-25 is reported within the Sustainability Annual Report and demonstrates year-on-year reductions in Scope 1 and 2 emissions, reflecting the early impact of estate decarbonisation activity.

The Trust has established long-term targets to achieve:

- Net Zero for Scope 1 and 2 emissions by 2040; and
- Net Zero for Scope 3 emissions by 2045.

Progress against these targets is monitored annually using nationally approved methodologies. The Trust recognises that reductions in total emissions remain modest and that further progress will increasingly depend on actions relating to clinical activity, procurement, and travel. Linear progress towards Net Zero would require our Scopes 1 and 2 emissions to be no more than 6063 tonnes by 2032.

In relation to climate adaptation, the Trust recognises that quantitative metrics are still developing. Progress is therefore currently monitored primarily through qualitative measures, including completion of climate risk assessments, development of the BSW Hospitals Group Climate Change Adaptation Plan, and progression of actions through established governance and risk management processes.

To support the gradual strengthening of adaptation monitoring, the Trust has identified a small set of Group-level metrics to begin measuring from 2026-27. These metrics are intended to provide greater visibility of adaptation readiness and governance maturity, while remaining proportionate to current data availability and organisational capability. The proposed metrics are:

1.	% of critical buildings with overheating risk assessments completed
2.	Number of climate-related estates incidents
3.	% of adaptation plan actions completed or in progress
4.	Frequency of climate risk reporting to the EFM Board
5.	% of departments with named climate risk owners assigned

Further development of adaptation-related monitoring and evaluation will be considered as data availability, consistency, and organisational capability continue to evolve.

Statement of Compliance

Based on the information available for the reporting period, Salisbury NHS Foundation Trust considers that it has complied with HM Treasury's TCFD-aligned disclosure requirements, applying a proportionate and evidence-based approach consistent with its size, complexity, and data maturity. Where full quantitative disclosure is not yet available, the Trust has provided clear explanation and set out planned next steps.

TCFD Requirements Mapping Table

TCFD Pillar	Recommended Disclosure	How SFT Has Addressed the Requirement
Governance	a) Describe the Board's oversight of	The Trust Board retains overall accountability for climate-related risks and opportunities. Board-level

	climate-related risks and opportunities	oversight is provided through established sustainability governance arrangements. Formal oversight of climate adaptation is provided through approval of the BSW Hospitals Group Climate Change Adaptation Plan.
	b) Describe management's role in assessing and managing climate-related risks and opportunities	Executive responsibility for Net Zero and climate-related activity is assigned at Board level. Management activity is supported through the Sustainability Committee and existing governance arrangements, with climate-related matters progressed through estates, procurement, clinical engagement, and risk management processes.
Strategy	a) Describe climate-related risks and opportunities identified over the short, medium, and long term	The Trust has identified physical and transition climate risks, including heat, flooding, extreme weather, energy price volatility, supply chain disruption, and policy change. Risks are informed by UK Climate Projections, flood risk mapping, and group-wide vulnerability assessments undertaken through the BSW Adaptation Plan.
	b) Describe the impact of climate-related risks and opportunities on the organisation's businesses, strategy, and financial planning	Climate considerations are reflected within estates strategy and are considered within capital planning and strategic discussions, particularly where decisions relate to infrastructure, energy, and service resilience.
	c) Describe the resilience of the organisation's strategy, taking into consideration different climate-related scenarios	While full quantitative scenario modelling is not yet undertaken, the Trust uses recognised evidence (UKCP, flood risk mapping, vulnerability assessments) to inform strategic priorities and resilience planning. This approach is considered proportionate to current data maturity and NHS guidance, with plans to strengthen scenario analysis over time.
Risk Management	a) Describe the organisation's processes for identifying and assessing climate-related risks	Climate-related risks are identified through Trust-level risk assessments and the BSW Hospitals Group Adaptation Plan, which provides a structured assessment of physical climate risks across sites and services.
	b) Describe processes for managing climate-related risks	Higher-scoring climate risks are planned to be integrated into corporate risk registers and linked to business continuity and emergency preparedness processes. Transition risks are considered through procurement processes, supplier engagement, and strategic planning activity.
	c) Describe how processes for identifying, assessing, and managing climate-related risks are integrated into overall risk management	Climate-related risks are managed through the Trust's existing risk management and assurance framework, rather than through a separate or standalone process. This includes alignment with corporate risk registers, business continuity planning, and capital project risk assessment.
Metrics and Targets	a) Disclose the metrics used to assess climate-related risks and opportunities in line with	The Trust monitors greenhouse gas emissions in line with Greener NHS guidance, alongside qualitative indicators for adaptation such as governance arrangements, risk assessments

	strategy and risk management	completed, and progress against priority adaptation actions.
	b) Disclose Scope 1, Scope 2, and relevant Scope 3 greenhouse gas emissions	Scope 1 and 2 emissions, and relevant Scope 3 emissions within the NHS Carbon Footprint boundary, are reported annually using nationally approved methodologies. Year-on-year changes and key drivers are disclosed.
	c) Describe the targets used to manage climate-related risks and opportunities and performance against targets	The Trust has committed to achieving Net Zero for Scope 1 and 2 emissions by 2040 and Scope 3 emissions by 2045. Progress against these targets is monitored annually. The Trust recognises that adaptation metrics are less mature and has set out plans to strengthen monitoring and evaluation over time.

Major in-year risks in 2025-26

The Board of Directors has identified, and manages the principal risks to the delivery of its strategy and objectives through its Board Assurance Framework (BAF) The principal risks to the delivery of its strategy and objectives identified by the Trust during 2025-26 were:

POPULATION - Improving the health and wellbeing of the population we serve

BAF 1	Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trust's operating model.
BAF 2	Due to the size of our catchment population, there is a risk that some services are not sustainable.
BAF 3	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.
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
BAF 5	There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss, impacting patient care, data security and Trust reputation
BAF 8	Demand for services outweighs capacity, resulting in an increased risk to patient safety, quality and effectiveness of patient care.

PEOPLE - Supporting our people to make Salisbury NHS Foundation Trust the best place to work

BAF 6	There is a risk that the Board has limited capacity in terms of time, skills and capability to effectively oversee the organisation and the delivery of key strategic priorities in 2025-26.
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills, impacting staff experience, morale and wellbeing and resulting in potential adverse impacts on patient care.

PARTNERSHIPS - Working through partnerships to transform and integrate our services

BAF 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability.
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System, with potential impact on the Trust at Place level.
BAF 11	Risk of not achieving the transformation requirements at the pace required to deliver a sustainable position in-year and beyond.
BAF 12	Risk of sustained deterioration across key elective performance metrics.

Overseas operations

The Trust does not have any overseas operations

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

The Board of Directors consists of Executive and Non-Executive Directors. Executive Directors are appointed by the Board and Non-Executive Directors are appointed by the Council of Governors. The Board is responsible for overseeing the strategic direction and performance of the Trust and is accountable to the local communities through the members and governors, NHS England and the Care Quality Commission. The Board 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 2025-26

Ian Green	Chair (left 30 June 2025)
Margaret (Eiri) Jones	Non-Executive Director (Senior Independent Director) Interim Chair (from 1 July 2025)
Cara Charles-Barks	Chief Executive Officer / Accountable Officer
Judy Dyos	Chief Nursing Officer Interim Group Chief Strategic Officer (from 2 Feb 2026)
Mark Ellis	Interim Chief Finance Officer (voting) (until 31 July 2025) Chief Finance Officer (voting) (from 1 August 2025) Site Chief Finance Officer (non-voting) (from 1 November 2025) Group Chief Risk Officer (from 26 Jan 2026)
Nick Johnson	Managing Director (from 1 September 2025)
Jude Gray	Group Chief People Officer (from 1 Nov 2025)
Ali Layne-Smith	Interim Chief People Officer (from 1 Sep - 28 Nov 2025)
Simon Wade	¹ Group Chief Financial Officer (from 1 Nov 2025)
Jonathan Hinchliffe	Chief Transformation and Innovation Officer (Interim) (from 7 April 2025)
Andrew Hollowood	Strategic Clinical Transformation Director (1 Sept 2025)
Duncan Murray	Chief Medical Officer
Lisa Thomas	Interim Managing Director (left 31 Aug 2025)
Niall Prosser	Chief Operating Officer
Melanie Whitfield	Chief People Officer (left 17 Aug 2025)
Rakhee Aggarwal	Non-Executive Director (left 31 Mar 2026)
Debbie Beavan	Non-Executive Director (left 30 Sep 2025)
Paul Cain	Non-Executive Director
Richard Holmes	Non-Executive Director
Peter Knell	Non-Executive Director (from 1 st Feb 2026)
Kirsty Matthews	Non-Executive Director (left 30 th June 2025)
Richard Samuel	Non-Executive Director (from 1 st Feb 2026)
Anne Stebbing	Non-Executive Director (Senior Independent Director)

¹ Group CFO is the statutory officer from 1st November 2025

Events after the Reporting Date

Paul Von Der Heyde was appointed Group Chair with effect from 1st April 2026.

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 England's Well Led Framework

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

The Care Quality Commission (CQC) undertook 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 2025-26, the Trust welcomed Peter Knell and Richard Samuel who joined the Trust as Non-Executive Directors.

As the Trust continues to progress towards an integrated Group model with GWH and RUH, several Group Directors were appointed to support this transition during 2025-26. The Trust welcomed Jude Gray, Chief People Officer, Simon Wade, Chief Financial Officer, Jonathan Hinchliffe, Chief Transformation and Innovation Officer and Andrew Hollowood, Strategic Clinical Transformation Director. These appointments strengthen collective leadership and enhance alignment across the developing Group structure. In addition, existing SFT Board Directors were appointed into Group roles, including Mark Ellis as Senior Risk Officer and Judy Dyos as Interim Chief Strategic Officer.

An external well-led review commenced in April 2023 for a period of three months. This was a developmental review with the key aim of understanding the Trust's strengths and areas requiring improvement from a well-led perspective. The outcomes of the review were shared

with the Board and wider Trust, and the resulting recommendations have now been fully implemented.

The Annual Governance Statement (AGS) provides additional detail on the Trust's approach to ensuring services are well-led, alongside its plans to undertake a further Group external well-led review.

Other disclosures

Modern Slavery Act 2025-26 Annual Statement

The Trust's commitment to preventing modern slavery and human trafficking was updated and published on our website on 4 September 2025. SFT remains 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 made no political donations during 2025–26. No political donations were made in the previous financial year (2024–25).

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. Interest was paid under the late Payment of Commercial Debts (Interest) Act 1998.

	2025/26		2024/25	
	Foundation Trust Number	Foundation Trust £'000	Foundation Trust Number	Foundation Trust £'000
Better payment practice				
Non NHS				
Total bills paid in the year	57,837	158,082	58,188	142,556
Total bills paid within target	48,268	133,087	44,811	110,863
Percentage of bills paid withn target	83.5%	84.2%	77.0%	77.8%
NHS				
Total bills paid in the year	2,141	8,579	1,829	7,618
Total bills paid within target	1,987	7,249	1,501	5,817
Percentage of bills paid withn target	92.8%	84.5%	82.1%	76.4%
Total				
Total bills paid in the year	59,978	166,661	60,017	150,174
Total bills paid within target	50,255	140,336	46,312	116,680
Percentage of bills paid withn target	83.8%	84.2%	77.2%	77.7%

Information on fees and charges

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

		2025/26	2024/25	2023/24
	<i>Expected sign</i>			
<i>Income</i>	+	16,297	18,782	19,602
<i>Full cost</i>	-	-14,079	-15,659	-15,239
<i>Surplus/Deficit</i>	+/-	2,218	3,123	4,363

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 and private patient treatment. The total income from all these areas amounted to around £9.563 million. The other areas contributed surpluses, which have been applied to meeting patient care

expenditure. In addition, the Trust received £7.8 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £3.224 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.

A handwritten signature in blue ink, appearing to read 'e.e.R.'.

Cara Charles Barks
Group Chief Executive (Accounting Officer)
26 June 2026 (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

Remuneration/ Nominations Committee

As the Chair of the Remuneration Committee, I am pleased to present our remuneration report for 2025-26.

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 policies in negotiating with Trade Unions on areas of local discretion.

Attendance at the Remuneration Committee for 2025-26 is shown below.

Remuneration Committee Attendance		
Name	Role	Attendance / possible attendance
Ian Green	Trust Chair	2/2
Rakhee Aggarwal	Chair of the Committee / Non-Executive Director	5/6
Margaret (Eiri) Jones	Non-Executive Director/ Interim Trust Chair	4/6
Debbie Beaven	Non-Executive Director	4/4
Richard Holmes	Non-Executive Director	5/6
Kirsty Matthews	Non-Executive Director	2/4
Paul Cain	Non-Executive Director	6/6
Anne Stebbing	Non-Executive Director	6/6
Peter Knell	Non-Executive Director	0/0
Richard Samuel	Non-Executive Director	0/0

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

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2025-26. 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.

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.

2025-26 Major decisions on remuneration

During 2025-26, the Remuneration and Nominations Committee conducted the following business.

- Approved the creation of two new Group executive roles: Group Transformation & Innovation Officer (GTIO) and Group Strategy Officer (GSO).
- Approved the job descriptions for the GTIO and GSO roles, subject to agreed amendments to strengthen requirements around professional credibility, strategy leadership, operational planning, collaboration and innovation experience.
- Approved the use of the Very Senior Manager (VSM) pay framework for the new Group roles.
- Noted interim arrangements for the Group Transformation & Innovation Officer role.
- Approved the principle that internal NHS search would be undertaken prior to using executive search agencies.
- Approved the appointment of Nick Johnson as Managing Director at SFT and the proposed remuneration for this role.
- Reviewed and noted the Executive Performance Appraisal outcomes for 2024/25, confirming that Executive Directors had met their objectives overall.
- Agreed to comply with the new NHS England Very Senior Manager Pay Framework on a "comply or explain" basis.
- Noted the national VSM pay uplift of 3.25%, effective from 1 April 2025, subject to NHSE authorisation and Trust segmentation.
- Approved the appointment of an Interim Chief People Officer from August to November 2025.
- Approved the appointment of Mark Ellis as substantive Chief Finance Officer.
- Approved the process, job description and recruitment approach for the substantive Chief Operating Officer, including internal group-only advertising in the first instance.
- Approved the salary range for the Chief Operating Officer, in line with regional benchmarking.

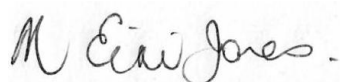
- Approved the appointment of Niall Prosser as substantive Chief Operating Officer from January 2026.
- Noted ongoing Executive structure development through the BSW Hospitals Group and forthcoming decisions on the wider Group leadership model.

The changes to the Trust's Executive team during 2025-26 were (please also see *BSW Remuneration Committee in Common*):

- Appointment of Mark Ellis as Chief Finance Officer (voting) from 1st August 2025. As Simon Wade was appointed as Group Chief Finance Officer from 1st November 2025, Mark Ellis became Site CFO (non-voting) from 1st November 2025.
- Appointment of Nick Johnson as Managing Director from 1st September 2025.
- Appointment of Niall Prosser as Chief Operating Officer from 1st January 2026.

Group Roles:

- Appointment of Jonathan Hinchliffe as Group Chief Transformation and Innovation Officer from 7 April 2025.
- Appointment of Simon Wade as Group Chief Finance Officer from 1st November 2025.
- Appointment of Jude Gray as Group Chief People Officer from 1st November 2025.
- Appointment of Andrew Hollowood as Group Strategic Clinical Transformation Director from 1st September 2025.
- Appointment of Mark Ellis as Group Chief Risk Officer from 26th January 2026.
- Appointment of Judy Dyos as Interim Group Chief Strategic Officer from 2nd February 2026.



Eiri Jones
26 June 2026
Non-Executive Director / Remuneration Committee Chair

Senior Managers' Remuneration Policy

Introduction

This report sets out the Trust's policy and governance arrangements for determining the remuneration of senior managers. For the purposes of this report, senior managers are defined as those individuals holding senior positions with authority or responsibility for directing or controlling the major activities of the Trust. This includes the Executive and Non-Executive members of the Board of Directors.

Very Senior Managers

The remuneration of Very Senior Managers (VSMs) is determined in accordance with the NHS England VSM Pay Framework, which was reissued with effect from 1 April 2025. The framework promotes transparency, consistency and proportionality in senior leadership remuneration across the NHS.

The remuneration of the Chief Executive and Executive Directors is determined by the Remuneration Committee of the Board. Following the adoption of Group governance arrangements, this responsibility transferred to a Remuneration Committees in Common, ensuring appropriate oversight and consistency of remuneration arrangements across the BSW Hospitals Group.

Policy on Remuneration

The Trust's remuneration approach is designed to support delivery of its strategic objectives and the provision of high-quality patient care, while maintaining financial sustainability. Remuneration arrangements are also informed by the Trust's commitment to equality, diversity and inclusion, and compliance with the Equality Act 2010 and the Public Sector Equality Duty

The Trust's remuneration principles seek to:

- Attract, motivate and retain high-calibre senior leaders.
- Align remuneration with the long-term interests of the Trust.
- Promote behaviours consistent with the Trust's values.
- Ensure fairness, transparency and compliance with NHS guidance.

The Trust will continue to apply the principles of the NHS England Very Senior Managers Pay Framework, ensuring remuneration arrangements remain transparent, proportionate and aligned with NHS guidance and good governance practice.

Non-Executive Directors

Responsibility for setting the remuneration of the Chair and Non-Executive Directors rests with the Council of Governors, advised by the Performance Committee. Remuneration is based on the structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts which was introduced in 2019.

www.england.nhs.uk/1sthi5thew4y/wp-content/uploads/sites/54/2020/08/Chair_and_NED_Remuneration_Structure_1nov.pdf

Non-Executive Directors do not receive bonuses, pension benefits or additional fees, and no payments are made other than reimbursement of legitimate travel and subsistence expenses incurred during Trust business.

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: - Improving the health and wellbeing of the population we serve. - Working through partnerships to transform and integrate our services. - Supporting our people to make	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and benchmarked against the NHSI Guidance for pay for senior managers.	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March.

	Salisbury NHS Foundation Trust the Best Place to Work		
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short- and long-term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic goals stated in the basic salary component.	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

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

The performance measures were chosen to reflect the Trust's adopted values and behaviours alongside its strategic goals which form the basis for Directors' performance objectives. Objectives for each Executive are agreed at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). The objectives / performance measures, alongside the refreshed national leadership competencies, are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-

Executive Directors does have the authority to decide on whether any pay or remuneration increase should be awarded each year based on performance.

No Executive Directors have been released to undertake other paid work elsewhere.

Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSE 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 remuneration	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of: - Improving the health and wellbeing of the population we serve. - Working through partnerships to transform and integrate our services. - Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work.	It is one single pay point based on research of NHS remuneration for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A
Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

*Non-Executive Directors Fees: Responsibility for setting the terms and conditions for the Chair and Non-Executive Directors lies with the Council of Governors. The policy on remuneration is that the Non-Executive Directors are paid a basic salary (see Salary

Scales). No additional duties which require a fee are carried out by the Non-Executive Directors.

Statement of consideration of employment conditions elsewhere in the Trust

While the Trust does not consult with employees on the remuneration policy regarding senior managers, it does consider the national pay and conditions of NHS employees.

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

Annual Report on Remuneration

Service contracts obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non- Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract, and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chair, Chief Executive and Non-Executive Directors. Guidance for VSM pay including for severance payments is noted in the NHS Employers: Guidance on pay for senior managers and Guidance for Making Severance payments. These guidance documents are referenced in the Trust Executive Pay framework.

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

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

Name	Role	Current term of office	Notice Period (months)
Ian Green	Chair	Commenced February 2023 (3-year term) Left on 30 June 2025	3
Rakhee Aggarwal	Non-Executive Director	Commenced January 2023 (3-year term) Extended from January 2026 – 31 March 2026. Left on 31 March 2026	3
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2022 (3-year term) Appointed Interim Chair from 1 July 2025.	3
Richard Holmes	Non-Executive Director	Commenced January 2023 (3-year term)	3
Debbie Beavan	Non-Executive Director	Commenced January 2023 (3-year term) Left on 30 Sept 2025	3
Paul Cain	Non-Executive Director	Commenced June 2024 (3-year term)	3
Peter Knell	Non-Executive Director	Commenced 1 February 2026 (3-year term)	3
Kirsty Matthews	Non-Executive Director	Commenced June 2024 (3-year term) Left on 30 June 2025	3
Richard Samuel	Non-Executive Director	Commenced 1 February 2026 (3-year term)	3
Anne Stebbing	Non-Executive Director	Commenced July 2024 (3-year term)	3
Cara Charles Barks	Group Chief Executive	Commenced November 2024	6
Judy Dyos	Chief Nursing Officer Chief Strategy Officer ¹	Commenced June 2020 Appointed 2 February 2026	6
Mark Ellis	Interim Chief Finance Officer (voting) Chief Finance Officer (voting) Site Chief Finance Officer (non-voting) Group Chief Risk Officer ¹	Commenced April 2025 Commenced August 2025 Commenced November 2025 Commenced January 2026	6
Jude Gray	Chief People Officer ¹	Commenced 1 November 2025	6
Jonathan Hinchliffe	Chief Transformation and Innovation Officer ¹	Commenced 7 April 2025	6
Andrew Hollowood	Strategic Clinical Transformation Director ¹	Commenced 1 September 2025	6
Nick Johnson	Managing Director	Commenced 1 September 2025	6
Ali Layne-Smith	Interim Chief People Officer	Commenced 1 September 2025	-

Duncan Murray	Chief Medical Officer	Commenced October 2024	6
Lisa Thomas	Interim Chief Operating Officer Interim Chief Executive Officer Interim Managing Director	Commenced August 2022 Commenced February 2024 Commenced November 2024. Left 29 August 2025	6
Niall Prosser	Interim Chief Operating Officer Chief Operating Officer	Commenced February 2024 Commenced 1 January 2026	6
Simon Wade	Chief Finance Officer ¹	Commenced 1 November 2025	6
Melanie Whitfield	Chief People Officer	Commenced September 2021 Left 17 August 2025	6

¹ These roles were introduced during 2025-26 as part of the transition to a Group BSW Hospitals structure

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.

BSW Remuneration Committee in Common.

As part of the transition to a BSW Hospitals Group governance model, the Trusts agreed to establish Board Remuneration, Nominations and Appointments Committees in Common to support aligned decision making in relation to the appointment and remuneration of shared executive roles.

The Terms of Reference for the Committees in Common were approved by the BSW Hospitals Group Joint Committee in July 2025, at which point the arrangements were brought into effect. The Terms of Reference were subsequently updated in November 2025 to reflect minor amendments, including clarification of quoracy and chairing arrangements.

