

Annual Report and Accounts 2012 / 2013



Salisbury NHS Foundation Trust

Annual Report and Accounts 2012/2013

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

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Message from the Chairman

The past year has been one of the most challenging for the NHS and, with the publication of the Francis Report into the care and treatment of people in Mid Staffordshire, it has been a year where we have seen increased scrutiny and focus on all organisations that provide healthcare to patients. In addition, the restructure of NHS Commissioners and reductions in the income we receive per patient have increased the complexity of the environment in which we operate.

Against this backdrop, patients must have confidence in our hospital and our staff, that they are treated with respect, dignity, care and compassion, and that they receive high standards of care - whether they are existing patients who use our general and specialist services, or others throughout Wiltshire, Dorset and Hampshire who are now selecting Salisbury District Hospital as their hospital of choice when deciding where to have their treatment.

During the year we had a routine unannounced inspection at Salisbury District Hospital by the Care Quality Commission (CQC) and I am pleased to say that we met all essential standards relating to care and cleanliness. This included respect and involvement of patients, their care and welfare and whether their nutritional needs have been met. While the report highlighted two action points around staffing and records management which are being addressed, this was a positive report and one which I am sure will be welcomed by our patients.

However, we will look to address the issues identified in the report that the CQC felt had a minor impact on our patients. Together with all other hospitals across the country, we are also reviewing all aspects of our services so that we respond proactively and effectively to any recommendations from the Francis Report.

During the year we have continued to maintain good waiting times for treatment and introduced a number of service improvements that benefit our patients. This includes the creation of a new infusion suite for patients who need intensive treatment for rheumatic diseases and a new Neonatal Intensive Care Unit (NICU), with a Family Accommodation Suite. The Neonatal Unit has improved clinical areas and dedicated on-site accommodation where families can stay close to their babies in privacy.

Feedback from patients on the quality of care they have received is essential for us, as we see this as a key way of monitoring their experience of hospital care and continually improving services for all patients. We have continued to receive positive comments through letters, our customer care department, national patient

surveys and our own 'real time' feedback, which is gathered daily from patients on wards and in clinics. Where our patients have raised concerns we have used these comments constructively to make appropriate changes. We welcome all comments from patients, their families and carers as we are determined to raise standards.



Luke March - Chairman

Our local community continues to play a key role in the development of the hospital and its services through our Governors and members, and the wide range of fundraising activities carried out in conjunction with the Stars Appeal. Local people and generous donors played a key role in raising money for improvements to the Neonatal Unit mentioned earlier, and the Benson Suite – a dedicated facility for families who lose a baby before or shortly after birth. This year the Stars Appeal aims to raise money for an additional CT Scanner which will help meet the increasing demand for CT scanning within the hospital and enable further development in this service. We also enjoy significant support from other charitable sources such as the Salisbury Hospital League of Friends and the Southern Spinal Injuries Trust. I cannot thank enough all those who have helped the hospital throughout the year. Their support and generosity is much appreciated by us and the whole community.



Clearly there are many challenges ahead, both operationally and financially as we look carefully at how we can provide more compassionate and efficient services for our patients. We will continue to work closely with new organisations established under the NHS reforms and build on these relationships in the future. We will continue to monitor the care we provide and review our services so that we maintain our high standards and the good quality of care which is such a key factor for patients at Salisbury District Hospital.

What is clear to me is that our achievements and future progress cannot take place without the hard work and commitment of our staff and I know from the many comments which I receive, our staff play the most important role in the Trust. Examples of their work and achievements can be seen throughout this year's annual report. There is no doubt that our staff are pivotal to our success, both now and in the future and so, on behalf of the Board, I want to thank them for their dedication to the hospital and the local

community – it is their professionalism that makes the hospital what it is today.

Barry Bull and John Stokoe retired as Non Executive Directors during the year, and I pay tribute to their many years of dedicated service on the Board. We are delighted to welcome Andrew Freemantle as a Non Executive Director on 1 January 2013 and Dame Sarah Mullally on 1 April 2013. Alan Denton retired as Director of Human Resources after 24 years service to the hospital and we thank him enormously for his wise counsel and support. We welcome Alison Kingscott as his successor, and congratulate Peter Hill on his appointment as Chief Executive.

