Salisbury NHS
NHS Foundation Trust

Annual Report and Accounts 2010/2011

2010-2011

Salisbury NHS Foundation Trust

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

contents

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Message from the Chairman and Chief Executive

Despite significant operational and financial challenges in the year, we have continued to make real progress in the areas that matter most to our patients, the delivery of good quality, safe, patient care. This has been set against a backdrop of proposed changes through the NHS reforms, which will in the future result in different ways of delivering care, a new commissioning role for GPs and a greater emphasis on patients' experiences and outcomes.

It is essential that we maintain our focus on these areas and, for this year, the national inpatient survey results show real improvements across the board from the previous year. Our Maternity Department also received positive feedback from new mothers and the unit also had a successful assessment by the NHS Litigation Authority (NHSLA). This was followed by a good NHSLA general assessment of the Trust. NHSLA assessments ensure that Trusts have good systems in place to ensure the safety of patients. We have made real progress on safety and quality of care and this will continue to be our number one priority. For this to succeed, we have to make best use of new technology and our resources, and ensure that our staff have the skills to develop within a culture of innovation and improvement. This is evident in the breadth of service improvement and patient and public involvement work which has again taken place in the year. While we continue to plan for the challenges in the future we must also acknowledge the diligence and professionalism of all our staff and our volunteers. There are so many examples of their work and achievements throughout this report and we cannot thank them enough for all for their hard work and commitment to their patients.

With the development of the new children's unit and a newly refurbished Accident and Emergency Department it has been a year of celebration and this was marked by the visit of HRH The Countess of Wessex at the end of the financial year.

The Trust also opened a new Cardiac Unit and local people who had previously had to travel to Bournemouth or Southampton for coronary angioplasty can now receive this treatment at Salisbury District Hospital. Coronary angioplasty involves opening up blocked or narrowed heart arteries by inserting a balloon through a thin metal tube to enable the blood to flow through more freely.

The local community continues to help the hospital through our Governors, members, and the many individuals and organisations who support the fundraising efforts of our Stars Appeal, for which we are universally grateful. This has provided additional assistance to ward and department staff across the hospital, and this included additional support for the new children's unit, A&E Department and Cardiac Unit.

We have just covered a small sample of the excellent work that has taken place throughout the year, and there is more within the report. It is clear that we are probably facing the greatest challenge so far as a Foundation Trust and there will be even greater financial and operational challenges ahead. However, we will continue to maintain high standards of care for all our patients and look to make further improvements wherever we can, together with our local community and our partners in health and social care. This is, and will continue to be, the key priority for the Board.

Luke March
Chairman

Peter Hill
Interim Chief Executive

6 June 2010

Values and Beliefs

All strategic planning is underpinned by a number of values and beliefs. These were developed in conjunction with staff and are used in their day to day work with patients, colleagues and stakeholders.

Patients

We will put the safety and wellbeing of patients at the forefront of everything we do

Respect

We will treat each individual with respect

Culture

We will be welcoming, friendly and helpful

Integrity

We will be open and honest

Improvement

We will continually find better ways of delivering our services

Involvement

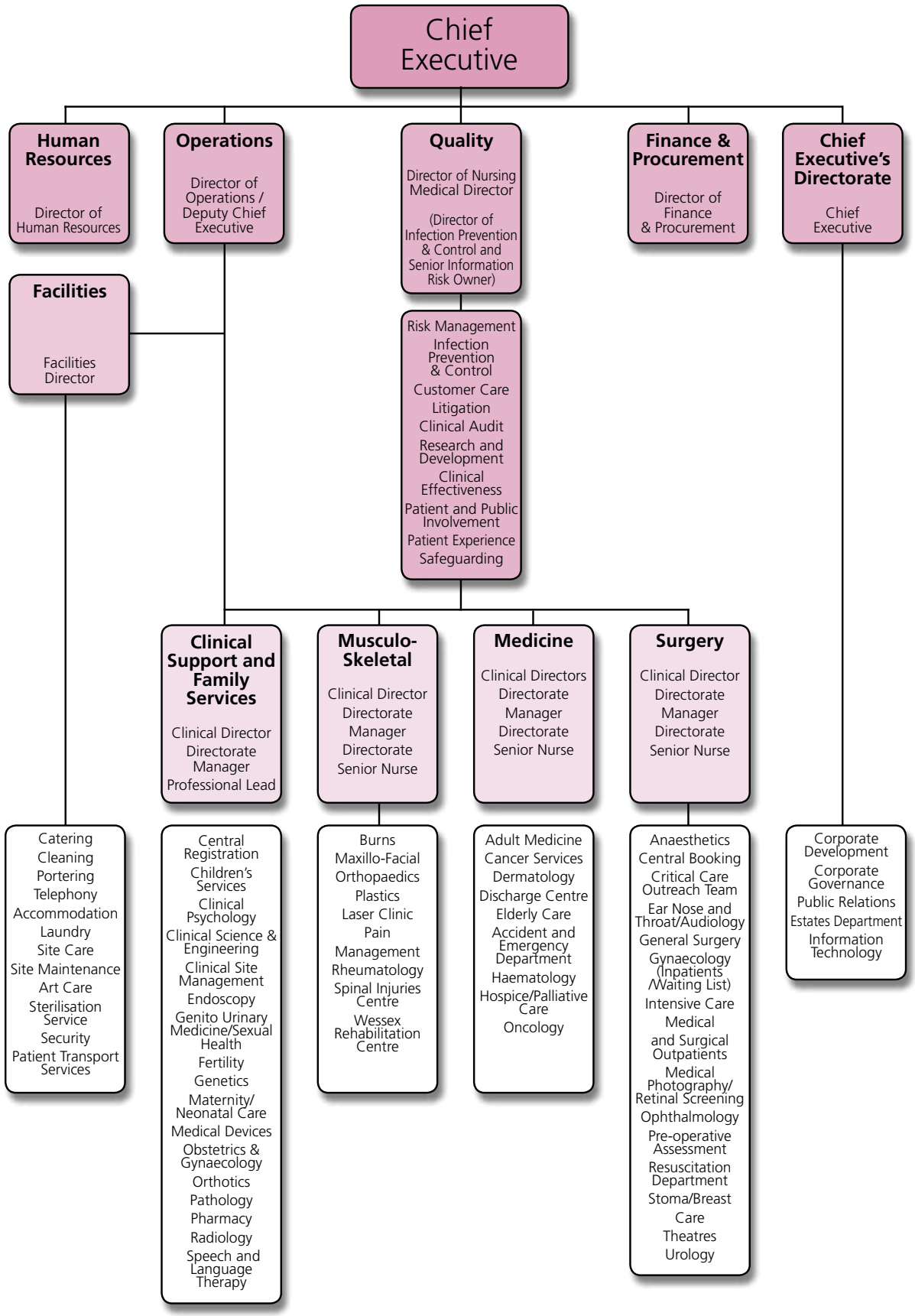
We will listen to colleagues and service users to shape our continuous improvement and development

Stewardship

We will respect our environment and use resources wisely




Organisational Structure



Directors' Report

Directors of Salisbury NHS Foundation Trust During 2009/2010

Luke March	Chairman
Peter Hill	Interim Chief Executive (Director of Operations until 8 November 2010)
Nigel Atkinson	Vice Chairman and Senior Independent Director
Lydia Brown MBE	Non Executive Director
Barry Bull	Non Executive Director
Malcolm Cassells	Director of Finance and Procurement
Alan Denton	Director of Human Resources
Ian Downie	Non Executive Director
Matthew Kershaw	Chief Executive (Until 8 November 2010)
Stephen Long	Non Executive Director
Tracey Nutter	Director of Nursing & Operations (Director of Nursing until 8 November 2010)
Sean O'Kelly	Medical Director (Until 18 April 2011)
Michele Romaine	Non Executive Director
John Stokoe CB, CBE	Non Executive Director

COMPANIES ACT DISCLOSURES

Principal Activities of the Trust

At Salisbury District Hospital, Salisbury NHS Foundation Trust provides a range of clinical care, which includes general acute and emergency services, to approximately 225,000 people in Wiltshire, Dorset and Hampshire. Specialist services, such as burns, plastic surgery, cleft lip and palate, genetics and rehabilitation, extend to a much wider population of more than three million people. The Duke of Cornwall Spinal Treatment Centre at Salisbury District Hospital covers most of southern England with a population of approximately 11 million people. Trust staff provide outpatient clinics in other locations in Dorset and Hampshire. Specialist staff hold outreach clinics in hospitals within the Wessex area and, in total, the Trust employed 3,917 staff at 31 March 2011. This includes full and part-time staff.

The Trust also has a subsidiary company called Odstock Medical Limited. This was set up in 2006 to market worldwide its experience and knowledge of functional electrical stimulation and its own pioneering electrical devices. This is so that income generated could be used to further research and create new developments that help NHS patients in this country.




Research and Development

The Trust undertakes its own research and attracts external funding in two main areas – genetics and functional electrical stimulation. A large number of cancer studies also take place at Salisbury District Hospital, led by other NHS organisations and universities. In addition, the Trust hosts the Research Design Service (SW) Salisbury Office, which advises researchers who are preparing a grant application. The Trust also meets the research governance objectives set by the National Institute of Health Research.

Policies for Potential and Existing Staff with Disabilities

The Trust has the 'Positive About Disabled' people 'two ticks standard' and has in place policies that apply to the recruitment, retention, training and development of staff with disabilities. This includes provisions to ensure that disabled people who apply to work for the Trust are treated fairly with regard for their particular aptitudes and abilities. Trust policies also ensure that employees with a disability have equal access to training and career development, which includes those who become disabled during their period of employment. The Trust also runs a disabilities staff forum. This is an online network that provides additional support, guidance and up-to-date information for staff with a disability, or staff who have an interest in disability issues.

Provision of Information and Involvement of Employees

The Trust has continued to build on its existing processes for staff communications and consultation, and has developed a good working relationship between Trust management, Trade Unions and staff. Regular communication through face to face briefings, the Intranet, a Chief Executive's message and publications are enhanced by topic based communications where and when appropriate. This includes sessions on the NHS reforms. The Trust has continued to create a common awareness of the financial and economic factors that affect the performance of the Trust as well as information covering all aspects that relate to the development of the Trust, and the quality of its services. This is supported by executive led safety and quality walkrounds that not only enable staff to share any concerns, but also give the Executive team the opportunity to feedback their views on these key areas to ward staff. Financial information and the Trust's position is also shared regularly with the Trust's Trade Union representatives.

Please note that the Trust has disclosed information on the above as required under the Companies Act that is relevant to its operations

BUSINESS REVIEW

Operational Review

The Trust has continued to provide patients with fast access to safe, high quality care and meet its operational demands during 2010/2011, despite the significant financial challenges faced by all NHS organisations.

This has been set against a backdrop of proposed major organisational change within the NHS through the publication of the Government's White Paper *Equity and Excellence: Liberating the NHS – Managing the Transition*, the Health and Social Care Bill, and a real emphasis on providing more efficient and effective services that also deliver savings locally and nationally.

As is the case with all public services, the NHS has entered a phase of tight budgetary constraint, and the Trust has been doing a lot of work to plan for the future of the hospital. This is so that it continues to improve services, maintain a focus on safety, patient's experiences and public involvement, while ensuring that it remains financially secure in the current and future economic environment.

Waiting times and access to treatment are important factors for patients and, in line with the NHS Constitution, the Trust met the national 18 week pathway across all specialties. All Trusts have to ensure that 90% of admitted patients – those whose treatment takes place as an inpatient or day case – have their initial outpatient appointment, any diagnostic procedures and treatment within 18 weeks of a GP referring the patient to hospital. The same applies to 95% of patients who receive their treatment as an outpatient.

Referral to treatment times are part of a number of national and local performance indicators and quality measures that are important to patients and underpin the development and business of the Trust. These are monitored monthly by the Trust Board and will adapt in time to meet proposed changes that will result in the removal of 'process' targets to a system of more outcome based measures.

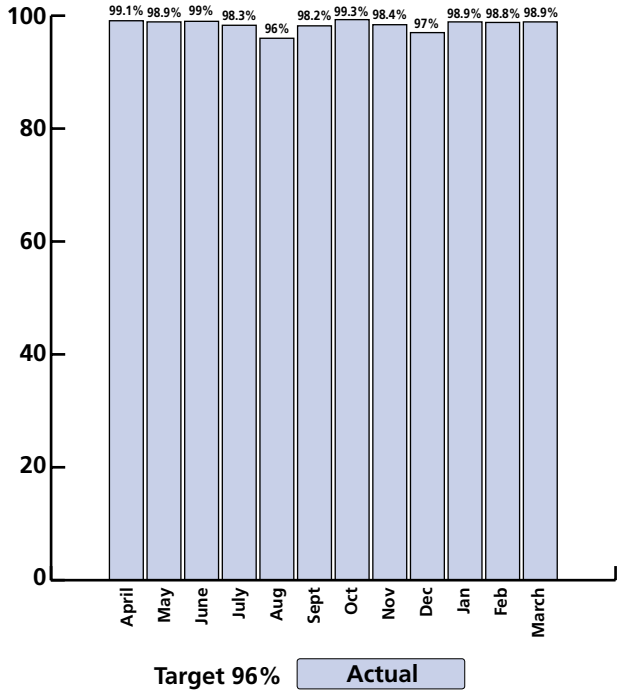
At the end of the 2010/2011 financial year the Trust met its cancer waiting time indicators. For instance, 94.7% (target 93%) of patients were seen within two weeks of referral and 92.7% (target 85%) treated within 62 days of referral. There was also good performance in diagnostic waiting times.

highlight of the year
excellent waiting times

Across all specialities, over 90%of patients admitted to Salisbury District Hospital were treated within 18 weeks of being referred by their GP. Over 95% of patients who needed an outpatient procedure were treated within 18 weeks of referral.

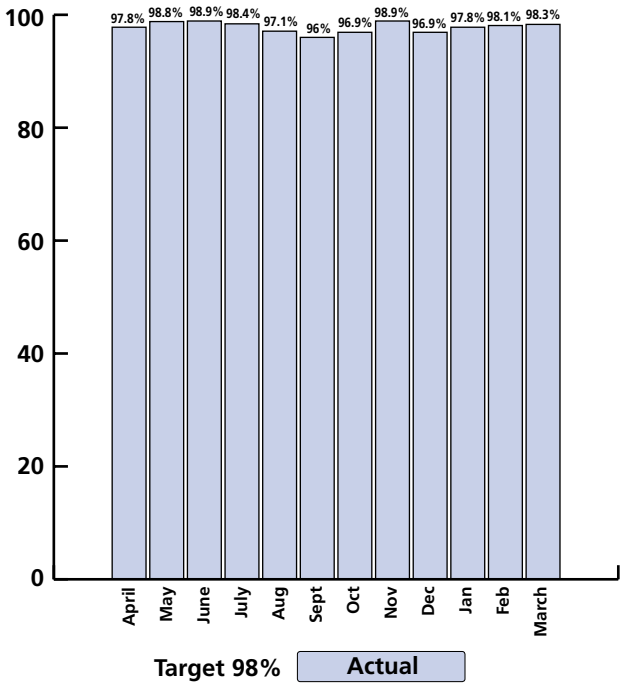
KEY PERFORMANCE INDICATOR
APRIL 2010 – MARCH 2011

Cancer Waiting Times – 31 days from decision to treat to treatment start.
Target: 96% for the year: Total 98.5%



KEY PERFORMANCE INDICATOR
APRIL 2010 – MARCH 2011

Proportion of A&E attendees who were admitted, treated or discharged within four hours.
Target: 98% for the year: Total 97.8%



Salisbury District Hospital continues to have good mortality rates. The mortality rate is one of several indicators of healthcare quality, and measures whether a death rate in a hospital is higher or lower than expected based on national figures. The national average is calculated at 100 and the Trust's latest figure of 97 means that the mortality rate is 3% lower than expected for a hospital of its size, type and the population it serves. The Trust has also continued to reduce the length of time people need to stay in hospital, which is now recognised as a key measure in the overall quality of care provided. The Trust's Right Treatment, Right Time, Right Place programme, which is a clinically led initiative to improve patient pathways, was supported by a range of other initiatives that aim to streamline care for both planned and emergency patients and provide an efficient and effective service that improves patients' experiences of hospital care.

Good examples of this can be seen throughout the hospital. For instance, the Medical Assessment Unit (MAU) is now able to send home patients without admitting them overnight, having had an assessment, tests and diagnosis within the day. In many cases GP access to specialist advice from a consultant meant that the GP did not feel the need to refer patients into hospital for assessment in the first place.

highlight of the year

reduction in overnight admissions to hospital

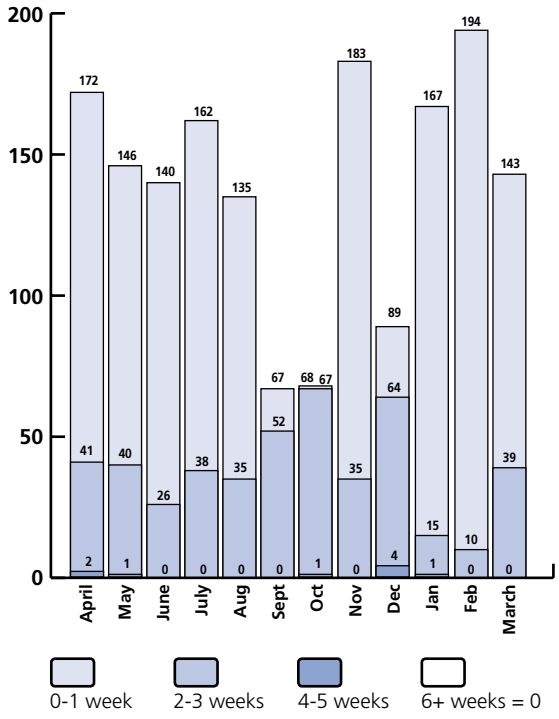
Many patients now avoid an overnight hospital stay because of same day assessment, tests and diagnosis in the Medical Assessment Unit

Doctors, nurses and therapists in other parts of the hospital also worked closely with GPs and community staff in multidisplionary team meetings and regular case conferences to proactively manage their patients' treatment and discharge plans and ensure that patients were able to leave hospital when they were clinically able to do so. These strands of work will continue in 2011/2012.

Safety continues to remain a high priority and is monitored regularly through the Safety Steering Group and the Clinical Governance Committee, with safety performance reported at the Trust Board. As part of its commitment in this area, the Trust is involved in the regional safety programme led by the Strategic Health Authority. The campaign aims are to ensure that the safety of patients is everyone's highest priority and that there should be no 'avoidable death, no avoidable harm'. The Trust is in the forefront on this project and received positive feedback from the SHA when it visited to review progress one year on from its implementation. The Trust is continuing to improve in this area through increased staff involvement and engagement and this will carry on into the 2011/2012 year.

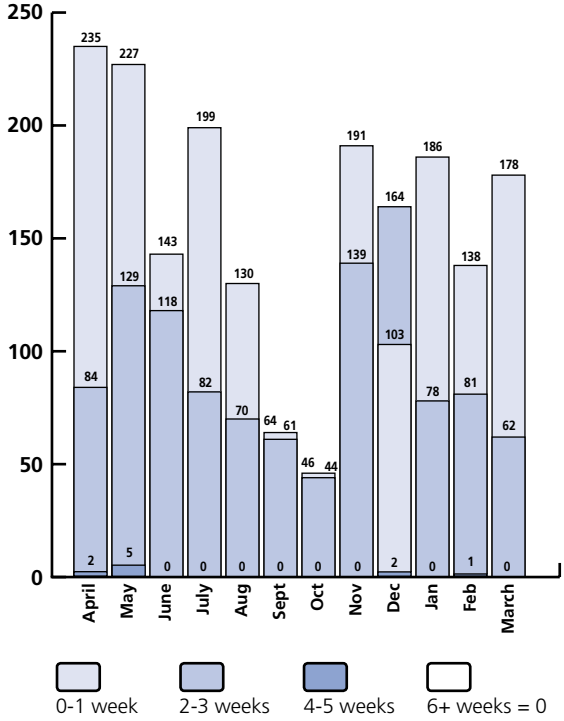
KEY PERFORMANCE INDICATOR APRIL 2010 – MARCH 2011

Target: 6 weeks for a CT scan



KEY PERFORMANCE INDICATOR APRIL 2010 – MARCH 2011

Target: 6 weeks for an MRI scan



highlight of the year

excellent cleanliness

The Trust received an *Excellent* rating for Hospital Environment, Food Quality and Privacy & Dignity. It was one of only 40 healthcare sites across the country to receive an excellent rating in all three categories and the only Trust to receive an excellent rating for environment in every year since inspections started.

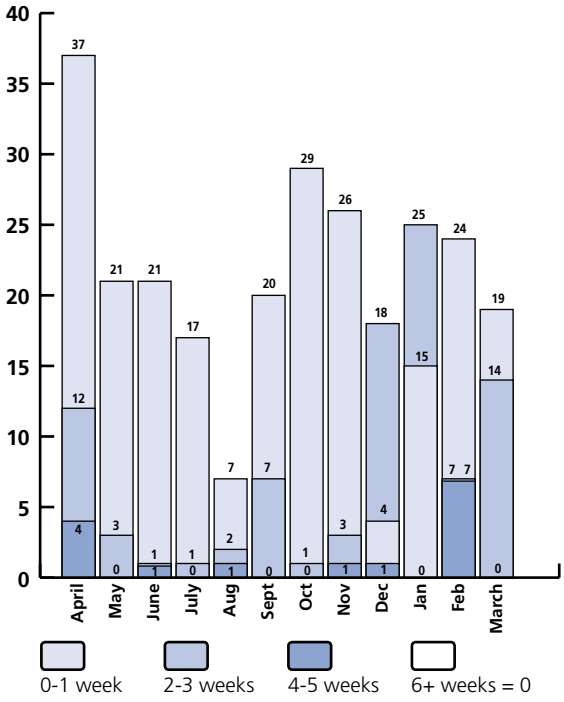
Cleanliness and good infection, prevention and control policies and procedures are essential to the safety of patients and the Trust again received an excellent rating for cleanliness, as part of the Hospital Environment category of the Patient Environment Action Team (PEAT) Inspection. The PEAT assessment includes patient and public representatives and modern matrons who have a central role in maintaining and improving standards at ward level, and hospitals are rated using a grading system of excellent, good, acceptable, poor or unacceptable. This covers hospital environment, food quality and privacy and dignity, and the Trust was one of only 40 sites across the country to receive an excellent rating in all three categories.

Regular handwashing initiatives, cleanliness audits and the 'Tidy Tuesday' campaign, where staff put out unwanted items for removal are just some of the initiatives the Trust continues to use to limit the risk to patients and improve safety while in hospital. This continued as part of its ongoing infection prevention and control campaign, as did the three times weekly meetings in this area led by the Director of Infection Prevention and Control and attended by directorate senior nurses, bed managers and the infection prevention and control team. All this together with regular audits on antibiotic prescribing, and the introduction of rapid response cleaning teams to support its terminal cleaning programme, are all positive indicators that are reflected in the infection rates at Salisbury District Hospital.

The Trust already had low MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia rates and these were reduced further to zero during the year. In hospital Clostridium Difficile (C.Diff) rates were also reduced and were better than those in other Trusts across the country.

KEY PERFORMANCE INDICATOR APRIL 2010 – MARCH 2011

Target: 6 weeks for an angiography



highlight of the year

low infection rates at Salisbury District Hospital

The Trust continues to maintain low infection rates as one of the best performing Trusts in the region

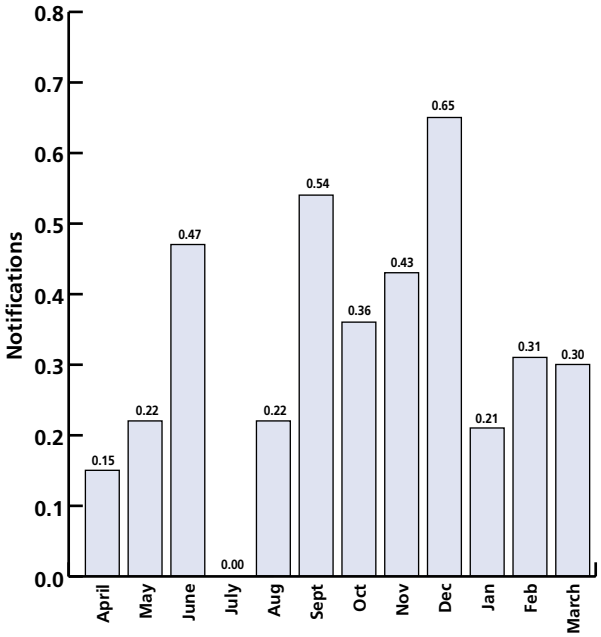
Quality will continue to be a key focus and, while the Care Quality Commission assesses compliance with essential quality standards, the primary responsibility for maintaining and improving quality remains with the Trust Board. In doing so, the Board has to have regard for Monitor's Quality Governance Framework. Monitor is the NHS Foundation Trust regulator. The Trust has a range of systems to ensure that quality governance is not only embedded firmly within the culture of the organisation, but that it also forms a key part in Trust strategy – with processes in place to monitor and measure capability and performance and review individual services. This is maintained through a quality framework. Information is gathered from patient feedback, reports, audits, external agency and peer reviews, and from Trust staff at ward and departmental level through Trust Board led quality walks. This is discussed at directorate quality meetings and presented to the Clinical Governance Committee as part of the assurance process. The Trust has clear reporting lines through individual directorates, the Clinical Management Board and the Trust Board itself, which reviews performance through a comprehensive series of quality indicators that are discussed in public at Trust board meetings. Full details of the work the Trust is carrying out in this area can be found in the Quality Report and the Annual Governance Statement later in this Annual Report. It is important to note that there are no material inconsistencies between the Trust's Annual Governance Statement, Board reports required by Monitor's Compliance Framework and any reports arising from Care Quality Commission reviews. The Trust Board will continue to monitor the governance of quality through its quality framework.

The NHS as a whole continues to face a number of other challenges and, as mentioned earlier, the Government's White Paper proposed significant structural changes to the NHS. During the 2010/2011 these were being taken through the Parliamentary legislative process as part of the Health and Social Care Bill and included the abolition of Strategic Health Authorities and Primary Care Trusts. The Bill also included plans for GP Consortia to take over commissioning, supported by a newly formed NHS Commissioning Board. Community services currently provided by PCTs have to move to provider organisations under the Transforming Community Services initiative. While the Trust submitted a variant bid to provide Wiltshire-wide community services, this was awarded to Great Western Hospitals NHS Foundation Trust.

NHS reform aims to help drive quality and productivity improvements through a system of quality standards and ensure that clinical and financial priorities are matched. While the proposed changes are too wide-ranging and complex to cover in detail here, they are likely to have an impact on the hospital, and its strategic objectives. The most immediate issue was to ensure that the Trust

KEY PERFORMANCE INDICATOR APRIL 2010 – MARCH 2011

Clostridium Dificile. Target agreed with Wiltshire PCT to have no more than 1.92 notifications per 1000 bed days for the year. Figures include community hospital and GP patients as well as those at Salisbury District Hospital. Total: 0.32



built on positive relationships already established with GPs as they started forming shadow consortia. This is so that they can take an active role in commissioning and ensure a smooth transition to a new model. At the time of writing, the Government was holding a 'Listening Exercise' to encourage further debate about the proposed plans. The Trust will continue to work closely with GP groups on how best to meet their needs. The Trust will also be flexible in its approach to ensure that arrangements are in place to continue to provide high quality seamless care for patients when proposed changes are finalised.

In order to meet the challenge and the impact of proposed changes, the Trust Board identified six key workstreams led by an Executive and Non Executive member of the Board to review its current provision of clinical and non clinical services, its workforce needs and how to make best use of information technology and the hospital site. Innovative and creative use of IT and information systems will be key, with the move towards providing more local information about clinical outcomes and performance to support patient choice.




The final area is stakeholder engagement and, while the Trust already has good working relationships with GPs, it looked to strengthen engagement further with this group and other key stakeholders by exploring whether to establish a Stakeholder Management Board (SMB) to supplement existing groups such as the Primary Care Forum. While the Trust decided not to establish an SMB at this stage, it may look again at the possibility at a later date. The work for these areas will be used to ensure that its short term plans are fit for purpose, influence long term planning, its vision for the future and to respond to ongoing operational and financial challenges faced by the Trust. These workstreams run in conjunction with a number of strategic principles that were agreed by the Trust Board. These are to:

- be the hospital of choice for local people for acute hospital services
- be the hospital of choice for a wider population under Choice and Payment by Results
- deliver high quality tertiary services
- be an exemplary employer known for the development of staff
- contribute to the growth and development of the local community

While planning took place to cover the changes proposed in the NHS reforms, the Trust Board put back publication of its long term vision, to ensure that when published it meets the economic, political and social factors that will influence health services nationally. Regardless of this the new vision will still link in closely with work carried out over the last three years through Striving for Excellence (SfE), a Trust wide organisational development strategy that ensures the continued development of the organisation. This focuses on six clear themes around safety, service improvement, patient and public involvement, customer service, staff wellbeing and surplus generation. Striving for Excellence defines the ethos of the Trust and its staff and ensures that the systems and processes that the Trust uses are aligned with these core areas, providing a focus for all service planning and one single coherent approach to the business of the Trust. SfE remains the driving force behind the overall strategy, giving the Trust the tools to move this important area of work forward.

Key to the development of the strategy is an understanding that it is essential that the Trust continues to provide core district hospital services to a high standard. It is also important to develop its regional specialties, make better use of clinical networks where they exist, work in conjunction with other organisations to provide services outside the hospital and extend the range of its non-core commercial activities. Staff will continue to play a major part in the development of the strategy, together with input from stakeholders, as we enter the new financial year.

New ways of working, staff innovation, investment in new technology and the modernisation of facilities has always played a key role in the Trust's ongoing development and plays an essential part in the overall care provided to patents. This year, HRH The Countess of Wessex, officially opened the new Children's Unit. This major redevelopment within the main hospital will mean that children's services moved away from wartime buildings into first class modern facilities based on level 3 and 4 of the existing hospital. Thanks to the support of the local community, the Stars Appeal's Caring 4 Kids campaign successfully raised over £1 million to fund additional facilities for the unit which includes parents' accommodation, home from home rooms, therapy facilities for children with disabilities, a multi-sensory room as well as indoor and outdoor play areas.

highlight of the year

top level plans to meet objectives for NHS reforms

The Trust Board identified six key workstreams led by an Executive and Non Executive member of the Board to review its current service provision and respond to proposed NHS Reforms

Patients who need emergency treatment can now benefit from better facilities and an improved service thanks to a complete redesign of the Accident and Emergency Department. Access is now easier and clearer with a more spacious and welcoming environment to improve the patient's experience. There are new waiting rooms, resuscitation and minor treatment areas and, with support from local people through the Stars Appeal, separate waiting and treatment facilities developed for children.

highlight of the year
new children's facilities open

New Children's Unit opened by HRH The Countess of Wessex. Children's services will move from older buildings to new refurbished area in the modern hospital.

highlight of the year
redesigned and refurbished A&E department

Patients can now benefit from a more spacious environment, new waiting rooms, resuscitation and treatment areas in the Salisbury District Hospital A&E.

highlight of the year
new local services for cardiac patients

Local people who had to travel to Bournemouth or Southampton for coronary angioplasty can now receive this treatment at Salisbury District Hospital

The local community also contributed to additional equipment for a new cardiac suite. This not only provides new state of the art facilities for cardiac patients, but also enabled specialists to carry out coronary angioplasty locally, rather than patients having to travel to Bournemouth or Southampton for this treatment. Coronary angioplasty involves opening up blocked or narrowed heart arteries by inserting a balloon through a thin metal tube to enable the blood to flow through more freely.