Each Trust's statutory Remuneration Committee retains independent accountability for its decisions, which are taken concurrently through the Committees in Common arrangements and recorded as decisions of the respective Trust committees.

Attendance at the Remuneration Committees-in-Common during 2025-26

Remuneration Committees-in-Common meeting attendance

Meeting date	RUH attendance	GWH attendance	SFT attendance	Comments
30 July 2025	Present	Present	Present	First formal meeting following establishment of the Committees-in-Common

29 September 2025	Present	Present	Present	Quorate for all Trusts
22 October 2025	Present	Present	Present	Quorate for all Trusts
17 December 2025	Present	Present	Present	Quorate for all Trusts
19 January 2026	Present	Present	Present	Quorate for all Trusts

Decisions taken by written circulation

Date	Nature of decision	RUH participation	GWH participation	SFT participation	Notes
January 2026	Appointment and remuneration of Group Chief Risk Officer	Confirmed by circulation	Confirmed by circulation	Confirmed by circulation	Circulation agreed at the January meeting. Quorum of responses received from all Trusts.
February 2026	Approval to recruit Group Chief Digital & Information Officer & associated remuneration	Confirmed by circulation	Confirmed by circulation	Confirmed by circulation	Quorum of responses received from all Trusts.

All formal meetings of the Remuneration Committees in Common during the year were quorate for each participating Trust. Where meetings could not be convened and a decision was time critical, the Committees agreed to take decisions by written circulation in accordance with the approved Terms of Reference. Decisions taken in this way were supported by full papers, confirmed by a quorum of members from each Trust, and subsequently noted to ensure a complete audit trail.

Remuneration decisions made by BSW Remuneration Committee in Common during 2025-26

During 2025-26, the Boards' statutory Remuneration Committees met in common to support aligned decision making in respect of the appointment and remuneration of shared executive roles across the BSW Hospitals Group. Each Trust's Remuneration Committee retained independent accountability for its decisions, which were taken concurrently through the Committees in Common arrangements and recorded as decisions of the respective Trust committees.

The Committees in Common met formally during the year, including meetings held in July, September, October and December 2025, and January 2026. Where appropriate, the

Committees also agreed to take certain time critical decisions by written circulation between meetings, in line with the approved Terms of Reference.

Key decisions taken by the Boards' Remuneration Committees in Common during 2025-26 included the following.

- **30 July 2025** – The Committees approved the application of the 2025-26 national Very Senior Manager pay award to the Group Chief Executive Officer, in line with national guidance. The Committees also agreed that future pay awards for Group roles should be explicitly linked to appraisal outcomes and the setting of clear annual objectives.
- **30 July 2025** – The Committees considered the development of the Group executive leadership structure, approving revised job descriptions and remuneration frameworks for Group executive roles and noting the introduction of interim arrangements to support delivery of the Group operating model. This included initial review of executive portfolios and alignment to the national VSM framework.
- **29 September 2025** – The Committees approved the appointment and remuneration of the Group Strategic Clinical Transformation Director, following an internal recruitment process, and noted that the postholder would remain on existing contractual terms in line with agreed arrangements.
- **22 October 2025** – Following completion of consultation on the Group leadership model, the Committees approved the appointment and remuneration of the Group Chief Finance Officer and Group Chief People Officer, including confirmation of start dates. The Committees also approved associated changes to executive roles and responsibilities and approved revisions to job descriptions to reflect updated Group portfolios.
- **22 October 2025** – The Committees reviewed the structure and balance of Group executive roles and approved updates to executive job titles and portfolios, including clarification of responsibilities across strategy, transformation, digital, clinical transformation and people functions. These changes clarified responsibilities and strengthened the separation of assurance, delivery and leadership roles within the Group executive structure.
- **17 December 2025** – The Committees approved the establishment of a new Group Chief Risk Officer role, including the role purpose, recruitment approach and remuneration framework. At the same meeting, the Committees approved progression to open competition for the Group Chief Strategy Officer role following review of interim arrangements and approved further refinements to Group executive portfolios and role titles.
- **19 January 2026** – The Committees approved interim executive arrangements to support continuity of strategic leadership pending substantive recruitment,

confirming the parameters and duration of interim cover in line with the approved governance framework.

Following the formal meeting held in January 2026, a meeting scheduled for February 2026 was postponed. In order to avoid delay to essential executive appointments, the Committees agreed that specific decisions could be taken by written circulation in line with the approved Terms of Reference. These decisions included:

- **January 2026 (by circulation)** – approval of the appointment and remuneration of the Group Chief Risk Officer, following completion of the agreed interview process.
- **February 2026 (by circulation)** – approval to proceed with external recruitment for the Group Chief Digital and Information Officer role, including approval of the associated remuneration level, following prior approval of the role description.

All decisions taken by correspondence were supported by appropriate papers, confirmed by a quorum of members from each Trust, and subsequently noted to ensure a complete and transparent audit trail.

Collectively, these decisions supported the transition to a Group executive leadership model, including the review and refinement of roles, responsibilities and job titles, while maintaining transparency, proportionality and alignment with national pay guidance. No discretionary performance-related pay was awarded outside national frameworks during the year.

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
2025/2026	20	17	£11,658	16	1	£288
2024/2025	19	10	£12,920	13	1	£54
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 2025-26.

Group Director remuneration arrangements

Group directors are employed under joint arrangements across the BSW Hospitals Group. Where an individual undertakes a Group-level role, their remuneration is apportioned and charged across the three participating foundation trusts in line with agreed cost-sharing arrangements. Each Trust discloses only the proportion of remuneration that relates to services provided to that Trust during the financial year. The total remuneration paid to each individual across the Group is determined in accordance with the NHS Very Senior Manager Pay Framework and relevant local approvals.

Name and Title	Remuneration Year to 1 April 2025 - 31 March 2026					
	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	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones - Chair	40-45	0	0	0	0	40-45
Rakhee Aggarwal - Non-Executive	15-20	0	0	0	0	15-20
Debbie Beavan - Non-Executive	5-10	0	0	0	0	5-10
Paul Cain - Non-Executive	15-20	0	0	0	0	15-20
Richard Holmes - Non-Executive	15-20	0	0	0	0	15-20
Kirsty Matthews - Non-Executive	0-5	0	0	0	0	0-5
Peter Knell - Non-Executive	0-5	0	0	0	0	0-5
Richard Samuel - Non-Executive	0-5	0	0	0	0	0-5
Anne Stebbing - Non-Executive	15-20	0	0	0	0	15-20
Cara Charles-Barks Group CEO	80-85	600	0	0	165-167.5	250-255
Judy Dyos - Chief Nursing Officer / Group Chief Strategic Officer	135-140	0	0	0	50-52.5	190-195

Name and Title	Remuneration Year to 1 April 2025 - 31 March 2026					
	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
Mark Ellis – Group Chief Risk Officer	115-120	1,600	0	0	50-52.5	170-175
Jude Gray - Group Chief People Officer	20-25	0	0	0	40-42.5	65-70
Jonathon Hinchcliffe - Interim Group Chief Transformation and Innovation Officer	110-115	0	0	0	0	110-115
Andrew Hollowood - Group Chief Clinical Transformation Officer	40-45	0	0	0	60-62.5	105-110
Nick Johnson - Managing Director	105-110	0	0	0	32.5-35	140-145
Duncan Murray - Chief Medical Officer	220-225	0	0	0	265-267.5	490-495
Niall Prosser - Chief Operating Officer	135-140	0	0	0	217.5-220	355-360
Simon Sethi - Group Chief Operating Officer	40-45	0	0	0	47.5-50	90-95
Lisa Thomas - Managing Director	75-80	0	0	0	5-7.5	85-90
Simon Wade - Group Chief Finance Officer	20-25	0	0	0	92.5-95	120-125
Melanie Whitfield - Chief People Officer	55-60	0	0	0	15-17.5	75-80

This table is subject to audit

- Ian Green left the Trust 30th June 2025
- Margeret Jones started the role 1st July 2025 to 30th June 2026
- Rakhee Aggarwal left 31st March 2026
- Debbie Beaven left 30th September 2025
- Peter Knell started 1st February 2026
- Kirsty Matthews left 30th June 2025
- Richard Samuel started 1st February 2026
- Lisa Thomas left the Trust 31st August 2025
- Judy Dyos started Group Role @ 0.4 WTE 2nd February 2026 retaining 0.6 WTE for SFT. Both roles have been incorporated into one line and the 30% split applied to the Chief Strategic Officer position only.
- Mark Ellis started Group Role 26th January 2026. Prior to this Mark was the Chief Finance Officer.
- Nick Johnson started 1st September 2025
- Melanie Whitfield left the Trust 17th August 2025

The following group roles provide executive leadership across Royal United Hospitals Bath NHS Foundation Trust (RUH), Salisbury NHS Foundation Trust (SFT), and Great Western Hospitals NHS Foundation Trust (GWH) under a shared leadership arrangement:

- Chief Executive – £272,783
- Chief Financial Officer – £68,909
- Strategic Clinical Transformation Director – £136,637
- Chief People Officer – £67,324
- Chief Strategic Officer – £10,561
- Chief Risk Officer – £28,765
- Chief Transformation & Innovation Officer (Interim) – £370,365
- Director of Elective Recovery – £147,732

In accordance with HM Treasury's Financial Reporting Manual (FReM) and the Department of Health and Social Care Group Accounting Manual (GAM), the apportioned cost of remuneration is disclosed above.

The apportionment of total salary is based on the following allocation: RUH 35%, GWH 35%, and SFT 30%. The salaries shown represent the total remuneration for the period in post during the financial year.

Name and Title	Remuneration Year to 1 April 2024 - 31 March 2025					
	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	0-5	0	0	0	0	0-5
Michael von Bertele -	5-10	0	0	0	0	5-10

Name and Title	Remuneration Year to 1 April 2024 - 31 March 2025					
	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
Non-Executive						
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	5-10	0	0	0	0	5-10
Richard Holmes - Non-Executive	10-15	0	0	0	0	10-15
Debbie Beavan - Non-Executive	10-15	0	0	0	0	10-15
Paul Cain - Non-Executive	10-15	0	0	0	0	10-15
Kirsty Matthews - Non-Executive	10-15	0	0	0	0	10-15
Margaret Stebbing- Non-Executive	10-15	0	0	0	0	10-15
Cara Charles-Barks (33%)	40-45	0	0	0	15-20	55-60
Lisa Thomas - Interim Chief Executive and Managing Director	180-185	0	0	0	160-165	340-345
Peter Collins - Chief Medical Officer	110-115	0	0	0	0	110-115
Duncan Murray – Chief Medical Officer	150-155	0	0	0	285-290	435-440
Judy Dyos - Chief Nursing Officer	140-145	0	0	0	85-90	225-230
Mark Ellis - Interim Chief Finance Officer	130-135	0	0	0	55-60	185-190
Niall Prosser – Interim Chief	130-135	0	0	0	27.5-30	155-160

Name and Title	Remuneration Year to 1 April 2024 - 31 March 2025					
	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
Operating Officer						
Melanie Whitfield - Chief People Officer	145-150	0	0	0	40-45	185-190

This table is subject to audit

- Peter Collins left the Trust on 13th October 2024
- Duncan Murray commenced as Chief Medical Director on 14th October 2024
- Lisa Thomas commenced as Managing Director on 1st November 2024
- Tania Baker left the Trust on 31st May 2024
- Michael Von Bertele left the Trust on 31st October 2024
- David Buckle left the Trust on 31st October 2024
- Paul Cain commenced as Non-executive Director on 1st June 2024
- Kirsty Matthews commenced as Non-executive Director on 17th June 2024
- Margaret Stebbing commenced as Non-executive Director on 1st July 2024
- Cara Charles-Barks works across Salisbury Hospital, Royal Hospital Bath and Great Western NHS Foundation Trust, spend a third of her time on each. As such, the remuneration shown above is the portion of her total remuneration attributable to Salisbury Hospital (33%)

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.

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 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2024	Employers Contribution to Stakeholder Pension
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	(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
Cara Charles-Barks Group Chief Executive Officer	7.5-10	12.5-15	65-70	140-145	1,439	165	1,239	0
Judy Dyos - Group Chief Strategic Officer	2.5-5.0	0-2.5	50-55	120-125	1,110	54	1,038	0
Mark Ellis - Group Chief Risk Officer	2.5-5.0	0-2.5	35-40	85-90	703	40	645	0
Jude Gray - Group Chief People Officer	2.5-5.0	0-2.5	15-20	0-5	322	36	267	0
Jonathan Hinchcliffe- Chief Transformation & Innovation Officer (Interim)	0	0	0	0	0	0	0	0
Andrew Hollowood - Group Chief Clinical Transformation Officer	2.5-5.0	0-2.5	110-115	285-290	2,691	86	2,575	0
Nick Johnson - Managing Director	0-2.5	0	20-25	0	287	15	239	0
Duncan Murray - Chief Medical Officer	12.5-15	25-27.5	95-100	250-255	2,380	311	2,042	0
Niall Prosser - Chief Operating Officer	10-12.5	22.5-25	40-45	95-100	723	180	531	0
Simon Sethi - Group Chief Operating Officer	2.5-5.0	0-2.5	40-45	90-95	763	37	708	0
Lisa Thomas - Managing Director	0-2.5	0	60-65	150-155	1,267	4	1,234	0
Simon Wade - Group Chief Finance Officer	5.0-7.5	5.0-7.5	60-65	145-150	1,300	95	1,185	0

Melanie Whitfield - Chief People Officer	0-2.5	0	20-25	0	394	18	347	0
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This table is subject to audit.

- Lisa Thomas left the Trust 31st August 2025
- Judy Dyos started Group Role @ 0.4 WTE 2nd February 2026 retaining 0.6 WTE for SFT
- Mark Ellis started Group Role 26th January 2026
- Nick Johnson started 1st September 2025
- Melanie Whitfield left the Trust 17th August 2025

Notes to Remuneration and Pension Tables

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

For Group Executive directors the Trust has included the full pension costs of the individual where they host the individual. The only apportionment that will be implemented is the real increase in the Cash Equivalent Transfer Values (CETV) as this is the remuneration cost in year. This is on the same basis as the salaries 35% RUH, 35% GWH and 30% SFT and apportioned not on the basis of start date if start date was in year.

The accounting policies for pensions and other retirement benefits and key management compensation are set out in the Note 1.6 to the accounts

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 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 2025-26 was £220-225,000 (2024-25 £210-215,000). This is a change between years of 5%. 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 2025-26 was from £5,000 to £270,000 (2024-25 £14,000 to £240,000). 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 6.27% (2024-25 3.2%). Five employee received remuneration more than the highest-paid director in 2025-26 (2024-25 one employee).

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.

2025/2026	25th percentile	Median	75th percentile
Salary component of pay	29,073	38,911	51,909
Total pay and benefits excluding pension benefits	29,073	38,911	51,909

Pay and benefits excluding pension: pay ratio for highest paid director	7.64	5.71	4.28
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□

2024/2025	25th percentile	Median	75th percentile
Salary component of pay	25,674	36,483	45,279
Total pay and benefits excluding pension benefits	27,230	37,024	48,064
Pay and benefits excluding pension: pay ratio for highest paid director	8.57	6.31	4.86

Payments for loss of office

There were no payments made to senior managers for loss of office in 2025-26.

Payments to past senior managers

None to report in 2025-26.

The Remuneration Report has been approved by the Trust Board.



Cara Charles - Barks
Group Chief Executive (Accounting Officer)
26th June 2026 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs

Analysis of Average Staff Costs	Total 2025-26	Permanently employed Total	Other Total
	£000	£000	£000
Salaries and wages	214,730	213,807	923
Social security costs	28,324	28,324	0
Pension cost - defined contribution plans employer's contributions to NHS pensions	24,952	24,952	0
Pension cost - Paid by NHSE on provider's behalf (6.3%)	16,251	16,251	0
Pension cost - other	107	107	0
Temporary staff/agency contract staff	6,853	0	6,853
Apprenticeship levy	1,048	1,048	0
TOTAL STAFF COSTS	292,265	284,489	7,776
Less: Costs capitalised as part of assets	4,095	4,095	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	288,170	280,394	7,776

Analysis of average staff numbers (subject to audit)

	Total 2025- 26	Permanently employed 2025-26	Other 2025- 26	Total 2024-25	Permanently employed 2024-25	Other 2024- 25
Medical and Dental	595	545	49	550	508	42
Administration and Estates	1,426	1,343	82	1,448	1,361	87
Healthcare assistants and other support staff	694	614	81	765	663	102
Nursing, midwifery & health visiting staff	1,309	1,213	96	1,305	1,180	125
Scientific, therapeutic and technical staff	514	492	22	502	477	25
Total	4,538	4,207	331	4,570	4,189	381

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 number of male and female directors, senior managers and employees as at 31 March 2026

Head Count	Female	Male	Total
Directors	4	8	12
*Senior managers	8	8	16
All other staff	4,075	1,443	5,518

**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:

[NHS Workforce Statistics - January 2026 - NHS England Digital](#)

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
23/24	51,278	3.67%	1.30%	2.37%	0.41%
24/25	56,559	3.84%	1.42%	2.42%	0.07%
25/26	37,379	2.48%	1.24%	1.24%	0.16%

Staff sickness absence increased during 2025–26, reflecting both a growth in workforce size and a higher incidence of short-term sickness absence. The total number of days lost due to sickness dropped to 37,379 days, with sickness absence representing 2.48% of total available days, compared to 3.84% in 2024–25.

The accuracy of sickness absence recording remains strong, with absence recorded without a stated reason remaining at nominal levels (0.16%). This reflects continued improvements in recording practices, supported by the use of e-rostering systems and targeted management support.

The Trust continues to focus on early intervention and effective attendance management. Line managers are supported through targeted training, HR advisory support aligned to Divisions and Corporate Directorates, and access to workforce data to prioritise areas of greatest need. Health and wellbeing initiatives, including access to physiotherapy services and mental health support, continue to support staff recovery and return to work.

Reducing sickness absence and improving staff wellbeing remain key priorities for 2026–27, supporting workforce resilience and the delivery of safe, high-quality patient care.

People Policies

Effective people policies are a core component of a well-led organisation and support delivery of the NHS People Promise. During 2025–26, the Trust continued its rolling programme of reviewing and updating workforce policies to ensure they remain current, legally compliant and aligned with strategic priorities. This approach supports fairness, consistency and inclusion, and provides assurance that managers and staff are equipped with clear guidance.

Key policy developments during the year included the introduction of a Relationships at Work Policy to promote openness and transparency, updates to the Retirement Policy to support flexible retirement options, and the introduction of an Advanced Clinical Practice Policy aligned to the BSW Hospitals Group. The Supporting Attendance at Work and Appraisal Policies were refreshed to improve clarity, consistency and staff experience. Group-wide Managing Organisational Change and Redeployment Policies were also adopted to ensure staff are supported fairly during periods of change.

Together, these developments demonstrate strong workforce governance, inclusive leadership and a continued focus on creating a compassionate, supportive and well-led workplace.

Health and Safety (H&S)

The Trust remains committed to providing a safe environment for staff, patients, volunteers and visitors. During 2025–26, the Health and Safety (H&S) team continued to provide assurance and technical support through the ongoing implementation of a formal H&S management system aligned to recognised standards. This supports continuous improvement and targeted, risk-based activity.

Formal H&S plans were delivered throughout the year, including inspections, audits, risk assessments and targeted programmes to reduce the risk of injury, particularly in relation to

manual handling equipment, sharps injuries, and violence and aggression. Performance is monitored through quarterly reporting to the Trust's Health and Safety Committee, with escalation through the Trust Management Committee to the Board.

In 2025–26, the Trust recorded 42 Lost Time Injuries, resulting in 423 days lost due to work-related injury. The Lost Time Frequency Rate was 2.9 per 10,000 hours worked, with a Lost Time Injury Frequency Rate of 3.6 per million hours worked. Planned task analysis activity was delivered at 95%, supporting proactive risk management.

Incidents of violence and aggression remained the most frequently reported cause of injury. The Trust continued to strengthen prevention and staff support through the Violence Prevention and Reduction Working Group, with appropriate actions taken where required, while maintaining access to essential patient care.

Health and safety remains a core element of the Trust's Well-Led framework, supporting staff wellbeing, organisational resilience and safe, high-quality care.

Staff Survey

In 2025, the NHS Staff Survey continued to be aligned to the NHS People Promise. The Trust achieved a 53% response rate, which was lower than the previous year but remained above the benchmarking group average. Results reflected the national picture, with a general decline across People Promise measures; however, the Trust continued to perform above the national average in seven of the nine areas.

The survey identified areas for improvement, including increased numbers of staff considering leaving, reduced confidence in career development opportunities, and a fall in the number of staff who would recommend the Trust as a place to work. These results were influenced by a challenging year, including organisational change and financial pressures. Positive results were maintained for staff involvement, colleagues looking forward to work, and the Trust's approach to making reasonable adjustments for staff with disabilities.

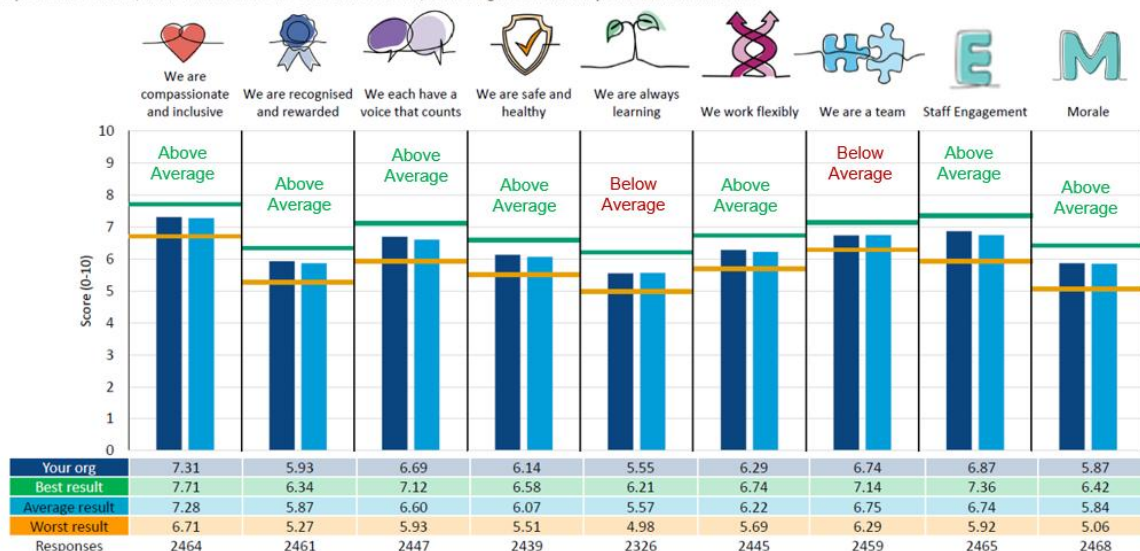
Staff Survey findings inform divisional action plans aligned to the People Promise, with oversight through the People and Culture Committee. Improving staff engagement, inclusion and retention remain priority areas for 2026–27.