Luke March, Chairman
24 May 2013

True 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

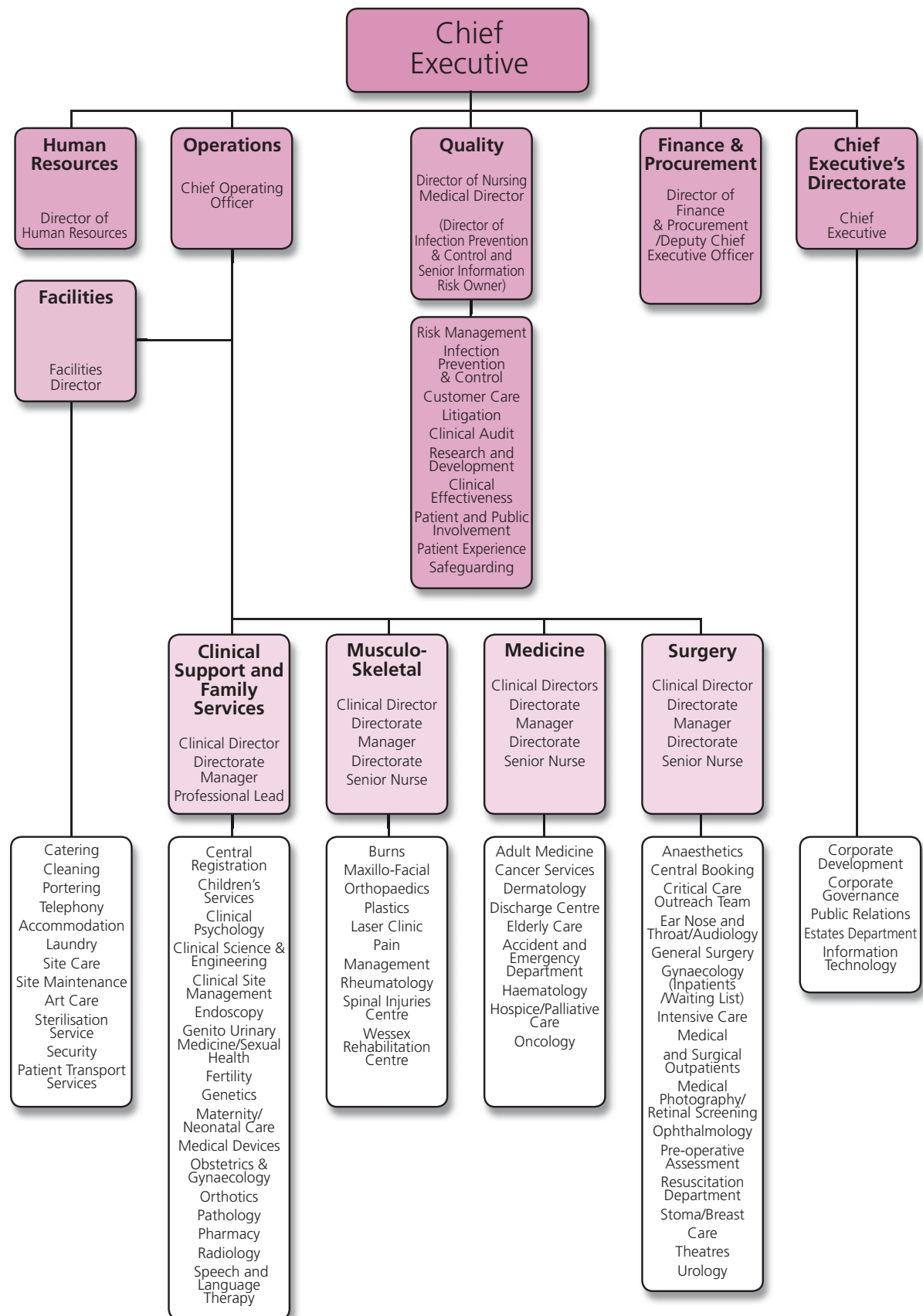
We will listen to colleagues and service users to shape our continuous improvement and development

Stewardship

We will respect our environment and use resources wisely



Organisational Structure



Directors' Report

Current Directors of Salisbury NHS Foundation Trust during 2012/2013

Luke March DL	Chairman
Peter Hill	Chief Executive (Chief Operating Officer until 4 September 2012, Interim Chief Executive between 5 September 2012 to 14 January 2013)
Nigel Atkinson	Non Executive Director
Christine Blanshard	Medical Director
Lydia Brown MBE	Non Executive Director (Vice Chairman and Senior Independent Director)
Malcolm Cassells	Director of Finance and Procurement
Ian Downie	Non Executive Director
Andrew Freemantle CBE	Non Executive Director (from 1 January 2013)
Alison Kingscott	Director of Human Resources and Organisational Development (from 8 October 2012)
Stephen Long	Non Executive Director
Tracey Nutter	Director of Nursing