Good patient care not only centres on treatment but also the prevention of accidents and illness. It also centres on ongoing support. This year staff worked hard on providing additional support or advice through health promotion campaigns in a number of areas such as breast care and pressure sore prevention.

The venous thromboembolism (VTE) team also built on the excellent work they have been doing on bloodclots. All hospitals should have systems in place to see whether patients are at risk of developing VTEs while in hospital and over 90% of patients are now assessed in Salisbury. The Trust is an 'Exemplar' site for VTE and is in the forefront nationally on VTE prevention. This year staff shared best practice with other hospitals across the country at a conference held at Salisbury District Hospital. VTE lead, Tamara Everington, gave a presentation to the All Party Parliamentary Thrombosis Group at the House of Commons, which was also supported by Interim Chief Executive Peter Hill.

The Trust has a strong tradition of creativity, high quality research and innovation and this continues to be reflected in the work carried out by clinical scientists at Odstock Medical Ltd - the company set up by the Trust to market worldwide its revolutionary Odstock Dropped Foot Stimulator. The Trust generates new ideas through the Healthy Ideas Competition and through Innovations South West and Trust staff have regularly received awards in this area. This year Innovation was recognised in the Trust's own Striving For Excellence Awards with theatre staff nurse Peter Amey winning the Innovation and Creativity category for an airway breathing device invention, which is now patent pending. Peter, now has a portfolio of 10 ideas developed over the last four years with eight under commercial discussion and is one of many members of staff who generate ideas in this way, reflecting the culture of creativity and innovation in Salisbury.

This innovation, coupled with the organisational commitment to create greater access, convenience and choice is a fundamental strength of the Trust. This strength can also be seen in the way the Trust uses views and comments from patients, public and staff to improve services. Patients were involved in over 60 projects this year, using many different methods including patient stories, focus groups and questionnaires. This strong tradition of community involvement continued to grow with the help of the Trust's Governors who also work with the Trust on a number of joint groups that aim to improve patients' experiences of hospital care. More details can be found in the membership section later in this report.

It is important that patients have the opportunity to comment on the care and treatment they receive in hospital, whether this is through patient and public Involvement projects, national patient surveys or our frequent feedback initiative where volunteers and Governors regularly tour the wards gathering patient's views. Feedback enables the Trust to use the individual experiences of patients to improve services. In the latest national inpatient survey, 93% of patients surveyed in July 2010 rated their overall care at Salisbury District Hospital as good or better.

highlight of the year

VTE work in Salisbury receives national recognition

Trust VTE lead presents to All Party Parliamentary Thrombosis Group at House of Commons

highlight of the year
maternity services rated highly in survey

In a national survey, 94% of mothers rated their overall care in Maternity Services at Salisbury District Hospital as Excellent, Very Good or Good

Respect & dignity and whether patients felt that they had confidence and Trust in staff treating them were also positive themes. The survey highlights specific areas for action which includes the prompt answering of call bells. This, along with other themes such as copying letters to patients, will provide a focus for improvements in the 2011/2012 financial year.

In a national survey of maternity services, new mothers rated quality of care, support and involvement in decisions highly at Salisbury District Hospital. The Maternity Unit was in the best performing category in 13 of the 20 areas covered, with 94% of mothers rating their overall care as either excellent, very good or good.

Patients' views are invaluable and the Trust has a frequent feedback initiative which gathers regular feedback from wards and clinical areas. Staff views are equally important to the development of services and the Trust continued to use their knowledge and expertise to improve services for patients through focus groups.

The Trust continues to work closely with organisations that commission services from the Trust, to ensure that contractual arrangements are adhered to and that patients are treated in an appropriate and timely manner. As well as Primary Care Trusts as the prime commissioners, the Trust works with other agencies, voluntary organisations and its key partners in health and social care. Major stakeholders - including Wessex Community Action - have a seat on the Council of Governors, which ensures that they are fully involved and kept informed. The Trust also meets the Overview and Scrutiny Committees for Wiltshire, Hampshire and Dorset. They are invited to comment on the Trust's Quality Account and annual commentary to the Care Quality Commission, as are the Trust's Governors. This commentary includes a wide range of information on healthcare provision, quality of services and the hospital environment.

As part of the Trust's commitment to the environment the Trust has its own Sustainability and Carbon Reduction Strategy and, as part of this, it continues to work with stakeholders to ensure that, where possible, the Trust uses renewable sources of energy. This year the Trust reviewed its Green Travel Plan which includes car sharing schemes, a bus ticket loan system and incentives for staff who cycle to work. These are just some of the initiatives at Salisbury District Hospital to support the strategy.

During the previous year the Trust carried out a baseline assessment to see what measures it had in place to meet the rights and pledges outlined in the NHS Constitution and ensure that they align with its current values and beliefs. A paper setting out how the Trust proposed to meet any outstanding issues around the NHS Constitution was presented to the Trust Board, ensuring top level involvement in this important area. Over this year the Trust created greater awareness of the NHS Constitution amongst patients and staff, using opportunities to highlight and 'badge' communications linked to the NHS Constitution and ensure that the values and principles are reflected in all service improvement work, and the day to day business of the Trust. From a staff perspective the Trust implemented a new online free personal healthcare management system to support staff in maintaining and improving their health and wellbeing in line with NHS Constitution staff pledges. For patients, we have developed detailed ward action plans based on learning from national patient surveys, real time feedback and complaints and these are now linked to the NHS constitution patient rights and pledges.




Continued high performance is important, as is good planning and a thorough assessment of risk. The Trust has a Risk Management Strategy which ensures that robust risk management processes are in place to assure the Trust Board that it is discharging its responsibilities effectively. The strategy ensures that key control processes are in place which informs the Trust Board of potential risks to the organisation and the actions being taken to resolve these risks. The Risk Register and Assurance Framework is the vehicle used to provide this information to the Board and this covers all departments. The Trust strongly encourages an open and honest culture in the reporting of any clinical and non-clinical incidents. In general, high reporting rates indicate a positive reporting culture and leads to a significant increase in the level of 'no harm' incidents. In reports compiled by the National Patient Safety Agency, the Trust has high rate of reporting and no harm incidents that reflects the value in its approach to this issue.

Education, training, rewards, recognition and support are key principles that the Trust believes are important to ensure that Salisbury District Hospital recruits and retains the best staff. Good quality staff enable the Trust to provide high standards of patient care and this was clear in the quality and number of nominations for the Trust's Striving for Excellence Awards. This year the Trust expanded the categories so that areas such as partnership working, equality and diversity and volunteering joined established areas around leadership, customer care and service improvement in the awards. These awards give staff recognition for their work and emphasises their importance to the continued development of the Trust and the strategic direction it takes in the future.

Financial Review

From a financial perspective this has been a very challenging and difficult year, yet despite this the Trust achieved its financial targets, continuing its record of sound financial management. This saw the Trust finish the year in a break even position in accordance with its plan and an overall financial risk rating of 3.

Key Financial Targets Met

- Break even
- Achievement of indicators used to derive financial risk rating: Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) in line with plan and margin; return on assets; I&E surplus margin; liquidity ratio.

This was despite a backdrop of increasing operational pressures both locally and nationally within the wider NHS and the need for services to be provided more efficiently in both primary and secondary care. Nationally the NHS has to make efficiency savings of between £15-20 billion over a five year period and, with Primary Care Trusts looking to make their own savings and provide more services in a community setting, this will impact on the Trust's own financial planning over the coming years. As mentioned in last years' report, the Trust has to make around £30 million savings over a 3 year period, whilst maintaining the quality of care we provide for patients and this programme started in 2009/2010. This means that we have to be more effective and efficient in the services we provide and become more flexible in our work. For instance, working with primary care to reduce length of stay, avoid unnecessary admission to hospital and facilitate more care and treatment in the community. While this brings benefits to patients we have to accept that this will have an effect on the hospital. During the year the Trust reduced bed numbers and staff posts. This will be ongoing, where it is thought that efficiency gains could be made.

In the previous year the Trust made £8.7 million savings and completed the end of year with a surplus of £1.9 million, which helped the Trust continue to develop services according to the requirements of both the local and wider health communities. At the start of the 2010/2011 financial year the Trust started with a savings target of £10.8 million, in order for it to achieve a break even position at the end of the year. The Trust made £9 million efficiency savings, whilst also delivering more activity than was originally forecast to be necessary. Much of this was for emergency treatment. Over activity resulted in prolonged discussions with the commissioners responsible for funding and, following lengthy negotiations with commissioners the Trust received additional income to cover the extra work.

The Trust will continue to work with commissioners and provide them with the information that they need to make local commissioning decisions. This will include both PCTs and GPs. As part of the proposed NHS reforms mentioned earlier in this report, PCTs and GPs will undergo significant change during 2011/2012 as emerging GP consortia and the NHS Commissioning Board develop.




Patients Treated			
	2010/2011	**2009/2010**	**2008/2009**
Elective inpatient (spells)	**7,282**	**7,600**	**7,590**
Day cases	**20,082**	**22,217**	**20,126**
Non elective (spells)	**28,837**	**26,133**	**24,863**
Regular day attendees	**5,320**	**5,271**	**4,747**
Outpatients (consultant led)	**178,789**	**176,581**	**174,025**
New attends	(66,480)	(67,094)	(65,029)
Follow up	(112,034)	(109,487)	(108,996)
Accident and Emergency	**40,749**	**40,656**	**40,813**
New attends	(39,827)	(39,587)	(39,748)
Follow up	(922)	(1,069)	(1,065)
Spells are the main way in which hospital activity is recorded. A spell is the period of time from Admission to Discharge and replaces the measure used in previous reports.			

In order to ensure that there is no unplanned loss of capacity and capability in commissioning while a new system develops, it is proposed that PCTs will be clustered with GP consortia working with them in shadow form. This would create space and support for the development of GP consortia and provide continuity until they take over the commissioning of services fully at a later date.

In this challenging climate, the Trust needs to have an effective Assurance Framework – a set of risks that it acknowledges and monitors in order to ensure the viability of the organisation. These are linked closely to the Trust's financial and operational objectives and includes: an assessment of income levels; provision of services and treatment; the achievement of budgetary targets and cost savings; general and financial targets. It also has a risk rating from the regulator for the achievement of plan, underlying performance, financial efficiency and liquidity and at the end of the financial year the Trust had an overall financial risk rating of 3. Cash flow remained reasonable and enabled the Trust to pay its staff and its bills promptly. This is reflected in the Trust's performance against the Better Payments Practice Code, with 80.1% of non NHS bills and 69.3 of NHS bills paid within the 30 day target. The Trust has made no political or charitable donations of its own.

Key financial indicators centre on a balanced financial position, net operating income, capital and assets, savings programmes and the Trust's cash position, as well as its Financial Risk Rating. Key financial indicators are monitored monthly by the Trust Board.

The Trust recognises that it has a challenging year ahead with a £10 million savings target for 2011/2012, not least because there is a need for the Trust to continue to make further savings due to reduced income from commissioners, changes in the national tariff and internal cost pressures.

Efficiency and Use of Resources

- High levels of efficiency maintained with overall costs 4% less than the national average
- Management and administrative costs contained within 4% of turnover

Capital Expenditure

Capital Expenditure of £9.7 million was incurred in 2010/2011 and spent on a range of service developments. Capital projects included:

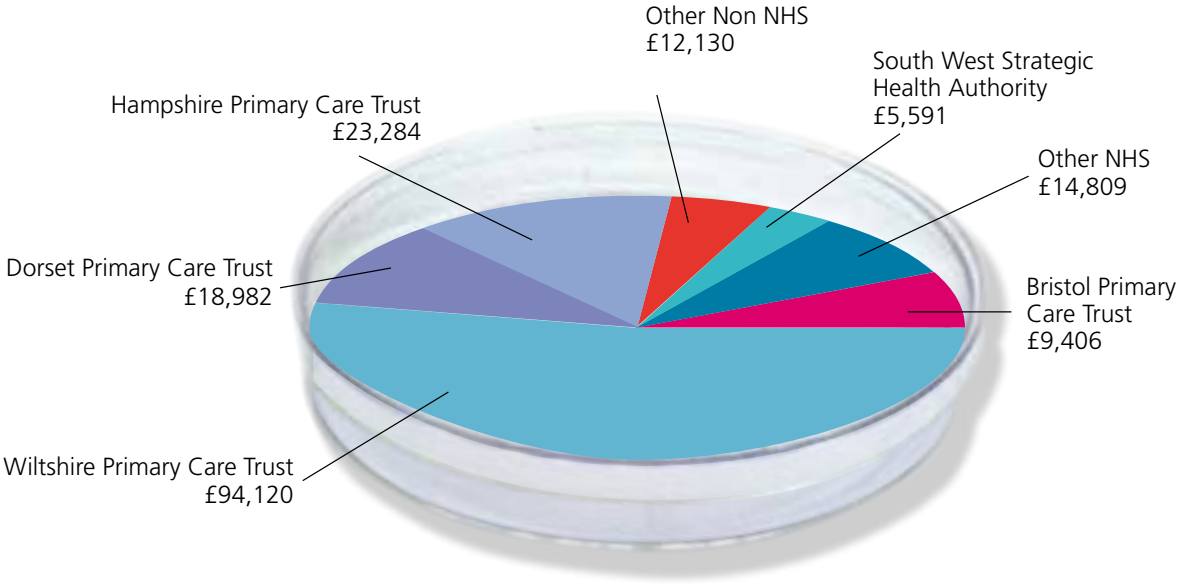
	£'000
Accident and Emergency Department Internal refurbishment	1,202
New Children's Unit	2,301
Virtualisation of Information technology (IT) Servers	523
IT Network Hardware Replacement	426

Investment in facilities and equipment has benefited patients in a number of ways and these can be viewed throughout this report.

Communication with staff is an essential task and staff receive regular monthly updates, with key operational and financial information cascaded throughout the organisation, as well as the day to day communications that take place at different levels of the Trust. Open sessions for all staff have taken place on the Trust's financial position and the NHS Reforms, so that staff are able to put the Trust's position in context with the national perspective and proposed changes. The Chief Executive regularly sends out a personal message to all staff as part of the wider communication process.




Sources of Income - 1 April 2010 to 31 March 2011



Total £178,322 million

Staff are also able to raise any issues during the Trust Board led safety walk rounds. Operational and financial information is presented in Public Board Meetings and placed in the public domain. The Trust's financial position is also assessed quarterly by the regulator.

Income generated by Odstock Medical Ltd (OML), is being used to further research and create new developments that help patients. The Trust owns 68% of OML. The Trust can report that OML made a profit and this is reflected in the consolidated accounts. The Trust also treats private patients through a partnership with Odstock Private Care Limited (OPCL), working within guidance published by Monitor, the independent Regulator for Foundation Trusts. To support this, the Trust opened the Clarendon Suite during the year, which is a designated unit where private patients can be treated on the Salisbury District Hospital site. While (OPCL) is contracted by the Trust to administer private care on site, income generated is used to benefit NHS patients by supporting our services. There are also a number of treatments offered by some of our existing services that are not available on the NHS. These are already provided privately within departments without compromising our own NHS service. A good example of this is the Laser Centre. As some commissioners extend the list of services not normally funded, this may result in a growth in the number of people using OPCL.

Good relationships and the flexibility to explore new business and commercial opportunities will again be key to the Trust in the coming year, as will its performance around existing targets and the new NHS Outcomes Framework.




Patient and Stakeholder relations

During the year the Trust introduced a number of developments and initiatives that have directly or indirectly improved patient's experiences and the quality patient care at Salisbury District Hospital. The Trust has also worked in conjunction with a number of other organisations on projects that reinforce partnership working, stakeholder relations and staff involvement. These are summarised within the following themes:

TAKING CARE OF OUR PATIENTS

Greater Support and Access to Acute Medical Care

As part of ongoing improvements in the Acute Medical Unit, staff have changed the focus from admission to assessment, with greater support and availability of consultant advice for GPs. This has resulted in closer working relationships between community and hospital staff and provided prompt assessment, investigation and diagnosis to prevent unnecessary admissions to hospital.

Online 'Visiting Rooms' to Keep Patients in Touch with Relatives

Relatives and friends now have access to a unique way of keeping in touch with their loved ones thanks to a new 'online visiting room' called justvisiting.com. Justvisiting is an independent and secure website that enables a relative or carer to set up a virtual visiting room on the site and invite others to view updates on a patient's progress. The website can be accessed directly at www.justvisiting.com .

Better Support for Cleft Lip and Palate Children

As children coming into the Palate Investigation Clinic have to complete assessments and consultations in different rooms causing confusion and waiting, staff in speech and language Therapy developed a child friendly map, which describes what happens, where to go and when there will be a wait. This is supported with a DVD supplied before the appointment which provides reassurance and achievement for the children.

Drop in Clinics for Pre-school Children with Speech and Language Difficulties

Following publication of a national action plan and a move to shorter waiting times the team has made significant changes to their systems, moving from traditional referral routes to direct access. This has resulted in the development of more efficient 'drop in clinics', giving parents better and faster access to advice, improved choice and more patient involvement.

Orthopaedic Enhanced Recovery Pilot for Hip Replacements

Improvements in surgical and rehabilitation techniques enabled orthopedic specialists to pilot a new service for total hip replacement patients, where they are discharged within two days of surgery with specialist support from the hospital's orthopedic outreach team. Patients are then followed up at two and six weeks led by the nurse practitioner and physiotherapy team.

Improvements to Stroke Services

The Stroke team carried out a review of performance around quality indicators, staff, patient and carer feedback which has resulted in changes to the ward environment, the development of stroke competencies for all staff, and wider multidisciplinary team involvement in planning.




Contraceptive Advice at Salisbury District Hospital

Specialists in Contraception and Reproductive Health held additional clinics to fit Long Acting Reversible Contraception (LARC) devices as part of a national drive to encourage women to consider alternative forms of contraception to the pill. The clinics also provided training opportunities for GPs, allowing these services to be more routinely available in local surgeries.

Patient Information at Salisbury District Hospital

The Trust has continued to develop information for patients and their relatives. The Child Health Department and the Day Surgery Unit are amongst others who have carried out a review of the information they provide to patients, resulting in publication of a large number of new and revised information leaflets. A small working group looks at different types and style of patient information, and members of the public comment on all patient information including leaflets, patient line videos and DVDs as part of the readership panel. The Trust has also redesigned the website, making it more accessible for patients.

IMPROVING SERVICES AND FACILITIES FOR OUR PATIENTS

New Local Service For Heart Patients

Local people who had to travel to Bournemouth or Southampton for coronary angioplasty can now receive this treatment at Salisbury District Hospital. Coronary angioplasty involves opening up blocked or narrowed heart arteries by inserting a balloon through a thin metal tube to enable the blood to flow through more freely.

New Children's Unit

A new children's Unit has been developed within the main hospital so that children's services can be moved away from older buildings into first-class modern facilities based on level three and four of the existing hospital. Thanks to the support of the local community, the Stars Appeal's Caring 4 Kids campaign successfully raised £1million to fund additional facilities for the new Unit, which includes home from home rooms, therapy facilities for children with disabilities, a multi-sensory room, as well as indoor and outdoor play areas.

Newly Refurbished Accident and Emergency Department

Patients who need emergency treatment now benefit from better facilities and an improved service thanks to the completion of a major redevelopment of the Accident and Emergency Department. A complete redesign of the department means that access is easier and clearer with a more spacious and welcoming environment to improve the patient's experience. There are new waiting rooms, resuscitation and minor treatment areas and separate waiting and treatment facilities developed for children.

Right Treatment, Right Time, Right Place, Programme

The Trust continued its 'Right Treatment, Right Time, Right Place' (RTRTRP) Programme to improve patient's experiences of hospital care and efficiency, with reduced length of stay for patients where appropriate. A broad range of staff are involved in the programme, which is clinically led, and they work closely with our partners in health and social care.

Easy Read Group Helps Patients with Learning Disabilities

Hospital staff and volunteers from the learning disability community have expanded the information they develop by distributing information further to local residential homes. The group was set up to improve communication between the hospital and local learning disability community and have written patient information leaflets applicable to their needs as well as giving stimulation and support for group members. The group were singled out for praise by NHS South West who felt that the Easy Read group was unique and provides ambassadors for learning disability patients within the Trust.

New Partial Booking Systems for Follow Up Appointments

The Trust introduced a new "Partial Booking" system for follow up appointments which involve a fixed diary, which takes bookings six weeks ahead. If follow ups are required beyond the six week period, dates are allocated and patients informed by letter nearer the time. This provides greater booking flexibility, fewer cancelled appointments and improved access to urgent follow up appointments.

Text Messaging Patients about Appointments

The Trust now uses text messages to remind patients to attend their outpatient appointments. These messages are sent using NHS mail, and helps to ensure that patients attend appointments. Last year, of the 242,534 new and follow-up appointments, 17,544 patients failed to turn up and did not let staff know.




Bed Availability Tracking System (B.A.T.S.)

Information technology staff have developed a user friendly handheld scanning device to help staff manage beds at Salisbury District Hospital. Details of bed availability can now to be viewed either on the scanning device or a personal computer and provides a more efficient use of bed stock within the hospital.

Faster Radiology Report Turnaround Times

The Radiology Department has made changes to processes which have improved turnaround times for radiology reports. The changes have resulted in a new rota system and distribution of workload, better cover arrangements during leave and fewer interruptions when reporting. In February 2010, 97% of reports were completed within 5 days, compared with 85% in 2009.

Expanded Out-of-Hours Patient Transport Service

Following requests to provide a full round-the-clock service to release beds sooner, the Patient Transport Team has expanded services making them more responsive to ward staff's needs and ensuring that patients get the right means of transport and at reduced overall service costs.

New Booking System In Rheumatology

The Rheumatology Department is now operating a new booking system for follow up appointments "Partial Booking". This involves a fixed diary, which takes bookings six weeks ahead. If follow ups are required beyond the six week period, dates are allocated and patients informed by letter nearer the time. This provide greater booking flexibility, fewer cancelled appointments and improved access to urgent follow up appointments.

KEEPING OUR PATIENTS SAFE

Successful General NHS Litigation Authority Assessment of Trust

The Trust has retained Level 2 in the NHSLA Risk Management Standards following a rigorous assessment of the unit by the external assessors. It is acknowledged that Level 2 represents a very high standard within the NHS and in its assessment, the Trust passed 44 of the 49 standards indicating a high pass rate. The Maternity Department is assessed separately from the Trust.

Successful NHS Litigation Authority Assessment of Maternity Department

The Maternity Department has retained Level 2 in the NHSLA Risk Management Standards following a rigorous assessment by the external assessors. The Maternity Department passed 49 of the 50 standards indicating a high pass rate.

Protecting Patients and Staff from Norovirus

As part of the Trust's normal winter plans, staff asked visitors and relatives not to come into hospital during the autumn and winter months if they had diarrhoea, vomiting or 'flu like' symptoms over the few days prior to an intended visit. This helps staff protect patients from infection by reducing the potential for the viruses that cause 'winter vomiting' to take hold on hospital wards.

Patient Safety Reporting

As part of a report by the National Health Service Litigation Authority, Salisbury District Hospital has been shown to have good incident reporting systems in place and an open and honest reporting culture. High reporting rates indicate a positive reporting culture and leads to a significant increase in the level of 'no harm' incidents. The Trust has high rate of reporting and a level of no harm incidents that are significantly higher than other Trusts of a similar type. The Trust uses incidents to review and check its systems and processes, target awareness training and make changes if and where appropriate.

Regional Patient Safety Improvement Programme

The Trust is working in partnership with the Strategic Health Authority's on its Patient Safety Improvement Programme. The aim is to improve safety across the region, with a particular focus on four key areas: peri-operative care, general wards, critical care and medicine's management. The Trust is in the forefront on this project and continuing improvement through increased staff involvement and engagement.

Trust Scores Well On Heart Audit

Salisbury District Hospital has performed above the national average in six of the seven areas in a national audit carried out by the Royal College of Physicians on the management of heart attacks. The audit covers access to drugs, treatment and a specialist member of the cardiology team, as well as the number and percentage of patients that receive clot busting drugs from the time a call is made to the ambulance service and from arrival in hospital.




Top Marks for Food, Environment and Privacy & Dignity

Salisbury District Hospital has again been given top marks for the hospital environment, food quality and privacy and dignity in a national report by the National Patient Safety Agency . The report follows an assessment made earlier in the year by the Patient Environment Action Team (PEAT). The PEAT team include patient and public representatives and modern matrons who have a central role in maintaining and improving standards at ward level.

LISTENING AND LEARNING FROM OUR PATIENTS

Women Rate Maternity Services

New mums have given a big thumbs up to the Salisbury District Hospital maternity service with quality of care, support and involvement in decisions rated highly in an independent Care Quality Commission survey of NHS maternity units. When compared with all 142 hospitals and 2 primary care trusts across the country, Salisbury District Hospital scored well and was in the best performing category in 13 of the 20 areas covered, with the rest in the intermediate range.

Cancer Patients' Survey

Patients have rated cancer services at Salisbury District Hospital well, in a national survey carried out by Quality Health on behalf of the Department of Health. In total 338 patients responded to 67 questions which covered referral from their GP, through diagnosis and treatment, to aftercare and support from NHS services. Salisbury District Hospital was rated amongst the top 20% of best performing hospitals in 32 questions with, privacy and dignity when being examined, choice of treatment and support for patients positive areas in the survey.

National Inpatients' Survey

In the latest published Inpatient survey results, the Trust has improved significantly across many areas covered in the survey in the previous year. In particular the Trust did well on whether patients felt they were treated with respect and dignity and whether they had confidence and Trust in staff treating them. Provision of information, cleanliness of toilet and bathroom facilities and involvement in discussions about their care were also areas of strength. The Trust is working on action plans for the coming year, which will include answering of call bells and the topic around sending patients copies of letters about them sent between the Trust and their GP.

Comments, Concerns, Complaints and Compliments

Last year the Trust treated 61,521 people as inpatients, day cases and regular day attendees. Another 40,749 were seen in A&E and 178,789 as outpatients. The Trust received 1050 thank you letters/cards sent to the Chairman, Chief Executive and Customer Care Department personally with many more sent directly to staff on wards and units. There were 640 comments, 780 concerns and 310 complaints taken by the Customer Care Department. The overall number of comments, concerns and complaints responded to in 0-10 working days = 1113 (64%), in 10-25 working days = 551 (32%) and above 25 working days 66 (4%). All comments, concerns and complaints were acknowledged either verbally or in writing within 3 working days.

The Trust welcomes feedback as it is one way in which it can learn and improve the quality of its service to its many patients. Areas where improvements were made following complaints included:

- A welcome pack was developed for all new admissions to the Stroke Unit.
- Development of guidance regarding patients with learning disabilities.
- Training has been reviewed for staff in relation to the management of patients who require end of life care.
- Development of a dementia strategy, focus group work and training to improve care of dementia patients.
- Nurse led discharge has been developed on two surgical wards.
- Expansion of the ambulatory bay in Acute Medical Unit is now operational following increased demand.
- Orthopaedics are undertaking a number of projects to improve services.
- The productive operating theatre work is exploring ways of improving trauma lists.

More detail about improvements can be found in quarterly reports presented at Trust Board meetings. Details of these can be found at the Trust website at: www.salisbury.nhs.uk




RECOGNISING INNOVATION THAT IMPROVES PATIENT CARE

Staff Across Country Learn Best Practice From 'Blood Clot' Specialists

NHS staff from across the country learnt more about how they can improve the number and quality of hospital assessments for blood clots known as venous thromboembolisms (VTE) at a special event put on by specialists at Salisbury District Hospital. Salisbury District Hospital is an 'Exemplar' site and is in the forefront nationally on VTE prevention.

Theatres Nurse Develops New Airways Device

Theatres staff nurse Peter Amy has developed an airways device which will help with airway management and the difficulties around intubation. Peter now has now seen a portfolio of 10 ideas, along with prototypes, develop over the past four years. One device is patent pending and eight are in commercial discussions. This will see an improvement in efficiency, patient benefit and eventually generate income for the Trust

Medical Engineers Develop Prototype Device For Charcot Foot

A team of medical engineers has developed an innovative prototype to help in the diagnosis of Charcot foot. UK and international commercial discussions are taking place for this patent pending device that is simple to use, improves patient care, reduces NHS costs and could bring recurrent income into the Trust.

Pharmacy Technician Develops Unique Memory Aid

Pharmacy technician Louisa Blake has developed a novel memory device that helps people with memory loss or impairment. It is easy to operate, portable and battery free and can be personalised to meet requirements. Commercial discussions are in progress with pharmaceutical companies as a promotional give-away which, if successful, will generate income for the Trust.

Electronic Patient Lists Inter-Specialty Referrals

Working with IT, junior doctors have developed an electronic referral system that can be integrated with existing patient lists so that more timely and detailed information can be provided to consultants about their patients to help with internal referrals.

RECOGNISING AND REWARDING THE BEST

Colorectal Team Wins Multidisciplinary Team Award

The Colorectal team won a Trust award for the way in which they involved staff across a range of roles and specialities in the implementation of enhanced recovery programmes that involve introducing new techniques and practices before, during and after surgery to reduce patients' length of stay in hospital.

Unsung Heroes Rewarded

Staff have been recognised for going that extra mile to support frontline staff and improve the service they deliver in the Outstanding Contribution and Unsung Hero Categories of the Striving for Excellence Awards. Tori Appleford was a winner for the way she supports the surgical directorate and Tracey Johns was the unsung hero, recognised for the way she organises medical and administrative staff and resolves patient's problems.

Fertility Department Rewarded For Customer Care To Patients

The Fertility Department Team won the Striving for Excellence Customer Care Team award for their helpfulness, sensitivity and individual attention they give to patients. Britford Ward, Day Surgery, the Fundraising Team and Plastic Surgery Physiotherapy were highly commended.

Individual Staff Rewarded For Excellent Customer Care

Outstanding support to patients and kind and positive attitude earned consultant plastic surgeon the Striving for Excellence Customer care award health care support workers and Rose Daish and Pamela Heydon, Plastic surgeon, Mansoor Khan and Children's ward play specialist Jane Poole, were all highly commended.

Trust Volunteers Rewarded

Former spinal patient Badg Champion won the Striving for excellence volunteer award for the way he has helped other patients use specially adapted computer equipment that keeps them in touch with relatives. Elaine Baggaley who works in the MRI/CT reception desk and Bryan and Marilyn Bechter who provide additional support in the Trust offices, were highly commended.