Scores for each indicator together with the average, best and worst scores in the benchmarking group across the NHS are presented in the table below:

People Promise elements and themes: Overview

 Survey
Coordination
Centre 

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Two of our Vision metrics are measured through the SFT Survey, these are Engagement and Retention. Progress against our vision metrics for improved staff engagement and staff retention are shown below:

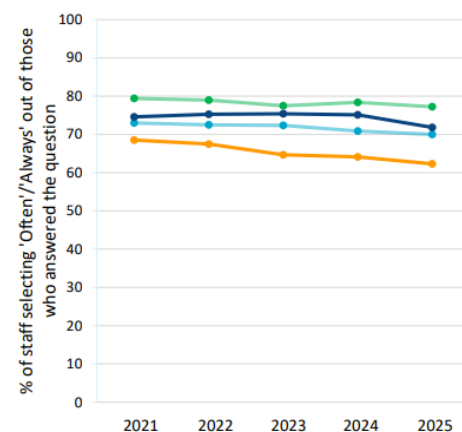
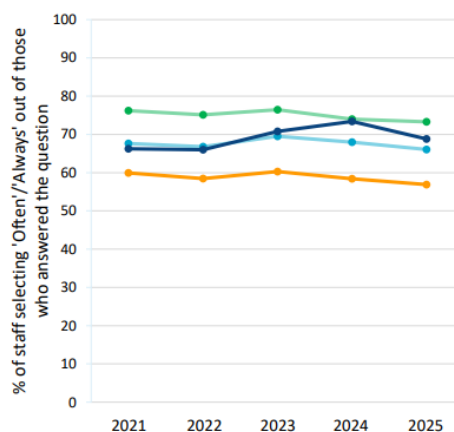
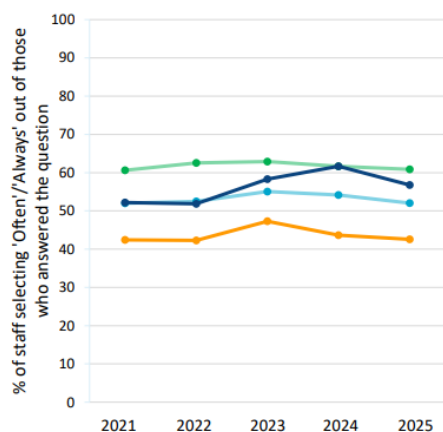
People Promise elements and theme results – Staff engagement: Motivation

 Survey
Coordination
Centre 


Q2a I look forward to going to work.

Q2b I am enthusiastic about my job.

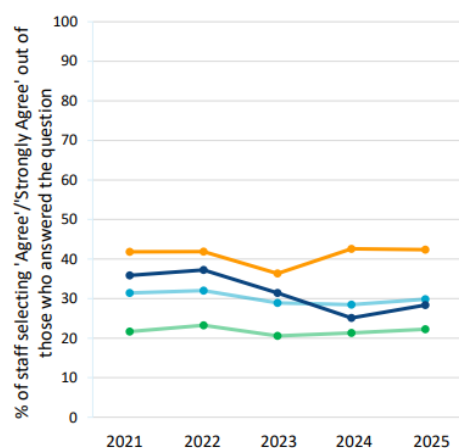
Q2c Time passes quickly when I am working.



People Promise elements and theme results – Morale: Thinking about leaving

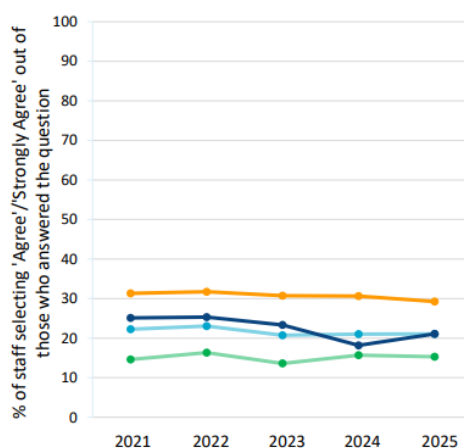
 Survey
 Coordination
 Centre
 


Q26a I often think about leaving this organisation.



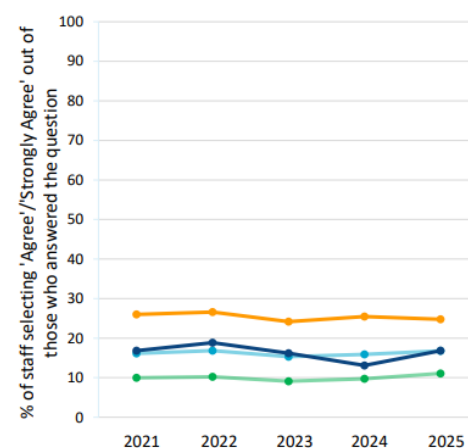
	2021	2022	2023	2024	2025
Your org	35.86%	37.24%	31.42%	25.11%	28.37%
Best result	21.67%	23.25%	20.56%	21.31%	22.27%
Average result	31.44%	32.02%	28.90%	28.46%	29.83%
Worst result	41.82%	41.89%	36.33%	42.59%	42.38%
Responses	1790	1845	2250	2634	2459

Q26b I will probably look for a job at a new organisation in the next 12 months.



	2021	2022	2023	2024	2025
Your org	25.13%	25.32%	23.33%	18.17%	21.07%
Best result	14.63%	16.33%	13.60%	15.69%	15.29%
Average result	22.24%	23.06%	20.73%	21.00%	21.07%
Worst result	31.33%	31.73%	30.75%	30.62%	29.26%
Responses	1789	1844	2251	2633	2451

Q26c As soon as I can find another job, I will leave this organisation.



	2021	2022	2023	2024	2025
Your org	16.84%	18.84%	16.18%	13.10%	16.81%
Best result	9.95%	10.19%	9.11%	9.75%	11.07%
Average result	16.15%	16.84%	15.32%	15.87%	16.77%
Worst result	25.98%	26.59%	24.17%	25.47%	24.76%
Responses	1784	1839	2245	2625	2447

Analysis of the free text comments in the survey was done in a more comprehensive manner this year than in previous years and the qualitative data confirmed a general concern over change management, financial pressures, workforce management and management culture in the Trust. Unsurprisingly this analysis matches areas of concern identified by the quantitative data for the question sets. Action plans at Trust level and within the divisions reflect these high-level concerns. Divisions were guided to use our improving together methodology to identify action plans that addressed the major causes of concern and focussed resource into these countermeasures.

Current Projects and workstreams in place as a result of previous Staff Survey and other identified requirements, which will be maintained include:

- **People Promise Projects** – International Educated Nurse development programmes; Recognition, Sharing Operational Excellence (SOX) and Staff Awards Review; Reduce detriment after Speaking Up; Appraisals Update; Team Based Rostering; Licence to manage; Flexible Working group actions.
- **WRES/WDES Action Plan** – Group Inclusion Questionnaire; Enhance reach and impact of Networks; Promote Health Passport awareness and use; reduce relative likelihood of disabled staff entering formal capability/absence processes.
- **Gender Pay Gap** – Female staff seeking coaching/training to achieve promotion into top quartile.
- **Improving the Working lives of Doctors** – 10 Point Plan actions

Actions plans are being developed to address Compassionate Culture and Leadership issues through use of our Leadership Behavioural Framework and in house leadership programmes

The impact of financial planning is already being addressed through a new series of engagement with staff led by the Managing Director, and improved communication through the CIP/Transformation Cell.

Divisional action plans are being formulated but include the following initial responses:

- **Medicine.** The division is focussing on three priority areas which are: Burnout, Morale and Internal Communications and Negative experiences at work. Actions include Staffing a wellbeing trolley and wellbeing posters featuring identification of burnout symptoms and support available; a monthly Divisional bulletin and cascade town hall briefing to improve internal communication and staff training to support responses to and prevention of violence and aggression.
- **Surgery.** Focus will be on recognition, learning and morale. Initial actions will be to purpose clinical governance days to conduct 'go and sees' for Plastics OP and Endoscopy nursing staff; analysis to improve quantity and quality of appraisal reporting; use of the improving together 'pink ticket' process to better recognise staff achievement through the PRM process; improve and streamline processes impacting staff such as annual leave approvals, recruitment approvals and absence decisions.
- **FASS.** Initial work is focussed on improving flexible working opportunities for staff within the division. Initial actions are targeted 'go and sees' to specialities to better understand the challenges and aspirations of staff in relation to work-life balance and flexible working options.

Staff engagement

Staff engagement is a key workforce priority for the Trust and is identified as a vision metric within our *Improving Together* methodology. The Trust's ambition is to achieve top-quartile performance against peer organisations in the NHS Staff Survey.

In 2024, the Trust's staff engagement score placed Salisbury NHS Foundation Trust 18th nationally, reflecting sustained efforts to strengthen communication, involvement and engagement. In 2025, the staff engagement score declined, with reductions noted particularly in measures relating to staff motivation and enthusiasm. This mirrors the wider national picture and reflects a challenging year for staff, including organisational change and broader system pressures, as a result, staff engagement remains an organisational focus.

A range of actions continue to support engagement and staff voice. These include regular listening events, the introduction of a Staff Council to provide a structured forum for dialogue, and ongoing cascade briefings to ensure staff are informed and able to share feedback. Communication is supported through daily bulletins, weekly Chief Executive messages, and regular line-manager updates, alongside group-wide briefings across the BSW Hospitals Group.

The Trust continues to place strong emphasis on recognition and appreciation. Our annual staff recognition event - *Thank You Week* – which includes staff awards and long-service celebrations, entertainment and a family's day remains well established, alongside peer-to-peer recognition schemes that enable staff, patients and families to acknowledge positive contributions.

Engagement extends beyond the organisation. The Trust remains committed to its role as a local anchor organisation, strengthening links with the community and local partners. Engagement activity during the year included a hospital open day with strong community attendance and continued participation in local place-based partnerships. These relationships have supported initiatives such as staff benefit schemes and increased access to community opportunities.

The Trust also continues to invest in future workforce engagement, with expansion of work experience opportunities for young people across the local area.

Improving staff engagement remains a priority for 2026–27, supported through ongoing listening, inclusive leadership, recognition, and action plans overseen through workforce governance arrangements.

Equality, Diversity & Inclusion (EDI)

During 2025–26, the Trust continued to progress its commitment to equality, diversity and inclusion, while recognising that delivery was impacted by operational pressures and reduced EDI capacity. Workforce data continued to reflect a diverse staff profile, supported by seven active staff networks that play an important role in promoting inclusion and staff voice.

Activity included development support to enhance the effectiveness of staff networks, leadership sessions to strengthen inclusive behaviours, targeted listening events with internationally educated nurses to better understand their experiences and the maintenance of our Disability Confident Leader (Level 3) accreditation.

Learning from this activity is informing actions to improve psychological safety, inclusion, and equitable access to development and career opportunities, supporting delivery of the Trust's Equality, Diversity and Inclusion objectives.

Collaborative working across the BSW Hospitals Group has supported alignment of EDI activity as the Trust transitions to the Group model. Equality, diversity and inclusion remain a core priority within the Trust's People Strategy.

At year end our workforce numbers reflected the diversity of our staff, as shown in the table below:

Ethnicity	Disability	Gender
Black and Minority Ethnic: 28.4%	Disabled 4%	Female 73.7%
White: 67.1%	Undeclared Disability Status: 5.3%	Male 26.3%
Undeclared Ethnicity: 4.5%		

Gender Pay Gap

Gender Pay gap information can be found on the Cabinet Office website <https://gender-pay-gap.service.gov.uk/> and also on our Trust website [here](#).

Freedom to Speak Up

The Freedom to Speak Up (FTSU) Guardian continues to play a vital role in supporting a culture where staff feel safe and confident to raise concerns. A strong speaking-up culture is essential to patient safety, staff wellbeing and organisational learning.

During 2025–26, staff continued to contact the Guardian for a range of issues. Just over half of concerns related to inappropriate behaviours or attitudes, reflecting national trends and reinforcing the importance of positive workplace culture. Other concerns related to patient safety, quality and staff wellbeing.

In response to feedback from the NHS Staff Survey, particularly in relation to feeling heard and included, further actions were taken to increase awareness and confidence in speaking up. These included strengthened communications, closer working with staff networks, thematic analysis of concerns and increased training to promote psychological safety. The Guardian continues to have direct access to senior leaders and Board members, enabling timely escalation where required.

Awareness of the FTSU service is actively promoted through staff communications, induction processes and visible materials across the organisation. The Guardian delivers regular training, including at Trust induction and resident doctor training, to ensure staff understand how to raise concerns and the support available to them.

Quarterly reporting to the Board provides oversight, assurance and learning. In 2025–26, 140 concerns were raised, representing an increase on the previous year and suggesting continued confidence in the Speak Up process. Of these, a significant proportion included patient safety or quality issues, which were escalated immediately to senior leaders. There was also an increase in concerns related to staff wellbeing and safety, informing future wellbeing activity.

The Trust maintains a clear stance against detriment for speaking up, supported by strong governance and leadership oversight. Overall, the Trust continues to demonstrate a mature and effective Freedom to Speak Up model, supporting openness, learning and continuous improvement, in line with national expectations.

Case breakdown by theme is shown in the table below.

	Themes	Cases Q1 (25/26)	Cases Q2 (25/26)	Cases Q3 (25/26)	Cases Q4 (25/26)
1	Element of Patient Safety/Quality	15	9	14	20
2	Worker Safety	16	13	24	36
3	Element of other inappropriate attitudes or behaviours	26	17	12	25
4	Bullying/Harassment	6	5	10	7
5	Disadvantageous and/or demeaning treatment (detriment as a result of raising concerns)	1	5	5	3

Note: Some cases record more than one theme

Education and Apprenticeships

The Trust is committed to developing a highly skilled and sustainable workforce, supporting staff to deliver safe, high-quality care and to develop their careers within the organisation.

Training and development are delivered through three main routes. Mandatory, statutory and core training is provided through the Trust's online learning system, ensuring staff meet essential requirements. Core clinical skills and simulation-based training are delivered by the Practice Education and Simulation teams, supported by specialist educators embedded within clinical services. In addition, the Trust provides continuing professional development (CPD) opportunities to support ongoing learning for both clinical and non-clinical staff.

During 2025–26, CPD funding was distributed through national and Trust-funded routes, enabling 692 staff to access funded training and development, representing an increase on the previous year. This investment supports skills development, professional progression and workforce retention across a wide range of roles.

Funding source	Amount distributed	Total Number of staff who accessed funds
NHSE CPD fund	£497,077	576
SFT Trust funded CPD	£126,372	116

In total 692 clinical and non-clinical staff received funded support for training and development delivered by external trainers / providers, an 11% increase on 2024-25.

The Trust continues to make strong use of the Apprenticeship Levy as part of its commitment to workforce sustainability and its role as a local anchor organisation. Apprenticeships are offered across both clinical and non-clinical roles, from entry-level through to postgraduate level. As of March 2026, there were 140 apprentices on programme, covering 32 different apprenticeship standards, with 25 staff completing their

apprenticeship during the year. Qualifications gained included registered clinical roles, leadership, digital, project management and business specialisms.

Apprenticeship funding is also used to support local organisations through levy transfers, strengthening partnership working and contributing to wider workforce development across the system.

We will again review how training investment and levy funding are used to maximise value, increase uptake and reduce expired levy, working collaboratively through the BSW Group model to explore new opportunities and create additional entry-level and development pathways.

Education and training remain central to the Trust's People Strategy, ensuring the workforce is equipped to meet future service needs while supporting staff wellbeing and retention.

The table below shows a comparator of the uptake of apprenticeships, and the monies provided to support our apprentices from the national levy across the last 4 years.

	2022-23	2023-24	2024-25	2025-26
Total Number of apprentices	143	160	165	165
Current Funds	£1,575,253	£1,788,691	£2,077,075	£2,139,178
Total paid into levy	843,279	£986,317	£1,073,735	£1,136,718
Total Spend in Year	£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	£621,054 Of which £48,857 (7.8%) was transferred to other organisations	£635,710 Of which £53,558 (8.4%) was transferred to other organisations
Annual Expired Levy	£136,370.30	£148,666	£222,675	£297,045

Leadership and Development

Leadership development remains a key priority for the Trust and is central to building a positive culture, effective teams and high-quality patient care. A core component of this work is our Leadership Behaviours Framework, which aligns the Trust's *Improving Together* approach with NHS values of compassion, civility and inclusion. During the year, the framework continued to be embedded across leadership, management and team development activities.

Progress during 2025–26 was delivered within a challenging organisational context, including significant organisational change and competing priorities. Despite this, the Trust maintained focus on high-impact leadership and organisational development activity, supporting sustainable cultural improvement.

The Organisational Development and Leadership (OD&L) team remains embedded across all divisions, providing targeted support to leaders and teams. Support is informed by workforce data, including the NHS Staff Survey, enabling interventions to be focused where they are most needed. OD&L Team work has continued to strengthen team development through the use of team charters, promoting shared responsibility, psychological safety and respectful working. Teams engaging with OD&L support have demonstrated improvements in performance and engagement over the year.

The leadership behaviours framework is also embedded within recruitment, appraisal and talent management processes to ensure consistent expectations of leadership behaviours across the organisation.

During the year, the Trust delivered its first Talent Development Programme for senior leaders, supported by enhanced 360-degree feedback aligned to national leadership frameworks. A coherent leadership development pathway is now in place, integrating internal programmes with external opportunities, supported by ongoing learning, coaching and mentoring.

Leadership development for medical staff has also expanded, with structured programmes now in place to support clinical and medical leaders.

To strengthen consistency in people management capability, the Trust introduced the 'Licence to Manage' framework. This provides core training for managers, covering essential people management skills and organisational processes. By year end, over 80% of managers had attended elements of the programme.

Leadership and organisational development remain central to the Trust's Well-Led framework, supporting effective leadership, staff engagement and continuous improvement.

Consultancy Expenditure Off Payroll Payments

An off-payroll engagement occurs where the Trust engages a worker through an agency or third party, rather than employing them directly via payroll, and where the individual has been in post for six months or more and earns over £245 per day.

The Trust uses off-payroll arrangements only in exceptional circumstances. Such arrangements are not used for Board members or senior officials with significant financial responsibility. However, during the reporting period, there was one off-payroll engagement. This related to an interim Chief People Officer employed from September 2025 to November 2025 while recruitment to the substantive Group Chief People Officer post was undertaken.

Where off-payroll arrangements are necessary, the Trust complies with its internal policies, Standing Financial Instructions, and all relevant HM Treasury guidance.

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater	25/26	24/25	23/24
Number of existing engagements as of 31 March 2025	12	22	44
Of which:			
Number that has existed for less than one year at the time of reporting	12	11	22
Number that has existed for between one and two years at the time of reporting	0	11	15
Number that has existed for between 2 and 3 years at the time of reporting	0	0	3
Number that has existed for between 3 and 4 years at the time of reporting	0	0	4
Number that has existed for 4 or more years at the time of reporting	0	0	0
Totals	12	22	44

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater	25/26	24/25	23/24
Number of off-payroll workers engaged during the year ended 31 March 2025	58	375	745
Of which:			
Not subject to off-payroll legislation	51	375	743
No. assessed as caught by IR35	2	0	0
No. assessed as not caught by IR35	5	5	2
No. of engagements reassessed for consistency / assurance purposes during the year	0	0	2
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 2025 and 31 March 2026	25/26	24/25	23/24
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Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	1 ¹	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)	12	19	15

¹ This individual was an interim Chief People Officer employed during September 2025 to November 2025 whilst the recruiting of the Group CPO was undertaken.

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 2025-26 included in this table. The 2024-25 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(0)	3(0)
£10,000 - £25,000	0(0)	1(1)	1(1)
£25,001 - £50,000	0(0)	1(0)	1(0)
£50,001 - £100,000	0(0)	2(0)	2(0)
£100,001 - £150,000	0(0)	0(0)	0
£150,001 - £200,000	0(0)	0(0)	0
Total number of exit packages by type	0(0)	7(1)	7(1)
Total resource cost	£0(£0)	£185,781(£13,809)	£185,781(£13,809)

This table is subject to audit.

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

Trade Union Facility

The new employment laws seek to stop recording of facility time and as such this data is no longer being collated.

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 2025-26 year; the Trust has not been fully compliant with the provisions of the Code. Following the departure of two Non-Executive Directors in June and September 2025 and the appointment of Eiri Jones to the position of Interim Chair, the Trust had five Non-Executive Directors and six Executive Directors. Therefore, the Trust was non-complaint under section B.2.7, 'At least half the Board of Directors, excluding the chair, should be Non-Executive Directors whom the board considers to be independent.' However, from 1st February 2026, the Trust is now fully compliant having appointed two Non-Executive Directors.

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

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 of Governor have the following committees and trust led working groups over which they can have an influence. In 2025-26 these covered:

- Membership and Communications Committee
- Nominations Committee (Chair and Non-Executive Directors)
- Performance Committee
- Self-Assessment Committee
- The Trust's Annual Plan prior to submission to the regulator
- Staff Governors Committee
- Patient Experience Group

The Governors review their work programme and the make-up of their committees and working groups annually. In November 2025 the Council resolved to restructure its governance structure and to merge the Membership and Communications Committee with the Self-Assessment Committee to form the Membership and Communications and Self-Assessment Committee. The Council also resolved to merge the Nominations Committee with the Performance Committee to form the new Nominations and Performance Committee.

Governors appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform and 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 have four scheduled meetings a year, in addition to the Annual General Meeting (AGM). However, depending on the business to be transacted Extra Ordinary can be arranged and in 2025, the Council had four additional meetings.

The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. Membership engagement continues to be an area of focus, and more meetings will be scheduled in 2026-27.