Directors who left Salisbury NHS Foundation Trust within 2012/2013

Barry Bull	Non Executive Director (Until 31 December 2012)
Alan Denton	Director of Human Resources until 31 May 2012.
Caspar Ridley	Chief Executive (From 1 March 2012 to 5 September 2012)
John Stokoe CB, CBE	Non Executive Director (until 31 October 2012)

Please note that Revd. Dame Sarah Mullally DBE was appointed Non Executive Director with effect from 1 April 2013

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 3,952 staff at 31 March 2013. 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 hosts the Research Design Service (SW) Salisbury Office, which advises researchers who are preparing a grant application. The South West RDS is part of the National Institute of Health Research (NIHR) and, as part of the regional structure, the Trust meets the research governance objectives set by the NIHR. Based on the latest available figures, the number of NHS patients taking part in clinical research in the Trust decreased in the 2012/2013 financial year with 611 people taking part in 45 National Institute of Health Research and Clinical Research Network studies hosted by the Trust, a decrease of 26% of people taking part over the previous year. Participation in clinical research forms part of the NHS constitution and the NHS operating framework, and enables the NHS to develop new treatments and shape services in the future.

Provision of Information and Involvement of Employees

The Trust continues to build on its existing processes for staff communication and consultation, and this includes the involvement of Trade Unions and staff on issues that affect them. 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 open sessions for staff on the financial challenges

facing the NHS, and Executive meetings with staff on the South West Pay Terms and Conditions Consortium. During the year the Trust carried out a survey to gauge the effectiveness of its current communication methods and received a positive response from staff. As part of this, the Trust discontinued a general open monthly session which was poorly attended and bolstered its cascade briefing processes with more directorate level information given to senior managers and renewed emphasis on engagement across the Trust through departmental and ward leaders.

The Trust has continued to create awareness of the financial and economic factors that affect the performance of the Trust as well as information that relates to the development of the Trust, and the quality of its services through its normal communication channels. 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

In 2012/2013 the Trust continued to maintain high standards of care, improve patient's experience and provide fast access to good quality safe treatment.

This was highlighted by the Care Quality Commission (CQC), following an unannounced routine inspection at Salisbury District Hospital. As part of the inspection the CQC talked to patients, carers and staff. They observed the care people received in hospital and looked at care and treatment records. They also looked at standards of cleanliness and the management of people's medicines.

Good quality care could also be seen in successful peer reviews, assessments, national patient survey results and the number of improvements and achievements, that make Salisbury District Hospital stand out when compared with many other hospitals across the country.

*Highlight
of the Year*



GOOD REPORT FROM CQC ON HOSPITAL CARE

The Trust meets essential care and cleanliness standards following routine CQC Inspection

During the visit the assessment team heard a wide range of positive comments from patients about staff and the care that they received. They also found staff to be open and honest about telling the CQC their views. In its final report the CQC felt that the Trust met the essential standards around treating patients with respect, their care and welfare and their nutritional needs. They also felt that the Trust monitored the quality of services effectively and, without exception, the patients they talked to thought that patient treatment and waiting areas were clean. The CQC did have minor concerns about staffing levels and the management of records at ward level. While the Trust already had plans in place to deal with some of these issues, these two standards were nevertheless identified as action points for the Trust which will be followed through into the 2013/2014 financial year.

As was the case last year a key priority area for the NHS is the care of patients with dementia and the Trust has continued to implement the eight South West Regional Standards for dementia care. These not only focus on all aspects of the care and treatment, but also how well hospitals create a 'dementia-friendly' environment, which is supported by dedicated staff training and development.

Throughout the year the Trust made good progress against all eight standards and introduced a number of improvements which help ensure that dementia patients are treated with respect and dignity, and that they have the necessary care, stimulation and support to fulfil the best possible outcome for them based on their condition and circumstances. This was highlighted in a positive second stage peer review. As part of this the peer review team was clearly impressed with the enthusiasm and professionalism of staff, the positive culture within the Trust, levels of staff engagement and the progress made in Salisbury - building on the key strengths of leadership and widespread engagement from the first assessment in the previous year.