PROMOTING AND SUPPORTING BETTER HEALTH AND SUPPORT FOR OUR PATIENTS

Staff Raise Awareness Of Smoking Dangers

Respiratory Nurse Fiona Stanford highlighted the dangers of smoking and the benefits of giving it up. As part of the campaign Fiona gave information and advice to patients and visitors and measured carbon monoxide levels in their blood, This year the campaign also focused on the financial benefits of stopping.

Learning Disability Awareness Week

As part of Learning Disability Awareness Week, hospital staff and community learning disability nurses from NHS Wiltshire were available in main reception to talk to staff, patients and visitors about learning disability issues, promote awareness of people with learning disabilities and gather information to help improve services.

Spinal Patients' Timeline

Staff in the Spinal Unit and ArtCare developed a timeline which provides a chronological insight into the unit and its patients through personal patient stories and photographs. The Timeline has provided inspiration for current patients, helped relatives by showing them examples of active lives being led by patients and given staff recognition and satisfaction for their role in their achievements.

Unique Support for Breast Cancer Patients

Breast cancer patients were able to enjoy each other's company and support as part of the annual lunch for past and present patients held by Salisbury District Hospital staff. The annual lunch was first held 24 years ago, so that existing patients could share their experiences and provide additional support to women newly diagnosed with breast cancer.

Cleft Lip and Palate Support

Parents and children enjoyed a wonderful day of entertainment and support as part of the Cleft Lip and Palate Party held at Salisbury District Hospital. This event gave staff an opportunity to talk to parents about cleft lip and palate and give them that extra bit of support and information in a friendly and less formal setting. While the children enjoyed a number of activities, parents were able to forge new friendships and enjoy the mutual support of each other.

Organ Donation

As part of National Transplant Week, staff at Salisbury District Hospital had a stand in main reception to raise awareness and support for organ donation and encourage people to join the organ donor register. The initiative was part of a national campaign to increase the number of people who want to join the NHS Organ Donor Register and ensure that the discussion of organ transplant is usual practice when appropriate.

LEADING THE WAY AND SHARING BEST PRACTICE

Burns Specialists Host International Conference

Groundbreaking local work and a national reputation for burn care attracted health professionals from across the world to the British Burn Association's annual scientific conference at the Salisbury Playhouse.

Good Practice in Bereavement Services acknowledged nationally.

Salisbury District Hospital has been sited as a centre of good practice in a latest Department of Health document, which deals with looking after the deceased and their relatives. Staff at Salisbury District Hospital have also been involved in a revision of the UK Core Bereavement Standards which have been published by the Department of Health.

Certification to Patient Information Scheme Retained

Following an assessment by the Royal Society for Public Health, the Trust has retained certification to the Information Standard. Only 6% of Trusts have achieved the Standard. The aim of the scheme is to reduce the potential for sub standard health and social care information and ensure that patients, public and health professionals know that the information that they are using is reliable. Certification shows that the Trust has systems and approval processes in place to ensure that patient information is evidence based, accurate, reader friendly and conforms to all elements of the Information Standard.



King's Fund Point of Care Programme

The Trust is one of only five hospitals chosen by the King's Fund to take part in its Point of Care Programme. The aim of the programme is to look carefully at patient pathways and improve the experience of hospital care for patients and their families. In Salisbury, the orthopaedic team is concentrating on the trauma pathway, while cardiology is looking at outpatient services for people that need assessment for suspected coronary heart disease.

Award For Venoues Thromboembolism (VTE) Work

Consultant Haematologist Tamara Everington has was won the Best VTE Prevention in Clinical Practice award from national thrombosis charity Lifeblood. The award recognised the way in which Tamara has led the way in developing comprehensive and effective VTE prevention strategies across the Trust. Salisbury District Hospital is an 'Exemplar' site and is in the forefront nationally on VTE prevention and Dr Everington also received a Trust leadership award for her work.

New Research Grant for Salisbury Scientists

Scientists at the Wessex Regional Genetics Laboratory were awarded a further grant from Leukaemia and Lymphoma Research to continue their groundbreaking research into a group of blood disorders called myeloproliferative neoplasms. This followed a breakthrough by the team, found a genetic susceptibility to the development of mutations in these disorders.

Salisbury Scientists Identify Gene Linked To Blood Disorders

Scientists at the Wessex Regional Genetics Laboratory identified a key gene, which, if mutated, can cause serious blood disorders. The findings shed light on how these disorders develop and could lead to the design of new drugs for patients in the future that specifically target the genetic abnormality.

CELEBRATING ACHIEVEMENTS

Patients Come Runners Up in Inter Spinal Unit Games

Patients from across Southern England were runners up in the Inter Spinal Unit Games for Salisbury District Hospital at the Stoke Mandeville Stadium in Aylesbury. The six strong team was pitted against 12 other teams from spinal units across Great Britain and Ireland. Team members have damage to the spinal cord and are either paralysed from the neck (tetraplegic) or the waist (paraplegic) down, depending on how high up the damage has occurred.

Salisbury Midwives Receive International Baby Friendly Award

Maternity staff were awarded the international Baby Friendly Award by United Nations Children's Fund (UNICEF) recognising the way staff have increased breastfeeding rates among new mothers and promoted awareness of the benefits. The Baby Friendly Initiative is a global programme set up by UNICEF and the World Health Organisation to provide a practical and effective way for health services to improve the care given to mothers and babies. The award is given to hospitals only after an assessment by a UNICEF team has shown that recognised best practice standards are in place.

Hospital Wins National Catering Award

Staff at Salisbury District Hospital have won the Hospital Caterers Association Team of the Year Award for the work they have done to create good nutritional food for patients and provide a good all round service for staff and visitors. As part of the award the team had to demonstrate that they provide good cost effective nutritional meals, use patient feedback to improve services and that they have effective training structures in place for staff.

Trust Non Executive Director Awarded MBE

President of the Veterinary Benevolent Fund (VBF) and Salisbury NHS Foundation Trust Non Executive Director Dr Lydia Brown was awarded an MBE in the Queen's New Years Honours list for her services to the veterinary profession.

Hospital 'Friends' Rewarded For Commitment To Local Health Service

Salisbury Hospitals League of Friends volunteers Elizabeth Batten, Freddy Forder, Peter Turner and the late John Rigiani were awarded Diamond Awards by the national volunteering organisation, Attend, in recognition of their work in supporting local health services. The Diamond Awards mark Attend's 60th anniversary and honour the contribution volunteers have made across the UK in health and social care.

B.U.G.S Celebrates 10 Years of Helping Burn Injured Patients

Volunteers in B.U.G.S. (Burns Unit Group Support) celebrated 10 years of achievements and outstanding work in providing help for burn injured patients at Salisbury District Hospital. B.U.G.S. is a nationally recognised independent charity that was set up in 2000 by a senior physiotherapist, a Burns Unit sister and a former patient.

Young Volunteer of the Year

Former Bishop Wordsworth's School sixth form student Denis Twomey won the Young Volunteer Award at Salisbury District Hospital for his dedication and commitment to patients. Denis spent a minimum of two hours a week over a 12 month period helping patients and staff on the Burns Unit.

Education Team Wins Training Award

The Education Team won the TABS Training Excellence Award at the South Wiltshire Business of the Year Awards. TABS Training said that the team was forward thinking in its approach, ensured that every employee has literacy and numeracy training where required. They also said that the training programme was so successful, it had been emulated throughout the country.

WORKING WITH OUR STAKEHOLDERS, PARTNERS AND LOCAL COMMUNITY

National Pathology Week

Pathology staff held a range of events for students and local people to celebrate National Pathology Week. The events included school and hospital based workshops, presentations and demonstrations in main reception on infection, prevention & control and the role blood tests have in diagnosing specific conditions. Staff were also encouraged to wear something red and make a donation to the Stars Appeal's Caring 4 Kids Campaign.

Kings Fund Visit

Senior managers from the Kings Fund were given the opportunity to increase their management skills by undertaking a project which benefited them and gave invaluable feedback about hospital services. The two projects focussed on cancellations in outpatients and waits for diagnostic procedures for inpatients. As part of the feedback patients were impressed with the overall care they received and the way staff took time to resolve issues.

Surgeon General Visit

Surgeon General, Vice Admiral Philip Raffaelli, visited Salisbury District Hospital to see first-hand the specialist expertise at the hospital and to meet some of the soldiers who have undergone extensive surgery here following injuries received in Afghanistan. Salisbury District Hospital is a regional specialty for plastic and reconstructive surgery and consultant Rod Dunn and his team has a particular interest and expertise in treating soldiers who have received major limb damage in war areas.

Energy Awareness

As part of an energy awareness campaign the Trust made a number of improvements - installing energy efficient lights and fittings, linking lights to motion and light level detectors and recovering heat from existing ventilation systems and reducing steam loss. It also carried out an internal campaign to raise awareness of the need to reduce energy costs across the Trust.

Salisbury Coalition Against Racism (SCAR) recognition for partnership working

The work of Salisbury Coalition Against Racism (SCAR) has been recognised as an outstanding example of partnership working. SCAR comprises of health and local authority organisations and was set up to raise awareness of racism and highlight the diverse nature of the Salisbury and south Wiltshire community. Public events and promotions have successfully increased awareness of SCAR and its aims, leading to expanded links with minority groups and an increase in the number of voluntary organisations now joining the coalition.

Cultural Awareness

Staff and visitors had an opportunity to experience the cultural diversity that exists within the hospital and enjoy a range of new culinary experiences as part of cultural awareness event held at Salisbury District Hospital. Over 150 people dropped in during the day to find out more about the different nationalities that work at the hospital and their cultures and food.

Local Groups Contribute to Internal Design for Children's Unit

Artists and designers had an opportunity to work with community and school groups to produce designs used in the new Children's Unit. The look and feel of the building has an essential role to play local people, community groups and schools helped make the unit interesting and welcoming for a whole age range of children – from a few days old, right up to 18 years of age.

Children See Science and Engineering in Action in Hospital Visit

Children from Broad Chalke Primary School came to see what clinical scientists and medical engineers can do to help improve the quality of life for people with disabling conditions as part of the Imagineering initiative. The initiatives aims to give children an introduction to the world of engineering through practical activities.




SUPPORTING OUR STAFF TO PROVIDE BEST CARE

Staff Health And Wellbeing - Walking To Work Week

The Trust used walking to work week to focus on walking and the physical and mental health benefits for staff. During the week staff could record their walking on a record card with a free pedometer for the first 50 people who registered and a prize for the person who covered the greatest distance over the week. It also gave the Trust the opportunity to promote 15, 45 and 1 hour walks around the hospital site.

Staff Stop Smoking Clinics

Salisbury NHS Foundation Trust staff who want to quit smoking are able to attend staff the Stop Smoking Clinic in work time and receive two weeks free nicotine replacement therapy (NRT). Staff are also able to contact their local NHS Stop Smoking Advisor for advice or discuss opportunities to provide group stop smoking sessions for their department.

English for Speakers of Other Languages

Hospital staff devised a number of alternative training methods to support staff whose first language is not English as an alternative to computer based training. This included classroom based work and one-to-one reading of the computer packages, which gave an opportunity for questions, built up confidence and encouraged further personal development.

Day Nursery Receives 'Good' Rating in Ofsted Report

In the latest Ofsted report, the Day Nursery has received a grading of 'Good' across all four main inspection areas. These cover the overall effectiveness of the early years provision, the effectiveness of leadership and management of the early years provision, the quality of the provision in the early years foundation stage and outcomes for children in the early years foundation stage. The Trust also received the Bristol Standard quality Improvement award.

End of Life Care

The Trust carried out a training needs assessment on End of Life Care, so that we can identify gaps and address any training issues. End of Life Care is an important part of the overall care pathway, for patients their relatives and carers so it is important that staff have the skills that they need to provide professional care in all situations.

NUMBER OF EMPLOYEES IN POST AT 31 MARCH			
	2011	**2010**	**2009**
Medical and Dental	379	382	357
Administration and Estates	889	952	958
Other Support Staff	343	353	403
Nursing and Midwifery	1,609	1,719	1,733
Scientific, Therapeutic & Technical Staff	697	710	672
Total	**3,917**	**4,116**	**4,123**
At 31 March 2011 the Trust employed 3,917 full and part-time staff (Equivalent to 2,724 full-time posts)			

BACKGROUND INFORMATION

History of the Trust

Consistently high standards and excellent financial management enabled Salisbury Health Care NHS Trust to start its application for NHS Foundation Trust status in the latter part of 2005. This led to authorisation under the Health and Social Care (Community) Act 2003 (now National Health Service Act 2006) on 1 June 2006, and a new name – Salisbury NHS Foundation Trust.

Statement on disclosure to the auditors

As far as the Directors' are aware there is no relevant audit information of which the auditors are unaware. Each individual director that has approved this Annual Report has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of the information.

Preparation of accounts

The accounts have been prepared under a direction issued by Monitor.

Accounting Policies for Pensions and other Retirement Benefits

These are set out in note 10 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

Going Concern

As part of the Trust's formal reporting requirements the Trust has to provide a statement on whether the accounts were prepared on a going concern basis. After making inquiries, the directors have a reasonable expectation that Salisbury NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.




REMUNERATION REPORT

Remuneration Committee

The Remuneration Committee reviews the salaries of the Executive Directors of the Trust and the individual reward packages of Executive Directors. These are fixed in comparison with packages given to holders of similar posts within the NHS. A salary range for each Director has been determined based on salaries paid across the NHS for similar posts. In setting, monitoring and reviewing salary ranges, the Committee uses survey material and received independent advice and guidance from Capita Health Service Partners, an organisation specialising in this work. A Consultant, John Langron, provided advice to the Committee and attended one meeting during the year. During the year Matthew Kershaw and Peter Hill, provided advice to the committee in the capacity of Chief Executive and Interim Chief Executive respectively, Alan Denton as Director of Human Resources, with John Williams providing administrative support in his position as Head of Corporate Governance.

Name	Role	Attendance from four meetings
Luke March	Chairman	4
Nigel Atkinson	Member	4
Lydia Brown	Member	4
Barry Bull	Member	3
Ian Downie	Member	3
Stephen Long	Member	4
Michele Romaine	Member	2
John Stokoe	Member	2

The personal performance of the Executive Directors was assessed against their job description and their achievement of objectives, agreed by the Remuneration Committee in advance. An individual performance review (IPR) was held at the mid-year position and at the end of the year between each Executive Director and the Chief Executive (or the Chairman in the case of the Chief Executive's performance). The Remuneration Committee received reports in respect of the outcome of the IPRs.

Advancement within the individual salary scales of Executive Directors based on successful IPR outcomes is the only performance-related element of Executive Director's remuneration. An overall limit in the cost of movement is agreed by the Remuneration Committee prior to recommendations for advancement being made. In view of the current economic climate, the Remuneration Committee decided not to increase individual salary scales for Executive Directors for the year starting 1 April 2010.

Responsibility for setting the terms and conditions of Non Executive Directors rests with the Council of Governors. In 2006, the Governors asked Capita, which provided independent advice, to review the existing terms and conditions and those agreed were based on the enhanced role for the Chairman and Non-Executive Directors of the Trust and levels of pay in NHS Foundation Trusts of a similar size and nature at the time. Subsequent independent reviews in 2008 and 2009 resulted in a modest uplift. In 2010 the Council of Governors decided not to award a pay increase to the Non Executive Directors following the example set by the Remuneration Committee on Executive Director's pay.

There is no bonus scheme for Executive Directors and any in-scale annual increment is based solely on individual performance. None of the current Executive Directors are subject to an employment contract that stipulates a length of appointment (see section on Trust Board Employment terms). In determining director's pay the Remuneration Committee for the executive directors and the governors in respect of the non executive directors sought to ensure pay awards reflected the current economic climate.




SALARY AND PENSION ENTITLEMENT

Remuneration						
	Salary (Bands of £5,000) £000		Other Remuneration Bands of (£5,000) £000		Benefits in Kind Rounded to the nearest £100	
	2009/2010	2010/2011	2009/2010	2010/2011	2009/2010	2010/2011
Luke March Chairman	40-45	40-45	0	0	0	0
Matthew Kershaw Chief Executive	145-150	85-90	0	0	3,500	4,200
Nigel Atkinson Non Executive	10-15	15-20	0	0	0	0
Lydia Brown Non Executive	10-15	10-15	0	0	0	0
Barry Bull Non Executive	10-15	10-15	0	0	0	0
Malcolm Cassells Director of Finance	110-115	110-115	0	0	4,000	4,000
Alan Denton Director of Human Resources	90-95	90-95	0	0	4,000	4,000
Ian Downie Non Executive	5-10	10-15	0	0	0	0
Peter Hill Interim Chief Executive	115-120	120-125	0	0	0	4,100
Stephen Long Non Executive	10-15	10-15	0	0	0	0
Tracey Nutter Director of Nursing and Operations	95-100	105-110	0	0	0	0
Sean O'Kelly Medical Director	95-100	165-170	0	0	0	0
Michele Romaine Non Executive	5-10	10-15	0	0	0	0
John Stokoe Non Executive	10-15	10-15	0	0	0	0

Benefits in kind relate to either the provision of a car or additional pension contributions

Matthew Kershaw was seconded to the Department of Health from 9 November 2010. Peter Hill was Interim Chief Executive from 9 November 2010.

Sean O'Kelly was appointed Medical Director on 7 September 2009. Ian Downie and Michele Romaine were appointed on 1 November 2009.

Notes to Remuneration and Pension Tables

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pensions 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 show 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 on CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pension Benefits 1 April 2010 – 31 March 2011								
	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2011 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 1 April 2010 £000	Real increase in Cash equivalent Transfer Value £000	Employers contribution to Stakeholder pension To nearest £100
Matthew Kershaw	0-2.5	2.5-5	105-110	80-85	308	347	(24)	0
Malcolm Cassells	0-2.5	2.5-5	195-200	145-150	1,028	1,082	(54)	0
Alan Denton	0-2.5	0-2.5	135-140	100-105	752	794	(43)	0
Peter Hill	5-7.5	17.5-20	175-180	130-135	751	722	29	0
Tracey Nutter	0-2.5	5-7.5	145-150	110-115	592	624	(32)	0
Sean O'Kelly	2.5-5	10-12.5	185-190	140-145	796	815	(19)	0

* Please note that these tables are subject to audit.




TRUST BOARD EMPLOYMENT TERMS

The Chairman and Non-Executive Directors of the Trust are appointed by the Council of Governors for a term of office of up to four years. This can be renewed for a second four year term with the agreement of both parties.

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 contract with no time limit attached and the contract can be terminated by either party with three-month's notice. The contract is subject to normal employment legislation.

Executive Directors are appointed by a committee consisting of the Chairman, Chief Executive and Non Executive Directors.

The Trust's Constitution sets out the circumstances in which a Director will be disqualified from office and employment terminated.

No significant awards have been made to past senior managers.

Peter Hill
Interim Chief Executive
6 June 2011




NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation.

In September 2006, Monitor, the independent regulator for Foundation Trusts, first published the NHS Foundation Trusts Code of Governance, which was updated on 1 April 2010. This Code builds on the Combined Code of Corporate Governance, which itself is the product of multiple corporate governance developments in the UK over many years.

The Trust Board supports the ideals and the ethos behind the Code and has reviewed the performance of the Trust against the main and supporting principles and provisions.

The way in which the Board applies the principles and provisions is described in the various sections of the report and the Directors consider that for the 2010/2011 year the Trust has been compliant with the Code with the exception of the following:-

C.2.2 – Appointment of Non Executive Directors for terms of no more than three years.

The Trust Board and the Council of Governors agreed that appointment of Non- Executive Directors should be for a term of four years in line with the constitution approved by the Regulator prior to authorisation as a NHS Foundation Trust on 1 June 2006

Details on the NHS Foundation Trust Code of Governance can be found on the Monitor website at www.monitor-nhsft.gov.uk

Statement Explaining How the Board of Directors and the Council of Governors Operate, Including a High Level Statement of Which Types of Decisions are Delegated to the Management by the Board of Directors

Board of Directors

The Board of Directors comprises the Chairman, Chief Executive, and seven Non-Executive Directors and five Executive Directors, making fourteen in total. The Board meets on the first or second Monday of each month. Normally, six of the meetings are held in public and six in private. The public and private meetings alternate. The dates of the public meetings are advertised on the Trust's web-site and in the local press.

The Agendas, Papers and Minutes of all public meetings are published on the web-site and are also available in hard copy on request.

The Directors have collective responsibility for:-

- Following regulatory guidance such as Monitor , Care Quality Commission
- Setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance
- Providing leadership and governance to the Trust within a framework of prudent and effective controls
- Providing accountability to Governors and being responsible to members and stakeholders
- Understanding and managing the operational, business and financial risks to which the Trust and its related businesses are exposed
- Monitoring the work undertaken and the effectiveness of the formal sub-committees of the Board
- Allowing flexibility to consider non-routine matters or items that are outside of the planned work programme
- Reviewing the performance of the senior management team

Annually the content of the agendas and the terms of reference of the Trust Board sub committees for the following twelve months are agreed to ensure there is a good order and appropriate timing to the management of the above functions.

The Board is required to comply with its Standing Orders, Standing Financial Instructions and the Terms of Authorisation as issued by Monitor, the Independent Regulator for Foundation Trusts. The Board has to submit an Annual Plan to Monitor and quarterly reports to confirm compliance with both the Trust's Financial and Governance targets and its terms of authorisation. During 2009/2010, the Trust prepared for its registration with the Care Quality Commission, which was approved without conditions attached on 1 April 2010. The Board's role is to ensure that it continues to comply with the regulations.

Council of Governors

The Council consists of 26 Governors:

- 1 Patient Governor
- 14 Public Governors
- 6 Staff Governors
- 5 Nominated Governors

The Chair of the Trust Board is also the Chair of the Council of Governors and is the conduit between the two bodies. The full Council of Governors meets in public four times a year and also holds an AGM. The Chief Executive normally attends the Council meetings to present a performance report and respond to questions.

Non-Executive Directors attend by invitation on a rota basis to develop their own understanding of the work of the Governors and their issues.

The work of the Governors is divided between their statutory and non-statutory duties.

The statutory duties are to:-

- Set the Terms and Conditions of Non-Executive Directors together with their remuneration and allowances
- Appoint or remove the Chairman and Non-Executive Directors of the Trust
- Approve the appointment of future Chief Executives
- Appoint or remove the Trust's External Auditor
- At the AGM consider the Trust's annual accounts, auditor's report and annual report
- Be consulted by the Board of Directors on the development of forward plans for the Trust and any significant changes to the health care provided.




Where appropriate Governors have been placed, on a voluntary basis, on to Committees or into Groups to look at the requirements of these functions and present recommendations for the full Council to consider. On the non-statutory side the Governors have been placed into groups to consider various topics over which they can have an influence. In 2010/2011 these covered:

- Membership Strategy
- Communicating with members
- A Commentary to the Care Quality Commission
- Performance of Chairman and Non Executive Directors
- The Trust's Annual Plan for 2010/2011 prior to submission to the regulator
- Patient experience
- Staff membership growth and communications
- Governor's self assessment
- The strategic direction of the Trust

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. The Board of Directors understands it is accountable to the Council of Governors.

Decisions Delegated to the Management by the Board of Directors

The Scheme of Delegation, which is included within the Trust's Standing Orders, sets out the decisions which are the responsibility of the Board of Directors. These are actioned either by the Trust Board or a committee of the Board.

Below Trust Board level the Executive Directors have established the Joint Board of Directors which consists of the Executive Directors, Clinical Directors and other senior post holders. The Joint Board of Directors meets monthly and is chaired by the Chief Executive. Its remit is to consider the management of the day to day business of the Trust, both operationally and clinically. The Joint Board of Directors is supported in its work by the Operational Management Board chaired by the Director of Operations and the Clinical Management Board chaired by the Medical Director.

The Council of Governors

The Council of Governors is made up of elected and nominated Governors who provide an important link between the hospital, local people and key organisations - sharing information and views that can be used to develop and improve hospital services.

There are seven public constituencies that have been created to cover the Trust's general and emergency catchment area using local government boundaries. The Trust's public constituencies are called Salisbury City, South Wiltshire Rural, New Forest, Kennet, West Wiltshire, North Dorset and East Dorset. Governors from these areas are elected by members from these constituencies in strict accordance with election rules stated in the Trust's constitution using the 'First Past The Post' voting system. Elections are carried out on behalf of the Trust by the independent Electoral Reform Services Ltd.

In addition, there are elected staff Governors split into six staff groups and Governors who are nominated by partner organisations that have an interest in how the Trust is run. These are Wessex Community Action, a body that provides an over-arching voluntary presence at local level; Wiltshire Council that provides the main local authority link; Wiltshire, Hampshire and Dorset Primary Care Trusts which are the three main health commissioning bodies for the Trust.

The public and patient constituencies must make up at least 51% of the total number of Governors on the Council of Governors.

In addition to the AGM, and the joint meeting with the Trust Board to review the Annual Plan, the Trust hosted four meetings of the Council of Governors during the 2010/2011 year. No Governors were elected or appointed within the year.




Elected Governors – Public Constituency

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
John Carvell (Lead Governor)	Salisbury City	May 2009	Three years	3
Celeste Collins	Salisbury City	May 2008	Three years	4
Chris Wain	Salisbury City	May 2009	Three years	4
Kate Beaumont	South Wiltshire Rural	May 2009	Three years	4
Robert Coate	South Wiltshire Rural	May 2009	Three years	4
Chris Horwood	South Wiltshire Rural	May 2008	Three years	4
Beth Robertson	South Wiltshire Rural	May 2009	Three years	3
Sara Willan	South Wiltshire Rural	May 2009	Three years	3
Paul Goldman	North Dorset	May 2008	Three years	4
Mary Hutcherson	North Dorset	May 2009	Three years	4
Wayne Arnett	New Forest	May 2009	Three years	2
John Markwell	Kennet	May 2009	Three years	4
Carole Noonan	West Wiltshire	May 2009	Three Years	4
Elizabeth Connock	East Dorset	May 2009	Three years	4

Elected Governors - Patient/Carer Constituency

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
Andrew Farrow	Patient/ Carer	May 2009	Three years	3

Elected Governors - Staff Constituency

Shaun Fountain	Medical & Dental	May 2009	Three years	3
Colette Martindale	Nurses & Midwives	Nov 2009	Three years	4
Lynda Weeks	Hotel & Property Services	May 2009	Three years	3
Louise Arnett	Clerical, Administrative and Managerial	May 2009	Three years	2
***Nick Cross**	Scientific & Therapeutic	May 2009	Three Years	2
Eric Gould	Volunteers	May 2009	Three Years	2

* Nick Cross resigned on 31 December 2010.

Nominated Governors

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
Anita Pheby	Wessex Community Action	May 2009	Three years	4
William Moss	Wiltshire Council	June 2009	Three years	3
Lis Woods	Wiltshire Primary Care Trust	June 2009	Three years	4
Elizabeth Stevens	Dorset Primary Care Trust	June 2009	Three years	4
Richard Samuel	Hampshire Primary Care Trust	June 2009	Three years	0

Please note that 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 John Williams, Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury. SP2 8BJ.




Statement Setting out the Steps that the Members of the Board, in Particular the Non Executives, Have Taken to Understand the Views of Governors and Members.

During the year the Directors have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chairman and these meetings are always attended by the Chief Executive who presents a performance report and answers questions. This is an opportunity for the Governors to express their views and raise any other issues, so that the Chief Executive can respond. Minutes of the meetings are shared with the Executive and Non Executive Directors who have the opportunity to pick up and action any points that are relevant to their areas. The minutes of all Governor's meetings and working groups are also made available to the Executive and Non Executive Directors. The Senior Independent Director and other board members attend the Council of Governor's meetings by invitation on a rota basis. Executive and Non Executive Directors also attend some of the Governor working groups. In addition, there was one joint meeting between the Trust Board Directors and Governors to consider the Annual Plan and progress on the development of the Salisbury District Hospital site, and another two meetings to discuss matters of mutual interest.

The Trust Board is aware of the work carried out by the working groups and information is fed back to the Directors. The Directors attend constituency meetings and the annual general meeting and answer member's questions. The Trust Board meets bi monthly in public and, as part of its commitment to openness, Governors and members are invited by the Chairman to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board. Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.




The Board of Directors

Statement about the Balance, Completeness and Appropriateness of the Board of Directors

The Board comprises the Chairman, Chief Executive, five other Executive Directors and seven other Non-Executive Directors. There is a clear separation of the roles of the Chairman and the Chief Executive, which has been set out in writing and agreed by the Board. As Chairman, Luke March has responsibility for the running of the Board, setting the Agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day to day business of the Trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. While, on appointment, the Chairman has to meet the Code's 'test of independence' it does not, thereafter, apply to this role.

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.

Four of the current Executive Directors who were in post at the time drafted the various strategies which formed the Trust's application for Foundation Trust status. These strategies were agreed by the whole Board at the time and these form the basis of the relationship with the Regulator. All Directors are equally accountable for the proper management of the Trust's affairs.

All Directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust. In both 2007/2008 and 2008/2009, the Board undertook an external assessment of the effectiveness of the Board as a whole. Preparatory work has been undertaken within the year for a further assessment which will take place in the summer of 2011.

At the present time the Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Statement Setting Out that the Board of Directors Undertake a Formal and Rigorous Evaluation of its Own Performance and that of its Collective and Individual Directors.

In 2007 and 2008, the Trust engaged the NHS Institute for Innovation and Improvement to help the Board of Directors undertake the evaluation of the Board and its sub committees using a 'Board Development Tool'. This process included questionnaires, observation of the Trust Board in a public meeting and one-to-one interviews with a cross section of Executive Directors, Non Executive Directors and Governors. An action plan was agreed to address minor shortcomings and the findings of the development tool presented to the Council of Governors which is responsible for the appointment and reappointment of the Non Executive Directors. This process was repeated, although based on learning from the previous year. This was confined to the Trust Board directors on this occasion and did not involve the observation of a public Board meeting. With a positive outcome to this exercise, the process will be repeated in 2011.

Evaluation of the Chairman's performance is led by the Senior Independent Director. The Chief Executive and Non Executive Directors' performance is evaluated by the Chairman, while an evaluation of the Executive Directors' performance is carried out by the Chief Executive.




Luke March DL – Chairman (Independent)

Luke March was appointed Chairman of the Trust on 1 January 2005 for a term of four years and reappointed by the Governors for a second four-year term on 1 January 2009. He has been a Non-Executive Director in the NHS since 1988, first in Winchester and later in East London, as Deputy Chairman of Barts and The London NHS Trust. In the commercial sector Luke has held senior management appointments at Lloyds TSB and BT and was Chief Executive of the Mortgage Board. More recently he was Compliance Director of the Royal Mail Group and is now Compliance Officer for the Independent Parliamentary Standards Authority. Luke lives in Great Durnford near Salisbury.

Peter Hill - Interim Chief Executive

Peter Hill has a nursing background and before coming to the Trust in 1986 worked on wards and intensive care units in London and Newcastle. He has a Masters degree in Business Administration and has extensive senior management experience. Peter was Director of Operations until 8 November 2010 and was appointed Interim Chief Executive when Matthew Kershaw took up a secondment at the Department of Health. Peter lives in Salisbury in Wiltshire.