Elected Governors - Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
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Kevin Arnold	Salisbury City	June 2023	Three years	3/8
Joanna Bennett	Salisbury City	June 2024	Three years	7/8
Frances Owen	Salisbury City	June 2023	Three years	7/8
William Holmes	South Wiltshire Rural	June 2023	Three years	6/8
Anthony Pryor-Jones	South Wiltshire Rural	June 2023	Three years	0/0
Frank Cunnane	South Wiltshire Rural	June 2023	Three years	0/0
Andrew Rhind-Tutt	South Wiltshire Rural	June 2024	Three years	7/8
Peter Russell	South Wiltshire Rural	June 2024	Three years	8/8
Sara Willan	South Wiltshire Rural	June 2024	Three years	7/8
Dr Susan Snoxall	North Dorset	June 2024	Three years	7/8
David Tucker	North Dorset	February 2024	One year three mths	0/0
Barry Bull	East Dorset	June 2024	Three years	7/8
Andi Leach	New Forest	November 2025	Three years	3/4
Jacqueline Hartas	New Forest	June 2024	Three years	0/0
Paul Hedge	Kennet	May 2025	Three years	6/8
Salil Ray-Chowdhury	Rest of England	June 2024	Three years	3/8

Notes*Anthony Pryor-Jones resigned in April 2025**Frank Cunnane resigned in April 2025**David Tucker resigned in July 2025***Elected Governor - Staff Constituency**

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
Paul Russell	Clerical, Administrative and Managerial	June 2021	Three years	6/8
Jane Podkolinski	Volunteers	June 2021	Three years	8/8
Vacant	Medical & Dental	June 2024	Three years	
Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	0/0
Jayne Sheppard	Nurses & Midwives (Lead Governor)	June 2021	Three years	8/8

Notes*Mark Brewin stepped down in April 2025***Nominated Governors**

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance
Cllr Pauline Church	Wiltshire Council	June 2024	Three Years	0/5
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
Jason Goodchild	Military	March 2024	Three years	2/8

Notes

Cllr Pauline Church stepped down in Feb 2026

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, the Managing Director and other Executive Directors. There is an opportunity for Governors to express their views and raise any other issues.

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.

The Trust Board meets 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 Audit Committee, the Finance and Performance Committee, its Clinical Governance Committee and the 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 2025-26.

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 2026 is:

Public Constituency	Number
Salisbury City	2,001
South Wiltshire Rural	3,616
Kennet	893
North Dorset	1,089
East Dorset	513
New Forest	894
Rest of England	1,063
Staff Constituency	1,787
Total	10,069

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 continues 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, will attract a more representative membership

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.

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, VTE, Clinical Ethics and any more Trust led working groups. Governors have also 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

Nominations Committee

The Council has a Nominations and Remuneration Committee which advises the Council on the appointment and remuneration of Non-Executive Directors and the Chair.

During the year the Committee met to recommend the appointment of Interim Chair for Salisbury NHS FT, the recruitment of two NEDs and the appraisal for the Chair and the NEDs.

The Board of Directors

The Board comprises the Chair, Chief Executive, four voting Executive Directors, four non-voting members and six 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. The chair 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 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 2025-26, the Trust appointed two new Non-Executive Directors after a rigorous recruitment process supported by the Council of Governors' Nominations Committee. All

new Non-Executive Directors were 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.

Joint Committee

As part of the transition to a Group operating model, a joint committee was established at the beginning of 2025, comprising representatives from each of the constituent Trust Boards. The committee operates under formally agreed terms of reference and exercises specified functions delegated to it by each Board, while ultimate accountability continues to rest with the individual statutory Boards. The purpose of the joint committee is to support greater alignment, consistency and collaboration across the Group in areas where collective decision-making adds value, while preserving the sovereignty of each Trust and ensuring compliance with constitutional, statutory and regulatory requirements. The joint committee provides a monthly report to each Trust Board, ensuring transparency, oversight and effective assurance. The delegated arrangements are kept under regular review to ensure that the governance framework remains effective, proportionate and fit for purpose as the Group model continues to evolve.

Board and Committee Effectiveness Review

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. During 2025-26, the Board continued to review progress in relation to the Well-Led improvement programme, noting that actions arising from the review were also being progressed as part of the wider BSW corporate governance workstream, supporting transition to a Group operating model. Further details 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

Anne Stebbing Non-Executive Director (Independent)

Dr Anne Stebbing joined the Trust in July 2024. Anne is the Senior Independent Director, Chair of the Clinical Governance Committee and a member of the Charitable Funds Committee and Remuneration Committee.

With over 30 years' experience as a consultant breast and general surgeon in the NHS, she has held many medical leadership roles from clinical director to deputy medical director at Hampshire Hospitals. She continues working part time in the breast surgery team.

Prior to joining SFT she was first a member of the East Berkshire CCG and then served 6 years as a non-executive director at South Central Ambulance Service.

Richard Holmes– Non-Executive Director (Independent)

Richard Holmes joined the Trust in January 2023 for his first three-year term as Non-Executive Director and has been re-appointed for another three-year term. 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 – Interim Chair/ Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019 and became Senior Independent Director (SID) in September 2023. In July 2025, Eiri was appointed as Interim Chair to support the transition to the BSW Group Structure and the recruitment of a Group Chair.

Eiri is a registered adult and children's Nurse, has an MA in Professional Development and trained as a Quality Service Improvement and Redesign (QSIR) Practitioner. She has clinical, managerial, and executive leadership knowledge and skills gained during a career spanning over 45 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority, GIRFT), 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; Regional Director of GIRFT in the Southwest of England and most recently as a Quality Improvement Director for Cwm Taf Morgannwg Health Board. Eiri is also Deputy Chair at Dorset County Hospital and a became a joint NED with Dorset Healthcare in September 2024 as part of the federated model in West Dorset.

Dr Paul Cain - Non-Executive Director (Independent)

Dr Paul Cain joined the Trust in June 2024 and is a member of the Trust's Finance and Performance Committee, Clinical Governance Committee, People and Culture Committee and Remuneration Committee.

He has 40 years of experience in healthcare, initially as a Consultant in Occupational and Aviation Medicine in the Army followed by a series of healthcare leadership roles. This included leading hospitals and pre-hospital trauma systems during conflicts and later the military's integrated Primary Healthcare system during COVID 19. As Director General Operations and Board member at the newly formed UK Health Security Agency, Paul was part of the team directing the response to the Omicron variant. Recent roles have focused on implementing multi-million-pound transformation programs delivering more efficient care, better organisational structures and modernising health IT systems.

Paul believes strongly in developing and empowering people and ensuring the healthcare system works effectively so that we can deliver the best possible care for patients.

Peter Knell - Non-Executive Director (Independent)

Peter Knell joined the Trust in February 2026. He initially joined the Army, specialising in finance and IT programme management, leading the finance component of several strategic change programmes. Since leaving the Army in 2011, he has subsequently held board positions in the public and charitable sectors within education, the NHS and social care, including as chair of the finance and audit committee of Dorset County Hospital for 6 years.

He is currently the Executive Finance Director of a local authority trading company providing adult social care services, including frail elderly, dementia, nursing, learning disability and mental health residential care and support, plus day services and employment support.

His professional interest in the delivery of change is reflected in his current research for a doctorate in business administration, which seeks to expand understanding of the effective leadership of successful change in the health and social care sector. He is particularly committed to the role of the Trust within the BSW Hospitals Group in supporting its patient community by delivering continual improvement in health and wellbeing, collaborating with all parts of the integrated healthcare system.

Richard Samuel - Non-Executive Director (Independent)

Richard joined the Trust in February 2026. He brings a wealth of experience in leadership roles across the NHS, healthcare commissioning, and regulatory sectors. As the former National Director of Outpatients, NHSX Director of Elective Innovation, Chief Executive of two NHS Clinical Commissioning Groups, a Director of a Specialist Care Provider, and leader in the Hampshire and Isle of Wight Integrated Care Board, Richard has been at the forefront of healthcare transformation. He advises a range of public and private sector organisations on the use of technology to transform healthcare

Executive Directors

Cara Charles-Barks MBE - Joint Chief Executive (voting)

Cara was appointed Chief Executive and Accountable Officer on 1 November 2024. This is a joint role between RUH, GWH and SFT. Cara qualified as a Registered Nurse in 1990 in Australia. She has 30 years' experience in the public and private health care sector and has been named as one of the NHS's top 50 Chief Executives.

Cara has been the Chief Executive Officer of the RUH since September 2020. Before that, she was CEO at Salisbury NHS Foundation Trust, during which time she received an MBE as part of the Queen's Birthday Honours for her leadership during the Novichok incident. In June 2019, she was appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Medical Services.

Judy Dyos – Chief Nursing Officer / Group Chief Strategic Officer (voting)

Judy Dyos has been the Chief Nursing Officer and an Executive Director at Salisbury NHS Foundation Trust since 2020. Judy Dyos was appointed as Interim Group Chief Strategic Officer in February 2026 on a part time basis to support strategic leadership across the BSW Hospitals Group pending substantive recruitment. In her interim capacity, she has supported system-level strategic planning and collaboration aligned to the Group operating model.

Judy has an extensive nursing profile having been a registered nurse since 1996. Judy has worked in several NHS trusts in London and the southern east prior to joining the team at Salisbury. Her focus is on Continuous Improvement in the delivery of high-quality care and providing the best patient experience. She holds an MSc in Advanced Critical Care Practice and a Post Graduate Certificate in Research from Kinds College London. Judy completed an internship with the National Institute in Research undertaking primary research and worked at the University of Southampton for 2 years as a visiting lecturer in the Faculty Health Science.

Mark Ellis – Group Senior Risk Officer (non-voting)

Mark has over 20 years leadership experience across finance, governance, and risk. He holds a master's degree in engineering science from the university of Oxford and is a Chartered Management Accountant. He was appointed Chief Risk Officer in January 2026, and prior to this was Chief Finance Officer at SFT for three years.

Mark champions culture and capability and has mentored emerging leaders in continuous improvement to help bring risk and performance capability across clinical and corporate teams. Mark is passionate about enabling colleagues to turn insight into action for our population and workforce.

Jude Gray– Group Chief People Officer (non-voting)

Jude Gray was appointed as Group Chief People Officer of the BSW Hospitals Group on 1st November 2025. Prior to this, she served as Chief People Officer at Great Western Hospitals NHS Foundation Trust from 2019. By way of background, Jude has senior people leadership experience across the public sector, including previous roles with the BBC and His Majesty's Prison and Probation Service. In her Group role, she is responsible for workforce planning, sustainability, health and wellbeing across the BSW Hospitals Group.

Andrew Hollowood –Group Clinical Transformation Director (non-voting)

Andrew Hollowood was appointed as Group Clinical Transformation Officer from 1st September 2025. He had previously worked as Chief Medical Officer at Great Western Hospitals NHS from September 2022 and was subsequently appointed Interim Managing Director following the appointment of the BSW Hospitals Group Chief Executive Officer. On appointment to this Group role, he became a non-voting member of the Board.

By way of background, Andy is a consultant cancer surgeon specialising in gastric cancer and has held senior medical leadership roles within the NHS, including Deputy Medical Director at University Hospitals Bristol and Weston NHS Foundation Trust. He brings extensive experience in patient safety, quality improvement and addressing health inequalities.

Jonathan Hinchliffe – Group Chief Transformation and Innovation Officer (non-voting)

Jonathan Hinchliffe joined the BSW Hospitals Group executive team in April 2025 and currently serves as Group Chief Digital and Information Officer. During 2025-26, the role title was refined to reflect its focus on digital enablement, information strategy and business intelligence, with no change to underlying responsibilities or governance arrangements. Jonathan provides strategic leadership for system-wide digital transformation and the implementation of a shared electronic patient record across the Group.

Jonathan is Delivery Director at St Vincents Consultancy, a company that provides interim roles and consultancy support to the NHS. Jonathan is employed as Group Chief Digital and Information Officer via St Vincents Consultancy.

Nick Johnson – Managing Director (voting)

Nick was appointed Managing Director of Salisbury NHS Foundation Trust (SFT) on 1st September 2025. He is responsible for leading SFT and working with the SFT Executive team to run the Trust on a day-to-day basis.

Nick joined SFT from Dorset County Hospital (DCH) where he spent almost ten years in Executive Board roles, including two spells as the Interim Chief Executive. For the past two and a half years he combined his role as Deputy CEO of DCH with a joint executive role between DCH and Dorset Healthcare NHS Foundation Trust (DHC), overseeing areas including strategy, transformation, improvement, digital and partnerships.

During his time in Dorset Nick collaborated with system partners to deliver system wide strategies and service improvements, secured funding for DCH's new ED and Critical Care unit, developed the Dorset Provider Collaborative, and jointly led the Working Together Programme creating the Federation between DCH and DHC. His first spell as Interim Chief Executive coincided with the first 5 months of the Covid pandemic and the second from January 22 to April 23 as DCH and DHC reviewed and established new leadership arrangements. Nick was also a member of the Wessex Health Innovation Network Board from 2017 until 2025.

Nick joined DCH in 2016 from the University Hospital Southampton NHS Foundation Trust, where he was responsible for strategy and commercial development projects, including establishing an innovative commercial development joint venture. Prior to that he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider, focussing on strategic public private

partnerships. Nick has also worked in several local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has a MSc from Warwick Business School and started his career on the National Graduate Development Programme for Local Government.

Niall Prosser – Chief Operating Officer (voting)

Niall Prosser joined the Trust in February 2024. He was appointed to the substantive role of Chief Operating Officer in January 2025. He has over 18 years of senior NHS operational, transformation and commissioning management experience working within the Bath, Swindon and Wiltshire and Bristol systems.

Niall has a strong track record of utilising data and devolved leadership to help services/teams to find and deliver their own innovations and improvements to support service improvement for our patients.

Duncan Murray - Chief Medical Officer (voting)

Duncan has worked in the NHS for more than 30 years after medical training in Cape Town. He joined SFT in January 2000 as a Consultant in Anaesthesia and Intensive Care Medicine, having completed specialist training in the Oxford region, with additional experience in Sydney.

He has held a number of medical leadership roles in the organisation over the last 16 years at service and divisional level, most recently as Deputy Chief Medical Officer and Associate Medical Director for the BSW Acute Hospital Alliance.

Duncan was appointed as interim Chief Medical Officer in August 2024, and to the substantive position in October 2024.

Simon Wade - Group Chief Finance Officer (voting)

Simon Wade was appointed as Interim Chief Finance Officer in September 2025, alongside his role as Chief Finance Officer at Great Western Hospitals NHS Foundation Trust. In November 2025, he was appointed as Group Chief Finance Officer for the BSW Hospitals Group. By way of background, Simon has extensive senior NHS finance experience. Prior to his appointment as Chief Finance Officer at Great Western Hospitals NHS Foundation Trust in 2020, he also served as Deputy Director of Finance of the Royal United Hospitals Bath NHS Foundation Trust. Simon has no declared interests.

Directors who left the Trust during 2025-26

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. Ian left the Trust in June 2025.

Debbie Beaven– Non-Executive Director (Independent)

Debbie Beaven joined the Trust in January 2023 for her first three-year term as Non-Executive Director, having been on the Board of the IOW NHS Trust for 2 years. Debbie is a Fellow of the Institute of Chartered Management Accountants with an extensive career in financial leadership roles. She is an experienced board director, bringing sound financial expertise around good governance, financial improvement plans and long-term financial modelling. She has other roles in her Non-Executive Director portfolio; Chair of Audit at Newbury Building Society, Chair of Audit and Risk at Southern Co-op and Chair of Audit and Risk at Boundless (CSMA). Debbie left the Trust in September 2025.

Kirsty Matthews – Non-Executive Director (Independent)

Kirsty Matthews joined the Trust in June 2024 and is a member of the Audit Committee, People and Culture Committee and Remuneration Committee. She has over 30 years' experience in the Health and Social Care sector and has held a variety of senior roles in both public and private organisations. Currently she is the Chief Executive Officer at DFN Project SEARCH, a charity for young people with special educational needs and disabilities. Kirsty left the Trust in June 2025.

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 works at the University of Gloucestershire as an Executive Dean with responsibility for Equity, Diversity and Inclusion and is also the Head of School for Health and Social Care. Rakhee was appointed for her second term of office of three years in December 2022 and extended for a further three months to March 2025 to support the transition to the BSW Group structure. Rakhee left the Trust in March 2025.

Lisa Thomas – Interim Chief Executive

Lisa joined the Trust in September 2017 as Chief Finance Officer before being appointed as Chief Operating Officer in August 2022 and Interim Chief Executive Officer in January 2024. With the recent appointment of a Joint CEO across Salisbury NHS Foundation Trust (SFT), Great Western Hospitals, and Royal United Hospitals Bath, Lisa is responsible for the day-to-day leadership at SFT, working alongside the executive team as Interim Managing Director from 1st November 2024.

Lisa has over twenty-five years' experience of working in the NHS working across hospitals in Bath, Hampshire and Gloucestershire. Lisa is passionate about improving healthcare and has been involved throughout her career in service and patient care improvement projects. She is also enthusiastic about recognising the challenges of delivering healthcare for a rural population. Lisa left the Trust in August 2025 to commence her new role as Managing Director at Great Western Hospitals NHS Foundation Trust.

Melanie Whitfield – Chief People Officer

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

With many years of organisational HR experience, including Board level experience within Private Equity and Public and Charity sectors, Melanie joined the national team at NHS England and Improvement as one of the founding authors of the NHS People Plan. She "got the bug" for health some 6 years ago and has worked in both the community and acute setting alongside the Department of Health and National Regulator.

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. In 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 SFT's executive team, she was 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. Melanie left the Trust in August 2025.

Ali Layne-Smith – Interim Group Chief People Officer

Ali Layne-Smith was appointed on an interim basis September-November 2025 to allow time for a substantive appointment to the Group Chief People Officer role and deliver stability during wider system changes.

Ali brings significant senior leadership experience from across the NHS, policing, central government and global industry and is a Non-Executive Director at Cambridge University Hospitals NHS Foundation Trust. She has previously held senior roles including Director of People and Culture at London Ambulance Service and Director of People and Organisational Development at West Midlands Police. Ali left the Trust in November 2025.

Board of Directors' Attendance 2025-26

Board member	Title	Attendance rate
Lisa Thomas	Managing Director	2/2
Judy Dyos	Chief Nursing Officer	7/7
Melanie Whitfield	Chief People Officer	2/2
Eiri Jones	Non-Executive Director/ SID/ Interim Trust Chair	7/7
Rakhee Aggarwal	Non-Executive Director	6/7
Richard Samuel	Non-Executive Director	1/1
Peter Knell	Non-Executive Director	1/1
Mark Ellis	Chief Finance Officer/Group Senior Risk Officer	7/7
Debbie Beaven	Non-Executive Director	3/3
Richard Holmes	Non-Executive Director	5/7
Ian Green	Trust Chair	1/1

Kirsty Mathews	Non-Executive Director	1/2
Paul Cain	Non-Executive Director	5/7
Anne Stebbing	Non-Executive Director	7/7
Duncan Murray	Chief Medical Officer	6/7
Niall Prosser	Chief Operating Officer	7/7
Cara Charles Barks	Group Chief Executive	5/7
Andrew Hollowood*	Group Strategic Clinical Transformation Officer	2/2
Jude Gray*	Group Chief People Officer	2/2
Nick Johnson*	Managing Director	5/5
Jonathan Hinchliffe*	Non-voting – Chief Transformation and Innovation Officer	7/7
Simon Wade*	Group Chief Finance Director	2/2

* Non-voting

The Board members attend Council meetings to develop an understanding of the views of governors and members about the NHS foundation trust

Register of Director's Attendance* – Public Council of Governors 2025- 26

	Attendance rate
Ian Green	1/1
Rakhee Aggarwal	0/4
Debbie Beaven	0/2
Richard Samuel	1/1
Paul Cain	4/4
Richard Holmes	0/4
Margaret (Eiri) Jones	4/4
Kirsty Matthews	1/1
Anne Stebbing	3/4
Peter Knell	0/1
Cara Charles-Barks	3/4
Nick Johnson	2/2
Judy Dyos	2/4
Mark Ellis	2/4
Duncan Murray	1/4
Niall Prosser	1/4
Lisa Thomas	1/2
Melanie Whitfield	1/2
Ali Layne-Smith	0/0
Simon Wade	1/2
Andrew Hollowood	0/2
Jude Gray	1/2
Jonathan Hinchliffe	0/0

* Executive Directors will attend in rotation based on papers reporting to the meeting.

Board Committees

The Board has identified a number of matters on which only it will make decisions. These include the power to set the vision, strategic aims, objectives and budget for the Trust.

These are set out in the scheme of delegation and reservation of powers to the Board. Other matters are delegated to Board committees, which operate within defined terms of reference. Details are set out below.

The Audit Committee

The purpose of the Audit Committee is to support the Board and Accounting Officer by reviewing assurances on governance, risk management and the control environment to ensure that they are comprehensive and reliable. The scope of the Committee encompasses all the assurance needs of the Board and Accounting Officer, the integrity of financial statements, any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them. The Committee also reviews and assesses the annual report and provides assurance on the effectiveness of integrated governance, risk management and internal control systems, across the whole Trust.

The Committee is supported in its work by the External Auditors, Deloitte. KPMG were appointed as the Trust's independent internal auditors and counter fraud specialists.

Membership of the Audit Committee

The Audit Committee comprises of three independent Non-Executive Directors and has been chaired by Richard Holmes, Non-Executive Director since 1st January 2023.

The Chief Financial Officer is the Lead Executive, and the Managing Director regularly attends meetings. Other Executive Directors and management staff are invited to attend meetings to present on specific areas of risk or operations that are within their area of responsibility.

Representatives from the internal and external auditors and the counter fraud specialist attend each meeting.

Attendance Audit Committee 2025-26

Name	Title	Attendance
Richard Holmes	Non-Executive Director – Committee Chair	4/4
Eiri Jones	Non- Executive Director	2/2

Anne Stebbing	Non- Executive Director	2/2
Kirsty Matthews	Non- Executive Director	0/1

Business conducted by the Committee in Discharging its Responsibilities

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.

Risk Management

The Committee reviewed the Trust's Board Assurance Framework (BAF) and the Corporate Risk Register to obtain a clearer view of the risks facing the Trust any gaps in controls or assurance and the actions being taken to manage these risks or any gaps in controls or assurance.

Compliance with Code of Governance

The Committee reviewed the Trust's compliance with the Code of Governance and identified two areas of non/partial compliance, which have since been addressed.

Annual Report and Accounts

As part of the year-end process and approval of the Annual Report and Accounts 2024- 25 the Committee received and considered:

- The final draft of the Annual Report and Accounts 2024-25
- The Head of Internal Audit Opinion
- External audit opinion on the accounts and the Annual Auditor's Report.
- Letter of Representation to external audit
- The Going Concern assessment

External audit

The Committee reviewed the reports prepared by external audit and agreed external audit's plan for the 2025-26 accounts and the significant risk areas of focus in 2025-26. The Committee also approved the professional fees of £245,700 plus VAT charged by Deloitte in the period from 1 April 2025 to 31 March 2026.

Internal audit

Throughout the year the Committee has worked effectively with internal audit to strengthen the internal control processes. The Committee also

- Reviewed the internal audit plan for 2026-27
- Considered the major findings of internal audit which will form the basis of the Head of Internal Audit Opinion.