They singled out a number of areas of good practice that they will be looking to share across the region, such as the development of stimulating activities and programmes for patients and an excellent staff training programme that had been developed in partnership with the Alzheimer's Society.



There were some areas for further improvement. However, these centred mainly around the continuation of the Trust's programme to create a truly dementia friendly environment. The Trust acknowledges that there is more work to do and this will remain a key priority in the coming year. Further details of this and other work in this area can be found in the Trust's Quality Report later on in this report.

*Highlight
of the Year*



POSITIVE SECOND STAGE REVIEW OF DEMENTIA CARE

Peer Reviewers found a positive culture and clear leadership and engagement across all areas and levels within the hospital.

Care of the elderly and issues around end of life care continue to be a focus and the Trust is working jointly with other health and social care organisations to ensure that patients are able to die in the setting of their choice and ensure that all who are involved in their care are aware of the patient's wishes. GPs continue to improve the recording of patients wishes and their preferred priorities for end of life care and more health professionals in hospital now have access to this information. The Trust also developed a rapid discharge process for patients in the last 72 hours of their life which ensures that care and equipment can be provided at home, with support from community teams.

As part of Dying Matters Awareness Week, Hospital and Hospice staff also held their own successful local public and media campaign to highlight the work that they do to support patients, carers and relatives and provide key messages for people who are nearing the end of their life. This centred on simple steps which could make a big difference to people when they are dying, such as sharing their wishes with someone close to them,

registering to be an organ donor or simply talking about their situation. Next year's campaign will be used to encourage wider debate within the community on what matters most to them in terms of end of life care.

*Highlight
of the Year*



MAJOR LOCAL CAMPAIGN SUPPORTS END OF LIFE CARE

Successful local campaign highlights key messages to support people who are coming to the end of their life and their relatives and carers.

Another area which has seen real progress and innovation is the Trust's cancer services and this can be seen both in hospital and also in the way the Trust is looking to provide more services in other centres and in the community.

For instance, some Salisbury District Hospital patients from Wiltshire, Hampshire and Dorset have to travel up to 60 miles a day for chemotherapy and related

*Highlight
of the Year*



NEW MOBILE CHEMOTHERAPY UNIT

New mobile chemotherapy unit enables some patients to have treatment closer to their home.



treatments on the Pembroke Suite. However, they are now able to have this closer to their home thanks to the launch of a new mobile chemotherapy unit, which was donated by national charity Hope for Tomorrow.

In terms of innovation, patients who need an operation to remove breast cancer that has spread can now have this carried out during the first procedure thanks to a new machine that gives an instant result. Previously surgeons would have had to wait for the results of a biopsy and patients who had a positive test would have had to come back for a second operation.

As mentioned earlier, peer reviews and patient surveys provide the Trust with invaluable information about the quality of its services and, if necessary, where to make improvements. In the latest national cancer survey over 90% of cancer patients rated their care as excellent or very good. This survey covered the patient's diagnosis and treatment, confidence in staff, hospital information and the support that they received at home.

Royal United Hospital in Bath and the Great Western Hospital in Swindon, where they found excellent management by the Trust of the three-site centre and overall standards of facilities and care.

Waiting times and access to treatment continue to be important factors for patients and are part of a number of performance indicators and quality measures that are monitored monthly by the Trust Board. In line with the NHS Constitution, the Trust again met the national 18 week pathway. 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.

YOU CAN'T ALWAYS SEE THE SIGNS

60+
take the
test

Bowel cancer is the third most common cancer in the UK. The earlier it's found, the more effectively it can be treated.

If you are aged 60-69 and registered with a GP, you will automatically be sent a free kit that can detect early signs of bowel cancer. If you are 70 or over, you can request a kit by calling freephone 0800 707 60 60.

EXCELLENT REVIEW OF BOWEL CANCER SCREENING PROGRAMME

Excellent management and facilities highlighted in bowel cancer screening programme peer review.

As the lead organisation which manages the Bath, Swindon & Wiltshire Bowel Screening programme the Trust received a positive peer review from the national Quality Assurance Reference Centre. The assessment team carried out site visits at Salisbury District Hospital,



*Highlight
of the Year*

EXCELLENT WAITING TIMES

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.

Referral to treatment times are part of a number of national and local performance indicators and quality measures that are important to patients and currently underpin the development and business of the Trust. These are monitored monthly by the Trust Board and are periodically reviewed in order to reflect any new performance measures. This includes the five domains within the NHS Outcomes Framework.