Nigel Atkinson - Non Executive Director (Vice Chairman and Senior Independent Director)

Nigel Atkinson is a chartered accountant and retired corporate financier and a former Head of Listing at the London Stock Exchange with some 30 years experience of corporate finance. Mr Atkinson was appointed on 1 February 2007 for a term of four years. He lives in Cholderton in Wiltshire.

Dr. Lydia Brown MBE - Non Executive Director (Independent)

Lydia Brown joined the Trust on 1 November 2008 for a four year term. She is a qualified vet and former President of the Royal College of Veterinary Surgeons. She has considerable business experience and is now a Managing Director within a Norwegian aquaculture business. Lydia lives in West Gomeldon in Wiltshire.

Barry Bull - Non Executive Director (Independent)

Barry Bull joined the Trust on 1 January 2005 for a four year term and was reappointed for a second four-year term on 1 January 2009. He has experience of private industry having worked his way up to director level within the Unilever group. He currently works for a charity that supports older people. He lives in Verwood in Dorset.

Malcolm Cassells - Director of Finance and Procurement

Malcolm Cassells is a qualified accountant with extensive financial experience gained through over 30 years in the NHS. He held senior financial positions at Regional Health Authority and District Health Authority level, before moving to Salisbury in 1986 as Director of Finance. He lives in Winterslow in Wiltshire.

Alan Denton - Director of Human Resources

Alan Denton has over 20 years NHS experience having worked throughout this period at senior management level in the field of Human Resources. He joined the Trust in 1988 having previously worked in the mechanical engineering and construction industries and lives in Blandford Forum in Dorset.

Ian Downie - Non Executive Director (Independent)

Ian Downie, who is Strategic Development Director of Serco group, joined the Trust on 1 November 2009 for a four year term. He has considerable management experience within the aviation industry and more recently through a number of roles within the Serco group. He lives in Gussage St Andrew in Dorset.




Stephen Long
- Non Executive Director (Independent)

Stephen Long joined the Trust on 1 November 2008 for a four year term, having retired as Deputy Chief Constable of Wiltshire after 30 years service. He was a diversity champion within the constabulary and a national lead for Science and Technology. Stephen lives in Wilton in Wiltshire.

Tracey Nutter - Director of Nursing & Operations

Tracey Nutter joined the Trust in April 2003 from Southampton University Teaching Hospitals NHS Trust where she was Associate Nurse Director. She has over 27 years NHS experience having worked in key senior nursing posts in Newcastle, London and Southampton. She has a Masters Degree in Health Services Management from the University of Manchester and an International Masters for Health Leadership from McGill University in Montreal. Tracey was Director of Nursing until 8 November 2010 and this Executive role was merged with Operations on 9 November 2010. She lives in Poole in Dorset.

Sean O'Kelly - Medical Director (Until 18 April 2011)

Sean O'Kelly joined the Trust in September 2009. He has over 20 years NHS experience in anaesthesia and intensive care. He has extensive managerial and clinical experience in Britain and America and also a Masters degree in Strategic Management from the University of Bristol. Before joining the Trust Sean worked at the Department of Health and was Associate Medical Director at the Great Western Hospital in Swindon. Dr O'Kelly left the Trust on 18 April 2011 to take up an appointment with University Hospitals Bristol NHS Foundation Trust.

Michele Romaine
- Non Executive Director (Independent)

Michele Romaine, who is a former director of production for the BBC, joined the Trust on 1 November 2009. She has considerable management experience through a number of senior positions within the media industry and more recently through her own media consultancy. She lives in Stapleford in Wiltshire.

Major General John Stokoe
CB CBE - Non Executive Director (Independent)

John Stokoe was a senior army officer who commanded 100,000 soldiers worldwide before he retired from the army in 1999. He has considerable board level experience and was a Divisional Managing Director in the BT Group until March 2011. John joined the Trust on 1 November 2008 for a four year term and lives in Ashmore in Dorset.

Matthew Kershaw
- Chief Executive (Until 8 November 2010)

Matthew Kershaw joined the Trust on 1 August 2008. He has over 17 years NHS experience having worked his way up through a number of roles within the NHS in Kent, Berkshire, Surrey and Sussex. He has led two national initiatives with the Department of Health and was Chief Operating Officer at East Kent Hospitals University NHS Trust before joining the Trust. Matthew joined the Department of Health on secondment on 9 November 2010.

At the end of the first term of office, the Chairman and Non Executive Directors are subject to an evaluation by the Governors Performance Committee, which will make a recommendation to the full Council as to their individual suitability to serve a second term.

The removal of the Chairman or a Non Executive Director of the Trust requires the approval of three-quarters of the members of the Council of Governors at a general meeting.

Appointment of the Vice Chairman and Senior Independent Director is reviewed annually.

Employment terms for Executive Directors can be found in the Remuneration report earlier in this report.




Board of Directors' Attendance

	Trust Board (7 meetings)	Audit Committee (4 meetings)	Remuneration Committee (4 meetings)	Finance Committee (12 meetings)	Clinical Governance Committee (6 meetings)
Luke March	7	N/A	4	12	N/A
Matthew Kershaw	5 from 5	N/A	N/A	6 from 7	2 from 3
Nigel Atkinson	6	4	4	N/A	5
Lydia Brown	6	4	4	N/A	6
Barry Bull	5	4	3	11	N/A
Malcolm Cassells	7	N/A	N/A	10	N/A
Alan Denton	6	N/A	N/A	N/A	N/A
Ian Downie	6	N/A	3	11	N/A
Peter Hill	6	N/A	N/A	12	3 from 3
Stephen Long	7	N/A	4	N/A	4
Tracey Nutter	6	N/A	N/A	4 from 5	4
Sean O'Kelly	7	N/A	N/A	N/A	6
Michele Romaine	5	N/A	2	N/A	5
John Stokoe	5	1 from 2	2	8	N/A

A register of interests is held in the Trust Offices. Information regarding the Directors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting John Williams, Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury. SP2 8BJ.

The Council of Governors understands the different process that should apply in the selection and appointment of a replacement Chairman and that the Chairman must not simultaneously be the Chairman of another Trust.

The Audit Committee

	Committee Role	Attendance out of four meetings
Nigel Atkinson	Chairman	4
Lydia Brown	Member	4
Barry Bull	Member	4
John Stokoe	Member	1 from 2

The Work of the Audit Committee in Discharging its Responsibilities

On 12 March 2007 the Audit Commission was appointed by the Council of Governors as the Trust's External Auditors for three years from 1 April 2007, with an extension for a further two years which was agreed in November 2009. In 2010/2011 the Audit Committee met on four occasions.

On 1 June 2010 the Committee met to specifically review the Trust's draft accounts for 2009/2010 together with the Head of Internal Audit (South Coast Audit) Opinion Statement and the Governance report prepared by the Audit Commission prior to the submission of this documentation to the Trust Board on 7 June 2010 for final approval.




On 12 July 2010 the Committee received reports from the Audit Commission on their 'work in progress' and the findings presented in their Annual Management Letter for 2009/2010, subsequently presented to the Trust Board on 4 October 2010. Reports from the Internal Auditors, South Coast Audit, covered their conclusions on a range of Trust activities within their 2010/2011 work plan as agreed by the Committee while the Local Counter Fraud Specialist presented a summary of the work undertaken across the Trust to deter, prevent or detect fraud.

On 11 October 2010 the Committee again received update reports from the Audit Commission, South Coast Audit, the Local Counter Fraud Specialist and, additionally, reviewed the timetable for the preparation of the 2010/2011 accounts as advised by Monitor, the Independent Regulator for Financial Trusts and, also, the management of the Assurance Framework and Risk Register. On 21 February 2011 the format and content of the meeting was similar to that of 11 October 2010.

At all meetings the Committee is particularly concerned to ensure the Trust has systems which:-

- Safeguard assets
- Maintain proper records
- Can produce reliable information
- Provide effective control systems
- Can be independently reviewed and assessed by both External and Internal Audit

The Director of Finance and Procurement, who has the Executive responsibility for liaising with both Audit functions, attends the Committee to comment and inform as required. The Minutes of all four meetings were presented to the Directors at the following public meeting of the Trust Board by the Chair of the Audit Committee, and subsequently made available for public reading on the Trust's website.

Financial Audit

The external auditors for the Trust are the Audit Commission. During the 2010/2011 period, the Trust has incurred the following costs on external audit:

- Audit services (statutory audit and reports to the Department of Health) £74,000
- Further assurance services: (Audit of Non Tariff costs: Jointly with NHS Wiltshire) £12,000
- Other services: Nil
- No post balance sheet events to report

As mentioned above, no other remuneration was paid to the auditor and the auditor was not involved in any other work that may have compromised its independence.

Directors' responsibilities for preparing the accounts

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executives Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This is can be found in the Annual Accounts for Salisbury NHS Foundation Trust.

NOMINATIONS COMMITTEE

The Trust's constitution allows the Council of Governors to form a Nominations Committee as and when there is a vacancy for a Non Executive Director. No such vacancy occurred during the year.

MEMBERSHIP

The Trust has traditionally had strong links with the local community, attracting around 700 volunteers and many more who take part in patient and public involvement activities. It has an excellent response rate for annual patient surveys and receives regular correspondence from grateful patients, highlighting the affection and interest local people have for Salisbury District Hospital.




The membership is made up of local people, patients and staff who have an interest in healthcare and their local hospital and these are broken up into three groups with different eligibility criteria.

Public Members

These are members of the public aged 16 and over who live in the geographical area outlined in the map.

Public members are placed in constituencies based on where they live. There are seven constituencies that have been created to reflect the Trust's general and emergency catchment area and these are based on local government boundaries. Following changes to these, the Trust revised its own constituency boundaries during 2010/2011 to ensure that they remained co-terminus with local government electoral ward boundaries.

Patient and Carer Members

This is made up of people from outside the general and emergency service catchment area (or their carers) who have been treated by the Trust's specialist services since 1 January 2003. These are plastic surgery, burns, cleft lip and palate and spinal injuries. Entitlement to become a new member ceases three years after discharge.

Staff Members

The Trust has a wide range of staff undertaking a variety of roles and professions who come from different backgrounds. The aim is that staff membership reflects that diversity. Initially staff membership was done on an 'opt in' basis rather than staff automatically being made members. During the 2008/2009 year, the Trust changed its policy and new members of staff who are eligible now automatically become members, with the option to 'opt out'. Eligible staff members are defined as those who:

- Hold a substantive contract of employment in excess of 12 months

- Hold a fixed term contract in excess of 12 months
- Hold a temporary contract in excess of 12 months
- Hold an honorary contract in excess of 12 months

The staff membership has six classes to reflect the following occupational areas:

- Medical and dental
- Nurses and midwives
- Scientific, therapeutic and technical
- Hotel and property services
- Clerical, administrative and managerial
- Voluntary

Patient and public members can only be a member of one constituency. Staff members can only be a member of the staff constituency. Members are able to vote and stand in elections for the Council of Governors, which is chaired by the Chairman of the Trust.

During the year the Trust sought to increase membership numbers. At 31 March 2011 the membership for Salisbury NHS Foundation Trust was as follows:

Public Constituency	**Number**
Salisbury City	2,815
South Wiltshire Rural	4,292
Kennet	1,616
North Dorset	1,854
East Dorset	970
New Forest	1,394
West Wiltshire	1,254
Patient/Carer Constituency	**1,406**
Staff Constituency	**2,399**
Total	**18,000**




Ownership of the Trust's membership strategy rests with the Governors with support from the Trust. The strategy was reviewed and updated in March 2009 to help ensure that membership involvement is encouraged in the Trust's governance and decision making process, so that services continue to meet the needs of local people. Another objective of the strategy is to ensure that the membership continues to grow and is representative of the population by geography, age, ethnicity and gender. This strategy will be updated again in 2011.

The Trust uses information from the Office of National Statistics (Census 2001) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in its aim to make the membership reflective of its population, and also to ensure that the number of Governors is representative of the population of the constituencies. Having built up a membership database of 18,000 members at 31 March 2011, the Trust regularly reviews the age, ethnicity, gender and geographical spread to ensure that the membership is reflective of the whole area that it serves.

The Trust has also determined the socio-economic breakdown of its membership and the population within its catchment area.

The Trust used its in-house database to monitor and increase the membership in line with demographic and statistical information and, at 31 March 2011, the membership had increased to 18,000 members. The Trust continued to use induction as a membership gathering point for staff.

In previous years mailing out to former patients was the principle membership gathering mechanism used for the public and patient/carer constituencies and the Trust wrote to former patients outlining the benefits of membership and inviting local people to apply. This year the Trust concentrated on its public meetings to highlight the benefits of membership and encourage recruitment and these took place for the South Wiltshire Rural, Salisbury City, North Dorset, Kennet, East Dorset and West Wiltshire constituencies. Members' newsletters were used to encourage existing members to promote membership amongst friends and acquaintances and Governors continued to use their 'Are You a Member' campaign to recruit members in outpatient clinics.

This year the Annual Review went to around 154,000 households. This brought the work of the Trust and its staff to a wide audience and again highlighted the benefits of membership. Governors have been working in groups on their statutory duties and have also been involved in the development of the Trust's Annual Plan. They have been working on patient and public involvement initiatives. For instance, providing Governor representation on the Dementia Care Group, which was formed to deliver the objectives set out in the national Dementia Care Strategy. This group has now set out a comprehensive implementation strategy.

Membership Size and Movements		
Public Constituency	**2010/2011**	**2011/2012 (estimated)**
At year start (1 April)	14,045	14,195
New members	600	880
Members leaving	450	500
At year end (31 March)	**14,195**	**14,575**
Staff Constituency		
At year start (1 April)	2,052	2,399
New members	434	201
Members leaving	87	100
At year end (31 March)	**2,399**	**2,500**
Patient Constituency		
At year start (1 April)	1,403	1,406
New members	13	37
Members leaving	10	18
At year end (31 March)	**1,406**	**1,425**
Overall Total	**18,000**	**18,500**




Governors have also been involved in Patient Environment Action Team (PEAT) inspections, which look at cleanliness and food quality and are also on the Transport Strategy Group which looks at a range of areas such as green travel, signage and car parking. Another group is looking at food and nutrition in the hospital and Governor's have joined catering managers on unannounced visits to check food quality and temperatures at ward level. Governors are also given a number of other opportunities to become involved or sample the 'patient's experience'. For example, Governors and volunteers visit wards and outpatient areas gathering instant feedback from patients about their hospital stay, which enables ward staff to resolve issues quickly. Around 3,600 patients last year were asked their views in this way.

The Trust continues to work with Governor Membership and Communication groups on a range of communication initiatives. This year Salisbury City Governor Chris Wain updated the SDH Round the Clock DVD, which is shown at constituency meetings and gives members an insight into the hospital and its services.

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 member's newsletters for staff and people in the public and patient/carer constituencies. Further opportunities are planned for Governors to meet their members formally in the 2011/2012 financial year.




Quality Report

PART ONE

Our Commitment to Quality - Chief Executives View

The Trust has continued to make real progress over the last year with the key quality measures that impact on patients', their families' and visitors' experiences. This is reflected in a number of positive improvements over the year. These include greater support and access to acute medical care, expansion of enhanced recovery programmes that reduce patients' length of stay, low infection rates and high standards of cleanliness. The Trust has also made significant progress on decreasing the number of grade 3&4 pressure ulcers. It is also a national exemplar site for its work on risk assessment and prevention of venous thromboembolism (VTE).

Provision of high quality care is a principle priority for the Trust and the Trust Board is committed to improving quality through a 'whole organisation approach'. The Trust has developed a trigger tool for each service to self assess against all elements of quality including, financial and human resource aspects. The trigger tool is a method that enables teams to self assess against key performance criteria. The outcome of this assessment helps the Trust and Directorates focus on key areas for improvement.

The Trust also uses its day to day activities, for instance clinical audit results, patient feedback and learning from complaints and safety reports. This shows where improvement might be needed. Quality of care is also included in directorate level plans and reporting processes. It is measured as part of directorate service reviews, and mid and end of year reports. The Trust uses Executive led Quality walk rounds, which enable staff and patients to talk directly with Executive and Non Executive directors. This also enables each service to review its own performance.

Quality is monitored regularly by the Board through a number of Quality measures and indicators. For instance, the Trust Board receives a quality indicator report every month and at every Clinical Governance Committee a patient story is heard. These stories may have come from complaints, incidents or from service improvement projects. The quality indicators and patients' stories ensure that the Trust keeps focused on the things that are important to our patients. Patients and staff are also involved in service improvement events that cover their own areas, and this has been widened to include GPs and external agencies in a process called Experience Based Design (EBD). This ensures that quality improvements include links with primary and secondary care.

This commitment to Quality will continue through a number of priorities for 2011/2012, which have been developed in accordance with views and comments from clinical staff, local people, commissioners and the Trust's Governors. These priorities will be addressed later in the Quality Account. Our staff continue to work hard to provide excellent standards of care and review and develop new ways of improving the experience of our patients. On behalf of the Board, I thank them for all their efforts in 2010/2011 and recognise the significant contribution that they will make in the future.

To the best of my knowledge the information in this document is accurate.

Peter Hill
Interim Chief Executive
6 June 2011

On behalf of the
Trust Board
June 2011




PART TWO

How we have prioritised our quality improvement initiatives

Our 2010/11 priorities as published in the last Quality Account were:

Priority 1
Continue to improve the in-hospital mortality rate to bring the Trust within the best performing hospitals in the country

Priority 2
Ensure patients privacy and dignity is maintained during their stay, and improve responsiveness to their needs

Priority 3
Reduce the average length of stay for all inpatients by 10%

Priority 4
Increase the percentage of patients who rate the quality of care they received in the hospital as good or better

Priority 5
Enforce zero tolerance for MRSA and Clostridium Difficile infection rates

Looking forward to 2011/2012, we have used a wide range of methods to gather information and determine our priority areas. This includes results from national patient surveys, real time patient feedback from wards, and comments, compliments and concerns made through our Customer Care Department, alongside the 'frequent feedback card' responses. We also used risk reports and issues raised by staff during the Executive led safety and Quality walk rounds. Priorities have also been discussed with clinical teams as part of the service planning process and directorate quality meetings. Having identified a number of areas we have then gathered views from our Foundation Trust Governors and staff and taken a number of opportunities to engage with local people through membership meetings and focus groups, before making our final choice. Local GPs and other external stakeholders have also been asked for their suggestions of where the organisation should focus its improvement work. A number of their comments and suggestions are included in this report.

The Trust Board has agreed that while good progress was made on last year's priorities, further improvements can be made and additional work areas have been identified. A number of these work areas complement our CQUIN scheme (Commissioning for Quality and Innovation) and support the Care Quality Commission (CQC) regulations. The Board is, therefore, committed to achieving the following priorities.

Although the priority areas remain the same or very similar to 2010/11, the work to support them is different. The priority areas are of equal importance.

Our selected priorities and proposed initiatives for 2011/2012 are:

Priority 1
Continue to improve the quality of end of life care for patients.

Priority 2
Ensure patients' privacy and dignity is maintained during their stay and improve responsiveness to their needs.

Priority 3
Further reduce the average length of stay for all inpatients by 10%.

Priority 4
Increase the percentage of patients who rate the quality of care they received in the hospital as very good or better.

Priority 5
Continue to keep patients safe during their stay in hospital.

Progress in these priority areas will be monitored through the Trust's clinical governance framework. The selected quality metrics will be reported through the quality indicator report, which is published every month for the Trust Board and Clinical Management Board.

Work is currently underway to ensure this report is published on the Trust's website for our members and the public.

Both the Medical Director and Director of Nursing and Operations lead in these priority areas.




PRIORITY ONE

CONTINUE TO IMPROVE THE END OF LIFE CARE FOR PATIENTS

Description of issue and rationale for prioritising

In the two previous Quality Accounts we have aimed to reduce the 'in house mortality rate' and have monitored the Trust HSMR (Hospital Standardised Mortality Ratio) and the actual number of deaths.

HSMR is an indicator of healthcare quality and safety that measures whether the death rate at a hospital is higher or lower than you would expect. The average for all Trusts across the country is an HSMR of 100. So an HSMR under 100 is better than average. Our latest HSMR is 97, so better than expected. A new national measure is likely to be agreed shortly; called Summary Hospital-level Mortality Indicator (SHMIs). The indicator will be able to be used by hospitals to help them better understand trends associated with patient deaths. We will adopt this new measure once agreed.

As well as reducing mortality rates, our patients and carers have told us that it is equally important to ensure high quality care during the 'end of life' stage – that patient's choices are listened to and that carers / family are kept fully informed and involved.

What did we do last year to support this improvement?

Work continued with End of Life Care. We undertook a survey which looked at staff training needs and also completed a clinical audit into use of 'care of the dying' pathway.

The Trust continued to focus on improving patient safety and the mortality rate further.

- Our work on Venous Thrombo-Embolism (VTE) continued. The Trust is a national exemplar site for VTE and has continued to work hard on all aspects of VTE prevention. The number of patients undergoing a full assessment for their risk of VTE increased to 91% in March 2011 from our rate at this time last year of 72%.

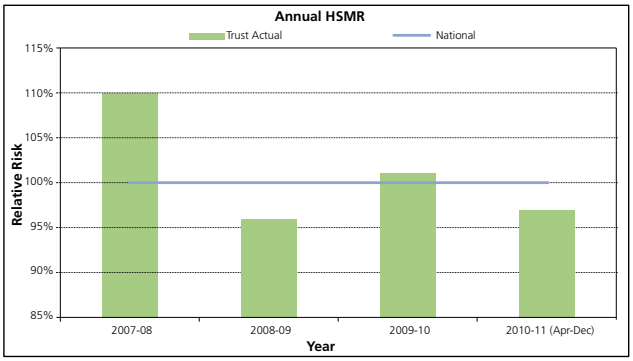
- The stroke team began using the new Trust mortality review tool in August. This tool provides structure for the review of deaths and it provides the team and the Trust with a summary of causes of death, events leading up to and contributing to death, quality indicators of caring for the dying and learning points.

We continued with our Patient Safety project. The Patient Safety Project has an overarching aim of reducing the hospital mortality rate further through several pieces of work:

- Executive Safety Walk Rounds continued throughout the year. An Executive Director visited a different department (clinical and non clinical) each week to discuss safety issues with staff.
- We continued to carry out monthly reviews of notes to identify what was causing harm to patients whilst in hospital. During 2009, this information showed us that we should focus on improving nutrition and the avoidance of pressure ulcers. You will read later on in the report (Priority 4) that we have made improvements in both these areas and the work continues as we want to achieve even more. We continue to use the information from the notes reviews to improve practice and in 2010 we have identified that we want to reduce the number of urinary tract infections that patients acquire after having a catheter inserted. This work is being tested in the Intensive Care Unit and will continue into 2011(see Priority 5).
- Safety briefings have been introduced into all inpatient ward areas. These short briefings between nursing staff identify which patients are most at risk of falls, developing pressure ulcers, or deterioration due to their condition.
- Practices to reduce infection rates (care bundles) have been sustained within the Intensive Care Unit who have had no reported MRSA bacteraemias during 2010/11.
- The same care bundles are now also being introduced into the wards and we shall continue to implement them across all ward areas during 2011.
- In the operating theatres we continued to ensure that the World Health Organisation Safe Surgery Checklist was in place for all operations.
- During 2010 we implemented some changes in practice to reduce surgical wound infections (surgical site infection care bundle). This work continues and will be spread to all theatres during 2011.
- Those who are leading on the patient safety project at a regional level visited the hospital in October 2010, one year into the work and provided us with a very positive report of our involvement. Some of the things they said were: *'Salisbury has a well deserved reputation for striving to deliver quality care', 'great progress in many of the interventions,' 'the Trust is embedding safety in its operational work' and 'clear visible effective leadership of the programme'.*




Current Status



HSMR per year from 2007/08 to 2010/11

What have our patients/public told us

'thank you ……last days as comfortable as possible with such patience and kindness'

' because my father was old …was not treated with dignity …there is a person inside the body …'

What will we do in 2011/2012?

We will ensure that the needs of our dying patients are met. We will also make sure that the treatment we provide is based on reliable clinical evidence. We want to focus on patients who are admitted, having suffered a stroke or a broken hip as these are particularly vulnerable groups.

- We will continue to roll out the mortality review tool to all clinical teams in the Trust. We will work with the teams to ensure that any lessons are shared across the Trust
- Quality indicator reports for stroke and fractured hip services will continue to be developed and used to agree improvement work.
- An education programme for staff will be developed and implemented to ensure that staff are confident in breaking bad news to patients and carers, symptom control including pain management is consistent and that patients and carers feel involved in their care and decisions about them
- We will develop an effective way of identifying the patient's preferred place of care and death and take action on this including procedures to discharge the patient in a safe, timely manner if required.

How will we report progress throughout the year?

The Trust End of Life Steering group and Mortality Working group will monitor the progress with this work regularly and report to the Clinical Management Board every three months and to the Clinical Governance Committee annually.

PRIORITY TWO

ENSURE PATIENTS PRIVACY AND DIGNITY IS MAINTAINED DURING THEIR STAY AND IMPROVE RESPONSIVENESS TO THE NEEDS OF PATIENTS

Description of issue and rationale for prioritising

Our patients expect to be treated with dignity and respect. They should also be able to expect services which are responsive to their needs. Patients and local GPs have told us that the care of patients with dementia is of particular concern, especially where this relates to medications and nutrition. The Trust's results in the national audit also show that there is room for improvement, and so we will focus on this patient group.

During 2010, the Clinical Governance Committee heard a story from a mother whose son has learning disabilities. This covered the experience she and her son had had at the Trust. The Trust is aware that the experience of patients with learning disabilities and mental health issues could be improved, so we need to work harder on this area.

What did we do last year to support this improvement?

Last year we undertook a total of 26 quality walks across the Trust in wards and outpatient departments. One outcome from these walks was that we introduced the 'just visiting' website for relatives and carers to use. This helps loved ones and friends stay in touch and be kept up-to-date on their relative / friends progress.

The Trust is one of five Trusts participating in the Kings Fund Hospital Pathways Programme. This is an ambitious programme that sets out to transform the care of patients in two care pathways, ensuring it is reliably excellent in terms of safety, clinical effectiveness, patient centeredness, timeliness and efficiency as assessed by patients themselves. This can be seen in the following examples:

- The orthopaedic team have been focusing on the needs of dementia patients after a hip fracture. Staff have attended dementia training workshops. The changes they have made so far include starting daily activities with OT and physio support. Patients are encouraged to eat and socialise together in a new dining area. A patient surveyed during Real Time Feedback said "Excellent staff. Good use of the seating area for physio sessions and having meals with the other patients."

- The Cardiology Team have been focusing on care for patients with Ischaemic heart disease. Changes they have made as a result of feedback from a focus group of patients include better information boards and reducing the number of times patients need to undress during outpatient tests.

Daily monitoring of same sex accommodation continued. The majority of our patients did not share a sleeping area with a member of the opposite sex, but for the few that did, action was taken to ensure that this was for the shortest possible time. We had particular difficulties avoiding mixed sex accommodation in the Stroke Unit and the Medial Assessment Unit and work continues to improve this.

What have our patients/public told us

Real Time feedback during the year showed that 92% of patients felt they were treated with dignity and respect (89.5% on 2009)

What will we do in 2011/2012?

We will put the following pieces of work in place that will help our staff deliver the quality of care they would want for themselves and their family. We are committed to ensuring all our patients have a positive experience of our services.

- We will continue to eliminate mixed Sex Accommodation – both with changes in the physical structure of some areas, such as the Medical Assessment Unit, and continuing to work with staff on possible solutions
- We will continue the improvements already made with the Kings Fund Hospitals Pathways Programme in orthopaedics and cardiology
- We will work on the action plan which was developed following the regional learning disability peer review. This includes an increase in staff training and the launch of a patient passport system.
- We will implement staff training on mental health needs, including Mental Capacity Act and 'best interests'
- We will complete a self assessment of dementia care against best practice guidance, and develop and implement actions to make improvements in this area. This will include introduction of the ' this is me' document for people with dementia and more involvement of relatives and carers in mealtimes.

How will we report progress throughout the year?

The Dementia Steering Group and Learning Disabilities Working Group will monitor the work. The Clinical Management Board (CMB) and the Clinical Governance Committee will receive reports every three months

Current Status

National Inpatient Survey Questions	2008	2009	2010
Were you involved as much as you wanted to be in decisions about your care and treatment?	56%	51%	54%
During your stay in hospital, did you ever share a room or bay with patients of the opposite sex	18%	14%	11%
Were you given enough privacy when discussing your condition or treatment	74%	72%	72%
Did you find someone on the hospital staff to talk to about your worries or fears	36%	33%	40%
Overall, did you feel you were treated with respect and dignity while you were in hospital	81%	80%	81%

Source: Percentage scores for the national inpatient survey results 2008-2010




PRIORITY THREE

REDUCE THE AVERAGE LENGTH OF STAY FOR ALL INPATIENTS BY 10%

Description of issue and rationale for prioritising

By comparing our figures with other similar hospitals and listening to our patients and their families, the Trust knows there is room to further reduce length of stay for patients. This is so that they do not spend unnecessary days in hospital. Reducing hospital admissions and caring for people more appropriately outside of hospital is key to delivering an efficient, high quality service. When hospital care is needed, we should minimise that time, whilst not undermining patient safety and quality of care. We can do this by improving the level of care, so that patients recover more quickly and are ready to leave hospital sooner. Nationally, there are many areas of good practice that we can implement here.

What did we do last year to support this improvement?

As part of our Right Treatment, Right Time, Right Place Programme (RTRTRP), a number of clinically led project teams have been improving the pathways of emergency patients through the hospital. The average length of stay for emergency patients has reduced from an average of 5.93 days in 2010, to 5.41 days in February 2011. Examples of the work completed to achieve this include:

- In the Emergency Department (ED) patients attending with minor injuries now complete their own medical history before discussing it with the clinician. This has reduced the time taken for paperwork to be completed.
- Nursing staff in ED and Medical Assessment Unit (MAU) now complete blood tests and order X-rays according to standard guidelines, without having to wait for a doctor. This reduces the wait for tests and investigation results so patients can be assessed and treated in a shorter time.
- Expansion of the ambulatory care assessment area on Whiteparish Medical Admissions Unit has allowed more patients to be assessed without delay in this area. By reducing the wait for tests and investigations, results can be seen and earlier decisions made by a senior doctor. This has led to more patients (about 30%) being able to go home on the day of admission without an overnight stay.
- The medical ward staff have significantly increased the number of patients referred earlier to community Neighbourhood Teams and Social Care services when needed. This has helped to reduce the delay for patients discharged with community support.
- The nurses in charge of the wards and the Site/Bed Management Team meet briefly at 11.00 every day to plan the movement of the right patients from the admissions areas to the right wards. The Discharge Centre Nurse attends to ensure suitable patients are cared for in the centre, freeing up beds earlier for new patients.
- Multidisciplinary whiteboard meetings are now in place on all medical and orthopaedic wards, greatly improving the communication between the team looking after the patients.
- The elderly care wards have introduced a 'Rapid Rehabilitation' programme for patients who will benefit from intensive input from therapists which would enable them to leave hospital sooner.