- Regularly reviewed outstanding audit actions and were assured that a robust progress monitoring process is in place.

Counter Fraud

The Committee approved the Counter Fraud Plan, reviewed the progress reports and the Annual Report.

Information Governance

The Committee reviewed the final Data Security and Protection Toolkit (DSPT) submission report and the Data Protection Officer yearly report.

Cost Control and Financial Governance

The Committee received reports on Losses and Compensation, Payroll Overpayments, Vacancy Control Process and single tender actions (STAs).

Governance documents

The Committee reviewed and recommended Board approval of the following key governance documents;

- Standing Orders
- Scheme of Delegation
- Standing Financial Instructions
- Committee Terms of reference and Workplan

Clinical Governance Committee

The Clinical Governance Committee is responsible for providing assurance to the Board that high quality care is provided to patients throughout the Trust. The Committee monitors the Trust's clinical governance and the quality agenda by focusing on;

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Service Improvement and Change Management
- Continuous Quality Improvement

Register of Attendance – Clinical Governance Committee 2025-26

Committee Member	Title	Attendance rate
Anne Stebbing	Non-Executive Director - Committee Chair	9/9
Nick Johnson	Managing Director	5/6
Niall Prosser	Chief Operating Officer	6/9
Debbie Beaven	Non-Executive Director	4/4
Paul Cain	Non-Executive Director	8/9
Duncan Murray	Chief Medical Officer	8/9
Judy Dyos	Chief Nurse	7/9

Lisa Thomas

Managing Director

2/3

Finance & Performance Committee

The Committee scrutinises high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHSE requirements and in particular:

- Financial strategy, policy, management, and reporting
- Management and reporting Performance
- Monitoring Cost Improvement Programmes
- Operational performance

Attendance at the Finance & Performance Committee in 2025-26.

Committee Member	Title	Attendance rate
Debbie Beaven	Non-Executive Director - Committee Chair	3/4
Lisa Thomas	Managing Director	3/3
Richard Holmes	Non-Executive Director – Committee Chair	9/9
Paul Cain	Non-Executive Director	7/9
Niall Prosser	Chief Operating Officer	9/9
Peter Knell	Non-Executive Director	2/2
Mark Ellis	Chief Finance Officer	9/9
Nick Johnson	Managing Director	5/6
Simon Wade	Group Chief Finance Officer	4/5

People and Culture Committee

The People and Culture Committee has responsibility for the delivery and assurance of the People Strategy. In addition, it has responsibility for:

- Ensuring the mechanisms are in place to support the development of compassionate and inclusive leadership capacity and capability within the Trust
- The development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies, and information to meet the required contractual obligations
- The mechanisms of improving how the Trust engages with its workforce so that they are motivated to do the best they can for the organisation and for the communities the Trust serves.
- That Organisational Development and Change Management are deployed well to maximise the opportunities of improvement and shape the Trust culture
- Continuous Quality Improvement methodology is readily made available, the skills reinforced and this way of working actively promoted

Attendance at the People and Culture Committee in 2025-26

Committee Member	Title	Attendance rate
Eiri Jones	Non-Executive Director - Committee Chair	4/4
Melanie Whitfield	Chief People Officer (Lead Executive)	0/1
Judy Dyos	Chief Nurse	5/9
Rakhee Aggarwal	Non-Executive Director – Committee Chair	8/9
Lisa Thomas	Managing Director	3/3
Duncan Murray	Chief Medical Officer	7/9
Paul Cain	Non-Executive Director	6/6
Ali Layne-Smith (Lead Executive)	Interim Chief People Officer	2/3
Jude Gray	Group Chief People Officer	5/5
Kirsty Mathews	Non-Executive Director	1/2
Alex Talbot	Director of Improvement	7/9
Nick Johnson	Managing Director	5/6

Charitable Funds Committee

The Committee provides the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

The Committee supports the Board in

- Ensuring the stewardship and effective management of funds which have been donated, bequeathed, and given to Salisbury District Hospital Charitable Fund for charitable fund purposes.
- Determining an investment strategy and arrangements for the investment of funds which are not immediately required for use.
- Coordinating the provision of assurance to the Board of Directors, acting as trustee of the funds, that the funds are accounted for, deployed, and invested in line with legal and statutory requirements.
- Considering and approving the annual accounts for charitable funds for submission to the Board of Directors, acting as trustee of the funds.

Attendance at the Charitable Funds Committee in 2025-26.

Committee Members	Title	Attendance rate
Ian Green	Trust Chair - Committee Chair	2/2

Debbie Beaven	Non-Executive Director	3/3
Peter Knell	Non-Executive Director	1/1
Anne Stebbing	Non-Executive Director	4/5
Judy Dyos	Chief Nurse	3/5
Mark Ellis	Chief Finance Officer (Lead Executive)	5/5
Eiri Jones	Trust Chair – Committee Chair	3/3

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, 88% 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.

Code of Governance Provisions to be 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 7) / Annual Governance Statement (page 105)
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 62)
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 7) / Code of Governance (page 76)

Part of Schedule A	Code section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. • Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Code of Governance (page 76)
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 89)
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 (pages 76-79)

Part of Schedule A	Code section	Summary of requirement	Annual Report Location
Required disclosures			
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).	na
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 81)
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 82-89)
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 82) (AGS page 124)
Disclose	C 4.13	The annual report should describe the work of the nominations committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - 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.	Remuneration Report (page 40)

Part of Schedule A	Code section	Summary of requirement	Annual Report Location
Required disclosures			
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 76-77)
Disclose	D 2.4	The annual report should include: - the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. - an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit. - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Code of Governance (page 91) AGS (page 130)
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.	Code of Governance (page 92)
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.	AGS (Page 107)
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.	Performance Report (page 33) AGS (Page 107)

Part of Schedule A	Code section	Summary of requirement	Annual Report Location
Required disclosures			
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.	Performance Report (page 16)
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.	na
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 77-79)
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 80)
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 80)
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012.	Code of Governance (page 76)

Part of Schedule A	Code section	Summary of requirement	Annual Report Location
Required disclosures			
		* Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	

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**.

As part of this process the Trust is required to have Enhanced Oversight Meetings chaired by the Integrated Care Board. Significant progress has been made during 2025-26 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 2026-27. 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 2026.

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*.

A handwritten signature in blue ink, appearing to read 'c.c.b.' followed by a long horizontal stroke.

Cara Charles-Barkes
Group Chief Executive
Date: 26 June 2026

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 2026 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, supported by the Managing Director.

The day-to-day oversight has been delegated to the Chief Nursing Officer and Chief Medical Officer who are 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 specifically responsible for patient safety, patient experience and medical legal matters and the Chief Medical Officer for Clinical Effectiveness.

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, Trust Management Committee, chaired by the Managing Director, 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 risks 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 (DPRs). The escalations through the DPRs connect our continuous improvement management system with the Executives. It is via this route a team or department's unmitigated risks and root causes to problems are escalated and can be unblocked by the wider multi-disciplinary team.

Risks are identified through third-party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, improvement huddles, A3 thinking sessions, 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 of 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 Trust risk appetite approach was first proposed at a Board Development Day in February 2024. A Risk Appetite Framework was developed as a result of several months of consultation with the Board and subject matter experts to develop risk definitions, risk categories and risk appetite level descriptors. The risk definitions and risk appetite were approved by Trust Board in October 2024. With changes to the system model and appointment of a Group Chief Executive Officer during 2024-25, the Trust risk management approach and risk appetite framework is subject to ongoing review and adaptation.

Applying a risk appetite framework involves translating the Trust's risk tolerance into actionable policies, controls and decision-making processes. This ensures that risks taken align with strategic goals, stakeholder expectations and regulatory requirements. The Trust has been evolving its approach to risk appetite with it predominantly being applied to the Board Assurance Framework (strategic risks) and the Corporate Risk Register. It is intended that the approach will become more sophisticated over time with risk appetite being implemented and embedded at Divisional level and then specialty level in the longer term.

The application of the revised risk appetite resulted in a significant shift of risks from within tolerance to out of tolerance and is subject to on-going Board scrutiny.

The Board recognises that, as at year-end, all twelve BAF risks sit outside the Board's agreed risk tolerance, an increase from ten in the prior year. This position reflects the sustained and increasing external pressures on NHS provider organisations during 2025-26, financial, operational and workforce, together with the cumulative effect of major strategic transitions, including the formation of the BSW Hospitals Group and the delivery of transformation programmes at pace.

The Board has maintained clear sight of the trajectory of each principal risk throughout the year; detailed mitigations are in place and under active delivery, and scrutiny has been provided through the appropriate Committees of the Board. The Board is satisfied that the risk management system has functioned as intended in surfacing these breaches for explicit acknowledgement, rather than allowing them to pass unremarked, and that no principal risk has been accepted without that acknowledgement.

The twelve BAF risks relate to:

Population

- BAF 1: Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trust's operating model.
- BAF 2: Due to the size of our catchment population, there is a risk that some services are not sustainable.
- BAF 3: 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.
- BAF 4: Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
- BAF 5: There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss, impacting patient care, data security and Trust reputation.
- BAF 8: Demand for services outweighs capacity, resulting in an increased risk to patient safety, quality and effectiveness of patient care.

People

- BAF 6: There is a risk that the Board has limited capacity in terms of time, skills and capability to effectively oversee the organisation and the delivery of key strategic priorities in 2025-26.
- BAF 7: Inability to effectively plan for, recruit and retain staff with the right skills, impacting staff experience, morale and wellbeing and resulting in potential adverse impacts on patient care.

Partnerships

- BAF 9: SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability.

- BAF 10: Failure to establish and maintain effective partnerships to support the Integrated Care System, with potential impact on the Trust at Place level.
- BAF 11: Risk of not achieving the transformation requirements at the pace required to deliver a sustainable position in-year and beyond.
- BAF 12: Risk of sustained deterioration across key elective performance metrics.

For each of the BAF risks, there is a detailed series of mitigations which will continue to be implemented throughout 2026-27. During this period there will be a transition to a Group Board Assurance Framework. The Group BAF will map the Group's strategic objectives to the principal risks that could prevent their achievement, the controls in place to manage those risks and assurance that those controls are effective and any gaps in control with actions taken to address them.

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:

- **Digital transformation and EPR delivery**

The BSW Hospitals Group Electronic Patient Record (EPR) Joint Committee is established and supported by a formal programme structure, overseen by the Group Chief Executive Officer. Delivery is supported by an internal Digital Steering Group, which provides routine oversight of digital priorities, risks and interdependencies. Digital maturity is embedded within the Trust Strategic Planning Framework as a strategic initiative for 2025-26. Cyber security controls, including regular penetration testing, continue to inform the Trust's cyber risk mitigation activity. Implementation of the Digital Strategy continues, with a focus on strengthening digital infrastructure, clinical safety controls and assurance processes, with progress and risks reported through established governance routes to the Board.

- **Strategic planning and transformation delivery**

Delivery of the Annual Plan 2025-26 is underpinned by the Trust Strategic Planning Framework, supported by an ICS-level programme structure of delivery groups overseeing BSW transformation priorities. Within Salisbury NHS Foundation Trust, dedicated Urgent Care and Planned Care Transformation Boards provide focused oversight of delivery, implementation and sustainability of key improvement programmes. Progress, risks and benefits realisation are monitored through the Integrated Performance Report and escalated through executive and Board governance arrangements.

- **Group governance and leadership capacity**

Continued focus is maintained on succession planning and leadership resilience, alongside the implementation and embedding of governance arrangements for the newly formed Hospitals Group. These arrangements are subject to ongoing review to ensure they remain proportionate, effective and support both Trust and Group-level accountability. Board development, induction and assurance processes support effective oversight during this period of transition.

- **Sustainability and collaboration**

As part of the BSW Hospitals Group, opportunities continue to be pursued to improve environmental, operational and financial sustainability through collaboration, shared planning and system-wide approaches to service delivery and investment.

- **Urgent care transformation**

Continued focus is maintained on the urgent care transformation programme, including Same Day Emergency Care (SDEC), Emergency Department improvement and enhanced models of care for older people. Delivery is overseen through established transformation governance structures, with system partners, to mitigate risks relating to demand, flow and patient safety.

- **Workforce and People Promise delivery**

A comprehensive improvement programme is in place across all seven elements of the NHS People Promise, supported by defined workstreams, governance schedules and performance metrics. Progress is monitored through workforce reporting and People and Culture Committee oversight, providing assurance to the Board on workforce sustainability, staff experience and leadership capability.

- **Financial control and value for money**

Increased focus continues on strengthening financial controls and ensuring best value decision-making, supported by enhanced scrutiny through the Finance and Performance Committee. Financial recovery and productivity initiatives are monitored through established reporting mechanisms, with assurance from internal and external audit.

- **Capital investment and estates governance**

Robust capital prioritisation processes are in place to ensure limited resources are deployed effectively and aligned to strategic priorities. A new Estates Strategy, approved by the Trust Board in March 2025, provides a clear framework for addressing estates risk, infrastructure sustainability and long-term site development, with progress monitored through routine governance and assurance arrangements.

Major risks 2026-27

As we enter 2026-27, the Trust remains focused on delivery of the operational and financial plans whilst dealing with significant operational challenges coupled with financial and workforce controls. The focus will be on the delivery of NHS England Operational Planning Priorities 2026-27.

- **Improving productivity and financial sustainability** - delivering at least a 2% productivity improvement through more efficient models of care, reduced waste, increased day-case activity and the introduction of the new 2026-27 Payment Scheme.
- **Transforming outpatient and digital services** - shifting away from traditional models towards digital-first and patient-led care, including increased use of the NHS

App, AI-enabled scheduling and automation, and ambient voice technology to improve efficiency and patient experience.

- **Improving Urgent and Emergency Care performance** - including Emergency Department waiting times and ambulance response, through enhanced clinical navigation, single points of access and improved patient flow.
- **Reducing cancer and diagnostic waiting times** - with a continued focus on improving the 28-day Faster Diagnosis Standard and reducing diagnostic waits of over six weeks.
- **Maintaining a strong focus on quality and safety** - ensuring that service transformation and productivity improvements are delivered without compromising patient safety or experience.

Key risks include:

- Sustainability of key services for the local population, driven by workforce challenges including recruitment and retention difficulties, affordability pressures and limited economies of scale in some specialties, with the potential to impact service continuity and quality.
- Delivery of productivity improvement and financial sustainability, including the risk of not achieving the required minimum 2% productivity improvement through more efficient models of care, increased day-case activity and reduced waste, and the effective implementation of the 2026-27 Payment Scheme.
- Transformation of services through place-based and system working, including the pace and effectiveness of service redesign delivered through the BSW Integrated Care System and BSW Hospitals Group, and the ability to realise benefits from collective working.
- Capacity and capability to deliver multiple transformation priorities concurrently, including outpatient and digital transformation, urgent and emergency care improvement, elective recovery and financial recovery, while maintaining effective leadership, governance and organisational focus.
- Managing demand and capacity pressures, particularly in Urgent and Emergency Care, cancer, diagnostics and elective services, with the risk that rising demand outstrips workforce and estate capacity, impacting performance against national access standards.
- Maintaining quality and safety during service transformation, ensuring that productivity and efficiency improvements do not compromise patient safety, experience or compliance with regulatory standards.
- Responding effectively to national policy change, including the implementation of the NHS ten-year plan and evolving operational, financial and workforce requirements, while navigating increasing system complexity.

- Investment in and effective use of digital and technological infrastructure, including the risk that digital maturity, skills and cyber resilience are insufficient to support new models of care, outpatient transformation and productivity improvement.
- Ensuring a sustainable workforce with the right skills and capability, across both clinical and non-clinical roles, to support new ways of working, digital adoption and service resilience.

Within this context, the Trust recognises the opportunities presented by closer integration with local partners and will continue to prioritise collaboration across the BSW Integrated Care System and BSW Hospitals Group. This includes shared approaches to service sustainability, workforce planning, urgent and emergency care, and system financial recovery. These risks will be reviewed regularly to ensure the Trust is well positioned to deliver the NHS and BSW ICS long-term plans, including the NHS People Plan ambition to make Salisbury NHS Foundation Trust “the Best Place to Work”.

Our underlying financial position remains a significant challenge, with an initial planned deficit of £13.8m in 2025/26 and an efficiency requirement of £21m. NHS England confirmed in year, cash backed, non-recurrent deficit support funding of £13.8m to bring the plan to break even. However, expenditure was £10m higher than planned which led to the clawback of £3.5m of Deficit Support Funding, and a £13.4m deficit against plan for SFT only against the control total.

The financial context for the NHS in 2026-27 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 and blended payments for Urgent and Emergency Care but fixed income for other care; we must therefore manage internally the expenditure risk associated with growth in demand for emergency pathways. As a healthcare system, financial sustainability is a priority; For our own part, SFT will be seeking to reduce our underlying deficit through a significant £32.5m savings plan, delivery of which is underpinned by the ‘Creating value for the patient’ breakthrough objective, which aligns with the national operational planning priority to reduce waste and improve productivity. Concurrently, BSW Hospitals Group and the wider system are 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.

Our focus for 2026-27 will be improving services for patients through focus on our breakthrough objectives:

- Reducing pressure injuries
- Reducing patients’ wait time to first outpatient appointment

- Reducing staff unavailability
- Creating value for our patients.

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 that nurtures and supports transformation 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 2025. 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, supported by the Managing Director. 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 excellence management system we share across 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 supports that Trusts that have a continuous improvement approach like this provide better patient care, and colleagues working in these Trusts have greater job satisfaction. The Trust staff survey results are reflective of this.

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 a data and 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.

Over the last year we have been successful in deepening the use of this approach in the Trust. We now have over 145 teams trained (of c.180 teams) and the development of our speciality and team level performance review meetings (PRMs) is ensuring we can show the 'golden thread' from ward to board in alignment with our strategy. The PRMs are also strengthening our governance by ensuring clear lines of escalation through the operational management system: team to speciality, speciality to divisional management team (DMT), and DMT to the Executives.

As part of the commitment to our improvement led approach all Board members take part in regular development and training, which focuses on the leadership behaviours that promote continuous improvement and compassionate, just and learning culture within an organisation. Underpinning this is the inclusion of leadership behaviours in the Executive appraisals whereby each Executive identifies with the Managing Director which behaviours they are focusing on to help nurture a culture of continuous improvement.

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 or workforce controls responding to headcount controls will not have an adverse impact on quality. This process was reviewed and refreshed in 2023-24 and again in February 2025 in response to increasing workforce controls. The Clinical Management Board and Workforce Control Panel, 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 2025-26 and the quality priorities selected for 2026-27. 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 Divisional 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 Power BI 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 Southwest 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 Trust-wide 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 Trust 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 Information Governance 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, Managing Director 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 ICB 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 transitioned to the Patient Safety Incident Response Framework (PSIRF) on the 8th January 2024. The four aims of the PSIRF are:

- compassionate engagement and involvement of those affected by patient safety incidents: patients, families and staff
- considered and proportionate responses to patient safety incidents and safety issues
- application of a range of systems-based approaches to learn from patient safety incidents
- supportive oversight focused on strengthen the response and improvement

As part of the transition, the Trust (SFT) developed and implemented the SFT Patient Safety Incident Response Plan and Policy which support the requirements of the PSIRF. They set out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and concerns for the purpose of learning. The policy and plan enable the Trust to use a systems-based approach to explore patient safety incidents and where there is identified new learning to support an improvement workstream to enable effective and sustainable change in the most important areas. As a Trust we are continuously learning and adapting our processes, as such the plan and policy remain active documents and can be reviewed depending on the situation and or within 12-18 months after transition and at regular intervals going forward.

The local risk management system is Datix Web, where as an organisation we are compliant with the national Learning From Patient Safety Events (LFPSE) system. The aim of this is to enable all patient safety incidents to be shared outside of the organisation to aid greater oversight, thus enabling the wider NHS system to understand the nature of patient safety incidents and to share learning and improvement.

PSIRF continues to mature at SFT, supporting a coordinated, data-driven approach to patient safety that emphasises systems-based learning, compassionate engagement, and continuous improvement. The Trust has prioritised delivery of its Patient Safety Incident Response Plan (PSIRP), ensuring that responses to incidents maximise learning, involve patients and families meaningfully, and address contributory factors at a system level.

A strengthened governance structure supports this work. A daily Trust-wide patient safety huddle reviews all incidents reported in the previous 24 hours, enabling immediate actions, oversight, and support, alongside review of patient deterioration indicators such as NEWS2. Incidents of moderate harm and above, or significant near misses, are escalated to the weekly Patient Safety Summit, attended by senior clinical leaders including the Chief Nursing Officer and Chief Medical Officer. More detailed analysis and learning responses are overseen through the Patient Safety Oversight Group, providing assurance on the quality, timeliness and impact of investigations, with escalation routes through to the Patient Safety Steering Group where required.

The Trust continues to build investigation capability and capacity through structured training, embedding systems-based methodologies and improving consistency and quality of patient safety reviews. This is underpinned by a focus on developing a just and restorative culture that supports staff wellbeing and psychological safety.

Improvement arising from patient safety learning is coordinated through the Patient Safety Steering Group, with clear links to divisional and Trust-wide improvement programmes. To strengthen organisational learning, divisions deliver monthly Learning from Incidents forums, complemented by a quarterly Trust-wide Learning from Incidents Summit. These multidisciplinary forums promote shared learning, transparency and continuous improvement across the organisation.

Patient and public involvement continues to grow. Patient Safety Partners (PSPs) are increasingly embedded across governance structures and safety activity, contributing to oversight, influencing improvement workstreams and ensuring the patient voice is central to decision-making. Further expansion of the PSP role is planned to enhance this contribution across the Trust.

Patient and staff stories remain a critical component of the Trust's governance and learning framework. At Board level, these stories provide powerful insight into the lived experience of care, complementing quantitative data and helping to ensure that quality discussions remain grounded in what matters most to patients, families and staff. Stories presented at Board reflect both positive and negative experiences, highlighting themes such as communication, compassion, and the impact of care processes. This qualitative insight supports a deeper understanding of risks, reinforces a culture of openness and reflection, and directly informs improvement priorities across the organisation. It also strengthens engagement, ensuring that

the patient and staff voice is consistently heard at the highest level of decision-making, and aligns with the Trust's commitment to person-centred care and continuous learning.

The Trust has strengthened its approach to surveillance and early intervention through daily safety huddles, proactive identification of cases for PSIRF review, and thematic analysis of incidents. This is complemented by the triangulation of data across patient safety, risk management, patient experience, Freedom to Speak Up, and legal services. Collective insights and emerging risks are escalated through governance structures, including the Clinical Management Board, to provide organisational assurance and drive improvement.