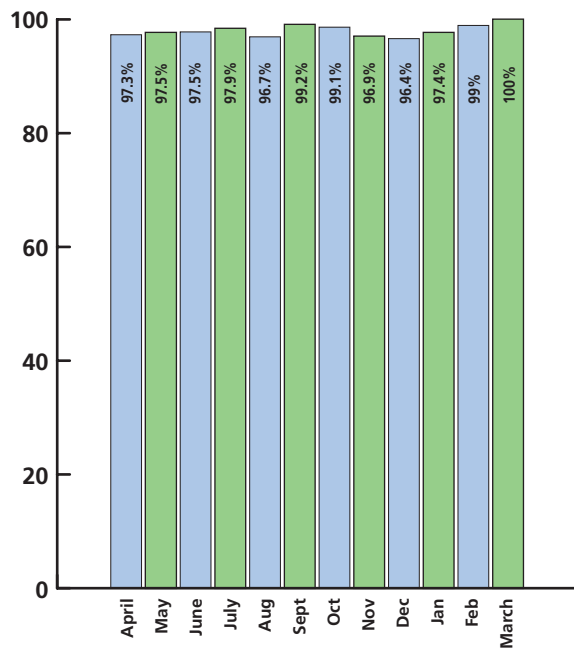
At the end of the 2012/2013 financial year the Trust met its cancer waiting time indicators. For instance, 94.4% (target 93%) of patients were seen within two weeks of referral from the GP and 90.1% (target 85%) treated within 62 days of GP referral. There was also good performance in diagnostic waiting times.



KEY PERFORMANCE INDICATOR APRIL 2012 – MARCH 2013

Cancer Waiting Times – 31 days from decision to treat to treatment start.

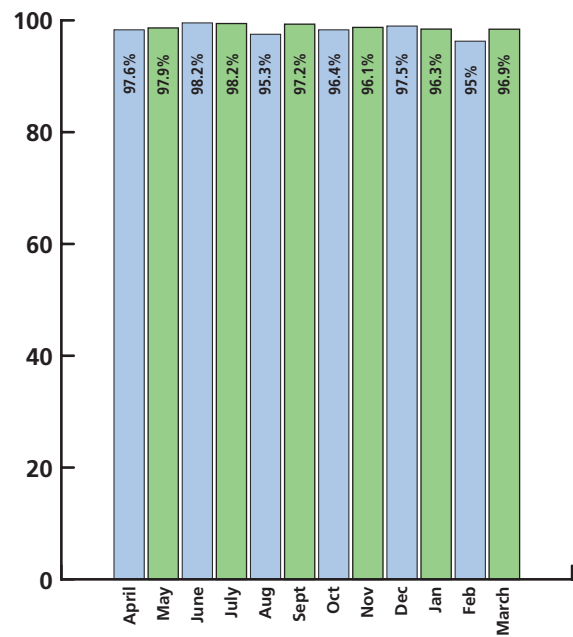
Target: 96% for the year: Total 97.8%



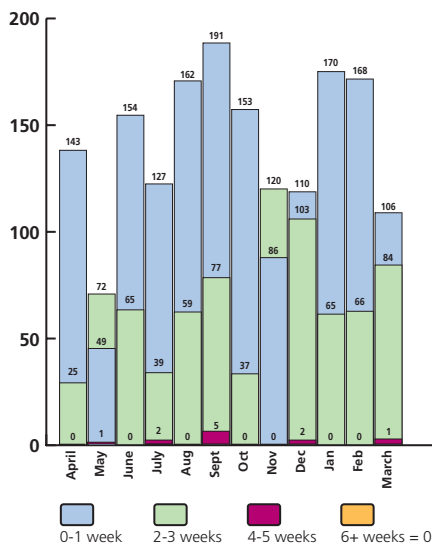
PERFORMANCE INDICATOR APRIL 2012 – MARCH 2013

Proportion of A&E attendees who were admitted, treated or discharged within four hours.