In addition to the work on our emergency care pathways, we have seen improvements for patients who are undergoing planned elective procedures. We have also continued to use the 'Enhanced Recovery Programme'. This programme uses the following:

- up-to-date surgical and anaesthetic techniques;
- new approaches to preparing patients for their surgery;
- additional nursing and therapy post surgery to reduce the recovery time from surgery.

This programme started in colorectal surgery but good progress has also been made for patients undergoing surgery in plastic surgery, urology, orthopaedics and gynaecology.

We have increased the number of patients undergoing day case surgery, laparoscopic gall bladder and hernia operations

We have increased the number of patients who come into hospital on the day of surgery.

We reviewed our patient information and developed a 'Leaving hospital' booklet which focuses particular attention on medication messages, discharge advice and advice on promoting health.

We introduced an induction of labour pathway, which reduced the length of stay for mothers by a further 2.5 hours

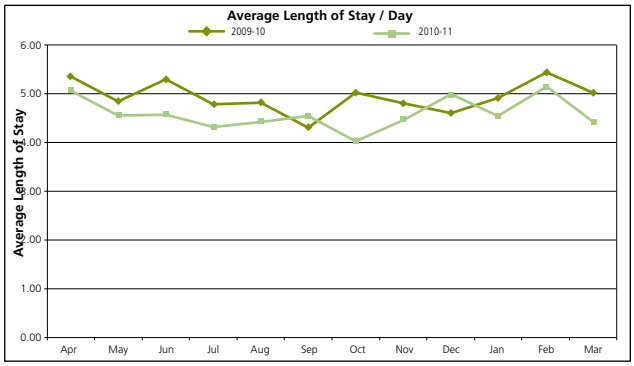
What have our patients/public told us

'Time taken to be discharged. It was not really a problem but the bed I was occupying could have been freed up sooner'

'…delayed a whole day for a scan'

'I must applaud how accurately the programme was kept to the schedule I was given'

Current Status



Average Length of Stay over time (all patients)

What will we do in 2011/2012?

We will continue to work with patients and families to implement a number of changes. This includes:

- Working with our primary and community care partners to explore alternative models and settings of care for some patients who do not need to be in an acute hospital.
- We will continue to develop the Ambulatory Emergency Care model in admission areas. This will provide patients with prompt tests, investigations and clinical assessment and reduce avoidable admissions.
- Continue to reduce unnecessary delays in patients' hospital stay.
- We will continue to develop our Discharge Team and processes, to help patients leave hospital with the right support, as soon as they are medically fit to do so.
- Develop an understanding of the reasons patients are readmitted and working to reduce avoidable readmissions.
- When patients wish to die at home, we have clear and responsive discharge processes in place to support them in their choice.
- Further roll out of the Enhanced Recovery Programme.

How will we report progress throughout the year?

Progress against length of stay, as well as a number of other objectives such as time to surgery, is monitored through the Directorate performance dashboards. Reports will be made to the Operational Management Board (OMB) twice a year.

PRIORITY FOUR

INCREASE THE PERCENTAGE OF PATIENTS WHO RATE THE QUALITY OF CARE THEY RECEIVED AS VERY GOOD OR BETTER

Description of issue and rationale for prioritising

It is important that the Trust does everything that it can to provide the best possible experience for each patient. If our patients are telling us that the quality of care is not as good as they would like, then we must identify those areas of concern and work to improve them. In the latest national inpatient survey, 81% of patients rated their care as excellent or very good (compared to 75% last year). We must continue to improve this. Patients have also told us through the national survey and real time feedback that:

- they do not always know what is going to happen to them next in their journey
- slow response to call bells and noise by other patients detracts from their experience

What did we do last year to support this improvement?

Nutrition had been identified as a key area for improvement in our last quality account -

- During 2010 the Patient Food Forum which has patient, public and Governor membership, continued to meet and work with our catering teams to inform the choice of dishes on our menus.
- Seasonal menus were implemented on a quarterly basis (part of the Department of Health 'Eat Seasonally' campaign). The amount of food sourced locally was also increased.
- A comprehensive Food and Nutrition Policy was ratified and launched
- The Food and Nutrition Working Group developed and delivered a new training programme for all grades of nursing staff on how to carry out nutritional assessment, ensure a balanced diet, care for patients with swallowing difficulties, and identify the links between good nutrition and prevention of pressure ulcers.
- Mealtime observations were commenced using the Care Quality Commission observational tool. The observation focuses on the quality of food, speed and efficiency of the food service, assistance given to those who need it, and patient assessment/ monitoring including whether staff are identifying those patients at risk of poor nutritional intake. Feedback is given to the ward immediately and good practice is being shared across departments. These observational rounds will continue through 2011.

- A review of the weighing equipment available in the Trust was conducted and as a result a replacement programme was commenced (including scales which can weigh a patient who is bed bound). Patient weight is an important part of the nutritional assessment of a patient.
- We improved the nutritional assessment of patients. An audit carried out in August 2010 showed that 88% of patients had been nutritionally assessed. This was a 4% increase from December 2009 and a 26% improvement from January 2009.

We also put a lot of work into reducing the number of patients who acquired a pressure ulcer while they were an inpatient -

- We reduced the number of grade 3&4 pressure ulcers from 58 to 19, but with 19 ulcers occurring in the hospital this year, more work is still required. This will be taken forward under Priority 5, which is 'Continue to keep patients safe during their stay in hospital'.
- Inpatient areas continue with completing the Productive Ward modules. A significant amount of this the work has linked in with the Patient Safety Programme & RTRTRP. All adult wards now have 'Bedside Handovers' which includes a Safety Briefing. Most wards have implemented changes to their Medicine Rounds & Meals processes.

What have our patients/public told us

'….I found the attitude of the staff was excellent'

'…except for a couple of staff, everyone was fantastic.'

'…some nurses don't seem to care anymore'

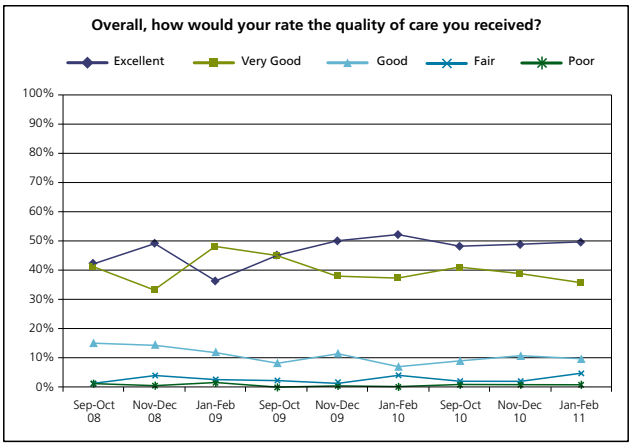
'Biggest 'grouse' …what is happening? Where are the facts?...'

'What could be better? ..information about timescales – when this would be done …timescales were a little vague'

"The response to the call bell has been very variable (up to 15 minutes).

'very disturbed by noise at night from other patients and staff …'

Current Status



Real time feedback is a method used in the Trust where current inpatients are asked a number of questions about their experience in Salisbury District Hospital (an average of 140 patients are questioned each month)

What will we do in 2011/2012?

- We will continue our work on the Productive Ward – Releasing Time to Care Programme to ensure that all wards have completed all modules. We have already seen a number of improvements across the Trust
- We will encourage relatives on all wards to discuss future plans with medical and nursing staff and staff will ensure time is made available for this
- We will make sure that relevant and appropriate information discussed and decided at the Whiteboard meetings (these are brief daily meetings held with Doctors, nurses and social workers to discuss patient progress / plans) which take place each morning is discussed with the patient.
- We have added a question to Real Time Feedback (RTF) to obtain further information regarding whether patients know what is happening now and next. This will be passed to ward leaders immediately for them to take action.
- Ward routine information will be updated so that patients know what to expect on a day to day basis
- Where patients have identified that call bells and noise at night are an issue these will be incorporated into ward action plans

How will we report progress throughout the year?

RTF is reported in the Trust Quality Indicator Report, which goes to the CMB every quarter. The other work programmes will be reported through the CMB and on to the Clinical Governance Committee. Our commissioners will also receive reports as part of our contract with them.

PRIORITY FIVE

CONTINUE TO KEEP PATIENTS SAFE DURING THEIR STAY IN HOSPITAL

The safety of our patients is the key driver in our quality improvement work. We have been actively engaged in a patient safety programme which has been co-ordinated at a regional level. This is a 5 year piece of work which is due to complete in October 2014. The overarching aims of this programme are to reduce levels of harm in hospital which we measure through things like pressure ulcer incidence, infection rates and cardiac arrest rates.

Our commissioners have told us that work on reducing the number of pressure ulcers, and the number of patients who have a fall that results in major harm, are important to them. Falls are the leading cause of accident-related deaths in older people and results in more than 60,000 broken hips nationally each year.

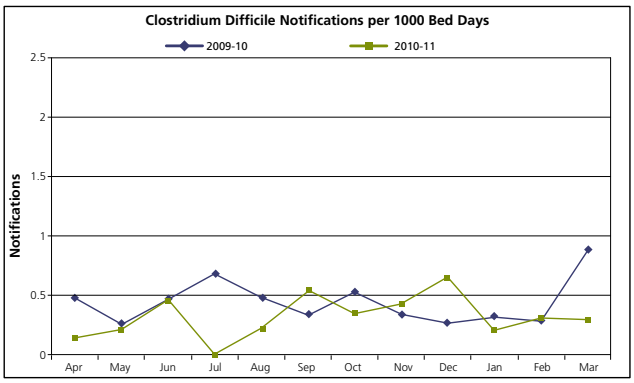
Patients continue to tell us that they want a clean hospital and that they do not want to get any infections during their stay with us. Our infection rates are below the national average - there have been no hospital apportioned MRSA bacteraemia in 2010/11 and a continued downward trend with C Difficile rates. However, the focus needs to remain on this important area.

What did we do last year to support this improvement?

- We reduced our number of clostridium difficile cases from 54 in 2009/10 to 52 in 2010/11.
- We had no hospital apportioned cases of MRSA bacteraemia during the reported year.
- We continued the emphasis on hand washing through the Clean Your Hands Campaign with ward based audits of hand washing occurring every month as a minimum. Since July 2010 compliance has achieved 95% or above trust wide.
- We continued the three times a week infection prevention and control update meetings covering every aspect of cleanliness (including the environment), practice (hand washing, uniform and work wear policy) and the management of infection across the site.
- We continued to monitor antibiotic prescribing practices across all specialities with an established rolling audit programme to maintain appropriate practice.
- We continued to monitor cleaning standards through Credits for Cleaning audit programme.
- We continued to monitor all aspects of infection control, practices and cleanliness through the Matrons Monitoring meeting.

What have our patients/public told us

Clostridium Difficile Rates



Current Status

Number of Hospital acquired MRSA Bacteraemia Notifications MRSA

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2008-09	0	1	0	1	0	0	0	0	0	2	0	1
2009-10	1	0	1	0	1	0	1	0	0	0	0	1
2010-11	0	0	0	0	0	0	0	0	0	0	0	0




What will we do in 2011/2012?

We will work with staff, patients and visitors to continue our safety work.

- We will continue with our Patient Safety project which has key areas of work aimed at improvement in:
  - o Leadership for Safety
  - o Reducing Harm in Critical Care – which we will expand to include the introduction of urinary catheter care bundle with the aim of reducing urinary tract infections.
  - o Reducing Harm in Perioperative Care (Theatres)
  - o Reducing Harm in General Wards – which we will expand to include work on reducing the number of patient falls which result in major harm (e.g. fractures), reducing the number of pressure ulcers, and reducing the number of urinary tract infections in patients with a catheter.
  - o Reducing Harm from High Risk Medicines (with particular focus on warfarin and insulin)

We will work with staff, patients and visitors to maintain high standards of infection prevention and control in the following ways:

- Complete the Bedpan Washer Replacement and Dirty Utility Room (sluice) Upgrade Programme for every inpatient area, and review outpatient areas, including areas with macerators.
- Continue to review Trust infection prevention and control policies to ensure the Trust remains compliant with current best practice.
- Continue to reduce our infection rates, particularly related to peripheral vascular lines, through the implementation of care bundles
- Continue to monitor hygiene standards (e.g. environmental and equipment cleanliness), using real time objective measurement via the ATP monitoring system (this monitors the effectiveness of our cleaning regimes, it will detect if there are any microorganisms etc.)

We will continue to focus on the importance of nutrition in the following ways:

- We will maintain baby friendly status in family services.
- We will continue to improve on nutritional assessment in adults and ensure that those patients who are at risk receive the specialist input required.
- We will also improve the mealtime experience by learning from the observational rounds and what patients are telling us in order to optimise nutritional intake.

How will we report progress throughout the year?

Infection control, VTE, falls resulting in major harm and pressure ulcers are reported in the Trust Quality Indicator Report, which goes to the Trust Board monthly. The Nutrition Steering Group will monitor progress with all nutrition work. The Safety Steering Group receives monthly reports on the safety work streams. Our commissioners will also receive reports as part of our contract with them.

Review of Services

During 2010/2011 Salisbury NHS Foundation Trust provided and/or subcontracted forty four NHS services*. Salisbury NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS Services reviewed in 2010/2011 represents 92% of the total income generated from the provision of NHS services by Salisbury NHS Foundation Trust for 2010/2011. *The services have been defined from ' service line reporting'

During the year, our Facilities Directorate (encompasses laundry, portering, catering , cleaning services) also reviewed all services with the assistance of an external advisor.

The Trust has established a quality framework for the review of individual services which includes completion of the Salisbury organisation trigger tool as well as full review and analysis of the quality information available – this includes the directorate quality indicator report, clinical audit results, patient feedback from surveys, real time feedback, complaints and compliments, as well as risk reporting. This information is discussed at the quarterly Directorate quality meetings, department / ward quality walks and is presented annually by the Directorate Management teams as part of the assurance process to the Clinical Governance Committee.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the Clinical Management Board (CMB) or Clinical Governance Committee (CGC), and where appropriate, being submitted to the commissioners as part of the Trust contract performance compliance.

Any external agency / peer reviews during the year have the reports, recommendations and action plans discussed at one of the assuring committees. For example, the diabetic retinopathy service was reviewed as part of the national review process this year and the subsequent report and recommendations have been discussed at the Clinical Governance Committee.

Areas where problems have been identified through this approach, have taken action, which is then monitored through the Trust 3:3 performance management framework. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or future Quality Account priority areas.




Participation in Clinical Audits

During 2010/2011, 42 national audits (of which 20 are ongoing datasets) and 5 national confidential enquiries covered NHS services that Salisbury NHS Foundation Trust provides.

During that period, Salisbury NHS Foundation Trust participated in (35/42) 83% national clinical audits, and (5/5)100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust was eligible to participate in during 2010/2011 are listed in the table below.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2010/2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audits	Eligible	Participation	% of cases submitted to each audit
NCEPOD			
NCEPOD 'An age old problem: a review of the care received by elderly patients undergoing surgery'	Yes	Yes	100
NCEPOD: Paediatric surgery	Yes	Yes	100
NCEPOD: Peri-operative care	Yes	Yes	100
NCEPOD: Cardiac Arrest Procedures	Yes	Yes	100
CEMACH: perinatal mortality	Yes	Yes	100
National Audits - using a sample of patients			
National Kidney Care Audit (2 days)	No	n/a	n/a
National Sentinel Stroke Audit (n=40-60)	Yes	Yes	100
National Audit of Dementia: dementia care (n=40)	Yes	Yes	100
National Falls and Bone Health Audit (n=60)	Yes	Yes	100
POMH: prescribing topics in mental health services	No	n/a	n/a
National Comparative Audit of Blood Transfusion: O negative use	Yes	Yes	100
National Comparative Audit of Blood Transfusion: Platelets	Yes	Yes	100
British Thoracic Society: Pleural procedures	Yes	Yes	100
British Thoracic Society: COPD	Yes	Yes	100
British Thoracic Society: Paediatric pneumonia	Yes	No	n/a
British Thoracic Society: Paediatric asthma	Yes	No	n/a
British Thoracic Society: Adult Community Acquired Pneumonia	Yes	No	n/a
British Thoracic Society: Adult Asthma	Yes	Yes	100
British Thoracic Society: Bronchiectisis	Yes	No	Plan to start in 2011
British Thoracic Society: Non Invasive Ventilation	Yes	Yes	100
British Thoracic Society: Emergency Oxygen	Yes	Yes	100
College of Emergency Medicine: Paediatric fever	Yes	Yes	100
College of Emergency Medicine: Vital signs in Majors	Yes	Yes	100
College of Emergency Medicine: Renal colic	Yes	Yes	100
National Clinical Audit of Familial Hypercholesterolaemia	Yes	Yes	100
National Inflammatory Bowel disease Ulcerative colitis and Crohn's disease	Yes	Yes	100
Parkinson's UK: National Parkinson's Audit	Yes	No	n/a
National audit of Pharmacological treatment of Schizophrenia	No	n/a	n/a

Audits	Eligible	Participation	% of cases submitted to each audit
Health promotion in hospitals	Yes	Yes	100
National paediatric diabetic audit	Yes	Yes	100
Continuous audits / datasets (consecutive patients)			
NNAP: neonatal care	Yes	Yes	100
NDA: National Diabetes Audit	Yes	Yes	100
National Elective Surgery PROMs: four operations*	Yes	Yes	Variable across 4 procedures
NIAP: Adult cardiac interventions: coronary angioplasty	No	n/a	Service started April 2011, will now commence
Congenital Heart Disease: Paediatric cardiac surgery	No	n/a	n/a
Adult cardiac surgery: CABG and valvular surgery	No	n/a	n/a
Renal Registry: renal replacement therapy	No	n/a	n/a
Pulmonary Hypertension Audit	No	n/a	n/a
NHS Blood & Transplant registry: intra-thoracic;	No	n/a	n/a
cardiothoracic and liver			
ICNARC CMPD: adult critical care units	Yes	Yes	100
NJR: hip, knee and ankle replacements	Yes	Yes	100
NCAA – Cardiac arrest audit	Yes	No	Ongoing local audit as part of safety work stream
PICAnet – Paediatric intensive care	No	n/a	n/a
NLCA: lung cancer	Yes	Yes	100
NBOCAP: bowel cancer	Yes	Yes	100
DAHNO: head and neck cancer	Yes	Yes	100
MINAP (inc ambulance care): AMI & other ACS	Yes	Yes	100
Heart Failure Audit	Yes	Yes	100
NHFD: hip fracture	Yes	Yes	100
TARN: severe trauma	Yes	Yes	10% data input difficulties due to staffing – resolved Feb 2010
NHS Blood & Transplant: potential donor audit	Yes	Yes	100
National Vascular Database – peripheral vascular surgery	Yes	Yes	100
National audit of schizophrenia	No	n/a	n/a
National pain database audit – chronic pain service	Yes	Yes	100
National childhood epilepsy audit (Epilepsy12)	Yes	Yes	100
National audit of heavy menstrual bleeding	Yes	Yes	100
SINAP – acute stroke	Yes	No	Stroke Network decision
Carotid intervention	Yes	Yes	100

The reports of twelve published national clinical audits were reviewed by Salisbury NHS Foundation Trust in 2010/2011. Of these twelve, 6 were formally reported to the Clinical Management Board (CMB) by the clinical lead responsible for implementing changes in practice and Salisbury NHS foundation Trust intends to take the following actions to improve the quality of healthcare provided.




Reviewing of reports published during 2010 and examples of resulting action taken by Salisbury NHS Foundation Trust

Audit Report	Reviewed By whom	Action required to improve
NCEPOD – 'Caring to the end'	Mortality Group and CMB	The Trust has reviewed the Consultant cover at weekends and implemented an 'on line' mortality reporting system that provides structure for the review of mortalities - the output provides the team and Trust with a summary including causes and quality indicators of caring for the dying as well as learning points
NCEPOD 'An age old problem: a review of the care received by elderly patients undergoing surgery'	In January by the CMB and a review of action plans was made at the March CMB	Medical staffing committee agreed a Consultant Orthopaedic MFOP post funded by Medical Directorate in Jan 11
NCEPOD – Parenteral nutrition	Nutrition Steering Group	Agreed guidance around parenteral nutrition, including who can prescribe it e.g. gastro and ITU only so that we ensure most up to date best practice. Implementing central line care bundles across all ward areas where parenteral nutrition may be administered
Mastectomy	In November by the CMB	Patient information being developed
RCP Continence Care	In December by the CMB	Continence assessment tool being redeveloped
Dementia	In February by the CMB	Learning programme put in place for all staff. Quality indicators for dementia added to existing indicator report for Trust Board.
NHFD – hip fracture	In December by the CMB	Additional trauma list made available

The Trust expects to formally review all national audits at the CMB within 2 months of publication. This gives the clinical team's time to discuss the findings and to develop an action plan which is presented to the CMB for approval and support

- Action plans have been developed for all national audits and confidential enquiries published during the year. Monitoring of these actions are through the 3:3 performance structure or through designated working groups, for example with the dementia audit action plan is being monitored by the dementia strategy group.

The reports of 130 of 290 local clinical audits were reviewed by the provider in 2010/2011 and Salisbury NHS Foundation Trust intends to take the following actions to improve the quality of healthcare.

- Reports of all clinical audit results that indicate a risk to patients or the organisation are reported to the clinical risk group. In the past year, nine audits have gone to the risk group for review – examples of work undertaken to improve practice include piloting a change in the prescribing of oxygen.




- All infection control audit reports were approved by the Infection Prevention & Control Working Group, and presented to the Infection Prevention & Control Committee (IPCC). Compliance with these standards is high.
- Ward based audits based on 'essence of care' areas such as nutrition, communication, privacy and dignity were undertaken - these audit reports were reviewed by the nursing and midwifery forum and a number of changes have been made including the introduction of ' intentional rounding'. This is where a patient who is identified as high risk of falls is reviewed by a nurse every hour to ensure that their needs are met and avoid them getting out of their bed/chair to carry out a task themselves.
- 50 audits were undertaken by the maternity service to support the NHSLA (NHS Litigation Authority) standards – NHSLA level 2 was maintained
- Other audit results / reports are reviewed by the Head of Clinical Governance and comments, suggestions for change or further dissemination of results are returned to the authors as well as a suggested re-audit timescale as appropriate

Salisbury NHS Foundation Trust participates in a number of audits that are not on the national clinical audit advisory group list and these have been included in the table above. This activity is in line with the Trust's annual clinical audit programme which aims to ensure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines. This enables the Trust to benchmark their performance against others nationally and to determine the focus of improvement programmes. The annual program also includes a number of audits agreed as part of the contracts with Commissioners.

Research

The number of patients receiving NHS services provided by Salisbury NHS Foundation Trust in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 339. This compares to 409 last year.*

This level of participation in clinical research demonstrates Salisbury's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

* End of year recruitment figures will not be finalised until later in the year. Please note that last years account stated 197 patients recruited to trials but this increased to 409 once full year figures validated later in year

Goals Agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust's income in 2010/2011 was conditional upon achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the commissioning for quality and innovation payment framework (CQUIN). The planned income through this route for 2010/2011 was £1,902.00. The amount received was £325,000, which was less than the planned amount for the reasons below.

There has been no CQUIN contract signed with the lead Commissioner during 2010/11 due to ongoing difficulties accessing the gateway indicators, which required every national and south west target to be met with any single failure wiping out CQUIN payment for the whole year. However, a CQUIN contract was agreed with NHS Hampshire and payment achieved through this for achieving the quality improvements as set out in the table on page 60. The Trust is currently having positive discussions to agree a CQUIN for 2011/12 and are confident that the gateway to access the funds is achievable and appropriate. Further details of the agreed goals for 2010/2011 and for the following 12 month period are available from the Finance Department, Salisbury NHS Foundation Trust, Salisbury District Hospital, SP2 8BJ.

Care Quality Commission (CQC) Registration

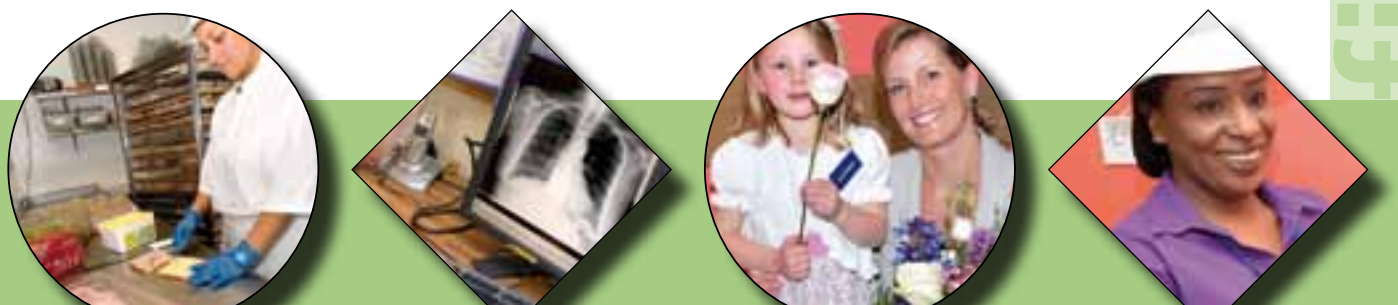
Salisbury NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional registration

The Care Quality Commission has not taken enforcement action against Salisbury NHS Foundation Trust during 2010/11.

Salisbury NHS Foundation Trust is not subject to periodic review by the Care Quality Commission.

Data Quality

Like all public services, Salisbury NHS Foundation Trust needs reliable, accurate and timely information to manage its services and account for its performance. Good information allows the Trust to make evidence based judgements about effectiveness, responsiveness and efficiency, and enables it to prioritise and plan effectively for the future.



CQUIN Indicators (Hampshire)		Domain	Target 10/11	Performance
1	Venous-thromboembolism (VTE) prevention - Reduce avoidable death, disability and chronic ill health from VTE	Safety	90%	Fully Achieved
2	Improve responsiveness to personal needs of patients	Patient Experience	Mean score improvement of 8 (73.4 and above)	Partially Achieved Mean score improvement 3
3	Pressure ulcers - A demonstrable reduction in the number of patients with preventable pressure ulcers by 2012.	Safety	25% reduction in 09/10 – baseline 19 ulcers	Fully Achieved
4	End of Life Care - to improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice	Safety Outcomes Experience	40% staff receive training outlined in training needs analysis 25% of patients who died were on LCP (Liverpool Care Pathway)	Fully Achieved Fully Achieved
5	Enhanced Recovery - Enhanced Recovery Programmes (ERPs) provide improved patient experience and clinical outcomes, improved staff experience, reduced length of stay (LoS) and improved waiting times.	Safety	90% patients admitted for a hysterectomy had an enhanced recovery programme experience Hip replacement ERP achievement of milestones towards implementation in 2011/2012	Fully Achieved Fully Achieved
6	Staying Healthy - Reduction in smoking prevalence and increasing smokers accessing specialist "Stop Smoking" services prior to elective treatment	Effectiveness	95% of adult patients who smoke have received smoking cessation advice prior to elective treatment; and antenatal booking	Fully Achieved
7	Maternity Care - Increase in the number of normal births and eliminate unnecessary Caesarean sections	Effectiveness	Caesarean rate <24%	Partially Achieved 24.6%

To this end the Trust runs a Data Quality Service that approaches this issue with the aim of ensuring staff record clinical and administrative information right first time round. This is achieved by :

Spending time considering the process of data collection – ie: does the correct person have the correct information about the care given, and has this person received the appropriate training to ensure accurate recording of the data captured.

Spending time working with clinicians and administrative staff to demonstrate errors made – achieved through use of automatic electronic data quality reports, and relevant reporting to leadership in the Trust about the volumes and types of errors captured.

Reporting and improving error rates – through local monitoring; through use of external audit; and through use of national benchmarking tools.




The use of these techniques give the Trust assurance that the information regarding quality of care given is an accurate representation of performance.

Salisbury NHS Foundation Trust submitted records during 2010/2011 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:
98.8% for admitted care (nationally 98.4%)
99.1% for outpatient care (nationally 98.8%)
96.3% for accident and emergency care (nationally 91.6%)

And which included the patients valid General Medical Practice Code was:
100% for admitted care (nationally 99.8%)
100% for outpatient care (nationally 99.8%)
100% for accident and emergency care (nationally 99.7%)

Information Governance Toolkit Attainment Levels

The Trust scored 79% in the Information Governance Toolkit Assessment which is one of the higher scores amongst hospitals in the South West Region. It achieved the necessary standard for all areas assessed, except two relating to corporate records management and information security. However, in order to secure a satisfactory rating, Trusts must achieve all the standards.

Clinical Coding Error Rate

The Payment by Results (PbR) Data Assurance Framework supports the improvement of data quality by auditing clinical coding for admitted patient care which underpins payments and financial flows within the NHS.

The Trust's performance in 2009/10 in terms of accurate HRG assignment was deemed to be excellent compared with the overall performance of trusts in 2008/09 and put Salisbury in the top 25% of Trusts for coding accuracy (see table at the foot of the page).

Due to the high levels of coding accuracy attained in 2009/10 Salisbury NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11.

The following areas were audited:
2009/2010:
General medicine
Plastics
Endoscopies
Neonatal

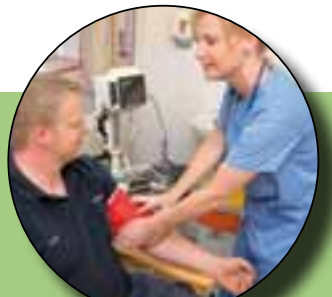
PART THREE

Review of Quality Performance

Performance of Trust against selected measures
We have chosen to measure our performance against the following metrics. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them e.g. cleanliness and infection control. Our commissioners measure our stroke performance, the SHA are driving the safety programme and our CQUIN contract supports a number of these measures. These indicators are included in the monthly quality indicator report that is presented to the Board and Clinical Governance Committee.

	Salisbury NHS FT		2009 National Average
	2009/2010	2010/2011	
Primary diagnosis incorrect	4.4%	N/A	13.1%
Secondary diagnosis incorrect	3.0%	N/A	14.1%
Primary procedures incorrect	4.7%	N/A	11.2%
Secondary procedures incorrect	4.5%	N/A	12.7%

Due to the targeted nature of the audit these results can not be extrapolated further than the actual sample audited.