SFT has also been an early adopter of Martha's Rule, launching "Call for Concern" in February 2025. This provides a 24/7 mechanism for patients, families, carers and staff to escalate concerns about deterioration if they feel they are not being heard. The Critical Care Outreach Team undertakes rapid review and facilitates escalation where required. In addition, the introduction of daily patient wellbeing questions has strengthened early recognition of deterioration, with digital capture of this information placing SFT at the forefront of practice regionally.

Alongside these developments, the Trust has implemented a focused programme to strengthen the fundamentals of care, supported by subject matter experts and audit tools, reinforcing high standards of safe and compassionate care delivery.

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 for the Board and Board Committees.

Arrangements detailed within this statement ensure that the Trust's leadership and governance are effective and align to best practice and are used to mitigate risks to compliance with the NHS provider licence section 4 (governance arrangements).

There is no requirement for 2025-26 to submit a Corporate Governance Statement as per previous years.

Workforce Planning and Safe Staffing

The Trust has established robust arrangements to ensure that workforce planning supports the delivery of safe, sustainable and effective staffing in the short, medium and long term.

A Strategic Workforce Plan is in development, covering a five-year period. This takes account of local population needs, national and system priorities, and the Trust's strategic objectives. The plan supports a long-term approach to recruitment, retention and workforce sustainability, ensuring the Trust can meet future service demand safely and effectively.

At a local level, workforce planning is reviewed through the annual operational planning process, developed at Divisional level and aligned to the Strategic Workforce Plan. This

ensures that services are appropriately staffed, clinical outcomes can be delivered within the agreed financial framework, and staffing levels meet safe staffing guidance. The Organisation Development and People (OD&P) team works closely with Divisions to support recruitment activity, role redesign and workforce development, with a particular focus on hard-to-recruit roles and areas of high turnover.

Any proposed in-year changes to workforce plans are subject to formal scrutiny through Divisional Management Teams and Trust-level governance arrangements. Additional oversight is provided by the Workforce Control Panel, ensuring that changes remain affordable, necessary and do not present risks to patient or staff safety. Proposed changes to clinical staffing profiles are subject to Quality Impact Assessment, in line with national guidance.

The Trust operates clear assurance arrangements for safe staffing. Ward nursing establishments and skill mix are reviewed bi-annually and reported to the Board through governance committees, in line with National Quality Board guidance. Workforce risks are monitored through Divisional risk registers and the Board Assurance Framework.

Staff wellbeing is routinely monitored alongside workforce capacity. Health and wellbeing arrangements include formal processes for junior doctors, supported by the Guardian of Safe Working, and wider monitoring through line management, wellbeing forums and sickness absence reporting. Workforce data, including staff availability, sickness absence, and use of temporary staffing, is reviewed regularly through integrated performance reporting.

Digital systems, including E-Rostering and workforce dashboards, support oversight of staffing levels, skill mix and absence. Performance is reviewed through Divisional and Trust-level performance meetings, with escalation to Executive and Board level where required.

The Trust remains fully compliant with Care Quality Commission (CQC) registration requirements and continues to strengthen workforce governance to support delivery of high-quality, safe care now and in the future.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

Care Quality Commission (CQC) Medical Services inspection

On 18–19 June 2025, the Trust was subject to a Care Quality Commission (CQC) inspection of Medical Services as part of the routine programme of regulatory assurance. Medical Services were rated **Good overall**.

Inspectors observed a positive safety culture and heard consistently from staff that they felt well supported and valued. Strong multidisciplinary working and effective communication

were evident across the wards visited. Staff demonstrated a good understanding of the Trust's *Improving Together* methodology and described it as an inclusive approach that encourages shared learning and collective ownership of improvement. International staff highlighted the effectiveness of the Trust's arrangements for cultural integration and support.

The inspection also identified areas requiring improvement. These included the need for more consistent application of infection prevention and control (IPC) practices, improvements to environmental cleanliness, equipment safety, and storage arrangements, and strengthening compliance with appraisal and mandatory training requirements. The CQC also identified workforce risks, including reliance on temporary staffing and turnover within healthcare assistant roles.

In addition, a number of performance risks were highlighted, including non-compliance with the stroke four-hour assessment standard, the cancer 62-day treatment standard, and diagnostic waiting times, particularly within endoscopy. Gaps in Speech and Language Therapy provision for stroke and Parkinson's patients were also identified, alongside inconsistencies in meeting national stroke therapy intensity standards.

While many of the issues identified were localised rather than systemic, they highlighted the need to strengthen routine assurance arrangements, reinforce local accountability for standards, and ensure consistent application of agreed clinical and operational processes across Medical Services.

The Trust has incorporated the required actions into its ongoing quality improvement and risk management programmes. This includes targeted work on IPC compliance, workforce stability, mandatory training oversight, therapy provision, and delivery against national performance standards. Progress is monitored through established governance and quality assurance structures.

Care Quality Commission (CQC) Surgical Services inspection

On 16–17 September 2025, the Trust underwent a CQC inspection of Surgical Services as part of its routine programme of regulatory assurance. Initial feedback was provided at the conclusion of the inspection; however, the final report, including the overall rating, has not yet been published.

Initial feedback was positive, with inspectors reporting strong patient experience, including personalised and compassionate care, and open and engaged staff across professional groups. The inspection team highlighted effective surgical pre-assessment processes, including the involvement of pharmacy to support patient safety and flow. Inspectors also recognised improvements to the clinical environment following the refurbishment of the Interventional Radiology and Cardiac Catheter Laboratories, which were noted to support the delivery of new and expanded services.

Areas for improvement identified through the initial feedback included environmental challenges associated with an ageing estate, space and storage constraints, and opportunities to strengthen the organisation and accessibility of emergency equipment. Inspectors also noted that clearer communication between some teams would support smoother patient pathways.

Although the final report had not been issued at the end of the reporting period, the Trust commenced work immediately to address the issues highlighted through initial feedback. Actions have been embedded within existing quality, safety and estates governance arrangements to mitigate identified risks and strengthen assurance.

CQC inspection under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017

On 6 November 2025, the Trust received an announced CQC inspection under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, focused on Nuclear Medicine services. The inspection included document review, observation of clinical practice, record review and discussions with staff.

The CQC concluded that the service was compliant with the majority of IR(ME)R requirements. No breaches met the threshold for enforcement action, and no statutory notices were issued. IR(ME)R inspections do not result in a rating and do not impact a provider's overall CQC rating.

Inspectors identified a number of areas of good practice, including strong multidisciplinary working, effective leadership oversight from radiology, and robust control and accessibility of governance documentation. Areas for improvement were also identified, including improved access to referral guidelines for external referrers, strengthening processes for the reporting of significant accidental or unintended exposures, more consistent designation of carers and comforters, and enhanced oversight of equipment used for sentinel lymph node procedures currently managed outside the Nuclear Medicine department.

The CQC required the Trust to submit an action plan by 19 January 2026, setting out how the recommendations would be addressed. The Trust submitted the plan within the required timeframe. The majority of actions have been completed, with the remaining actions progressing in line with agreed timescales and subject to routine governance oversight.

The CQC's approach to monitoring and regulation and our preparedness

The CQC's single assessment framework (launched in November 2023) and provider portal have been under scrutiny as to their effectiveness over the past year and improvement work is on-going. It is unlikely all elements of the single assessment framework will be removed, so work has continued to embed elements of this across the organisation.

Engagement with the core services commenced in year which involves a self-assessment process. This process involves a self-assessment against themed, common must dos and 'should dos' gathered from a variety of CQC reports with different ratings by the Head of Compliance and, developing an improvement plan if required. Part of this process includes a 'check and challenge' of their findings by Divisional Management Teams prior to presentation at the Trust Management Committee (TMC). At TMC the core service leads present key findings, challenges and their learning from having undertaken the process. On-going oversight of the process requires improvement plan actions to be monitored through divisional management team and senior leadership team meetings and sharing at divisional governance meetings for wider learning and, escalation to Executives via divisional performance reviews if required. This process has received positive feedback from the services who have engaged in it to date and members of the TMC.

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. 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".

There have been bi-annual reports to Board on progress against the key improvement themes. There has been significant progress made against all identified areas for improvement. The Trust has aligned the key areas for improvement to existing programmes of work to ensure this has oversight through existing governance arrangements. Some of this work now forms part of a wider BSW corporate governance workstream supporting the move to a Group Model.

Looking ahead, the Trust intends to commission a further Aqua review during 2026-27, with a specific focus on the effectiveness and maturity of Group governance arrangements. This will provide external assurance to the Board on the operation of the developing Group model and help identify any further areas for improvement

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 continues to recognise financial sustainability as a key strategic risk. During 2025–26, the Trust has operated within a highly challenging financial environment, reflecting ongoing structural pressures including the complexity of the patient cohort, workforce costs, and the age and scale of the estate.

A significant weakness has been identified in relation to financial sustainability. This reflects the scale of the financial challenge facing the Trust, together with weaknesses in the robustness and deliverability of financial plans, including the identification and achievement of cost improvement programmes and the management of funding gaps and liquidity risks.

Whilst this significant weakness does not arise from a failure of internal financial controls, it highlights material uncertainty in the Trust's ability to deliver a sustainable financial position over the medium term. In response, the Trust has continued to develop its financial recovery arrangements during 2025–26, including strengthening oversight of financial performance, savings delivery and associated risks.

The Trust has established a dedicated internal Turnaround team, with sole focus on supporting financial turnaround and sustainability. The efficiency schemes across the three years of the Medium-Term Plan are being developed alongside the strategic planning

framework of the Trust, and the Improving Together methodology is being continually applied to identify and stratify the main areas of focus.

The Trust reviews economy, efficiency and effectiveness through a range of mechanisms, including benchmarking, reference costs, Model Hospital metrics, GIRFT outputs and population health data, alongside routine performance management. Divisional performance is regularly scrutinised with Executive Directors and assessed against agreed financial, workforce and quality plans. All investments are supported by business cases, with benefits realisation and outcomes monitored against agreed objectives.

The external auditor did not identify a significant weakness in arrangements for improving economy, efficiency and effectiveness.

The Audit Committee provides independent oversight of probity, propriety, regularity of public finances and value for money, drawing assurance from the work of external audit, internal audit and the local counter fraud service. In addition, the Trust continues to work closely with system partners across BSW to identify opportunities to reduce cost, improve productivity and support financial sustainability through collaborative approaches, with progress reviewed through Hospital Group and Directors of Finance forums. Departmental and divisional cost improvement programmes are tracked through Directorate Performance Reviews and supported by the Trust's *Improving Together* operating management system. Building on arrangements established in 2024-25, financial recovery and delivery risks continue to be escalated and monitored through dedicated executive-led forums, reporting into the Finance and Performance Committee as part of the Trust's core financial governance framework.

The Trust's financial position, alongside workforce and quality performance, is reviewed in detail each month by the Finance and Performance Committee and scrutinised by the Board through the Integrated Performance Report. These arrangements provide the Board with assurance that resources are being used economically, efficiently and effectively, and that financial risks are actively managed and mitigated in support of the Trust's strategic objectives.

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 Group Chief Digital & Information 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 2024/25 and is on course to meet the standards again in 2025-26. 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 1st July - 30th June. In line with the NHS England guidance, the Trust confirms it will submit the 2025-26 DSPT assessment on or before 30th June 2026.

Since July 2025, the Trust reported one data security incident to the Information Commissioner's Office. The incident related to a subject access request that was sent to a patient's old address. The information was returned to the Trust and re-sent to the correct address. The ICO took no action.

During the year, work has continued to align processes within the Group. This has included sharing knowledge and resources, aligned 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 February 2026. 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 index (DQMI) for all metrics used in core external returns such as Commissioning Datasets and internal monitoring by Trust committees. Monitoring of all DQMI data helps the Trust identify Key Performance Indicators (KPIs) which are monitored via ISG and shared with Clinical Divisions where appropriate. Where potential improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process via the Data Quality Change Advisory Board.

As a result of the formation of BSW Hospitals Group the Trust seeks to standardise and align BI and reporting outputs with Group counterparts as well as the creation of Group level reporting. The formation of a single BI function across BSW Group will enable sharing of expert resources 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 Trust 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 now supported by a new digital system, AMaT.

Head of Internal Audit Opinion

The Head of Internal Audit provides an independent opinion on the adequacy and effectiveness of the Trust's arrangements for governance, risk management, and internal control, including those supporting the Board Assurance Framework. For 2025-26, the Trust has received the following findings aligned to the Global Internal Audit Standards (GIAS): governance; risk management and control; financial reporting and management; and data captured and used by the organisation. During 2025/26 KPMG completed nine reviews. Based on the controls reviewed the following conclusions were drawn:

- **Governance:** Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed the need to improve the operating effectiveness of controls.
- **Risk management and control:** Overall findings on design showed controls are effectively designed. Our testing showed some controls to be operating effectively, and others could be more consistently applied.
- **Financial reporting and management:** Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed some controls to be operating effectively, and others could be more consistently applied.
- **Data captured and used by the organisation:** Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed the need to improve the operating effectiveness of controls.

Notwithstanding this assurance, the external auditor has identified a significant weakness in relation to financial sustainability. This reflects the scale of the financial challenge facing the Trust, together with weaknesses in the robustness and deliverability of financial plans, including the identification and delivery of cost improvement programmes and the management of funding gaps and liquidity risks. Whilst this weakness does not arise from a failure of internal financial controls, it highlights material uncertainty in the Trust's ability to deliver a sustainable financial position over the medium term. In response, the Trust has strengthened its financial recovery arrangements during 2025/26, including enhanced oversight of financial performance, savings delivery and associated risks, although further work remains to ensure plans are fully developed and deliverable.

The Trust reviews economy, efficiency and effectiveness through a range of mechanisms, including benchmarking, reference costs, Model Hospital metrics, GIRFT outputs and population health data, alongside routine performance management. Divisional performance is regularly scrutinised by Executive Directors and assessed against agreed financial, workforce and quality plans, with all investments supported by business cases and monitored for delivery of benefits. The external auditor did not identify any significant weakness in arrangements for improving economy, efficiency and effectiveness.

Overall, the Board is satisfied that the Trust has appropriate systems of internal control in place, while recognising the ongoing risks and challenges associated with financial sustainability.

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 Sponsor attended the Audit Committee to discuss the report and actions taken. There is an established process in place 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 2025-26 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 effectively. Any serious incidents or non-compliance with standards and regulatory requirements are appropriately escalated and are subject to timely and effective remedial action. This provides assurance that patients, service users, staff and stakeholders can have confidence in the quality of services delivered and in the effective, economic and efficient use of resources. There remains in place a dynamic and embedded process for the management of internal control, which is reviewed and updated regularly by the Executive Team and the Board Committees that support me in discharging my responsibilities as Accounting Officer. The key risks facing the Trust, together with the actions taken to mitigate these, are set out within this Annual Governance Statement.

My review confirms that Salisbury NHS Foundation Trust has generally sound systems of internal control in place up to the date of approval of the Annual Report and Accounts. However, I recognise the significant weakness in financial sustainability, relating to the scale of the financial challenge facing the Trust and the need to strengthen the robustness and deliverability of financial plans, including cost improvement programmes and management of liquidity risks.

While this does not reflect a failure of internal financial controls, it represents a material risk to the Trust's ability to deliver a sustainable financial position. Actions are in place to address

this, including strengthened financial oversight and recovery arrangements, and this will remain a key focus for the Board.

Taking these factors into account, I am satisfied that, overall, the Trust has appropriate systems of internal control in place, with no other significant internal control issues identified.

A handwritten signature in blue ink, appearing to read 'e.e.R'.

Cara Charles-Barkes
Chief Executive (Accounting Officer)
26th June 2026 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2026

INDEX

	Page
FOREWORD TO THE ACCOUNTS	(i)
INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS	(ii)
STATEMENTS OF COMPREHENSIVE INCOME	1
STATEMENTS OF FINANCIAL POSITION	2
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY	3
CONSOLIDATED STATEMENTS OF CASH FLOWS	4
NOTES TO THE ACCOUNTS	5 - 58

FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2026 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, appearing to read 'C. Charles-Barks', followed by a period.

Cara Charles-Barks - Group Chief Executive

Date: 26th June 2026

Independent auditor's report to the board of governors and board of directors of Salisbury NHS Foundation

Report on the Audit of the Financial Statements

Opinion

In our opinion the financial statements of Salisbury NHS Foundation Trust (the 'foundation 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 2026 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 statements of comprehensive income; the group and trust statements of financial position;
- the group and trust statements of changes in equity;
- the group and foundation trust statements 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 Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, 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 irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- 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 team, including relevant internal specialists such as valuations and IT specialists, 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 an expenditure is capital in nature, is subjective: we tested a sample of expenditure to assess whether they meet the relevant accounting requirements to be recognised as capital in nature.

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.

In our audit report dated 20 June 2024 on the 2023/24 financial statements, we reported a significant weakness in the foundation trust's arrangements to secure financial sustainability. The significant weakness reported was in how the trust planned to bridge its funding gaps, identified achievable savings and planned finances to support the sustainable delivery of services in accordance with strategic and statutory priorities. Our recommendations for improvement included;

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,
to continue to focus on its governance arrangements over the cost improvements programme and related implementation plans,
that the timetable and governance arrangements around the cost improvement programme are further developed to enable identification of cost improvement opportunities and project planning ahead of the start of the relevant period,
to closely monitor the liquidity position and ensure that robust plans are in place to manage any liquidity shortfalls,
keeping open dialogue with DHSC 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.

On 19 June 2025 we additionally recommended that the trust should also work with the BSW Hospitals Group to identify efficiencies that are possible within this structure.

This weakness has not yet been addressed.

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 2026 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.

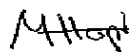
Certificate of completion of the audit

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Salisbury NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial

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.



Michelle Hopton (Senior Statutory Auditor)
For and on behalf of Deloitte LLP Appointed Auditor
Bristol, United Kingdom
26 June 2026

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2026

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	395,805	373,347	392,581	373,347
Other operating revenue	4	40,128	43,530	31,433	29,396
Operating expenses	6	(442,737)	(422,613)	(431,820)	(408,283)
OPERATING (DEFICIT)/ SURPLUS FROM CONTINUING OPERATIONS		(6,804)	(5,736)	(7,806)	(5,540)
FINANCE COSTS					
Finance income	11	2,007	1,635	2,198	1,418
Finance expense	12	(3,116)	(3,586)	(3,073)	(3,514)
PDC Dividends payable		(5,095)	(5,242)	(5,095)	(5,242)
NET FINANCE COSTS		(6,204)	(7,193)	(5,970)	(7,338)
Other (losses)/ gains	7.2	(10)	51	(10)	(174)
Share of profit/ (losses) of associates/ joint ventures	33		(168)		(168)
Movement in fair value of other investments	17	1,220	75		
Corporation tax expense		(101)	(81)		
(DEFICIT) / SURPLUS FOR THE YEAR FROM CONTINUING OPERATIONS		(11,899)	(13,052)	(13,786)	(13,220)
(Deficit) / surplus from discontinued operations and the (loss) on disposal of discontinued operations			(163)		(163)
(DEFICIT) / SURPLUS FOR THE YEAR		(11,899)	(13,215)	(13,786)	(13,383)
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations	15	2,013	(951)	2,006	(951)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		(9,886)	(14,166)	(11,780)	(14,334)
NOTE: ALLOCATION OF SURPLUS/ DEFICIT FOR THE YEAR					
(a) (Deficit) / surplus for the period attributable to:					
(i) Non-controlling interest, and		25	59		
(ii) Owners of Salisbury NHS Foundation Trust		(11,924)	(13,274)	(13,786)	(13,383)
TOTAL		(11,899)	(13,215)	(13,786)	(13,383)
(b) Total comprehensive (expense)/ income for the year attributable to:					
(i) Non-controlling interest, and		25	59		
(ii) Owners of Salisbury NHS Foundation Trust		(9,911)	(14,225)	(11,780)	(14,334)
TOTAL		(9,886)	(14,166)	(11,780)	(14,334)

The notes on pages 5 to 58 form an integral part of these financial statements.

With the exception of Wiltshire Health and Care LLP which ceased trading after 31st March 2025 (see note 33) all revenue and expenditure is derived from continuing operations.

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2026

		Group		Trust	
		31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
NON-CURRENT ASSETS	Note				
Intangible assets	14	17,078	11,557	17,078	11,557
Property, plant and equipment	15	227,775	204,154	227,670	203,414
Right of use assets	16	6,373	7,015	4,383	4,664
Other investments	17	10,937	9,428	500	500
Other financial assets	18	3,440	3,177	3,942	3,830
Receivables	21	285	344	285	344
Total non-current assets		265,888	235,675	253,858	224,309
CURRENT ASSETS					
Inventories	20	8,095	7,520	5,777	5,664
Receivables	21	24,808	19,063	27,753	20,820
Investments	17	395	396		
Other financial assets	18			303	420
Cash and cash equivalents	22	32,185	28,951	20,730	19,591
Total current assets		65,483	55,930	54,563	46,495
Total assets		331,371	291,605	308,421	270,804
CURRENT LIABILITIES					
Trade and other payables	23	(66,665)	(47,219)	(65,630)	(45,414)
Borrowings	24	(3,086)	(3,261)	(2,385)	(2,994)
Provisions	25	(566)	(590)	(566)	(590)
Total current liabilities		(70,317)	(51,070)	(68,581)	(48,998)
Total assets less current liabilities		261,054	240,535	239,840	221,806
NON-CURRENT LIABILITIES					
Borrowings	24	(32,421)	(30,479)	(31,276)	(28,604)
Provisions	25	(401)	(492)	(401)	(492)
Total non-current liabilities		(32,822)	(30,971)	(31,677)	(29,096)
TOTAL ASSETS EMPLOYED		228,232	209,564	208,163	192,710
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	34	170,542	141,988	170,542	141,988
Revaluation reserve	38	81,500	79,494	81,500	79,494
Income and expenditure reserve	38	(42,518)	(28,079)	(43,879)	(28,772)
Charitable fund reserves	35	18,488	15,966		
OTHERS' EQUITY					
Minority Interest	38	220	195		
TOTAL TAXPAYERS' AND OTHERS' EQUITY		228,232	209,564	208,163	192,710

The notes on pages 5 to 58 form an integral part of these financial statements.