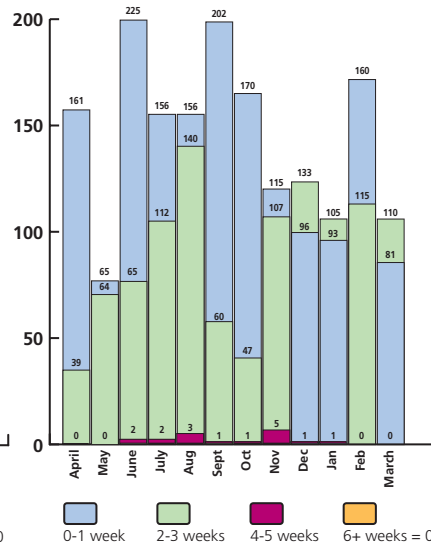
Target: 95% for the year: Total 96.9%



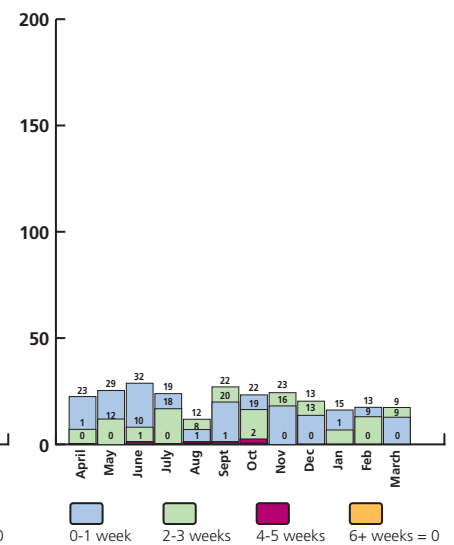
KEY PERFORMANCE INDICATOR APRIL 2012 – MARCH 2013 Target: 6 weeks for a CT scan



KEY PERFORMANCE INDICATOR APRIL 2012 – MARCH 2013 Target: 6 weeks for an MRI scan



KEY PERFORMANCE INDICATOR APRIL 2012 – MARCH 2013 Target: 6 weeks for an angiography



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 figure is in line with what would be expected for a hospital of its size, type and population it serves.



The Trust has continued with its work to streamline care for both planned and emergency patients and provide an efficient and effective service that improves patients' experiences of hospital care, reduces length of stay and, in some cases avoids unnecessary hospital admission. Reducing the length of time people need to stay in hospital is now recognised as a key measure in the overall quality of care provided and the Trust has continued to make good progress in this area. Expansion in both the number of conditions suitable for same day assessment and treatment and the use of enhanced recovery programmes – which involve small changes to all aspects of care from the initial assessment through to post-operative care - are just two ways in which the Trust has made further improvements in this area. The introduction of a discharge coordinator who works at weekends has also helped patients return home as soon as they are fit to do so.

*Highlight
of the Year*



EXCELLENT CLEANLINESS

***Salisbury is the only general hospital
in the country to receive highest rating
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. Salisbury is the only general hospital in the country to have received the highest rating for cleanliness each year since (PEAT) inspections started in 2000. 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.

Regular hand washing initiatives, cleanliness audits and campaigns, are just some of the initiatives the Trust uses to limit the risk to patients and improve safety while in hospital. The Trust continues to strive towards maintaining low MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia and Clostridium Difficile infection rates, as well as other infections such as norovirus which can, if not controlled appropriately, spread on hospital wards. When compared with other hospitals across the country, the Trust still continued to have low infection rates. Good infection control procedures and staff responsiveness, also enabled the Trust to manage and maintain low levels of norovirus at a time when the Health Protection Agency reported unprecedented increases in the prevalence of norovirus across the country.

*Highlight
of the Year*



MORE PATIENTS ABLE TO RECEIVE SAME DAY ASSESSMENT AND TREATMENT

***Trust increases the number of conditions suitable
for same day assessment and treatment***

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. Following the issuing of improvement notices by the Health and Safety Executive (HSE) relating to the management of risk to staff from violence & aggression and dermatitis prevention, the Trust took prompt action. In summary, improved processes, increased staff training around conflict resolution and better reporting of incidents resulted in the removal of the first notice. Better surveillance and monitoring of dermatitis and changes to policies and procedures meant that the second notice was also removed by the HSE.



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.