Patient Safety Indicators						
	2008/09	**2009/10**	**2010/11**	**National Average**	**What does this mean?**	**Source of metric**
1. Mortality rate (HSMR)*	96	101	97	100 (2010/2011)	Lower than 100 good	Based on the national definition through Dr Foster of Hospital Standardised Mortality Rate
2. MRSA notifications**	0 (5)	0 (5)	0 (5)	Not available	0 is excellent	National definition
3. Patients with C. Difficile infection / 1,000 bed days	0.3	0.45	0.32	1.2	Lower than 1.2 is excellent	National definition
4. Global Trigger / Adverse events Rates	44 (Average)	42 (Average)	33 (up to 31st Jan)	Not available	Lower score better	Definition based on Patient Safety First Campaign
5. 'Never Events' that occur within the Trust. For instance, National Patient Safety Agency examples include operations that take place on the wrong part of the body.	0	0	2 (These were associated with surgery and were promptly identified and rectified with no long term harm)	Not available	0 is good	Definition from National Patient Safety Agency
6. Falls resulting in major harm	Not measured	24	21	Not available	Low number good	Definition from National Patient Safety Agency
Clinical Effectiveness Indicators						
7. Patients having surgery within 36 hours of admission with fracture neck of femur (hip)***	60%	75%	80%	Not available	Higher number better	Based on national definition with data taken from hospital systems and national databases
8. % of patients who have a risk assessment for VTE (venous thrombo embolism)	57%	72%	91%	Not available	Higher number better	Based on national definition with data taken from hospital systems and national databases
9. % patients who have a CT scan within 24 hours of admission with a stroke	56%	89%	90%	Not available	Higher number better	Based on national definition with data taken from hospital systems and national databases




	2008/09	2009/10	2010/11	National Average	What does this mean?	Source of metric
10. Compliance with NICE Technology Appraisal Guidance (TAG) published in year	83%	92%	80%	Not Measured	Higher number better	Local indicator
Patient Experience Indicators						
11. Number of patients reported with pressure ulcers (grade 3 &4)	45	58	19	Not available	Lower is better	National definition with data taken from hospital reporting systems
12. % of patients stating the quality of care was very good or better	80%	75%	81%	Not available	Higher number better	Data taken from national inpatient survey
13. % of patients in mixed sex accommodation	19%	14%	11%	Not available	Lower number better	Data taken from national inpatient survey
14. % of patients who stated they had enough help from staff to eat their meals	60%	55%	67%	Not available	Higher number better	Data taken from national inpatient survey
15. % of patients who thought the hospital was clean	61%	65%	66%	Not available	Higher number better	Data taken from national inpatient survey
16. % of patients who would recommend the hospital to a family or friend	82%	86%	88%	Not Measured	Higher number better	Data taken from Trust real time feedback system

Notes on recommended metrics:

*** This number has changed from the previous quality report as the HSMR is constantly updated. The Trust previously reported a three-year Hospital Standardised Mortality Rate (HSMR). The Trust now reports a one-year HSMR. Please note that for 2010/2011 the latest figure is quoted.**

**** In previous Annual Reports the Trust quoted Trust and non-Trust apportioned notifications as a total figure. This will have included community hospital and GP patients. This total figure is quoted in brackets in the table.**

***** This metric has changed from the previous quality report. The Trust previously reported on a target of surgery within 24 hours. The Trust now reports on a target of surgery within 36 hours.**




National Targets and Regulatory Requirements

	2008/09	2009/10	2010/11	2011/12 (Target)
Clostridium Difficile year on year reduction (From 2010/11 positive samples taken within 72 hours of admission are reported as non trust apportioned)*	73	79	52 (21 Non-Trust & 31 Trust Apportioned)	25 (Trust apportioned)
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half of the 2003/2004 level. (See explanatory notes on previous table)	2 (5)	4 (5)	0 (5)	2
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	100%	94.5%	94.7%	93%
2 Week Wait for Symptomatic Breast Patients (Cancer not initially suspected)	31.5%	89.2%	96.6%	93%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99.3%	96%	98.5%	96%
Maximum waiting time of 31 days for subsequent treatments of all cancers – anti cancer drug treatments	n/a	99.4%	100%	98%
Maximum waiting time of 31 days for subsequent treatments of all cancers - surgery	n/a	98.1%	98.5%	94%
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	96.1%	85%	92.7%	85%
62 day wait for First treatments from consultant Screening Service Referral: All Cancers	n/a	93.8%	100%	90%
For admitted patients, maximum time of 18 weeks from point of referral to treatment	90.86%	90%	94.9%	90%
For non admitted patients, maximum time of 18 weeks from point of referral to treatment	95.1%	95%	98.6%	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.2%	98.3%	97.8%	95%
People suffering heart attack to receive thrombolysis within 60 minutes of call (This target is also reliant on Ambulance Trusts performance)	46.67%	68%	42.1%	No longer monitored through compliance framework
Screening all elective inpatients for MRSA	N/A	N/A	100%	No longer monitored through compliance framework
The Trust has fully met the national core standards	24	24	Registered with CQC without conditions attached	Maintain registration with CQC without conditions attached
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Not measured	Not measured	Compliant	Maintain compliance

*** In 2008/2009 and 2009/2010 the Trust quoted total number of positive samples recorded at the hospital based on national definitions in place at the time. This included community hospital, GP patients and Trust in-patients. This is reflected in the figures above from 2008 to 2010. From 2010/2011 definition changed and this reflects the number of positive Trust in-patient cases split between Trust apportioned (over 72 hours after admission) and non-Trust apportioned (less than 72 hours of admission).**




Statements from NHS Wiltshire (coordinating PCT)

NHS Wiltshire as lead commissioner has reviewed the Quality Account produced by Salisbury NHS Foundation Trust and provided the following response:

NHS Wiltshire, as lead commissioner for Salisbury NHS Foundation Trust, is pleased to assure the Trust's second annual Quality Account. The document is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

NHS Wiltshire can confirm that we consider that the Quality Account contains accurate information in relation to the quality of services provided to the residents of Wiltshire and beyond. NHS Wiltshire is assured that Salisbury NHS Foundation Trust provides overall high quality care for patients, with dedicated, well trained, specialist staff. The trust achieves good results in national surveys of patient experience the hospital standard mortality ratio is low relative to the national average and it has achieved significant reductions in MRSA and Clostridium Difficile.

Salisbury NHS Foundation Trust provides a range of general and specialist services, and it is right that these services should aspire to make year on year improvements in the standards of care they can achieve. SFT priorities for 2011-2012 are aligned with those identified by service users and commissioners and we therefore support the Trust's aspirations in these areas. The inclusion of success measures within the Quality Account provides a gauge upon which service users, carers and commissioners can observe SFT achievements in the coming year.

NHS Wiltshire's strategy for improving health and health care services in Wiltshire, sets out clear priorities for ensuring that wherever possible patients can be looked after in their own home and that, where treatment in hospital is required, they have access to services which offer excellence in terms of clinical outcomes and patient experience. NHS Wiltshire is fully committed to continuing its close co-operation with the trust over the coming year as they fulfil their commitment to continuously improve the quality of care for our local service users, their families and carers.

Statement from Wiltshire Overview and Scrutiny Committee (coordinating OSC)

Salisbury NHS Foundation Trust invited comments on their Quality Account from the Health Overview and Scrutiny Committees (OSCS) of Wiltshire, Hampshire and Dorset Councils. As coordinating OSC, Wiltshire Overview and Scrutiny Committee provided the following response (please note that Hampshire OSC chose not to comment).

Wiltshire Council – Health & Adult Social Care Select Committee

The Health & Adult Social Care Select Committee established a 5 member Task Group to respond to the QA on its behalf. The Task Group met on 18 May to consider the QA and to formulate a response.

Task Group members feel that it is clear to see that priorities identified by the trust match those of the public as descriptions of issues and the rationale for prioritising them is clearly documented throughout the QA, along with examples of patient and public feedback and results from national patient surveys.

It is pleasing to see the level of engagement that has taken place with patients, staff and stakeholders in identifying and prioritising quality improvement initiatives such as obtaining feedback from membership meetings, focus groups, safety and quality walk rounds and through listening to patient stories at each Clinical Governance Committee.

Members do not feel that there are significant omissions of issues of concern and the content of the QA is consistent with the briefing provided to the group in February 2011.

Key issues to emerge from the briefing were in relation to infection control and pressure ulcers. In undertaking a site visit, also facilitated by representatives of the trust in February, councillors felt they could see that these were two areas clearly being addressed.

This is also reflected in the QA which outlines the reduction in the number of grade 3&4 pressure ulcers (by 25%) and the improvement in the % number of patients who thought the hospital was clean.

It was also obvious to see the measures being taken to create a safe environment for staff and patients e.g. through actions taken as part of the 'anti clutter' programme.'




Councillors welcomed the reader friendly style of the QA with its logical format, clear headings and explanations of planned activities to ensure improvements are made.

The Task Group welcomed the opportunity to consider the Quality Account and the Health & Adult Social Care Select Committee looks forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of the year.

Please note that the Task Group asked for some additional information or points of clarification to be included in the Quality Account and these have been incorporated in the final published document.

Dorset County Council – Health Scrutiny Committee

The Dorset Health Scrutiny Committee and the Dorset LINk had limited engagement with Salisbury NHS Foundation Trust during 2010/11 on the Quality Account. The Committee has always found the Trust to be helpful and have provided information when requested in both a timely manner and in an appropriate format.

Statement from Wiltshire Involvement Network (WIN)

The Wiltshire Involvement Network has reviewed the Quality Account produced by Salisbury NHS Foundation Trust and provided the following response:

Priority 1: We are pleased that the Trust will continue to improve the quality of end of life care.

Priority 2: Although the Hospital is compliant with single sex wards there are a few occasions in the Stroke Unit and the MAU when both sexes have to share, although it is noted 92% felt they were treated with dignity compared with 89% in 2009.

Priority 3: While we have no objection to reducing the length of stay by 10% care should be taken that a "too early discharge" does not lead to a later readmission.

Priority 4: We are pleased that the Hospital has a Food Forum (which WIN takes part in) and that all the food is cooked on site and fresh vegetables are used. We are pleased that there has been an improvement of nutritional assessment of patients.

Priority 5: We are pleased that MRSA and C-diff remains low in the Hospital which we feel is mainly down to the fact that cleaning is done in house and should remain so and that "mini" PEAT Inspections should continue throughout the year.

How to provide feedback

All feedback is welcomed and the Trust listens to these concerns and steps are taken to address individual issues at the time. Comments are also used to improve services and directly influence projects and initiatives being put in place by the Trust.

Statements of Director's Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 18th May 2011
- Feedback from governors dated 28 April 2011
- Feedback from LINks dated 24th May 2011




- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, presented to the Trust Board dated: 12 April 2010, 7 June 2010, 4 October 2010, 7 February 2011 and 4 April 2011

- The national patient survey dated 21 April 2011

- The national staff survey dated16 March 2011

- The Head of Internal Audit's annual opinion over the trust's control environment dated 20 April 2011

- CQC quality and risk profiles. Presented to the Trust Board dated : 6 December 2010

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Luke March
Chairman
6 June 2011

Peter Hill
Interim Chief Executive
6 June 2011

Independent Assurance Report to the Council of Governors of Salisbury NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of Salisbury NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Salisbury NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addressed the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the Commissioners dated 18 May 2011
- Feedback from Governors dated 28 April 2011
- Feedback from LINKS dated 24 May 2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, presented to the Trust Board dated 12 April 2010, 7 June 2010, 4 October 2010, 7 February 2011 and 4 April 2011
- The 2010 national patient survey dated 21 April 2011
- The 2010 national staff survey dated 16 March 2011
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 20 April 2011
- Care Quality Commission quality and risk profiles presented to the Trust Board dated 6 December 2010.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Salisbury NHS Foundation Trust as a body, to assist the Council of Governors in reporting Salisbury NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Salisbury NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000)'. My limited assurance procedures included:

- Making enquiries of management.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents listed above.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Simon Garlick
Engagement Lead

Audit Commission
Collins House
Bishopstoke Road
Eastleigh
Hampshire
SO50 6AD

6 June 2011




Sustainability / Climate Change Report

Trust Strategy on Sustainability

Governments, organisations and individuals have a responsibility to think carefully about the environment and the impact that their actions may have. This is reflected in national legislation and phased targets to reduce carbon emissions by 80% by 2050. The NHS Sustainable Development Unit (SDU) has also set initial targets for the NHS of a 10% reduction in carbon emissions by 2015. Salisbury NHS Foundation Trust takes sustainability and carbon emissions seriously and uses the NHS Carbon Reduction Strategy and the SDU's Good Corporate Citizen (GCC) Self Assessment Tool to assess the Trust's impact on the environment. This also provides a practical framework for its own Sustainability and Carbon Reduction Strategy.

This strategy covers travel and transport, procurement, facilities management, workforce issues, community engagement, facilities and new buildings, which includes objectives, actions and targets. This strategy can be found at www.salisbury.nhs.uk. Sustainable practices are also corporate responsibilities and the strategy has been implemented through the Environmental Executive Committee, which reports to the Operational Management Board. There is also a process to report to the Trust Board.

Summary Performance

Summary Performance in the table on page 71.

Future Priorities and Targets

The Trust is using the GCC as its basis for its own internal priority areas for the future. These are incorporated in the Trust's comprehensive action plan which can be found at: www.salisbury.nhs.uk. This will be monitored through the Environmental Executive Committee, together with a reporting process that includes the Operational Management and Trust Board. The priority areas and targets are summarised as follows:

Travel

Policies and performance: Build up a long-term evidence base about transport and travel impacts and set targets for carbon reduction. During 2010/2011 information on business travel was gathered through a transport study in conjunction with the Carbon Trust and Energy Saving Trust. This will now be used to inform policies and strategy. Target: December 2011.

Active Travel: Engage with staff and the local community and develop a plan to encourage active travel with supporting facilities. This resulted in the development of a new external cycle path on Odstock Road in conjunction with Wiltshire County Council. Staff engagement and promotion is ongoing. Target: December 2011.

Traffic management: Work with partners and stakeholders to develop plans to reduce traffic impacts, promote public transport and active travel supported with information and incentive schemes. Also minimise suppliers' traffic burden. Initiatives for better management for on site-car parking developed in 2010/2011 and ongoing. Target: December 2011.

Procurement

Policies and performance: Work ongoing to develop a sustainable procurement policy that supports local community and minimizes environmental impacts. Target: December 2011.

Procurement skills: Work ongoing to provide staff with accessible information on sustainable procurement; provide training and review learning and development needs of staff against key sustainable development objectives. Target: December 2011.




Summary Performance

Area		Non Financial data	Non Financial data		Financial data	Financial data
		2009/2010	2010/2011		2009/2010	2010/2011
Greenhouse Gas Emissions	Scope 1 (Direct) GHG Emissions	Gas; 7018 tonnes CO_{2e} 36,935,782 kWhs Transport; 180 tonnes	6395 tonnes CO_{2e} 34,527,107 kWhs Transport; 176		Gas; £891,294 Transport; £215,475	Gas; £867,018 Transport; £228,813
	Scope 2 (Indirect) GHG Emissions	4510 tonnes CO_{2e} 10,697,889 kWhs	6220 tonnes CO_{2e} 11,410,365 kWhs		£1,046,142	£1,039,324
	Scope 3 * Official Business Travel Emissions	202 tonnes CO_{2e}	179 tonnes CO_{2e}		£281,083	£249,104
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust Methods of disposal	1,260 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	1,189 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	Expenditure on waste disposal	£260,219	£260,166
Finite Resources	Water & Sewerage	137,886 m^3	142,287 m^3	Water & Sewerage	£299,409	£330,123

Source: Final Estates Return Information Collection (ERIC) information for 2009/2010 and 2010/2011
*** Please note that Scope 3 reporting includes business mileage rates but not public transport travel**

Engaging suppliers: Ongoing work to assess impact of key suppliers on our sustainable development objectives, create understanding of our objectives and help improve their understanding of sustainable development. Target: December 2011.

Sustainable procurement: Review current procurement practices and adopt sustainable development clauses in tendering documents and contracts. Evaluate bids and award contracts on this basis. Target December 2011.

Facilities Management

Policies and performance: Ongoing work to review environmental impacts of the Trust, develop operations plan covering carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity. Communicate plan to staff and local community. Target: March 2012.

Minimising waste: Introduce contract specifications that minimise waste, including water, and use recycled/ recyclable materials where possible. Active campaign carried out in 2010/2011 to recycle outdated office equipment and furniture through volunteer scheme. Water usage review carried out, new efficiency measures in place and ongoing staff awareness maintained. Target: December 2011.




Workforce

Policies and performance: Assess local employment conditions, conduct impact assessment to develop employment strategy addressing health and include sustainable development objectives in inductions. Target: December 2011.

Healthy workplace: Provide incentives and facilities to promote active low carbon travel, healthy and sustainable food choices and regular exercise. The Trust has an onsite fully equipped leisure facility which promotes fitness programmes and healthy activities. Catering staff are building on existing links with local suppliers to increase use of fresh, locally sourced food ingredients. Staff and trade unions involved in developing initiatives to support healthy lifestyles and provide accessible areas for staff rest and reflection. Target: December 2011.

Childcare and carer support: Ensure staff involved in development and provision of private spaces for parents and carers and plans to improve support. Target: December 2011.

Learning and development: Develop learning and development strategy for staff and support sustainable development training objectives. Target: December 2011.

Community Engagement

Policy and performance: Develop community engagement action plan with clear social, economic and environmental objectives. Work ongoing with Wiltshire County Council sustainability lead. Target: December 2010.

Community participation: Develop clear mechanisms for seeking and gathering views on sustainable development objectives. Target: December 2011.

Healthy and sustainable food choices: Develop plans for healthy and sustainable food choices, develop a system to track sourcing, transportation, consumption and disposal of food and drink products and set targets to increase healthy and sustainable food choices. Target: December 2011.

Assets and resources: Review assets and resources available to share with local community (e.g. green or commercial space) and develop plans to maximise benefit to community. Target December 2011.

Buildings

Policies and performance: Review building stock, develop sustainable buildings strategy and communicate to key partners and suppliers. Review taken place in 2011/2012 and communication taking place. Target: December 2011.

Design: Minimise whole life costs of building and refurbishment projects through design, produce design briefs that encourage low carbon, low environmental impact proposals from suppliers and partners and use views of staff and local community. Some examples where this took place in 2010/2011: New Children's Unit and refurbished Accident and Emergency Department. Target: December 2011.

Equality and Diversity Report

Approach to Equality and Diversity

At Salisbury NHS Foundation Trust we respect and value the diversity of our patients, their relatives and carers, and our staff. We are committed to meeting the needs and expectations of the diverse communities we serve and providing high quality care. In striving to achieve this we will make best use of the range of talents and experience of our workforce.

The Trust has undertaken a considerable amount of work on Equality and Diversity (E&D), laying foundations to deliver better services to patients from diverse groups and to promote equality of opportunity for staff. The Equality and Diversity Steering Group reports to the Trust Board and is responsible for determining the strategic direction on E&D, taking into account current legislation and national initiatives. The group provides twice yearly reports to the Trust Board with details about its work, agreed action plans and progress. This also gives the Board regular detailed analysis of the make up of the workforce and patient data.




The Trust also has the REACH (Reaching Equality Aspiring Confident Hope) group which provides a forum for Black Minority Ethnic (BME) staff, disability staff forum and LGBT (Lesbian, Gay, Bisexual and Transgender) forum which enables staff to discuss issues that relate to their employment experiences and the services provided by the hospital.

Publication Duties

The Trust has a Single Equality Scheme (SES), which brings together the previous Race, Disability, and Gender Equality Schemes. It also covers other areas of equality and diversity – namely age, sexual orientation, religion and beliefs. The Trust also carries out impact assessments to ensure that any Trust policy, procedure, development or activity does not have an unintentional adverse impact for patients or staff from diverse backgrounds. Equality impact assessments are a statutory requirement of the schemes and key staff have been trained to undertake them. The Trust is compliant with its publication duties. Its website has a dedicated Equality and Diversity page which has employment monitoring statistics, results of impact assessments and links to various documents and other related websites. This can be found at: www.salisbury.nhs.uk/about us

As from April 2011 the Trust will update its SES to ensure we are complaint with the Equality Act 2010. The Trust will be adopting a new approach to equality objectives and will be piloting the EDS (Equality Delivery System) led by the NHS EDC (Equality Delivery Council). This self audit tool will ensure that SFT will analyse and grade our performance against 12 outcomes grouped into 4 objectives. This will ensure that we can identify equality groups that are disproportionately affected in both staff and patient experiences and enable us to deliver better outcomes for these identified equality groups.

Summary of performance – workforce statistics

	Staff 2009/10	%	Staff 2010/11	%	Membership 2009/10	%	Membership 2010/11	%
Age								
0-16	0	0.00	0	0.00	0	0.00	1	0.04
17-21	214	5.20	132	3.37	137	6.68	126	5.25
22+	3,902	94.80	3,785	96.63	1,915	93.32	2,272	94.71
Total	4,116		3,917		2,052	100	2,399	100
Ethnicity								
White	3,657	88.85	3,465	88.46	1,920	93.57	2,213	92.25
Mixed	19	0.46	20	0.51	7	0.34	5	0.20
Asian or Asian British	227	5.52	235	6.00	92	4.48	128	5.34
Black or Black British	51	1.24	49	1.25	25	1.22	30	1.25
Other	162	3.94	148	3.78	8	0.39	23	0.96
Total	4,116		3,917		2,052	100	2,399	100
Gender								
Male	948	23.03	922	23.54	462	22.51	553	23.05
Female	3,168	76.97	2,995	76.46	1,590	77.49	1,846	76.95
Trans Gender	0	0.00	0	0.00	0	0.00	0	0.00
Recorded Disability	54	1.31	54	1.38	19	0.93	24	1.00

More detailed data can be found in our Equality and Diversity Annual Report for 2010. Workforce statistics can be found at www.salisbury.nhs.uk/about us under equality and diversity web pages. This also gives further information on our staffing and patient profile.

Priorities and targets going forward

We will be formally adopting the EDS model using the four objectives:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

In addition we will also:

- Update our Equality Impact Assessments to Equality Analysis
- Implementing a new online Equality and Diversity Training Programme to take into account the Equality Act 2010.
- Work collaboratively with PPI (Public, Patient and Involvement) to ensure we are meeting our equality objectives for patients and visitors.

These priorities are regularly reviewed and performance monitored and measured through the Equality and Diversity Steering Group, which is chaired by a non-executive director of the Trust.




Staff Survey Report

Approach to Staff Engagement

The Trust has continued to build on its existing processes for staff communications and consultation and there is a good working relationship between Trust management, Trade Unions and staff. Regular communication through face to face briefings, the Intranet and publications are enhanced by topic based communications where and when appropriate. For instance, this year Trust staff have been involved in sessions about the NHS reforms. Trade union representatives are actively involved in discussions around the future financial challenges facing the Trust, as are staff themselves through a number of open events. These also provide opportunities to feedback ideas and comments. The Trust has an open and honest culture of involvement and engagement and effective feedback mechanisms for staff. In more general terms, staff are able to provide feedback through the monthly Cascade Brief, the Chief Executive's message and executive led 'safety walkrounds', as well as the national staff survey. The 2010 staff survey included a new measure of 'staff engagement' – a combination of questions relating to the ability of staff to contribute towards improvements, staff recommending the Trust as a place to work or receive treatment, and staff motivation at work. The Trust score placed it in the best 20% of acute Trusts.

Summary of performance – NHS Staff Survey

	2009/2010		2010/2011		Trust Improvement/ deterioration
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	58%	55%	57%	54%	1% deterioration

	2009/2010		2010/2011		Trust Improvement/ deterioration
Top 4 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Percentage of staff having equality and diversity training in last 12 months	64%	35%	61%	41%	3% deterioration, not statistically significant
Percentage of staff reporting good communication between senior management and staff	33%	26%	33%	26%	No change
Staff recommendation of the Trust as a place to work in receive treatment	3.75	3.50	3.71	3.52	0.04 deterioration
Percentage of staff suffering work related stress in last 12 months	24%	28%	25%	28%	1% deterioration, not statistically significant




	2009/2010		2010/2011		Trust Improvement/ deterioration
Bottom 4 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Percentage of staff agreeing their role makes a difference to patients	89%	90%	87%	90%	2% deterioration, not statistically significant
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	N/A	N/A	19%	15%	Comparison not possible with 2009 survey
Percentage of staff feeling valued by their work colleagues	81%	77%	72%	76%	9% deterioration
Percentage of staff appraised in last 12 months	65%	78%	68%	78%	3% improvement, not statistically significant

In addition to the top and bottom ranking scores above, the Trust has made significant progress from the previous year in the following area. Please note that the lower the score, the better.

	2009/2010		2010/2011		Trust Improvement/ deterioration
Improving scores	**Trust**	**National Average**	**Trust**	**National Average**	
Work pressure felt by staff	3.09	3.11	3.03	3.11	0.6 improvement, statistically significant

In addition to the top and bottom ranking scores above, the Trust's scores have deteriorated from the previous year in the areas shown in the table on page 76. Please note that in all areas apart from % staff feeling valued by their work colleagues, the Trust ranks better than average compared with all acute Trusts.

Future Priorities and targets

National staff survey scores measure how the Trust performs in relation to other acute Trusts and in terms of staff perceptions. Scores are not absolute scales or targets of good or bad performance. However, following publication of the staff survey, the Trust has an action plan that focuses on four key areas for improvement, which are listed below. These will be monitored by the Trust Board, reported upon in Trust Board meetings held in public and measured through the 2011 staff survey.

Appraisals: The 2010 staff survey shows that the Trust is in the worst 20% of Trusts for the number of staff who receive appraisals when benchmarked against other acute Trusts. The Trust is 'worse than average' in relation to associated personal development planning and staff reporting that appraisals were well structured. The Target for 2011, building on work already started in 2010, is to increase the number of appraisals and their quality across the Trust so that the Trust is no worse than 'average' in these categories.




	2009/2010		2010/2011		Trust Improvement/ deterioration
Deteriorating scores	**Trust**	**National Average**	**Trust**	**National Average**	
% staff feeling valued by their work colleagues	81	77	72	76	8% Deterioration, statistically significant
Quality of job design	3.49	3.38	3.43	3.41	0.06 deterioration, statistically significant
Staff motivation at work	3.93	3.84	3.86	3.83	0.07 deterioration, statistically significant
Staff intention to leave jobs	2.33	2.51	2.44	2.53	0.10 deterioration, statistically significant

Harassment, bullying or abuse from staff in last 12 months, physical violence from staff, perceptions of effective action from employer towards violence and harassment and feeling valued by work colleagues: The Trust was in the worst 20% or 'worse than average' in the 2010 staff survey when benchmarked against other acute Trusts in all these related categories. The Target for 2011/12 is to reduce the number of instances of harassment, bullying or abuse to put the Trust at no worse than 'average'.

Satisfaction with the quality of work and patient care individuals feel able to deliver: Although there has been no significant change in our score we remain 'worse than average' in this area when benchmarked against other acute Trusts. It is important that staff feel empowered and able to play their part and the target is to improve in this area to reach at least 'average' in this area.

Staff feeling pressure to attend work when feeling unwell: Although there has been no significant change in our score we are now 'worse than average' in this area when benchmarked against acute Trusts. We need to ensure that staff are not attending work when they are too unwell to do so, and the target is to reach 'average' in this area.

Regulatory Ratings Report

Financial Rating

When assessing financial risk, Monitor will assign a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS Foundation Trusts. These indicators are:

- achievement of plan
- underlying performance
- financial efficiency
- liquidity

The risk rating, on a scale of 1 to 5 with 5 representing the least risk and 1 the highest risk, is intended to reflect the likelihood of a financial breach of the Authorisation.




The most common scores are 3 or 4. While the Trust has a sound record of financial management, it has had to bear the cost of extra drugs, services and additional activity, but has nevertheless achieved a rating of 3.

Governance Risk Rating

Monitor's assessment of governance risk is based predominantly on the Trust's plans for ensuring compliance with its Terms of Authorisation, but will reflect historic risk performance where this may be indicative of future risk.

The governance rating is determined by an assessment of eight governance elements which are:

- legality of constitution
- growing a representative membership
- appropriate Board roles and structures
- service performance (compliance with healthcare targets and indicators)
- clinical quality and patient safety
- effective risk and performance management
- co-operation with NHS bodies and local authorities
- provision of mandatory services

NHS Trusts will, in general, supply the information that determines their governance risk rating. In particular they are responsible for self-certification on a quarterly basis on most areas of governance and for supplying any relevant exception reports.

Until 2010/2011 Monitor assessed the Risk Rating using the green, amber, red traffic light system where green indicated low risk and red high risk. From 2010/2011 this system was enlarged from these three measures to four - green, amber-green, amber-red and red.

Each year the Trust submits an Annual Plan for agreement with Monitor in which the Trust forecasts its performance. The Trust then submits quarterly reports on which it is assessed by Monitor against the agreed plan. The Annual Plan forecast ratings and the quarterly performance against these ratings for 2009/10 and 2010/2011 are set out in the table at the foot of the page.

As was reported last year, the Trust failed to achieve a green rating for governance throughout 2009/2010 as a consequence of the failure to achieve the Thrombolysis target. This target requires people who have a heart attack to receive Thrombolysis within 60 minutes of making the telephone call. The geography of Wiltshire and the distances involved, made this a particular challenge for the Great Western Ambulance Service NHS Trust to deliver the patients to the Trust within the required timescale. This challenge continued into the first half of 2010/2011 but, since the autumn of 2010, new arrangements have applied, with patients either receiving a new type of procedure or being re-routed to different hospitals. This has resulted in no Thrombolysis breaches in Quarters 3 and 4 in 2010/2011.

Otherwise in 2010/2011 the Trust met all its targets, apart from narrowly missing the requirement to screen all elective patients for MRSA in Quarter 2 (99% achieved as opposed to the 100% target) and the failure in Quarter 3 to re-book within 14 days a small number of patients who had been unable to attend a scheduled symptomatic breast clinic in December due to consultant illness. As this latter target had only been very narrowly missed, Monitor left the rating for the Quarter at Green.

At no time since the Trust was authorised as a Foundation Trust on 1 June 2006 has Monitor had to formally intervene under any of the powers which are available to the Regulator.

	Annual Plan 2009/2010	Q1 2009/2010	Q2 2009/2010	Q3 2009/2010	Q4 2009/2010
Financial Risk Rating	3	3	3	3	4
Governance Risk rating	Amber	Amber	Amber	Amber	Amber

	Annual Plan 2010/2011	Q1 2010/2011	Q2 2010/2011	Q3 2010/2011	Q4 2010/2011
Financial Risk Rating	3	3	3	3	3
Governance Risk rating	Green	Amber-Green	Amber-Green	Green	Green




Public Interest Disclosures

Partnership Working

The Trust works in partnership with other statutory, non statutory and voluntary sector organisations to commission and develop work to support diverse communities. Current work includes supporting the work of the South Wiltshire Diversity Partnership which looks at the needs of local people so that there is an integrated approach to service planning. Working with SCAR (Salisbury Coalition against Racism) which raises awareness of racism and highlight the diverse nature of the local community. The Trust is also working with learning disability groups to improve these patients' and their carers' experiences of hospital care.

Occupational Health and Safety

Each member of staff has access to a comprehensive in-house Occupational Health Service that includes a full-time staff counsellor. The Trust has an active Health and Safety Committee, where management and staff Health and Safety representatives meet regularly to consider the Trust's performance against a range of indicators and to discuss actions and developments for improvement.

Policies and Procedures to Counter Fraud

As part of its communications with staff and the public, the Trust acknowledges that it has a responsibility to ensure that public money is spent appropriately and that it has policies in place to counter fraud and corruption. The Trust has detailed Standing Financial Instructions and a Counter Fraud and Corruption Policy to ensure probity. In addition, the Trust raises awareness of fraud in its staff communications and through displays in public and staff areas.