The financial statements on pages 1 to 58 were approved by the Board on 26th June 2026 and signed on its behalf by:

Signed:



Cara Charles-Barks - Group Chief Executive

STATEMENT OF CHANGES IN EQUITY

		Trust				Subsidiary		Charitable Fund	Group
		Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Trust Reserves	Income& expenditure Reserves	Minority interest	Charitable Funds reserve	Total taxpayers' equity
Note		£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2024		120,382	(15,389)	80,451	185,444	1,215	136	15,329	202,124
Changes in equity for 2024/25									
	Retained surplus/(de ficit) for the year		(13,383)		(13,383)	(528)	59	637	(13,215)
	Impairment of property plant and equipment			(951)	(951)				(951)
	Other reserve movements			(6)	(6)	6			
34	Public dividend capital received in year	21,606			21,606				21,606
Balance at 31 March 2025		141,988	(28,772)	79,494	192,710	693	195	15,966	209,564
Changes in equity for 2025/26									
	Retained surplus/(de ficit) for the year		(13,786)		(13,786)	(653)	25	2,515	(11,899)
	Transfers between reserves		(1,321)		(1,321)	1,321			
	Other recognised gains and losses								
7.1	Impairment of property plant and equipment			(195)	(195)				(195)
15.1	Net gain/(loss) on revaluation of property plant and equipment			2,201	2,201			7	2,208
34	Public dividend capital received in year	28,554			28,554				28,554
Balance at 31 March 2026		170,542	(43,879)	81,500	208,163	1,361	220	18,488	228,232

The notes on pages 5 to 58 form an integral part of these financial statements.

STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED
31 MARCH 2026

		Group		Trust	
		2026	2025	2026	2025
	Note	£000	£000	£000	£000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating (deficit)/ surplus		(6,804)	(5,899)	(7,412)	(5,540)
		(6,804)	(5,899)	(7,412)	(5,540)
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	6	17,068	15,683	16,464	14,905
Impairments	6	574	8,097	574	8,097
Expense/ income recognised in respect of capital donations - NHS Charity		(742)	608	(1,053)	(1,032)
Income recognised in respect of capital donations - Other			(489)		(489)
(Increase)/ decrease in trade and other receivables	21	(5,818)	14,788	(7,362)	12,435
(Increase)/ decrease in inventories	20	(575)	1,108	(113)	813
Increase/ (decrease) in trade and other payables	23	12,780	565	13,424	1,350
(Decrease) / increase in provisions	25	(121)	143	(121)	143
Corporation tax (paid) / received		(100)			
Movements in charitable fund working capital		(395)	107		
Net cash inflow / (outflow) from operating activities		15,867	34,711	14,401	30,682
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		1,486	1,080	1,486	1,080
Payments to acquire property, plant and equipment	15	(24,883)	(25,246)	(26,217)	(25,008)
Receipt of cash donations to purchase capital assets			489		489
Payments to acquire intangible assets	14	(7,525)	(4,849)	(7,525)	(4,849)
NHS charitable funds - net cash flows from investing activities		137	27		
Net cash (outflow) from investing activities		(30,785)	(28,499)	(32,256)	(28,288)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	28,554	21,606	28,554	21,606
Loans repaid	24		(5,011)		(5,011)
Loan repayment received	24			134	134
Movement in loans from the Department of Health and Social Care	24	(319)	(631)	(319)	(631)
Capital element of lease liability repayments		(1,242)	(1,059)	(613)	(482)
Capital element of Private Finance Initiative obligations	29	(1,656)	(1,492)	(1,656)	(1,492)
Interest paid		(6)	(13)	(6)	(13)
Interest element of lease liability repayments		(313)	(251)	(234)	(179)
Interest element of Private Finance Initiative obligations	29	(1,856)	(1,898)	(1,856)	(1,898)
PDC dividend paid		(5,010)	(5,475)	(5,010)	(5,475)
Net cash inflow from financing		18,152	5,776	18,994	6,559
Increase/ (decrease) in cash and cash equivalents		3,234	11,988	1,139	8,953
Cash and cash equivalents at the beginning of the financial year		28,951	16,963	19,591	10,638
Cash and cash equivalents at the end of the financial year	22	32,185	28,951	20,730	19,591

The notes on pages 5 to 58 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 2025/26 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 management to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

Further detail is outlined in notes 36 and 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.

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). 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. 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.

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.

The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such 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 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 is provided to integrated care boards to fund the commissioning of elective services within their systems. 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.

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.

1.5.2 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure it is credited to the 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 apprenticeship service 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 employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

National Employment Savings Trust (NEST)

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

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

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

Subsidiary pension scheme

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

These schemes comply with legislative requirements.

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 controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets 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.

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 where it meets recognition criteria.

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.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown 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 provided 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. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

Buildings (excluding dwellings)	4 - 78 years
Dwellings	5 - 56 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.

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 PF/ 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.

Lifecyc/e 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 value at 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 using 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.

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, i.e., when receipt or delivery of the goods or services is made.

1.14.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing 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.

Financial assets reported include loans made to Sterile Supplies Limited and to Salisbury Trading Limited, and cash balances held by HSBC Private Bank (UK) Limited on behalf of the charitable fund. Financial liabilities include PFI lease liabilities, trade and other payables, obligations under leases, provisions, charitable fund financial liabilities and a loan from the Department of Health and Social Care.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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. 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 not recognised but 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 2025/26 (2024/25 £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

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 in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note (note 31) to the accounts in accordance with the requirements of HM Treasury's FRoM.

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

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

1.28 IFRS standards and amendments issued but not yet adopted in the FReM

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets - The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £235m as at 31 March 2026.

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 reviews and makes 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 Income From Patient Care Activities

3.1 Income by Nature

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Income from commissioners under API contracts - fixed and variable elements*	300,136	315,066	300,136	315,066
Other NHS clinical income	61,074	27,655	61,074	27,655
Total income at full tariff	361,210	342,721	361,210	342,721
Private patient income	2,544	2,731	2,501	2,731
Elective recovery fund			0	0
Agenda for change pay award central funding***		746	0	746
Additional pension contribution central funding**	16,251	15,229	16,251	15,229
Other clinical income	15,800	11,920	12,619	11,920
Total income from patient care activities	395,805	373,347	392,581	373,347

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

Other types of activity income above includes amounts due for specialist services such as community and hospice services.

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Due to a coding review Odstock Medical Limited income classified as other operating income in 2024-25 (£3,185k) was reclassified within Income from patient care activities in 2025-26 (£3,166k).

3.2 Income by Source

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
NHS England	73,898	76,103	73,898	76,103
Integrated Care Boards	298,888	279,941	298,888	279,941
Department of Health and Social Care	20	5	20	5
Other NHS providers	9,778	9,048	9,778	9,048
NHS other		531		531
Local authorities	1,589	1,564	1,589	1,564
Non NHS:				
- Private patients	2,544	2,731	2,501	2,731
- Overseas patients (chargeable to patient)	485	208	485	208
- NHS Injury cost recovery scheme	677	327	677	327
- Other	7,926	2,889	4,745	2,889
	395,805	373,347	392,581	373,347

NHS Injury Scheme income is subject to a provision for doubtful debts of 24.62% (2025: 24.45%) 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 Income 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		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	357,346	349,661	357,346	349,661
Income from services not designated as commissioner requested services	38,459	23,686	35,235	23,686
	<u>395,805</u>	<u>373,347</u>	<u>392,581</u>	<u>373,347</u>

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

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Income recognised this year	485	208	485	208
Cash payments received in-year	249	65	249	65
Amounts written off in-year	122	13	122	13

3.5 Transaction price allocated to remaining performance obligations

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Income from existing contracts allocated to remaining performance obligations is expected to be recognised:				
within one year	1,395	1,366	1,395	1,366
after one year, not later than five years	1,395	1,366	1,395	1,366
Total income allocated to remaining performance obligations	<u>2,790</u>	<u>2,732</u>	<u>2,790</u>	<u>2,732</u>

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Income from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises income directly corresponding to work done to date is not disclosed.

NOTES TO THE ACCOUNTS

4. Other operating income

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Research and development	1,378	1,450	1,378	1,450
Education and training	14,187	12,816	14,187	12,816
Non-patient care services to other bodies	3,065	3,161	3,065	3,161
Received from other bodies- donated assets		746		746
Received from NHS charities - donated assets			1,053	1,032
Contributions to expenditure - from other bodies	38		38	
Income from laundry services	7,849	10,493		
NHS Charitable Funds: Incoming Resources excluding investment income	2,781	2,519		
Odstock Medical Limited		3,185		
Accommodation	1,878	1,785	1,878	1,785
Administrative services provided to Sterile Supplies Limited	172	253	172	253
Car Parking	1,101	2,114	1,101	2,114
Catering	975	903	975	903
Procurement framework income	2,252	3,024	2,252	3,024
Other	4,452	1,081	5,334	2,112
	40,128	43,530	31,433	29,396

Included within 'Other' income above are: Royalty Income £324k (2024/25: £360k), Leisure Centre income £248k (2024/25: £216k), income from the rent and hire of rooms £10k (2024/25: £169k), cancer transformation £83k (2025/25: £39k).

Due to a coding review Odstock Medical Limited income classified as other operating income in 2024-25 (£3,185k) was reclassified within Income from patient care activities in 2025-26 (£3,166k).

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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Rental income from operating leases - variable lease receipts	145	144	394	283

NOTES TO THE ACCOUNTS

5. Operating lease income (continued)

5.3 Total future lease income

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Future minimum lease receipts due at 31 March:				
- not later than one year	301	164	465	169
- later than one year and not later than two years	281	145	281	145
- later than two years and not later than three years	188	145	188	145
- later than three years and not later than four years	188	145	188	145
- later than four years and not later than five years	128	145	128	145
- later than five years	192	85	192	85
Total	1,278	829	1,442	834

6. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	3,876	3,980	3,876	3,980
Purchase of healthcare from non-NHS and non-DHSC bodies	7,694	4,949	7,694	4,949
Staff and executive directors costs	288,170	269,428	281,311	261,746
Non-executive directors	155	182	155	182
Supplies and services - clinical (excluding drugs costs)	37,320	34,609	36,233	33,138
Supplies and services - general	2,004	4,685	2,649	3,010
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	39,089	35,633	39,089	35,633
Inventories written down	198	484	198	484
Consultancy costs	6	209	6	209
Establishment	3,629	3,905	3,423	3,905
Premises	24,280	22,591	22,781	21,539
Transport	1,726	1,909	1,570	1,249
Depreciation on property, plant and equipment and right of use assets	15,064	14,062	14,460	13,284
Amortisation on intangible assets	2,004	1,621	2,004	1,621
Impairments net of (reversals)	574	8,097	574	8,097
Movement in credit loss allowance: contract receivables / contract assets	442	23	438	23
Provisions arising /(released) in year	3	189	3	189
Change in provisions discount rate(s)	(2)		(2)	
Audit fees payable to the external auditor:				
audit services- statutory audit	258	275	250	275
other auditor remuneration (external auditor only)		2		2
Internal audit costs	198	97	198	97
Clinical negligence	8,537	7,979	8,537	7,979
Legal fees	228	118	213	118
Insurance	484	464	345	464
Research and development	45	26	45	26
Education and training	2,183	1,827	2,153	1,827
Charges to operating expenditure for on-SoFP PFI scheme	1,384	1,342	1,384	1,342
Other NHS charitable fund resources expended	406	963		
Other	2,782	2,964	2,233	2,914
	442,737	422,613	431,820	408,283

The total employer's pension contributions are disclosed in note 8.1

Seven staff received Mutually Agreed Resignation Scheme payments from the Trust totalling £186k (0 in 24/25). There were six compulsory redundancy payments made by STL subsidiary in 25/26 totalling £36k. (0 in 24/25).

The impairment of £574k relates to property, plant and equipment in year (see note 15).

There is a limitation on the Auditor's liability of £1000k (2024/25 : £1000k). 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 operating expenses include professional fees £1.8m (£1.5m 2024/25),

NOTES TO THE ACCOUNTS

7.1 Impairment of assets

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Net impairments charged to operating surplus/ deficit resulting from:				
Loss or damage from normal operations		163		163
Other	574	7,934	574	7,934
Total net impairments charged to operating surplus/ deficit	574	8,097	574	8,097
Impairments charged to the revaluation reserve	195	951	195	951
Total net impairments	769	9,048	769	9,048

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.

7.2 Other gains and losses:

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Gain on disposal of asset held for sale		225		
Loss on disposal of property, plant and equipment.	(10)	(174)	(10)	(174)
Total	(10)	51	(10)	(174)

8. Employee benefits

8.1 Staff costs

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Salaries and wages	214,730	202,631	208,932	195,385
Social security costs	28,324	21,703	27,691	21,267
Apprenticeship levy	1,048	1,006	1,043	1,006
Employer's contributions to NHS pensions	41,203	38,615	41,106	38,615
Pension cost - other	107			
Temporary staff (including agency)	6,853	8,094	6,634	8,094
Total gross staff costs	292,265	272,049	285,405	264,367
Of which				
Costs capitalised as part of assets	4,095	2,621	4,095	2,621

NOTES TO THE ACCOUNTS

8. Employee benefits (continued)

8.2 Directors' remuneration

	Group and Trust	
	2025/26	2024/25
	£000	£000
Salaries and wages	1,432	1,238
Social Security Costs	130	138
Employer contributions to Pension Schemes	113	170
	<u>1,675</u>	<u>1,546</u>

The total number of Directors accruing benefits under pension schemes is 7 (2024/25: 7). 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 was £24.9m (2024/25: £23.6m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf at 9.4% (2024/25: 9.4%), as at 31 March 2026 (and 2025), contributions of £3.47m (2024/25: £3.32m) 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience,) and to recommend the contribution rate payable by 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 1 April 2024 to 23.7% of pensionable pay. 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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 2026 there were no new (2024/25: 0) early retirements from the Trust on the grounds of ill-health.

NOTES TO THE ACCOUNTS

11. Finance income

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Interest on bank accounts	1,486	1,080	1,486	1,080
Interest on other investments / financial assets	193	270	318	338
NHS charitable fund investment income	328	285		
	<u>2,007</u>	<u>1,635</u>	<u>1,804</u>	<u>1,418</u>

12. Finance expenditure

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	1	9	1	9
Interest on lease obligations	313	251	273	179
Interest and compensation on late payment of debt	3			
Finance costs on PFI obligations:				
Main finance costs on PFI obligations	1,857	1,897	1,857	1,897
Remeasurement of the liability resulting from change in index or rate*	936	1,424	936	1,424
Total interest expense	<u>3,110</u>	<u>3,581</u>	<u>3,067</u>	<u>3,509</u>
Unwinding of discounts on provisions	6	5	6	5
Total finance costs	<u>3,116</u>	<u>3,586</u>	<u>3,073</u>	<u>3,514</u>

The interest and compensation on late payment of debt included interest of £150 and compensation of £2,480 in 25/26 (£0 24/25).

13. Losses and special payments

	Group and Trust			
	2025/26		2024/25	
	Number	Value £000	Number	Value £000
Losses				
Bad debts and claims abandoned	31	131	46	45
Stores losses	4	198	3	567
	<u>35</u>	<u>329</u>	<u>49</u>	<u>612</u>
Special payments				
Ex-gratia payments	19	13	21	5
Special severance payments			1	14
	<u>19</u>	<u>13</u>	<u>22</u>	<u>19</u>
Total losses and special payments	<u>54</u>	<u>342</u>	<u>71</u>	<u>631</u>

There were no special payments that exceeded £0.1m in year (24/25 zero). There was no stock losses that exceeded £0.1m in year (24/25 one loss, £0.4m).

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 2025	7,813	9,058	16,871
Additions - purchased	7,525		7,525
Additions - donated			
Reclassifications	(3,939)	3,939	
Disposals		(47)	(47)
At 31 March 2026	11,399	12,950	24,349
Amortisation			
At 1 April 2025		5,314	5,314
Provided during the period		2,004	2,004
Reclassifications			
Disposals		(47)	(47)
Amortisation at 31 March 2026		7,271	7,271
Net book value at 31 March 2026			
- Purchased at 31 March 2026	11,399	5,679	17,078
Total at 31 March 2026	11,399	5,679	17,078
Cost or valuation			
At 1 April 2024	5,692	18,939	24,631
Additions - purchased	4,849		4,849
Additions - donated	148		148
Reclassifications	(2,876)	3,483	607
Disposals		(13,364)	(13,364)
At 31 March 2025	7,813	9,058	16,871
Amortisation			
At 1 April 2024		16,869	16,869
Provided during the period		1,621	1,621
Reclassifications		120	120
Disposals		(13,296)	(13,296)
Amortisation at 31 March 2025		5,314	5,314
Net book value at 31 March 2025			
- Purchased at 31 March 2025	7,813	3,735	11,548
- Donated at 31 March 2025		9	9
Total at 31 March 2025	7,813	3,744	11,557

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 2025	2,101	142,350	6,801	17,841	57,044	110	14,276	3,102	243,625
Additions - purchased				35,006					35,006
Additions - donated				645					645
Impairments		(574)							(574)
Reclassifications		4,612	195	(10,710)	3,315		2,367	221	
Revaluation	79	(2,975)	(431)						(3,327)
Disposals					(3,885)		(6)	(145)	(4,036)
At 31 March 2026	2,180	143,413	6,565	42,782	56,474	110	16,637	3,178	271,339
Accumulated depreciation									
At 1 April 2025		3			30,524	71	6,380	2,493	39,471
Provided during the period		5,250	239		5,366	8	2,436	160	13,459
Impairments									
Reclassifications			(2)					2	
Revaluation		(5,104)	(236)						(5,340)
Disposals					(3,876)		(6)	(144)	(4,026)
Accumulated depreciation at 31 March 2026		149	1		32,014	79	8,810	2,511	43,564
Net book value at 31 March 2025									
Owned	2,101	106,550	6,801	16,788	22,266	39	7,877	380	162,802
On balance sheet PFI		22,817							22,817
Donated		12,980		1,053	4,254		19	229	18,535
Total at 31 March 2025	2,101	142,347	6,801	17,841	26,520	39	7,896	609	204,154
Net book value at 31 March 2026									
Owned	1,690	108,363	6,564	42,782	20,732	31	7,786	366	188,314
On-SoFP PFI		22,333							22,333
Donated	490	12,568			3,728		41	301	17,128
Total at 31 March 2026	2,180	143,264	6,564	42,782	24,460	31	7,827	667	227,775

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. Newmark, 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 2025 and 2026. 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 £574k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £2,834k 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 2024	2,071	124,711	7,004	40,296	52,826	110	16,391	3,618	247,027
Additions - purchased				19,080					19,080
Additions - donated				1,373					1,373
Impairments		(8,379)							(8,379)
Reclassifications		31,755	2	(42,908)	7,120		3,699	(275)	(607)
Revaluation	30	(5,737)	(205)						(5,912)
Transfer to assets held for sale									
Disposals					(2,902)		(5,814)	(241)	(8,957)
At 31 March 2025	2,101	142,350	6,801	17,841	57,044	110	14,276	3,102	243,625
Accumulated depreciation									
At 1 April 2024					28,474	61	10,049	2,813	41,397
Provided during the period		5,168	226		4,718	10	2,105	224	12,451
Impairments		(445)							(445)
Reclassifications		15			162		11	(308)	(120)
Revaluation		(4,735)	(226)						(4,961)
Disposals					(2,830)		(5,785)	(236)	(8,851)
Accumulated depreciation at 31 March 2025		3			30,524	71	6,380	2,493	39,471
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
Net book value at 31 March 2025									
Owned	2,101	106,550	6,801	16,788	22,266	39	7,877	380	162,802
On-SoFP PFI		22,817							22,817
Donated		12,980		1,053	4,254		19	229	18,535
Total at 31 March 2025	2,101	142,347	6,801	17,841	26,520	39	7,896	609	204,154

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. Newmark, 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 and desktop valuations using indices of the Trust's land and buildings as at 31 March 2024 and 31 March 2025. The valuation was carried out in accordance with the RIGS 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 £8,846k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £39k 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

15.3 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 2025	1,700	142,350	6,801	17,742	54,612	110	14,276	3,102	240,693
Additions - purchased				35,006					35,006
Additions - donated	408			645					1,053
Impairments		(574)							(574)
Reclassifications		4,612	195	(10,611)	3,216		2,367	221	
Revaluation	72	(2,975)	(431)						
Disposals					(3,895)		(6)	(145)	
At 31 March 2026	2,180	143,413	6,565	42,782	53,933	110	16,637	3,178	268,798
Accumulated depreciation									
At 1 April 2025		3			28,322	71	6,380	2,493	37,269
Provided during the period		5,250	239		5,132	8	2,436	160	13,225
Impairments									
Reclassifications			(2)					2	
Revaluation		(5,104)	(236)						
Disposals					(3,876)		(6)	(144)	
Accumulated depreciation at 31 March 2026		149	1		29,578	79	8,810	2,511	41,128
Net book value at 31 March 2025									
Owned	1,700	106,550	6,801	16,689	22,026	39	7,877	380	162,062
On balance sheet PFI		22,817							22,817
Donated		12,980		1,053	4,254		19	229	18,535
Total at 31 March 2025	1,700	142,347	6,801	17,742	26,280	39	7,896	609	203,414
Net book value at 31 March 2026									
Owned	1,690	108,363	6,564	42,782	20,627	31	7,786	366	188,209
On-SoFP PFI		22,333							22,333
Donated	490	12,568			3,728		41	301	17,128
Total at 31 March 2026	2,180	143,264	6,564	42,782	24,355	31	7,827	667	227,670

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. Newmark, 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, 2025 and 2026. 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 £574k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £2,827k 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 2024	1,670	124,711	7,004	40,197	50,490	110	16,391	3,618	244,191
Additions - purchased				18,984					18,984
Additions - donated				1,373					1,373
Impairments		(8,379)							(8,379)
Reclassifications		31,755	2	(42,812)	7,024		3,699	(275)	(607)
Revaluation	30	(5,737)	(205)						(5,912)
Disposals					(2,912)		(5,814)	(241)	(8,967)
At 31 March 2025	1,700	142,350	6,801	17,742	54,602	110	14,276	3,102	240,683
Accumulated depreciation									
At 1 April 2024					26,395	61	10,049	2,813	39,318
Provided during the period		5,168	226		4,595	10	2,105	224	12,328
Impairments		(445)							(445)
Reclassifications		15			162		11	(308)	(120)
Revaluation		(4,735)	(226)						(4,961)
Disposals					(2,830)		(5,785)	(236)	(8,851)
Accumulated depreciation at 31 March 2025		3			28,322	71	6,380	2,493	37,269
Net book value at 31 March 2024									
Owned	1,670	95,952	7,004	29,871	23,482	49	6,342	805	165,175
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	24,085	49	6,342	805	204,863
Net book value at 31 March 2025									
Owned	1,700	106,550	6,801	16,689	22,026	39	7,877	380	162,062
On-SoFP PFI		22,817							22,817
Donated		12,980		1,053	4,254		19	229	18,535
Total at 31 March 2025	1,700	142,347	6,801	17,742	26,280	39	7,896	609	203,414