Better Payment Practice Code

	Number	£000s/Amount
Total Non-NHS trade invoices paid in the period	63,441	57,674
Total Non-NHS trade invoices paid within target	50,803	44,768
Percentage of Non-NHS trade invoices paid within target	80.1%	77.6%
Total NHS trade invoices paid in the period	2,058	5,820
Total NHS trade invoices paid within target	1,426	4,883
Percentage of NHS trade invoices paid within target	69.3%	83.9%
The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.		

Management Costs

Management Costs (excluding subsidiary)	
	£000
Total Trust Management Costs	6,922
Total Trust Income	176,839
% of total Income	3.91%




Size and Profitability of Income Generation Activities

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service and makes a contribution towards funding patient care. Services that generate income include: accommodation, catering, laundry, car parking, private patient treatment, pharmacy products, sterile supplies, equipment, and professional health care advice. The total income from these areas amounted to just under £5 million. Some areas, such as day nursery and the Staff Club, aim to break even. The other areas contributed surpluses, which have been applied to meeting patient care expenditure

Patient and Public Involvement Initiatives

Patients were involved in over 60 projects this year, using many different methods including patient stories, focus groups and questionnaires. Projects have been carried out within a wide range of wards and departments and has included work with the stroke team, rheumatology, orthopaedics, cardiology, sexual health and children's services which have resulted in service improvements.

Policies Adopted with Suppliers

Tender specifications now require companies or individuals to disclose their approach to equality and diversity.

Sickness Absence Information

The Trust has robust procedures for the management of sickness absence with regular reporting at departmental, directorate and Trust Board level. For the 2010/2011 year the sickness absence rate was 3.82%. This represents a significant improvement from the previous year, which stood at 4.15 %.
As part of the formal annual reporting process, sickness absence data is provided quarterly to the cabinet office and figures for the period of January to December 2010 must also be published in the Annual Report in the following way.

- The total number of Full Time Equivalent (FTE) Days lost to sickness absence 24,155
- The total number of FTE years available 2,790
- Average number of days sickness absence per FTE 8.6

Compliance with HM Treasury and Office of Public Sector Information Guidance

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.

Serious Untoward Incidents involving data loss or confidentiality

During 2010/2011 there were no reported Serious Untoward Incidents involving data loss or confidentiality breach.

Review of Effectiveness of Trust's System of Internal Control

The Trust Board has carried out a review of the effectiveness of its systems of Internal Control. This is covered in the Annual Governance Statement in the Annual Accounts.

The Annual Report has been approved by the Trust Board on 6 June 2011.

Peter Hill
Interim Chief Executive
6 June 2011




Salisbury NHS Foundation Trust
Consolidated Financial Statements
For The Year To 31 March 2011




INDEX

FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2011 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, and comply with the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Annual Reporting Manual (FT ARM) for the financial period.

Salisbury NHS Foundation Trust Annual Report and Accounts are presented to Parliament pursuant to Schedule 7 paragraph 25(4) of the National Health Service Act 2006.

The results of the Trust's subsidiary company, Odstock Medical Limited, for the year to 31 March 2011 and its assets and liabilities as at that date have been consolidated into these financial statements. Details of the subsidiary company can be found in note 32.

Signed:

Peter Hill - Interim Chief Executive

Date: 6 June 2011

Statement of the Chief Executive's responsibilities as the Accounting Officer of Salisbury NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the 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 Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed Salisbury NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him 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 Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:

Peter Hill - Interim Chief Executive

Date: 6 June 2011

Annual Governance Statement

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Salisbury 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.

2. 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 a 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 2011 and up to the date of approval of the annual report and accounts.

3. CAPACITY TO HANDLE RISK

As Accounting Officer I have overall responsibility for risk management but day to day management has been delegated to an Executive Lead for Risk. The Executive Lead for Risk is responsible for reporting to the Trust Board on the development and progress of risk management and for ensuring that the Risk Management Strategy is implemented and evaluated effectively. A Head of Risk Management supports the Executive Lead for Risk 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/teams directly, all underpinned by a comprehensive suite of risk management policies. The Head of Risk Management works closely with Directorate and General Management teams across the Trust to ensure they understand their responsibilities and accountabilities for managing risk in their areas. The approach is informed by various sources of information including incident reports, key quality indicator reports, survey feedback and comments, risk analysis exercises and central guidance. Areas of good practice are identified through the above intelligence which feeds into the Directorate performance meetings (3:3s). The mechanisms allow the organisation to identify, learn from, and share good practice.

4. THE RISK AND CONTROL FRAMEWORK

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 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 clear expectations about the roles, responsibilities and requirements of all Trust staff.

The strategic goals are as follows: -

• To ensure the Trust remains within its licensing authorisation as defined by Monitor and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its licensing authorisation.
• Continued development of the Assurance Framework as the vehicle for informing the Annual Governance Statement.
• To ensure that Risk Management Policies are implemented ensuring that:
  > all risks, including principal risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
  > the open reporting of adverse events is encouraged and learning is shared throughout the organisation.
• To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators.
• To further develop the organisational safety culture and its effectiveness through implementation of Striving for Excellence, and the Patient Safety First Campaign interventions.
• To develop an Annual Risk Management Plan, which is agreed, reviewed and monitored by the Trust Board.
• To ensure that all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management.
• To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.
• To ensure compliance with NHSLA Risk Management Standards, Monitor, Care Quality Commission registration requirements, and Health and Safety Standards.

The risk assessment and risk register procedure is set out within the Trust's Risk Management Policy. This policy gives clear singular instruction on the risk assessment process including risk identification, evaluation, treatment and monitoring. It also describes how risk assessments and the register are operationally managed through centralised Datix software and how the risks are communicated up and down the organisation. Directorate risk registers are reviewed at the Directorate performance meetings (3:3's) on a quarterly basis.

The Risk Management Policy makes it clear that it is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. In such instances a balance needs to be struck between the costs of managing a risk and the benefits to be gained.

A decision must therefore be made regarding the level which a risk would be deemed acceptable. A risk is considered acceptable when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable. Risks requiring a cost benefit analysis are fed into the Trust Risk Register for wider debate and decision on 'acceptability' through the assurance committees.

Quality Governance Arrangements

Quality is clearly embedded in the Trust overall strategy and includes a number of goals:

• There will be a shared understanding of quality across the Trust.
• The achievement of quality is a core activity of all Trust staff who understand their individual roles and responsibilities.
• The Trust has a quality measurement system to support evaluation and improvement.
• To ensure the Trust continues to drive and innovate quality thinking.

The overall Quality Strategy is supported by the Quality Directorate whose service plan includes objectives that drive year on year improvement across patient safety, clinical effectiveness and outcomes as well as patient experience in line with national and local priorities. The strategy is further supported by the annual quality report where the key priorities have been identified using for example quality performance information such as trends in reported incidents or patient survey results.

The Trust has established a quality framework for the review of individual services which includes completion of the Salisbury organisation trigger tool as well as full review and analysis of the quality performance information available - this includes the directorate quality indicator report, clinical audit results, patient feedback from surveys, real time feedback, complaints and compliments, as well as risk reporting. This information is discussed at the quarterly Directorate quality meetings and performance meetings, department/ward quality walks, and is presented annually by the Directorate Management teams as part of the assurance process to the Clinical Governance Committee.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the monthly Clinical Management Board (CMB) and/or the bi-monthly Clinical Governance Committee (CGC), and where appropriate, submitted to the Commissioners as part of the Trust contract performance compliance.

Any external agency/peer reviews during the year have the reports, recommendations and action plans discussed at one of the assuring committees and any identified are added to the Trust risk register.

Areas where risks have been identified through this approach, have agreed action taken/planned, which is then monitored through the Directorate 3:3 performance management framework. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or future Quality Report priority areas.

The CQC assurance processes are clear. Following registration without conditions on 1 April 2010 each Outcome has been assigned to a Lead Manager and Executive Director who maintain an up to date Provider Compliance Assessment form which is subject to periodic review by an independent assuring committee. The independent assuring committees have this duty recorded in their Terms of Reference. The process and the individual Provider Compliance Assessment forms were overviewed by the Trust Board at the year end and this overview will continue to be undertaken on an annual basis. Any areas of concern would be included in the Trust risk register. The Trust's approach has also been evaluated by the internal auditors, South Coast Audit, and found to be satisfactory. It is expected that the Care Quality Commission will audit the Trust's approach in 2011/12 as all Foundation Trusts have to be audited by 31 March 2012.

The Assurance Framework

From 2004/05 all NHS bodies were required to sign a full Statement on Internal Control/Annual Governance Statement and have the evidence to support the statement. The Assurance Framework brings together this evidence.

The Assurance Framework is agreed annually by the Trust Board. The Framework identifies the principal risks facing the Trust and informs the Trust Board how each of these risks is being managed and monitored effectively. Each principal risk has an identified local risk manager who is responsible for managing the reporting on the overall risk, controls, gaps, and actions being taken to mitigate against the risk. The identified local risk manager is normally an Executive Director. Assurance Committees are also identified to assure the Trust Board that each principal risk is being monitored, gaps in controls identified and processes put into place to minimise the risk to the organisation.

The designated Assurance Committees of the Trust Board are the Clinical Governance Committee, the Finance Committee and the Joint Board of Directors.

In order for the Board to be able to evaluate the quality and robustness of the Assurance Framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements the Head of Risk Management attends the Assurance Committees to review and update the Assurance Framework on a quarterly basis. At these reviews the Trust Risk Register (risks scoring 12 and above - high and extreme) is also presented so that the assurance committees can consider the breadth and depth of information included, the robustness of agreed mitigating actions, and whether there are risks which may impact on the principle risks within the Assurance framework. The assurance committees can recommend inclusion of such risks on the assurance framework should there be sufficient concern as to their impact.

The Audit Committee, on behalf of the Trust Board, and Internal Audit formally review the Assurance Framework.

Aligned to the headings in the Trust Service Plan the assurance framework has identified in-year strategic risks around:

(i) Improving Safety - for example, compliance with infection control practices, compliance with patient safety standards, compliance with safeguarding requirements. These are all being managed/mitigated through a comprehensive programme of controls and reporting arrangements such as monthly infection control audits across all clinical areas, monthly reporting of patient safety activity through the regional Quality and Patient Safety Improvement Programme, close involvement with the regional safeguarding boards. Internal groups such as the Infection Control Committee, Clinical Risk Group, Safety Steering Group, Clinical Management Board, and Clinical Governance Committee assess the impact of the control measures and actions in place.

(ii) Service Improvement - for example planning of activity, reputation, development and procurement of IT systems. Actions are in place to mitigate these risks which are monitored and evaluated through internal groups such as the Operational Management Board, Clinical Information Advisory Board, and Joint Board of Directors who receive regular performance reports across these activities in order to consider adequacy of the actions in place.

(iii) Customer Care - for example the implementation of Choice. Referral patterns are monitored and reported through the Joint Board of Directors. As commissioning responsibilities change the Trust continues to explore collaborative working opportunities with primary care partners to improve the patient experience.

(iv) Staff Wellbeing - for example ensuring a competent workforce and absence management, and maintaining standards through a changing workforce. Development of workforce plans across the Trust are developed to inform any service change. A workforce design steering group has been established to focus on this area and outcomes/performance is monitored through the Joint Board of Directors.

(v) Finance - for example securing income, meeting savings targets and budgetary control. These financial risks are mitigated through performance management of the Directorates with robust financial information available so that outcomes of actions can be assessed. The Programme Steering Group oversees the breadth of the organisations savings programme which have been clustered into several key schemes with performance indicators reported at each monthly meeting. All financial information is ultimately reported up to the Finance Committee on a monthly basis.

As the organisation looks towards 2011/12, emerging risks are being identified through the Annual Plan process. In the current climate future risks to the organisation include, restructure of commissioning services external to the Trust and the potential impact of this, continued emphasis on the cost reductions and savings plans, and the maintenance of a critical mass in some services.

These emerging risks will be managed and controlled within the established risk management framework which has been described above. Outcomes and effectiveness of controls/actions will be monitored through the assurance committees through performance reporting and the review of mitigation measures as detailed within the assurance framework and risk register.

The Trust recognises the importance of information assets and is committed to managing them through clear leadership and accountability underpinned by staff education. The Trust has identified a Senior Information Risk Owner (SIRO) at Board level to monitor and report on all information related risks. The Information Risk Policy defines how the Trust manages information risk and how the effectiveness of the policy is assessed and measured. The Information Risk Policy fits within the overall risk management framework for the Trust. It identifies the roles and responsibilities of the Information Asset Owners and Administrators who work with the SIRO to ensure that all information risks are identified and monitored through the Trust risk register and risk assessment processes. During 2010/11 the Information Asset Owners went through a comprehensive training programme to ensure a common understanding of the requirements of this role.

Information Governance arrangements within the organisation have continued to improve in 2010/11. All laptops have been encrypted, and all computers have been "locked down" so users cannot save data to unencrypted memory sticks. We have re-assessed ourselves against version 8 of the IG toolkit and improved our compliance so that we achieved a level 2 or 3 on all key requirements as per Monitor's expectations.

Another example of how risk management is embedded into organisational activity is illustrated through the policy ratification process. It is a requirement that all Trust policies have undergone equality impact assessment screening and where indicated, a full assessment.

Incident reporting is encouraged throughout the organisation under a single process described in the Adverse Events Reporting Policy. Numbers of incidents reported by professional group and department are monitored as a quality indicator within the risk management report cards at the directorate performance meetings. The 2010 staff survey showed that whilst the respondents were 1% below the national average on reporting errors, the trust performed very well (top 20%) for staff having confidence in the fairness and effectiveness of the incident reporting procedures. Work continues with identified staff groups who report at low levels to improve this position.

Patient and public involvement projects have been active in considering risk issues, and have been engaged in some key pieces of work for example the public were involved in the redesign of hand gel notices outside of clinical areas. Key risk areas are also discussed, where appropriate, through Governors meetings and Constituency meetings with the membership.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission. The Trust was granted registration with the Care Quality Commission from 1 April 2010 without conditions.

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 foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust regularly reviews the economy, efficiency, and effectiveness of the use of resources through: benchmarking, reference costs, regular meetings between the Directorates and Executive Directors, and assessing performance against plans. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Trust Board, through its Sub-Committee the Finance Committee, reviews performance against savings plans and the delivery of efficient services within budget.

During the year the Trust Board supported the use of external consultants to develop efficient services in the Facilities Directorate. A similar approach is being piloted with a view to applying this across the organisation as a whole.

A Programme Steering Group has been established to drive forward savings across the Trust. Membership comprises the Executive Directors, Directorate Managers and other senior staff within the organisation. The Group has assisted in achieving a significant proportion of the savings target for 2010/11 and will continue its work in 2011/12. A systematic approach is used to monitor performance based on the work performed at the Trust by external consultants.

The Trust has also been successful in achieving cost savings through service improvement projects, which continue to optimise the efficient and effective use of resources whilst enhancing the patient experience.

Procurement of goods and services is undertaken through professional procurement staff and through working with neighbouring organisations within a Procurement Confederation. The cost of goods is regularly benchmarked.

In year cost pressures are rigorously reviewed and challenged, and means of avoiding cost pressures are always considered.

Internal Audit is used to ensure resources are used effectively.

The Trust's Reference Costs shows it to be approximately 4% below the national average costs, based on the last published data, which relates to 2009/10.

6. ANNUAL QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

To ensure that the Quality Report presents a balanced view and there are appropriate controls in place to ensure accuracy of data the following steps are taken:

• The Trust has a Quality Strategy in place which informs the organisation's direction of travel taking into account local and national priorities.

• There is clear corporate leadership for Quality. The Medical Director and Director of Nursing and Operations lead on the areas of work identified within the Quality Report.

• Progress against the priority areas within the Quality Report is monitored through the clinical governance framework and selected quality metrics are reported via the Quality Indicator report which is published every month for the Trust Board and Clinical Management Board.

• There is corporate leadership for data accuracy with the Director of Corporate Development holding responsibility for the quality of performance data which is reported monthly at the Joint Board of Directors and Trust Board.

• The Trust has a Data Quality Policy in place (underpinned by documented department based administrative processes) which detail the steps taken to ensure data accuracy.

• Data Quality features within the roles and responsibilities (job descriptions) of key staff members for example those working in the Information Department.

• The Quality Report process is coordinated by the Head of Clinical Governance and Deputy Director of Nursing. There is an established timetable of stakeholder engagement including staff, governors, and membership. A wide range of methods have been utilised to gather information, and input in order to inform the priority areas. This includes the use of national inpatient surveys, real time feedback in clinical areas, risk reports, issues raised through executive lead Quality Walks and Safety Walkrounds. The priorities have been discussed with clinical teams as part of the service planning process, and views from staff, Trust Governors, and the membership have been sought. Local GPs have been asked for their feedback and the Quality Report is reviewed by our readership panel to ensure ease of reading for the lay person.

• The Quality Report is only published following the above timetabled reviews and data scrutiny by internal and external stakeholders including the Audit Commission.

7. 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, and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance Committee, Clinical Governance Committee, and Joint Board of Directors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit has provided me with an opinion of significant assurance on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the annual internal audit plan; there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design of controls and/or inconsistent application have been identified in the Internal Audit Annual Report. These include an area which was identified last year - workforce performance management, in particular the application of the Trust's Management of Attendance Policy, ensuring that all aspects are followed with a clear and accurate audit trail of documentation. Other areas identified in the 2010/11 report include arrangements for transport to satisfy statutory compliance, and electronic staff record system access controls. Action plans have been put in place to address these and are being monitored by the Assurance Committees.

Executive Managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Other sources of assurance on which reliance has been placed include the external audit opinion (The Audit Commission), the assurance committees (including the Audit Committee), the self assessment process against the CQC essential standards of quality and safety, NHSLA Risk Management assessments, South Coast Audit and the Internal Clinical Audit Team who have provided me with information and comments.

8. CONCLUSION

Overall there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. I conclude that no significant internal control issues have been identified for the year ended 31st March 2011.

Signed:

Peter Hill
Interim Chief Executive

Date: 6 June 2011

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

I have audited the financial statements of Salisbury NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers' Equity, the Consolidated Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Salisbury NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and Auditor

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.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the Annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion:

- give a true and fair view of the state of affairs of Salisbury NHS Foundation Trust as at 31 March 2011 and of its income and expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts of Salisbury NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Simon Garlick

Engagement Lead
Audit Commission
Collins House
Bishopstoke Road
Eastleigh
Hampshire
SO50 6AD

6 June 2011

STATEMENT OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2011

		Group		Trust	
		2010/11	2009/10	**2010/11**	2009/10
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**161,794**	160,436	**161,794**	160,436
Other operating revenue	5	**16,528**	17,147	**15,045**	15,663
Operating expenses	7	**(172,987)**	(170,787)	**(171,540)**	(169,410)
OPERATING SURPLUS		**5,335**	6,796	**5,299**	6,689
FINANCE COSTS					
Finance income	12	**105**	112	**105**	112
Finance costs - financial liabilities	13	**(1,819)**	(1,711)	**(1,819)**	(1,711)
Finance costs - unwinding of discount on provisions	13	**(13)**	(9)	**(13)**	(9)
PDC Dividends payable		**(3,566)**	(3,240)	**(3,566)**	(3,240)
NET FINANCE COSTS		**(5,293)**	(4,848)	**(5,293)**	(4,848)
Corporation tax expense		**(7)**	(26)	**-**	-
RETAINED SURPLUS FOR THE YEAR		**35**	1,922	**6**	1,841
OTHER COMPREHENSIVE INCOME					
Revaluation gains/(losses) on property plant and equipment		**8,132**	4,671	**8,132**	4,384
Receipt of donated assets		**2,052**	198	**2,052**	198
Reduction in the donation reserve in respect of depreciation		**(183)**	(181)	**(183)**	(181)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**10,036**	6,610	**10,007**	6,242
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**9**	25	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**26**	1,897	**6**	1,841
TOTAL		**35**	1,922	**6**	1,841
(b) Total comprehensive income/(expense) for the year attributable to:					
(i) Minority interest, and		**9**	25	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**10,027**	6,585	**10,007**	6,242
TOTAL		**10,036**	6,610	**10,007**	6,242

The notes on pages 5 to 34 form part of these financial statements.

All revenue and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION
31 MARCH 2011

	Note	Group 31 March 2011 £000	Group 31 March 2010 £000	Trust 31 March 2011 £000	Trust 31 March 2010 £000
NON-CURRENT ASSETS					
Intangible assets	16	**86**	-	**86**	-
Property, plant and equipment	17	**137,665**	126,442	**137,627**	126,394
Investments in subsidiaries	32	**-**	-	**-**	-
Total non-current assets		**137,751**	126,442	**137,713**	126,394
CURRENT ASSETS					
Inventories	18	**2,263**	1,698	**2,179**	1,643
Trade and other receivables	19	**13,313**	11,041	**13,274**	11,016
Cash and cash equivalents	20	**10,040**	10,193	**9,915**	10,039
Total current assets		**25,616**	22,932	**25,368**	22,698
CURRENT LIABILITIES					
Trade and other payables	21	**(16,404)**	(12,004)	**(16,303)**	(11,897)
Borrowings	22	**(2,165)**	(1,262)	**(2,165)**	(1,262)
Provisions	23	**(331)**	(325)	**(331)**	(325)
Tax payable	21	**(7)**	(26)	**-**	-
TOTAL CURRENT LIABILITIES		**(18,907)**	(13,617)	**(18,799)**	(13,484)
TOTAL ASSETS LESS CURRENT LIABILITIES		**144,460**	135,757	**144,282**	135,608
NON-CURRENT LIABILITIES					
Trade and other payables	21	**-**	-	**-**	-
Borrowings	22	**(25,618)**	(26,971)	**(25,618)**	(26,971)
Provisions	23	**(334)**	(362)	**(334)**	(362)
TOTAL NON CURRENT LIABILITIES		**(25,952)**	(27,333)	**(25,952)**	(27,333)
TOTAL ASSETS EMPLOYED		**118,508**	108,424	**118,330**	108,275
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		**57**	48	**-**	-
Public dividend capital		**51,229**	51,181	**51,229**	51,181
Revaluation reserve		**58,628**	51,302	**58,628**	51,302
Donated asset reserve		**3,013**	1,144	**3,013**	1,144
Income and expenditure reserve		**5,581**	4,749	**5,460**	4,648
TOTAL TAXPAYERS EQUITY		**118,508**	108,424	**118,330**	108,275

The notes on pages 5 to 34 form part of these financial statements.

The financial statements on pages 1 to 34 were approved by the Board on 6 June 2011 and signed on its behalf by:

Signed:

Peter Hill - Interim Chief Executive

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS EQUITY
31 MARCH 2011

	Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Donated asset reserve	Minority interest	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009	**51,080**	**2,384**	**47,010**	**1,216**	**23**	**101,713**
Changes in taxpayers' equity for 2009-10						
Net gain/(loss) on revaluation of property plant and equipment			4,760	(89)		**4,671**
Retained surplus/(deficit) for the year		1,897			25	**1,922**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		409	(409)			**-**
Transfers of realised profits/(losses) to the income and expenditure reserve		59	(59)			**-**
Receipt of donated assets				198		**198**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets				(181)		**(181)**
Transfers between reserves						**-**
Other recognised gains and losses		-				**-**
Public dividend capital received in year	101					**101**
Public dividend capital repaid in year						**-**
Balance at 31 March 2010	**51,181**	**4,749**	**51,302**	**1,144**	**48**	**108,424**
Changes in taxpayers' equity for 2010-11						
Net gain/(loss) on revaluation of property plant and equipment			8,132	-		**8,132**
Retained surplus/(deficit) for the year		26			9	**35**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		806	(806)			**-**
Transfers of realised profits/(losses) to the income and expenditure reserve		-	-			**-**
Receipt of donated assets				2,052		**2,052**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets				(183)		**(183)**
Transfers between reserves						**-**
Other recognised gains and losses		-				**-**
Public dividend capital received in year	48					**48**
Public dividend capital repaid in year						**-**
Balance at 31 March 2011	**51,229**	**5,581**	**58,628**	**3,013**	**57**	**118,508**

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Note	2011 £000	2010 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Total operating surplus		**5,335**	6,796
NON-CASH INCOME AND EXPENSE			
Depreciation and amortisation charge		**7,744**	7,348
Non-current asset impairments and reversals		**-**	-
Transfer from donated asset reserve		**(183)**	(181)
(Increase)/decrease in trade and other receivables		**(2,272)**	(2,249)
(Increase)/decrease in inventories		**(565)**	(462)
Increase/(decrease) in trade and other payables		**3,264**	(4,184)
Increase/(decrease) in other liabilities		**-**	-
Increase/(decrease) in provisions		**(22)**	(174)
Tax (paid)/received		**(26)**	(7)
Other movements in operating cash flows		**(557)**	312
Net cash inflow from operating activities		**12,718**	7,199
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		**105**	112
Payments to acquire property, plant and equipment		**(11,736)**	(9,434)
Receipts from sale of property, plant and equipment		**1,465**	479
Payments to acquire intangible assets		**(92)**	-
Net cash inflow/(outflow) from investing activities		**(10,258)**	(8,843)
CASH FLOWS FROM FINANCING ACTIVITIES			
New public dividend capital received		**48**	101
Loans repaid		**(746)**	-
Loans received		**1,959**	3,800
Capital element of finance lease rental payments		**(73)**	(67)
Capital element of Private Finance Initiative obligations		**(596)**	(564)
Interest paid		**(96)**	(9)
Interest element of finance lease rental payments		**(44)**	(49)
Interest element of Private Finance Initiative obligations		**(1,692)**	(1,662)
PDC dividend paid		**(3,425)**	(3,240)
Cash flows from other financing activities		**2,052**	198
Net cash (outflow)/inflow from financing		**(2,613)**	(1,492)
(Decrease)/increase in cash and cash equivalents		**(153)**	(3,136)
Cash and cash equivalents at the beginning of the financial year		**10,193**	13,329
Cash and cash equivalents at the end of the financial year	20	**10,040**	10,193

A separate cash flow for the Trust has not been prepared as the amounts involved are not significantly different to that of the Group as a whole.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Basis of Consolidation

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. 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 the minority interests are included in a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries accounting policies are not aligned with those of the Trust (including where they report under UK Gaap) then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less cost to sell'.

NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

Unless otherwise stated the notes to the accounts refer to the group and not the Trust, as the Trust's balances are not materially different.

1.2 Accounting convention

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

1.3 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, however, inpatient income is recognised in the accounts based on completed spells. Where income is received for a specific activity which is to be delivered in the following year, that income is deferred.

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 e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 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. Accruals at 31 March 2011 are based on estimates of invoices where services/goods were received but not invoiced at the year end.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated
Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Software
Software which is integral to the operation of hardware e.g. 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 e.g. application software, is capitalised as an intangible asset.

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 fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

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

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

1.6 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they 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, the components are treated as separate assets and depreciated over their own useful economic lives.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

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

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost until 31 March 2011, when the assets were valued at modern equivalent value.

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

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

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. 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 derecognised.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. All other assets are being depreciated as follows:
Buildings (excluding dwellings) 2 - 62 years
Dwellings 36 - 67 years
Plant and Machinery 5 - 15 years
Transport equipment 5 - 10 years
Information Technology 5 - 7 years
Furniture and Fittings 5 - 15 years

Property, plant and equipment which has been reclassified as ' held for sale' ceases to be depreciated upon the reclassification.

Revaluation gains and losses
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating income.

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.

1.6 Property, plant and equipment (continued)

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'Other comprehensive income'.

Each year the Trust makes a transfer from the Revaluation Reserve to the Income and Expenditure Reserve to reflect the excess of current cost depreciation over historical cost depreciation.

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income 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 revaluations 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.

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised when all material sale contract conditions have been met. Fair value is opening market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

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

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Donated Assets
Donated fixed assets are capitalised at the current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donation reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

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

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.7 Investment

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.

1.8 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.9 Government Grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the offset the expenditure.

1. ACCOUNTING POLICIES (CONTINUED)

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured on the First In, First Out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life, in determining an approximation of net realisable value.

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and form an integral part of the Trust's cash management.

1.12 Provisions

The NHS Foundation 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 the HM Treasury's discount rate of 2.2% in real terms except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 23, but is not recognised in the NHS Foundation 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 the NHS Litigation Authority 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 as and when the liability arises.

1.13 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

1. ACCOUNTING POLICIES (CONTINUED)

1.13 Employee benefits (continued)

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

Subsidiary pension scheme

The subsidiary company (Odstock Medical Limited) operates a defined contribution scheme for employees who have contracts of employment directly with the company. Employer's pension costs are charged to operating expenses as and when they become due.

1.14 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.

1.15 Corporation Tax

The Trust does not have a corporation tax liability for the year 2010/11. Tax may be payable on activities described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- Annual profits from the activity must exceed £50,000

The Corporation Tax sum shown for the year 2010/11 relates to the Trust's subsidiary company.

1.16 Foreign Exchange

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2011. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual, see note 30.

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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

The trust as lessor

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 so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

The Trust leases land to Salisbury District Hospital Charitable Fund at a nominal amount and, as a result, no separate disclosure has been made of this arrangement.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.19 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.20 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 each individual case is handled.

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

1. ACCOUNTING POLICIES (CONTINUED)

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

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

Classification
Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through income and expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method and credited to the Statement of Comprehensive Income.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

1. ACCOUNTING POLICIES (CONTINUED)

1.22 Financial assets (continued)

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Trust can be summarised as that of 'healthcare'. These activities comprise five key operating areas or segments, where costs are closely monitored during the year. Income is not allocated to each area of activity. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board review and make decisions on activity and performance of the Trust as a whole entity, not for its separate business activities.

3 Revenue

Group and Trust

3.1 Revenue by Type

	2011	2010
	£000	£000
Elective revenue	**36,195**	35,477
Non-elective revenue	**62,444**	63,037
Outpatient revenue	**28,161**	27,858
A & E revenue	**4,089**	3,852
Other types of activity revenue	**23,381**	24,604
Total revenue at full tariff	**154,270**	154,828
Revenue from activities		
Private patient revenue	**1,387**	384
Other non-protected clinical revenue	**6,137**	5,224
	161,794	160,436

Other types of activity revenue above includes amounts due for specialist services (e.g. spinal, burns, genetics, cleft lip and palate), direct access, intensive care, community and hospice services.

3.2 Revenue by Source

	2011	2010
	£000	£000
Foundation Trusts	**839**	699
NHS Trusts	**1,141**	1,326
Strategic Health Authorities	**129**	81
Primary Care Trusts	**155,424**	154,420
Local Authorities	**-**	138
Department of Health - grants	**-**	-
Department of Health - other	**-**	377
NHS Other	**41**	49
Non NHS:		
- Private patients	**1,387**	384
- Overseas patients (non-reciprocal)	**23**	60
- NHS Injury scheme (was Road Traffic Act)	**1,088**	1,187
- Other	**1,722**	1,715
	161,794	160,436

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 9.6% to reflect expected rates of collection. Other income includes £1.4m income from Salisbury Hospicecare Trust.

3.3 Mandatory Services

Under its Terms of Authorisation the Trust is required to provide the mandatory services, the allocation of operating revenue between mandatory services and other services is provided in the table below:

	2011	2010
	£000	£000
Mandatory services	**155,617**	153,855
Non-mandatory services	**6,177**	6,581
	161,794	160,436

NOTES TO THE ACCOUNTS

4. Private Patient Revenue

Group and Trust	Base year 2002/03 £000	**2011 £000**	2010 £000
Private patient revenue	1,098	**1,387**	384
Total patient related revenue	90,173	**161,794**	160,436
Proportion (as a percentage)	1.2%	**0.9%**	0.2%

Section 44 of the 2006 Act requires that the proportion of private patient revenue to the total patient related revenue of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year.

Following a High Court Judgement in December 2009, Monitor revised its rules on how the Private Patient Income Cap should be operated by Foundation Trusts from 1 April 2010. The Decision provided greater clarity on how the private patient charges provisions of Section 44 of the 2006 Act should be interpreted and applied. The Trust's Private Patient Income disclosure for the current year is based on the 2010/11 Foundation Trust Annual Reporting Manual (FT ARM) issued by Monitor.

The Private Patient Income disclosure for 2009/10 is calculated on the basis of the FT ARM for that financial year.

5. Other Operating revenue

Group	**2011 £000**	2010 £000
Research and development	**1,185**	1,134
Education and training	**5,293**	5,342
Charitable and other contributions to expenditure	**-**	-
Transfers from donated asset reserve	**183**	181
Non-patient care services to other bodies	**1,536**	1,359
Profit on disposal of property	**588**	-
Profit on disposal of plant and equipment	**-**	-
Other	**7,743**	9,131
	16,528	17,147

Included within 'Other' revenue above are amounts received from lodgings £1.2m, car parking £0.9m, catering £0.9m, laundry £1.1m, child care services £0.5m and trading revenue of the Trust's subsidiary company £1.5m.

6. Revenue

Total revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial.

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

Group	**2011** **£000**	2010 £000
Services from other NHS Foundation Trusts	**232**	233
Services from NHS Trusts	**1,103**	1,114
Services from other NHS bodies	**597**	552
Purchase of healthcare from non-NHS bodies	**2,223**	780
Executive directors costs	**876**	948
Non-executive directors costs	**149**	147
Staff costs	**113,152**	114,420
Drug costs	**10,811**	10,146
Supplies and services - clinical (excluding drug costs)	**16,151**	16,230
Supplies and services - general	**2,742**	2,872
Establishment	**1,981**	2,179
Transport	**629**	635
Premises	**6,223**	6,074
Provision for impairment of receivables	**770**	19
Depreciation and amortisation	**7,744**	7,348
Impairments and reversals of property, plant and equipment	**-**	287
Loss on disposal of plant and equipment	**31**	25
Audit services - statutory audit	**74**	45
Other auditors remuneration	**12**	16
Clinical negligence	**2,839**	2,511
Other	**4,648**	4,206
	172,987	170,787

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

Redundancy payments totalling £0.1m are included in staff costs and further details are disclosed in note 9.4.

Other expenses include payments for course fees £0.3m, patient's travel £0.2m, the service element of the PFI contract £0.7m, consultancy fees £0.6m, insurance fees £0.3m, legal fees £0.3m, internal audit fees £0.2m, contracted out services £0.3m and costs attributable to the Trust's subsidiary company £1.4m.

8. Operating leases

Group and Trust

8.1 As lessee

The Group has entered into commercial leases on certain items of property, motor vehicles and equipment. The principal arrangements are in respect of motor vehicles. For these, rentals are for an agreed mileage over a three year term. Excess mileage is charged at a price per mile determined at the inception of the lease.

8.2 Payments recognised as expense

	2011 **£000**	2010 £000
Minimum lease payments	**339**	379
Contingent rents	**-**	-
	339	379

NOTES TO THE ACCOUNTS

8. Operating leases (continued)

8.3 Total future minimum lease payments

	2011	2010
Payable:	**£000**	£000
Within 1 year	**95**	266
Between 1 and 5 years	**31**	211
After 5 years	**25**	-
Total	**151**	477

9. Staff costs and numbers

9.1 Staff costs

Group	**Total 2011 £000**	Permanently Employed 2011 £000	Other 2011 £000	Total 2010 £000	Permanently Employed 2010 £000	Other 2010 £000
Salaries and wages	**93,088**	93,088	-	92,496	92,496	-
Social Security Costs	**6,941**	6,941	-	6,881	6,881	-
Employer contributions to NHSPA	**10,767**	10,767	-	10,579	10,579	-
Other pension costs	**-**	-	-	-	-	-
Agency and contract staff	**3,232**	-	3,232	5,559	-	5,559
	114,028	110,796	3,232	115,515	109,956	5,559

9.2 Average number of persons employed - WTE basis

Group	**Total 2011 Number**	Permanently Employed 2011 Number	Other 2011 Number	Total 2010 Number	Permanently Employed 2010 Number	Other 2010 Number
Medical and dental	**338**	322	16	349	324	25
Ambulance staff	**15**	15	-	16	16	-
Administration and estates	**610**	608	2	626	616	10
Healthcare assistants & other support staff	**269**	261	8	279	265	14
Nursing, midwifery & health visiting staff	**1,240**	1,197	43	1,267	1,201	66
Nursing, midwifery & health visiting learners	**-**	-	-	-	-	-
Scientific, therapeutic and technical staff	**442**	437	5	468	446	22
Total	**2,914**	2,840	74	3,005	2,868	137

The figure shown under the 'Other' column relates to agency staff, disclosed under the operational areas where they worked.

9.3 Directors' Remuneration

	2011	2010
	£000	£000
Salaries and wages	**830**	889
Social Security Costs	**89**	96
Employer contributions to Pension Schemes	**106**	110
	1,025	1,095

The total number of Directors accruing benefits under pension schemes is 6 (2010: 6)

9.4 Redundancy Costs

	2011 No. of compulsory redundancies	2010 No. of compulsory redundancies
Exit package cost band		
£10,000 - £25,000	5	-
£25,000 - £50,000	1	-

There were no other redundancy payments made in the year (2010; £Nil). There were no redundancy costs relating to senior managers in the year.

NOTES TO THE ACCOUNTS

10 Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution scheme for Odstock Medical Limited was £10,767,000 (2010: £10,579,000). As at 31 March 2011, contributions of £1,319,000 (2010: £1,370,000) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

10.1 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions . The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

NOTES TO THE ACCOUNTS

10.1 Pension costs (continued)

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

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.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

11. Retirements due to ill-health

During the year to 31 March 2011 there were 5 (2010: 2) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £107,000 (2010: £71,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

NOTES TO THE ACCOUNTS

12. Finance income

Group	2011 £000	2010 £000
Interest revenue:		
Bank accounts	**105**	112
Other loans and receivables	**-**	-
	105	112

13. Finance costs

Group and Trust	2011 £000	2010 £000
Interest on loans from Foundation Trust Financing Facility	**83**	-
Interest on other loans	**-**	-
Interest on obligations under finance leases	**44**	49
Finance costs on obligations under Private Finance Initiatives	**1,460**	1,496
Contingent finance costs	**232**	166
Total finance expense - financial liabilities	**1,819**	1,711
Other finance costs - unwinding of discounts on provisions	**13**	9
Total	**1,832**	1,720

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

There were no amounts payable arising from claims made by businesses under this legislation (2010: £Nil).

15. Losses and special payments

Group and Trust	2011 Number	2011 Value £000	2010 Number	2010 Value £000
Losses	**364**	**64**	312	15
Special payments	**41**	**48**	42	41
Total losses and special payments	**405**	**112**	354	56

There were no case payments that exceeded £100,000.

The above payments are the cash payments made in the year and are not calculated on an accruals basis.

16. Intangible Assets - Group

16.1 Intangible assets at the balance sheet date comprise the following elements:

	Software Licences £000	Total £000
Cost or valuation at 1 April 2010		
At 1 April 2010	-	-
Additions - purchased	92	92
At 31 March 2011	**92**	**92**
Amortisation at 1 April 2010		
At 1 April 2010	-	-
Provided during the period	6	6
Amortisation at 31 March 2011	**6**	**6**
Net book value at 31 March 2010		
- Purchased at 31 March 2010	-	-
- Donated at 31 March 2010	-	-
Total at 31 March 2010	**-**	**-**
Net book value at 31 March 2011		
- Purchased at 31 March 2011	86	86
- Donated at 31 March 2011	-	-
Total at 31 March 2011	**86**	**86**

17. Property, plant and equipment

Group

17.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010									
At 1 April 2010	5,760	90,075	5,715	2,488	45,691	661	11,533	844	162,767
Additions - purchased	-	1,547	-	4,938	2,758	-	316	125	9,684
Additions - donated	-	224	-	827	952	-	49	-	2,052
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	1,123	-	(1,911)	160	-	557	71	-
Revaluation	(22)	4,132	-	-	-	-	-	-	4,110
Disposals	(800)	-	-	-	(294)	-	-	-	(1,094)
At 31 March 2011	**4,938**	**97,101**	**5,715**	**6,342**	**49,267**	**661**	**12,455**	**1,040**	**177,519**
Accumulated depreciation at 1 April 2010									
At 1 April 2010	-	-	-	-	27,374	626	7,831	494	36,325
Provided during the period	-	3,896	127	-	2,576	7	1,076	56	7,738
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation	-	(3,896)	(127)	-	-	-	-	-	(4,023)
Disposals	-	-	-	-	(186)	-	-	-	(186)
Accumulated depreciation at 31 March 2011	**-**	**-**	**-**	**-**	**29,764**	**633**	**8,907**	**550**	**39,854**
Net book value at 31 March 2010									
Owned	5,760	70,014	5,715	2,488	16,752	35	3,692	350	104,806
Finance leased					431				431
On balance sheet PFI		20,061							20,061
Donated	-	-	-	-	1,134	-	10	-	1,144
Total at 31 March 2010	**5,760**	**90,075**	**5,715**	**2,488**	**18,317**	**35**	**3,702**	**350**	**126,442**
Net book value at 31 March 2011									
Owned	4,938	74,940	5,715	5,515	17,230	28	3,490	490	112,346
Finance leased	-	-	-	-	369	-	-	-	369
On balance sheet PFI	-	21,937	-	-	-	-	-	-	21,937
Donated	-	224	-	827	1,904	-	58	-	3,013
Total at 31 March 2011	**4,938**	**97,101**	**5,715**	**6,342**	**19,503**	**28**	**3,548**	**490**	**137,665**

17.2 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2011	2,390	92,337	-	-	-	-	-	-	94,727
Unprotected assets at 31 March 2011	2,548	4,764	5,715	6,342	19,503	28	3,548	490	42,938
	4,938	**97,101**	**5,715**	**6,342**	**19,503**	**28**	**3,548**	**490**	**137,665**

Protected assets are those required to provide either mandatory goods or services under Salisbury NHS Foundation Trust's terms of authorisation

In accordance with the requirements of HM Treasury, the District Valuer revalued the Trust's estate on 31 March 2010 using the Modern Equivalent Asset (MEA) valuation method. On 31 March 2011 the District Valuer reviewed the Trust's land, buildings and dwellings on an MEA basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their fair value at 31 March 2011.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Group

17.3 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 2009									
At 1 April 2009	6,016	87,692	6,449	2,879	42,517	661	10,706	816	157,736
Additions - purchased	179	3,908	26	1,873	2,836	-	387	27	9,236
Additions - donated	-	89	-	-	99	-	10	-	198
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	983	103	(2,264)	747	-	430	1	-
Revaluation	(135)	(2,597)	(199)	-	-	-	-	-	(2,931)
Disposals	(300)	-	(664)	-	(508)	-	-	-	(1,472)
At 31 March 2010	**5,760**	**90,075**	**5,715**	**2,488**	**45,691**	**661**	**11,533**	**844**	**162,767**
Accumulated depreciation at 1 April 2009									
At 1 April 2009	-	3,702	142	-	25,377	620	6,969	450	37,260
Provided during the period	-	3,772	184	-	2,480	6	862	44	7,348
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation	-	(7,474)	(298)	-	-	-	-	-	(7,772)
Disposals	-	-	(28)	-	(483)	-	-	-	(511)
Accumulated depreciation at 31 March 2010	**287**	**-**	**-**	**-**	**27,374**	**626**	**7,831**	**494**	**36,325**
Net book value at 31 March 2010									
Owned	5,760	70,014	5,715	2,488	16,752	35	3,692	350	104,806
Finance leased	-	-	-	-	431	-	-	-	431
On balance sheet PFI	-	20,061	-	-	-	-	-	-	20,061
Donated	-	-	-	-	1,134	-	10	-	1,144
Total at 31 March 2010	**5,760**	**90,075**	**5,715**	**2,488**	**18,317**	**35**	**3,702**	**350**	**126,442**

17.4 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2010	2,412	85,626	-	-	-	-	-	-	88,038
Unprotected assets at 31 March 2010	3,348	4,449	5,715	2,488	18,317	35	3,702	350	38,404
	5,760	**90,075**	**5,715**	**2,488**	**18,317**	**35**	**3,702**	**350**	**126,442**

17.5 Included within plant and machinery is the following held by the subsidiary company

	31 March 2011	31 March 2010
	£'000	£'000
Cost	**88**	79
Accumulated depreciation	**(50)**	(30)
Net book value	**38**	49

NOTES TO THE ACCOUNTS

17.6 Net Book Value of Assets Held Under Finance Leases	Plant & Machinery	PFI Arrangements	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2010	616	20,061	20,677
Additions - Purchased	-	-	-
Revaluations	-	1,876	1,876
Disposals	-	-	-
At 31 March 2011	616	21,937	22,553
Accumulated depreciation			
At 1 April 2010	185	-	185
Provided during the period	62	523	585
Revaluation	-	(523)	(523)
Disposals	-	-	-
Accumulated depreciation at 31 March 2011	247	-	247
Net book value at 31 March 2011			
- Purchased	369	21,937	22,306
- Donated	-	-	-
Total at 31 March 2011	369	21,937	22,306
Cost or valuation			
At 1 April 2009	616	13,139	13,755
Impairments	-	-	-
Revaluation	-	6,922	6,922
Disposals	-	-	-
At 31 March 2010	**616**	**20,061**	**20,677**
Accumulated depreciation			
At 1 April 2009	123	998	1,121
Provided during the period	62	522	584
Impairments	-	-	-
Revaluation	-	(1,520)	(1,520)
Disposals	-	-	-
Accumulated depreciation at 31 March 2010	**185**	**-**	**185**
Net book value at 31 March 2010			
- Purchased	431	20,061	20,492
- Donated	-	-	-
Total at 31 March 2010	**431**	**20,061**	**20,492**

17.7 Impairments

	2011	2010
Land	**£000**	£000
Changes in market price	**-**	-
Other	**-**	179
Total	**-**	179
Property		
Changes in market price	**-**	0
Other	**-**	108
	-	108
Total	**-**	287

The impairment in 2010 arose from a loss of economic benefit from the land and buildings.

NOTES TO THE ACCOUNTS

18. Inventories

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Drugs	**1,188**	880	**1,188**	880
Consumables	**360**	100	**276**	45
Energy	**15**	10	**15**	10
Work-in-progress	**5**	4	**5**	4
Finished Goods	**695**	704	**695**	704
	2,263	1,698	**2,179**	1,643
Inventories recognised as an expense in the period	**13,963**	13,278	**13,645**	12,935
Write-down of inventories (including losses)	**-**	-	**-**	-
Reversal of write-downs that reduced the expense	**-**	-	**-**	-
	13,963	13,278	**13,645**	12,935

19. Trade and other receivables

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
19.1 Amounts falling due within one year:				
NHS receivables	**9,796**	*7,507	**9,796**	*7,507
Other receivables with related parties	**246**	183	**246**	183
Provision for impairment of receivables	**(1,024)**	(284)	**(1,024)**	(284)
Prepayments	**1,214**	731	**1,214**	731
Accrued income	**-**	-	**-**	-
Other receivables	**3,081**	2,904	**3,042**	2,879
	13,313	11,041	**13,274**	11,016
19.2 Amounts falling due after more than one year:				
NHS receivables	-	-	-	-
Provision for impairment of receivables	-	-	-	-
Prepayments	-	-	-	-
Other receivables	-	-	-	-
	-	-	**-**	**-**
Total	**13,313**	11,041	**13,274**	11,016

The majority of transactions are with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts 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 21 days (2010: 18 days). No interest is charged on trade receivables

Other receivables include non-NHS trade debts £1.7m and amounts due from Charitable Funds of £1.0m.

* The balance due from the Compensation Recovery Unit has been re-classified from 'Other Receivables' to 'NHS Receivables' following guidance issued in 2010-11.

19.3 Movement in the provision for impairment of receivables

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Balance at beginning of year	**284**	265	**284**	265
Amount written off during the year	**(30)**	-	**(30)**	-
(Decrease)/increase in allowance recognised in income	**770**	19	**770**	19
Balance at end of year	**1,024**	284	**1,024**	284

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

NOTES TO THE ACCOUNTS

19.4 Impaired receivables past their due date

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
By up to three months	-	-	**-**	-
By three to six months	**644**	8	**644**	8
By more than six months	**380**	276	**380**	276
Total	**1,024**	284	**1,024**	284

19.5 Non-impaired receivables past their due date

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
By up to three months	**3,532**	824	**3,532**	824
By three to six months	**2,199**	78	**2,199**	78
By more than six months	**2,742**	2,816	**2,742**	2,816
Total	**8,473**	3,718	**8,473**	3,718

The sums included in receivables past due date by more than six months, but not impaired, relate to the amount due from the NHS Injury Scheme. The Department of Health issued guidance to provide for debts on the amount owed at 9.6%. These debts relate to insurance claims and hence the date of receipt of monies is not known and so the debts are disclosed as due after one year.

20. Cash and cash equivalents

	Group		Trust	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Balance at beginning of year	**10,193**	13,329	**10,039**	13,189
Net change in year	**(153)**	(3,136)	**(124)**	(3,150)
Balance at end of year	**10,040**	10,193	**9,915**	10,039
Made up of:				
Cash with Office of HM Paymaster General	**9,469**	9,340	**9,469**	9,340
Cash at commercial banks and in hand	**571**	853	**446**	699
Current asset investments	**-**	-	**-**	-
Cash and cash equivalents as in balance sheet	**10,040**	10,193	**9,915**	10,039
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**10,040**	10,193	**9,915**	10,039

NOTES TO THE ACCOUNTS

21. Liabilities

21.1 Trade and other payables

	Group		Trust	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Amounts falling due within one year:				
NHS payables	**2,623**	2,370	**2,623**	2,370
Amounts due to other related parties	**2,366**	2,402	**2,366**	-
Non-NHS trade payables - revenue	**3,873**	2,001	**3,772**	1,894
Non-NHS trade payables - capital	**1,436**	931	**1,436**	931
Receipts in advance	**2,500**	1,413	**2,500**	1,413
Accruals and deferred income	**683**	946	**683**	946
PDC payable	**141**	-	**141**	-
Other	**2,782**	1,941	**2,782**	4,343
	16,404	12,004	**16,303**	11,897
Tax payable	**7**	26	**-**	-
	16,411	12,030	**16,303**	11,897

NHS payables includes £1.3m outstanding pensions contributions due to the NHS Pensions Agency at 31 March 2011 (2010: £1.4m)

Amounts due to related parties includes income tax and national insurance contributions of £2.4m.

22. Borrowings

Group and Trust	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Obligations under finance leases	**78**	73	**464**	542
Amounts due under on-SoFP PFI (note 29)	**596**	564	**21,426**	22,054
Foundation Trust Financing Facility loan	**1,250**	625	**3,125**	4,375
Other loans	**241**	-	**603**	-
	2,165	1,262	**25,618**	26,971

The finance lease relates to the purchase of microbiology equipment and is for a term of 10 years. For the year ended 31 March 2011 the effective borrowing rate was 7.7% (2010: 7.7%). Interest rates are fixed at the contract date. The lease is denominated in Euros.

The loan from the Foundation Trust Finance Facility is unsecured and for a 5 year period, repayable in equal instalments commencing on 15 March 2011. Interest is payable on the loan at a rate of 1.88% pa.

Other loans relate to two interest free 4 year loans from Salix Finance Limited. A not for profit company funded by the Department for Energy and Climate Change. These loans are repayable in equal instalments commencing on 1 March 2011.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease	
	2011	2010	**2011**	2010
	£000	£000	**£000**	£000
Within one year	**117**	117	**78**	73
Between one and five years	**468**	468	**292**	292
After five years	**88**	205	**172**	250
	673	790	**542**	615
Less finance charges allocated to future periods	**(131)**	(175)		
	542	615		
Included within:				
Current borrowings			**78**	73
Non-current borrowings			**464**	542
			542	615

NOTES TO THE ACCOUNTS

23. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Pensions relating to other staff	**26**	26	**132**	153
Legal claims	**140**	128	**-**	-
Other	**165**	171	**202**	209
	331	325	**334**	362

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2010	179	128	380	687
Change in the disount rate	-	-	-	-
Arising during the year	-	74	-	74
Utilised during the year	(26)	(40)	(21)	(87)
Reversed unused	-	(22)	-	(22)
Unwinding of discount	5	-	8	13
At 31 March 2011	**158**	**140**	**367**	**665**
Expected timing of cash flows:				
Within 1 year	26	140	165	331
1 - 5 years	104	-	58	162
5-10 years	28	-	144	172
	158	**140**	**367**	**665**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury claims. These are based on valuation reports provided by the Trust's legal advisers.

Other provisions include the following:
a) £217,000 the Trust has provided for injury benefits payable to former employees as a result of an injury suffered whilst in the Trust's employment (2010: £223,000).
b) £48,000 for legal fees in respect of a claim against the Trust (2010: £50,000).
c) £102,000 in respect of a compromise agreement reached with a former employee (2010: £102,000).

£30,582,000 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (2010: £26,827,000).

NOTES TO THE ACCOUNTS

24. Prudential Borrowing Limit

Trust	2011 £000	2010 £000
Total long term borrowing limit set by Monitor	**28,233**	38,000
Working capital facility agreed by Monitor	**13,000**	13,000
Total Prudential Borrowing Limit set by Monitor	**41,233**	51,000
Long term borrowing at 1 April 2010	**28,233**	23,864
Net actual borrowing/(repayment) in year - long term	**(450)**	4,369
Long term borrowing at 31 March 2011	**27,783**	28,233
Working capital borrowing at 1 April 2010	**0**	0
Net actual borrowing/(repayment) in year - working capital	**0**	0
Working capital borrowing at 31 March 2011	**0**	0

The Trust had a £10,000,000 approved working capital facility in place although this was unused during the period. The renewal date of this facility is 31 May 2011.

Financial Ratios	2011 Actual Ratios Ratios	2011 Approved PBL Ratios	2010 Actual Ratios Ratios	2010 Approved PBL Ratios
Minimum Dividend Cover	3	>1	4	>1
Minimum Interest Cover	7	>3	8	>3
Minimum Debt Service Cover	4	>2	6	>2
Maximum Debt Service to Revenue	0.02	<2.5%	0.01	<2.5%

The NHS Foundation Trust is required to comply and remain within the prudential borrowing limit.
This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- The amount of working capital facility approved by Monitor.

25. Capital Commitments

Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £3,752,000 (2010: £6,278,000).

26. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £500,000.

The Trust is currently defending a legal claim by one of its former contractors. The claim relates to a contract entered into a considerable number of years ago, which was terminated under legal advice nearly six years ago. The Trust has taken further legal advice recently and will vigorously defend its position.

27. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

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.

The Department of Health is regarded as a related party. During the year the Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. These entities are listed below:

2011	Income £000	Expenditure £000	Receivables £000	Payables £000
Wiltshire PCT	94,120	554	6,529	449
Dorset PCT	18,982	118	3	1
Hampshire PCT	23,284	7	109	4
Bournemouth and Poole PCT	2,061	-	76	-
Bristol PCT	9,406	-	262	-
Southampton City PCT	1,244	3	110	1
West Kent PCT	2,351	-	455	-
South West Strategic Health Authority	5,591	-	12	-
Wiltshire Unitary Authority	60	1,071	-	-
DH Compensation Recovery Unit	1,088	-	2,777	-
NHS Litigation Authority	-	2,950	-	-
NHS Business Services Authority	-	3,274	-	162
NHS Blood and Transplant Agency	-	959	-	6
NHS Pension Scheme	-	10,767	-	1,319

NOTES TO THE ACCOUNTS

27. Related Party Transactions (continued)

2010	Income £000	Expenditure £000	Receivables £000	Payables £000
Wiltshire PCT	94,463	402	2,414	15
Dorset PCT	18,779	117	528	117
Hampshire PCT	21,956	28	126	28
Bournemouth and Poole PCT	1,733	-	45	-
Bristol PCT	9,348	-	-	107
Southampton City PCT	1,156	8	163	1
West Kent PCT	2,397		372	-
South West Strategic Health Authority	5,604	-	-	-
Portsmouth Hospitals NHS Trust	171	281	39	64
Southampton University Hospitals NHS Trust	121	525	33	223
NHS Litigation Authority	0	2,611	-	1
NHS Business Services Authority	-	3,646	-	241
NHS Blood and Transplant Agency	36	1,251	36	2
NHS Pension Scheme	-	10,579	-	1,373

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds, for which it is the corporate Trustee.

28. Private Finance Initiative Schemes (PFI) - Group and Trust

28.1 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.

	2011 £000	2010 £000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**687**	645
Depreciation of PFI asset	**522**	522
Net charge to operating expenses	**1,209**	1,167

Imputed finance lease obligations comprise:	**Minimum lease payments**		**Present value of minimum lease payments**	
	2011 £000	2010 £000	**2011** £000	2010 £000
Rentals due within one year	**2,035**	2,055	**596**	564
Rentals due within 2 to 5 years	**7,690**	7,891	**2,435**	2,442
Rentals due thereafter	**35,146**	36,981	**18,991**	19,612
	44,871	46,927	**22,022**	22,618
Less: interest element	**(22,849)**	(24,309)		
Total	**22,022**	22,618		

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

The Trust is committed to make the following service payments on the PFI:	**2011** £000	2010 £000
Due within one year	**675**	633
Due within 2 to 5 years	**2,936**	2,807
Due after 5 years	**21,310**	22,114
	24,921	25,554

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

29. Financial Instruments

IFRS 7, IAS 32 and IAS 39, Financial Instruments: Disclosure, requires 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.

NOTES TO THE ACCOUNTS

29. Financial instruments (continued)

29.1 Foreign 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 and therefore has low exposure to currency fluctuations.

The carrying amount of the Group's foreign currency denominated monetary asset and liabilities at the reporting date is as follows

	Assets		Liabilities		Cash	
	2011	2010	**2011**	2010	**2011**	2010
	£'000	£'000	**£'000**	£'000	**£'000**	£'000
Euro	**-**	-	**542**	615	-	-
GBP	**15,576**	12,739	**44,317**	40,335	10,040	10,193
	15,576	12,739	**44,859**	40,950	10,040	10,193

The Euro denominated financial instruments relate to the Trust itself

29.2 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.

29.3 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.

29.4 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 2011

Fixed rate	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**
Finance lease obligations	7.7	-	29	88	117	351	88	(131)	**542**
PFI obligations	6.5	170	340	1,525	2,004	5,686	35,146	(22,849)	**22,022**
Foundation Trust Financing Facility Loan	1.88	-	-	1,274	1,274	1,909	-	(82)	**4,375**
Salix Loan	0			241	241	362	-	0	**844**
Floating rate									
Trade and other payables	-	11,397	-	-	-	-	-	-	**11,397**

As at 31 March 2010

Fixed rate	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**
Finance lease obligations	7.7	-	29	88	117	351	205	(175)	**615**
PFI obligations	6.5	171	343	1,541	2,035	5,856	36,981	(24,309)	**22,618**
Foundation Trust Financing Facility Loan	1.88	-	-	637	1,273	3,184	-	(94)	**5,000**
Floating rate									
Trade and other payables	-	8,182	-	-	-	-	-	-	**8,182**

29.5 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 2011 are in receivables from customers, as disclosed in note 19.

NOTES TO THE ACCOUNTS

29.6 Financial instruments by category

	At Fair value through income and expenditure account	Loans and receivables	Available for sale	Total
Financial assets	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	-	9,353	-	**9,353**
Cash and cash equivalents	-	10,040	-	**10,040**
Other financial assets	-	-	-	**-**
Total at 31 March 2011	**-**	19,393	**-**	**19,393**
Trade and other receivables excluding non financial assets	-	*8,019	-	***8,019**
Cash and cash equivalents	-	10,193	-	**10,193**
Other financial assets	-	-	-	**-**
Total at 31 March 2010	**-**	18,212	**-**	**18,212**

* This figure has been re-stated to remove amounts due from HM Revenue and Customs and The Compensation Recovery Unit as these sums are due under statutory and not contractual arrangements.

	At 'Fair value through profit and loss'	Other	Total
Financial liabilities	**£000**	**£000**	**£000**
Borrowings	-	5,219	**5,219**
Private Finance Initiative	-	22,022	**22,022**
Finance lease obligations	-	542	**542**
Trade and other payables	-	11,397	**11,397**
Provisions under contract	-	665	**665**
Total at 31 March 2011	**-**	39,845	**39,845**
Borrowings	-	5,000	**5,000**
Private Finance Initiative	-	22,618	**22,618**
Finance lease obligations	-	615	**615**
Trade and other payables	-	*8,182	***8,182**
Provisions under contract	-	687	**687**
Total at 31 March 2010	**-**	37,102	**37,102**

* This figure has been re-stated to remove amounts due to HM Revenue and Customs (PAYE/NIC) as this is a statutory and not contractual liability.

29.7 Fair values of financial liabilities at 31 March 2011

	Book Value £'000	Fair Value £'000
Provisions under contract	665	665
Loans	5,219	5,319
	5,884	**5,984**

30. Third Party Assets

The Trust held £1,000 cash at bank and in hand at 31 March 2011 (2010: £8,000) 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.

NOTES TO THE ACCOUNTS

31. Intra-Government and Other Balances

	2011		2010	
	Receivables: current and non-current £000	**Payables: current and non-current £000**	Receivables: current and non-current £000	Payables: current and non-current £000
English NHS Foundation Trusts	**135**	**117**	169	43
English NHS Trusts	**371**	**481**	282	395
Department of Health	**2,777**	**-**	2	-
English Strategic Health Authorities	**48**	**6**	47	-
English Primary Care Trusts	**6,462**	**520**	4,358	300
RAB Special Health Authorities	**-**	**-**	-	242
NHS CGA bodies	**-**	**-**	-	-
NHS WGA bodies	**-**	**1,499**	85	1,390
Other WGA bodies	**246**	**2,366**	221	2,409
Public Corporations and Trading Funds	**-**	**-**	-	-
Bodies External to Government	**3,274**	**11,422**	5,877	7,251
	13,313	**16,411**	11,041	12,030

32. Investment in subsidiary

Salisbury NHS Foundation Trust has established, following Department of Health approval, a subsidiary company, Odstock Medical Limited, 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 68% of Odstock Medical Limited.

Shares	Trust £
At 31 March 2011 and 31 March 2010	**34**

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.

Salisbury NHS
NHS Foundation Trust

Annual Report and Accounts 2010/2011

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