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. Newmark, 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 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024 and 31 March 2025. The valuation was carried out in accordance with the RIGS 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 £8,846k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £39k has been charged 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 - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Cost or valuation						
At 1 April 2025	1,847	7,385	1,158		10,390	25
Additions - leases	110	401	324		835	
Remeasurements of the lease liability	179				179	
Disposals / derecognition / lease termination		(28)	(198)		(226)	
At 31 March 2026	2,136	7,758	1,284		11,178	25
Accumulated depreciation						
At 1 April 2025	713	2,180	482		3,375	4
Provided during the year	300	1,037	268		1,605	2
Disposals / derecognition / lease termination		(28)	(147)		(175)	
Accumulated depreciation at 31 March 2026	1,013	3,189	603		4,805	6
Net book value at 31 March 2026	1,123	4,569	681		6,373	19

NOTES TO THE ACCOUNTS

16.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Cost or valuation						
At 1 April 2024	1,429	6,434	961	1,943	10,767	25
Additions - leases	520	1,245	360		2,125	
Remeasurements of the lease liability	119				119	
Disposals / derecognition / lease termination	(221)	(294)	(163)	(1,943)	(2,621)	
At 31 March 2025	1,847	7,385	1,158		10,390	25
Accumulated depreciation						
At 1 April 2024	561	1,484	397	1,943	4,385	2
Provided during the year	373	990	248		1,611	2
Disposals / derecognition / lease termination	(221)	(294)	(163)	(1,943)	(2,621)	
Accumulated depreciation at 31 March 2025	713	2,180	482		3,375	4
Net book value at 31 March 2025	1,134	5,205	676		7,015	21

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.3 Right of use assets - 2025/26

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 2025	639	5,814	140			6,593	25
Additions - leases	110	401	119			630	
Disposals/ derecognition / lease termination		(28)	(103)			(131)	
At 31 March 2026	<u>749</u>	<u>6,187</u>	<u>156</u>			<u>7,092</u>	<u>25</u>
Accumulated depreciation							
At 1 April 2025	293	1,508	128			1,929	4
Provided during the year	64	812	35			911	2
Disposals/ derecognition / lease termination		(28)	(103)			(131)	
Accumulated depreciation at 31 March 2026	<u>357</u>	<u>2,292</u>	<u>60</u>			<u>2,709</u>	<u>6</u>
Net book value at 31 March 2026	<u>392</u>	<u>3,895</u>	<u>96</u>			<u>4,383</u>	<u>19</u>

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.4 Right of use assets - 2024/25

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 2024	685	4,863	155	1,943		7,646	25
Additions - leases		1,245				1,245	
Disposals/ derecognition / lease termination	(46)	(294)	(15)	(1,943)		(2,298)	
At 31 March 2025	<u>639</u>	<u>5,814</u>	<u>140</u>			<u>6,593</u>	<u>25</u>
Accumulated depreciation							
At 1 April 2024	193	1,037	98	1,943		3,271	2
Provided during the year	146	765	45			956	2
Disposals/ derecognition / lease termination	(46)	(294)	(15)	(1,943)		(2,298)	
Accumulated depreciation at 31 March 2025	<u>293</u>	<u>1,508</u>	<u>128</u>			<u>1,929</u>	<u>4</u>
Net book value at 31 March 2025	<u>346</u>	<u>4,306</u>	<u>12</u>			<u>4,664</u>	<u>21</u>

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	31 March	31 March	31 March
	2026	2025	2026	2025
	£'000	£'000	£'000	£'000
Carrying value at 1 April	5,899	4,714	3,757	2,994
Lease additions	835	2,125	630	1,245
Lease liability remeasurements	179	119		
Interest charge arising in year	313	251	273	179
Early terminations	(51)			
Lease payments (cash outflows)	(1,555)	(1,310)	(886)	(661)
Carrying value at 31 March	5,620	5,899	3,774	3,757

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 2026

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,521	1,339	833	678
- later than one year and not later than five years;	4,180	4,144	3,076	2,736
- later than five years.	676	1,355	462	1,072
Total gross future lease payments	6,377	6,838	4,371	4,486
Finance charges allocated to future periods	(757)	(939)	(597)	(729)
Net lease liabilities at 31 March	5,620	5,899	3,774	3,757
Of which:				
- Leased from other DHSC group bodies	19	21	19	21

NOTES TO THE ACCOUNTS

17. Investments

Non-current	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Carrying value at 1 April	9,428	9,143	500	500
Additions	5,558	4,740		
Fair value gains taken to I & E	1,220	75		
Disposals	(5,269)	(4,530)		
Carrying value at 31 March	10,937	9,428	500	500
Current				
Financial assets designated at amortised cost	395	396		

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 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Carrying value at 1 April	3,177	2,907	3,830	3,577
Transfer (to)/ from current assets			117	117
Amortisation at the effective interest rate	263	270	263	270
Repayments in year			(268)	(134)
Carrying value at 31 March	3,440	3,177	3,942	3,830
Current				
Carrying value at 1 April			420	537
Transfer (to) non-current assets			(117)	(117)
Carrying value at 31 March			303	420

Current other financial assets represent loans made to:

- a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due in less than one year
- b) Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.

Non-current other financial assets represent loans made to:

- a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due after more than one year. This loan is excluded from the Group position and included in the Trust position.
- b) Sterile Supplies Limited to re-develop a new production facility with a third party. £3440 k Group and Trust in 2025/26 (£3177 in 2024/25).

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 would 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 Iona term.

The long term loan of £2.0m was 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. The building became operational in May 2025 and the Trust is formalising the loan repayment plan.

19. Non-current assets for sale and assets in disposal groups

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Net Book Value of non-current assets for sale				
Carrying value at 1 April		1,415		
Less assets sold in year		(1,415)		
Carrying value at 31 March				

The Charitable Trustees, following a review of core operations, have sold the Charity's residential properties realising a gain of £225k.

NOTES TO THE ACCOUNTS

20. Inventories

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Drugs	1,863	1,820	1,863	1,820
Consumables	3,779	3,711	3,779	3,711
Laundry and other subsidiary stock	2,318	1,856		
Other	135	133	135	133
	<u>8,095</u>	<u>7,520</u>	<u>5,777</u>	<u>5,664</u>
Inventories recognised as an expense in the period	<u>77,816</u>	<u>68,682</u>	<u>76,466</u>	<u>67,288</u>

21. Receivables

21.1 Non-current

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Clinician pension tax provision reimbursement funding from NHSE	285	344	285	344
	<u>285</u>	<u>344</u>	<u>285</u>	<u>344</u>
Of which receivables from NHS and DHSC group	285	344	285	344

21.2 Current

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Contract receivables	19,493	13,133	22,292	15,118
Capital receivables		403		403
Allowance for impaired contract receivables / assets	(1,329)	(1,158)	(1,329)	(1,158)
Prepayments (non-PFI)	5,140	4,497	5,048	4,497
PDC dividend receivable	440	525	440	525
VAT receivable	590	1,297	828	1,297
Clinician pension tax provision reimbursement funding from NHSE	22	13	22	13
Other receivables	452	353	452	125
	<u>24,808</u>	<u>19,063</u>	<u>27,753</u>	<u>20,820</u>
Of which receivables from NHS and DHSC group	11,969	3,314	11,969	3,314

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 23 days (2024/25: 19 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2026		31 March 2025	
	Receivables All other and contract receivables		Receivables and contract receivable	All other s
	assets £000	es £000	assets £000	s £000
Allowance for credit losses at 1 April - brought forward	1,158		1,151	
Changes in the calculation of existing allowances	442		23	
Utilisation of allowances (write offs)	(271)		(16)	
Balance at 31 March	1,329		1,158	

22. Cash and cash equivalents

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Balance at beginning of year	28,951	16,963	19,591	10,638
Net change in year	3,234	11,988	1,139	8,953
Balance at end of year	32,185	28,951	20,730	19,591
Made up of:				
Cash with Government Banking Service	20,520	19,345	20,520	19,345
Cash at commercial banks and in hand	11,665	9,606	210	246
Cash and cash equivalents as in balance sheet	32,185	28,951	20,730	19,591
Bank overdrafts				
Cash and cash equivalents as in cash flow statement	32,185	28,951	20,730	19,591

NOTES TO THE ACCOUNTS

23. Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current:				
Trade payables	23,736	23,234	24,082	21,834
Capital payable	14,673	8,079	14,673	8,079
Accruals	4,101	2,937	3,170	2,937
Deferred income	4,201	3,024	4,028	3,024
Social security and other taxes payable	6,095	5,288	5,830	5,288
Pay and pensions related	3,481	3,316	3,481	3,316
Other	10,378	1,341	10,366	936
	66,665	47,219	65,630	45,414
Of which payables from NHS and DHSC group bodies:	15,379	4,710	15,379	4,710

All Trade and other payables are current liabilities. The increase in other payables in 25-26 relates to cash owed to our commissioners: including NHS Somerset ICB £8.4m, NHS Bath and North East Somerset, Swindon and Wiltshire ICB £5.3m and Hampshire and Isle of Wight ICB £1.586m.

24. Borrowings

Group	Current		Non-current	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Lease liabilities	1,182	1,339	4,438	4,560
Amounts due under PFI (note 30.7) *	1,767	1,601	25,034	25,919
Loans from Department of Health and Social Care (DHSC)		321		
Other borrowings	137		2,949	
	3,086	3,261	32,421	30,479
Trust				
	Current		Non-current	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Lease liabilities	481	1,072	3,293	2,685
Amounts due under PFI (note 30.7) *	1,767	1,601	25,034	25,919
Loans from Department of Health and Social Care (DHSC)		321		
Other borrowings	137		2,949	
	2,385	2,994	31,276	28,604

* The Trust has applied IFRS 16 to PFI arrangements within these accounts from 1 April 2023 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

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

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	321		5,899	27,520	33,740
Cash movements					
Financing cash flows - payments and receipts of principal	(319)		(1,242)	(1,656)	(3,217)
Financing cash flows - payments of interest	(3)		(313)	(1,856)	(2,172)
Non-cash movements					
Additions			835		835
Lease liability remeasurements			179		179
Remeasurement of PFI liability resulting from change in index or rate				936	936
Interest charge arising in year (application of effective interest rate)			313	1,857	2,171
Early terminations			(51)		(51)
Other changes		3,086			3,086
Carrying value at 31 March 2026		3,086	5,620	26,801	35,507

Group - 2024/25	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	956	5,011	4,714	27,589	38,270
Cash movements					
Financing cash flows - payments and receipts of principal	(631)	(5,011)	(1,059)	(1,492)	(8,193)
Financing cash flows - payments of interest	(13)		(251)	(1,898)	(2,162)
Non-cash movements					
Additions			2,125		2,125
Lease liability remeasurements			119		119
Remeasurement of PFI liability resulting from change in index or rate				1,424	1,424
Interest charge arising in year (application of effective interest rate)			251	1,897	2,148
Changes in fair value	9				9
Carrying value at 31 March 2025	321		5,899	27,520	33,740

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.2 Reconciliation of liabilities arising from financing activities (Trust)

Trust - 2025/26	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	321		3,757	27,520	31,598
Cash movements					
Financing cash flows - payments and receipts of principal	(319)		(613)	(1,656)	(2,588)
Financing cash flows - payments of interest	(3)		(234)	(1,856)	(2,093)
Non-cash movements:					
Additions			630		630
Remeasurement of PFI liability resulting from change in index or rate				936	936
Interest charge arising in year (application of effective interest rate)			234	1,857	2,092
Other changes		3,086			3,086
Carrying value at 31 March 2026		3,086	3,774	26,801	33,661

Trust - 2024/25	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	956	5,011	2,994	27,589	36,550
Cash movements					
Financing cash flows - payments and receipts of principal	(631)	(5,011)	(482)	(1,492)	(7,616)
Financing cash flows - payments of interest	(13)		(179)	(1,898)	(2,090)
Non-cash movements:					
Additions			1,245		1,245
Remeasurement of PFI liability resulting from change in index or rate				1,424	1,424
Interest charge arising in year (application of effective interest rate)			179	1,897	2,076
Change in effective interest rate	9				
Carrying value at 31 March 2025	321		3,757	27,520	31,598

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Pensions - early departure costs	9	12	3	9
Pensions - injury benefits	30	27	113	139
Legal claims	505	538		
Clinician pension tax reimbursement	22	13	285	344
	566	590	401	492

	Pensions - Early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax £000	Other £000	Total £000
At 1 April 2025	21	166	538	357		1,082
Change in the discount rate		(2)		(24)		(26)
Arising during the year		3				3
Utilised during the year	(10)	(29)	(33)	(22)		(94)
Reversed unused				(24)		(24)
Unwinding of discount	1	5				20
	26					
At 31 March 2026	12	143	505	307		967

Expected timing of cash flows:

Within 1 year	9	30	505	22		566
1 - 5 years	3	113		46		162
5+ years				239		239
	12	143	505	307		967

	Pensions - Early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax £000	Other £000	Total £000
At 1 April 2024	26	181	348	334	45	934
Change in the discount rate				(3)		(3)
Arising during the year	7	10	438	15		470
Utilised during the year	(13)	(29)	(27)	(6)		(75)
Reversed unused			(221)		(45)	(266)
Unwinding of discount	1	4				17
	22					
At 31 March 2025	21	166	538	357		1,082

Expected timing of cash flows:

Within 1 year	12	27	538	13		590
1 - 5 years	9	77		45		131
5+ years		62		299		361
	21	166	538	357		1,082

Pension provisions arise from early retirements (£12k) and from ill health (£143k). These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to a pension provision of £479k and the Trust's provision for personal injury and employee claims of £26k totalling £505k.

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 related to an additional tax liability following revised guidance by HMRC which was reversed in 2024/25.

£59.6 m is included in the provisions of NHS Resolution at 31 March 2026 in respect of clinical negligence liabilities of the Trust (2024/25: £63 m).

26. Capital and other commitments**Capital commitments - Group and Trust**

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	7,479	2,008
Intangible assets	7,948	1,025
Total	15,427	3,033

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 (2024: £0.5m).

28. Related Party Transactions

Salisbury NHS Foundation Trust is a corporate body 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 2026 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 £000	Expenditure £000	Receivables £000	Payables £000
Year ending 31 March 2026				
Salisbury Trading Limited	1,621	1,572	3,699	29
Odstock Medical Limited	630	175	59	
Salisbury District Hospital Charitable Fund	1,092	39	1,420	
Sterile Supplies Limited	172	2,690	32	
Locums Nest Limited		60		
NHS Confederation		14		
Princess Alice Hospice Ltd		1		
Year ending 31 March 2025				
Salisbury Trading Limited	1,123	1,053	3,061	26
Odstock Medical Limited	652	3	67	3
Salisbury District Hospital Charitable Fund	1,071	27	871	
Sterile Supplies Limited	252	2,399	51	478
Wiltshire Health and Care LLP	501	942	9	8
Locums Nest Limited		60		
NHS Confederation		13		
Vyair UK 236 Limited		62		

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 covering a number of specialties including: Burns, Plastics, Orthopaedics, Elderly Medicine, Inpatient and Outpatient facilities. A replacement Laundry also forms part of the scheme, which brought the off-site service onto the District General Hospital premises.

At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration.

There were no changes to the terms and conditions of the PFI agreement during the year.

Terms of the Arrangement - the unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a service fee which is subject to indexation based upon 'the Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

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

	Group and Trust	
	2026	2025
	£000	£000
Interest	1,857	1,897
Repayment of finance lease liability	1,656	1,492
Service element	1,384	1,342
Capital lifecycle maintenance	442	433
Unitary payment payable to service concession operator	5,339	5,164

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

The Trust is committed to make the following service payments on the PFI:	2026	2025
	£000	£000
Due within one year	3,513	3,397
Due within 2 to 5 years	14,380	13,777
Due after 5 years	19,445	22,333
Gross PFI liabilities	37,338	39,507
Finance charges allocated to future periods	(10,537)	(11,987)
Net PFI liabilities	26,801	27,520
- not later than one year;	1,767	1,601
- later than one year and not later than five years;	8,697	7,757
- later than five years.	16,337	18,162

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:

	2026	2025
	£000	£000
Total	61,175	65,515
of which due:		
Within one year	5,564	5,339
Within 2 to 5 years	23,681	22,726
Due thereafter	31,930	37,450
Total	61,175	65,515

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 2026

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	Total £000
Fixed rate									
Finance lease obligations	0.95 - 7.16	127	380	1,014	1,393	2,787	676	(757)	5,620
PFI obligations	6.5	293	586	2,635	3,595	10,785	19,445	(10,537)	26,801

Floating rate

Trade and other payables		42,510							42,510
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As at 31 March 2025

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	Total £000
Fixed rate									
Finance lease obligations	0.95 - 7.16	112	335	892	1,040	3,104	1,355	(939)	5,899
PFI obligations	6.5	283	566	2,548	3,444	10,333	22,333	(11,987)	27,520
DHSC capital loan	1.64			324				(3)	321

Floating rate

Trade and other payables		34,250							34,250
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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 2026 are in receivables from customers, as disclosed in note 21.

30.6 Carrying values of financial assets

Unless otherwise stated below, carrying value is considered to be a reasonable approximation of fair value.

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
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Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets	17,902		17,902
Other investments / financial assets	3,440		3,440
Cash and cash equivalents (excluding NHS Charitable fund cash)	24,144		24,144
Consolidated NHS Charitable fund financial assets	8,983	10,937	19,920
Total at 31 March 2026	54,469	10,937	65,406

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
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Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets	12,141		12,141
Other investments / financial assets	3,177		3,177
Cash and cash equivalents	22,530		22,530
Consolidated NHS Charitable fund financial assets	7,008	9,428	16,436
Total at 31 March 2025	44,856	9,428	54,284

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
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Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets	20,963		20,963
Other investments / financial assets	4,745		4,745
Cash and cash equivalents	20,730		20,730
Total at 31 March 2026	46,438		46,438

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
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Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets	14,363		14,363
Other investments / financial assets	4,750		4,750
Cash and cash equivalents	19,591		19,591
Total at 31 March 2025	38,704		38,704

NOTES TO THE ACCOUNTS

30. Financial Instruments {continued}

30.7 Carrying values of financial liabilities

Unless otherwise stated below, carrying value is considered to be a reasonable approximation of fair value.

Group	Held at amortised cost £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2026		
Other borrowings excluding lease and PFI liabilities	3,086	3,086
Obligations under leases	5,620	5,620
Obligations under PFI, LIFT and other service concession contracts	26,801	26,801
Trade and other payables excluding non financial liabilities	51,616	51,616
Provisions under contract	967	967
Consolidated NHS charitable fund financial liabilities	12	12
Total at 31 March 2026	88,102	88,102

Group	Held at amortised cost £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2025		
Loans from the Department of Health and Social Care	321	321
Obligations under finance leases	5,899	5,899
Obligations under PFI, LIFT and other service concession contracts	27,520	27,520
Trade and other payables excluding non financial liabilities	31,403	31,403
Provisions under contract	1,023	1,023
Consolidated NHS charitable fund financial liabilities	51	51
Total at 31 March 2025	66,217	66,217

Trust	Held at amortised cost £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2026		
Other borrowings excluding lease and PFI liabilities	3,086	3,086
Obligations under finance leases	3,774	3,774
Obligations under PFI, LIFT and other service concession contracts	26,801	26,801
Trade and other payables excluding non financial liabilities	51,066	51,066
Provisions under contract	967	967
Total at 31 March 2026	85,694	85,694

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 2025			
Loans from the Department of Health and Social Care	321		321
Obligations under finance leases	3,757		3,757
Obligations under PFI, LIFT and other service concession contracts	27,520		27,520
Trade and other payables excluding non financial liabilities	29,913		29,913
Provisions under contract	51		51
Total at 31 March 2025	61,562		61,562

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
In one year or less	57,365	36,992	56,115	36,331
In more than one year but not more than five years	19,422	17,921	18,318	16,513
In more than five years	22,609	23,688	22,395	23,405
Total	99,396	78,601	96,828	76,249

31. Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2026 (2024/25: £nil) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Investment in subsidiary

32.1 Odstock Medical Limited

Salisbury NHS Foundation Trust established , following Department of Health approval, a subsidiary company, Odstock Medical Limited (registered in England), to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 70% of Odstock Medical Limited.

	Trust 31 March 2026 £'000	Trust 31 March 2025 £'000
Shares at cost		
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.

	2026	2025
Shares at cost	£000	£000
At 31 March 2026 and 31 March 2025	<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 has re-developed a new production facility within the space of the Trust's former sterilisation and disinfection unit, from which it markets and delivers sterilisation services. Sterile Supplies Limited reported a loss in 2024-25 and so the carrying value of the investment has fallen to zero.

Group and Trust	2026	2025
	£000	£000
Carrying value of investment at 1 April	0	168
Share of (loss)/ profit in the period		(168)
Carrying value of investment at 31 March	<u>0</u>	<u>0</u>

33.2 Wiltshire Health and Care

The Trust was a one third partner in Wiltshire Health and Care LLP, a limited liability partnership registered in England. The other equal partners were Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. Wiltshire Health and Care was focused solely on delivering improved community services in Wiltshire and enabling people to live independent and fulfilling lives for as long as possible. Wiltshire Health and Care LLP lost the contract for the provision of community health services from 1st April, 2025 and therefore the investment was written down in 2024-25.

Group and Trust	2026	2025
	£000	£000
Carrying value of investment at 1 April		163
Impairments		(163)
Carrying value of investment at 31 March	<u></u>	<u></u>

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	2026 £000	2025 £000
Public Dividend Capital at 1 April	141,988	120,382
New public dividend capital received	<u>28,554</u>	<u>21,606</u>
Public Dividend Capital at 31 March	<u>170,542</u>	<u>141,988</u>

The new public dividend capital received in the year relates to additional funding to purchase capital items of £28,554k (2024/25: £16,406k) and £0k revenue support (2024/25 £5,200k).

35. Charitable fund balances

Group only	2026 £000	2025 £000
Restricted funds	4,199	4,199
Unrestricted funds	<u>14,289</u>	<u>11,767</u>
	<u>18,488</u>	<u>15,966</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.

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. 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.

The Trust's estate of land and buildings was valued using an index on 31 March 2026 by Newmark, Chartered Surveyors. Newmark valued the land and buildings (including dwellings) at £151.6m, of which £145m relates to specialised assets valued on a depreciated replacement cost basis. It is the rebuilding cost values determined by the valuer using industry standard rates that gives rise to the uncertainty in the valuation.

A 10% change in the valuation would have £15.2m impact on the statement of financial position with a £487k impact on the PDC dividend due to be paid next year and accrued in these financial statements.

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. Events after the reporting date

With effect from 1 April 2026 Paul von der Heyde was appointed the Group Chair for the BSW Hospitals Group.