*Highlight
of the Year*

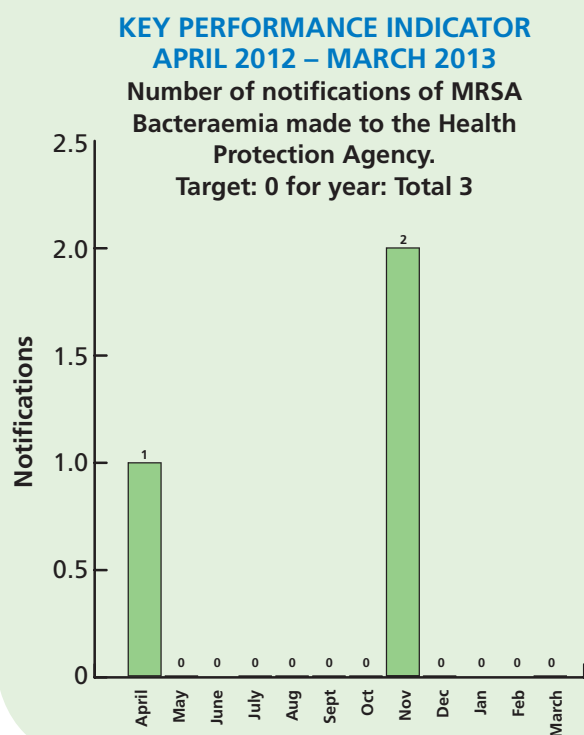
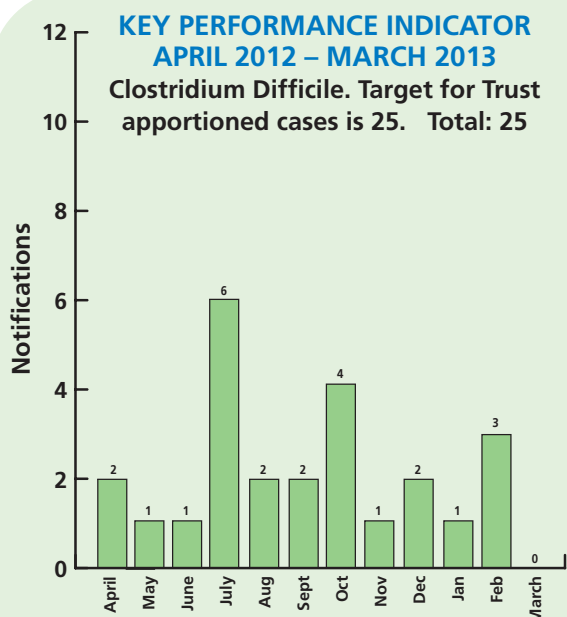


IMPROVING QUALITY THROUGH EFFECTIVE STRATEGY

Quality maintained as key priority for the Trust

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 the NHS Reforms continued to move forward following Royal Assent in March 2012, with Clinical Commissioning Groups (CCGs) working in shadow form with Primary Care Trusts prior to authorisation, with or without conditions. Within the year Monitor started to take on new and greater regulatory functions and will have an ongoing role in assessing NHS trusts for Foundation Trust status. They will also ensure that, once authorised, Foundation Trusts are financially viable and well-led, working closely with other healthcare organisations such as the Care Quality Commission.



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



During the year, the NHS Commissioning Board (now NHS England) was formally established as a public body responsible for planning, together with other bodies such as Health and Wellbeing Boards, which will take over the role of the Overview and Scrutiny Committees, and Healthwatch which will retain Local Involvement Networks' role in promoting patient and public involvement and supporting patients who want to exercise 'choice'.

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 will have an impact on the hospital, and its strategic objectives. For instance, the introduction of Any Qualified Provider (AQP) now means that patients can choose from a range of providers who meet NHS standards and prices. This includes those from the private sector.

- **Choice:** We will provide a comprehensive range of high quality local services, enhanced by developing our specialist services portfolio, which patients choose to access for their responsiveness, effectiveness and reputation.
- **Partnership:** We will work effectively with our partners to provide safe well coordinated care in the most appropriate location for our patients' needs.
- **Staff:** We will develop a high quality, innovative workforce proud to work at Salisbury NHS Foundation Trust.
- **Value:** We will provide efficient and effective services which deliver the best possible outcomes for patients.

The strategy was approved by the Trust Board in February 2013 and will be monitored regularly and reviewed periodically by the Board.

New ways of working, staff innovation, investment in new technology and the modernisation of facilities have always played a key role in the Trust's ongoing development and play an essential part in the overall care provided to patients.

For instance, during the year the trust opened a new Neonatal Intensive Care Unit (NICU). This £800,000 redevelopment saw an older ward transformed into a new NICU which is over three times the size of the old NICU, with modern first-class facilities. The NICU is joined to the former NICU building, which has become the parent's accommodation, so that they can stay close to their babies. Before that parents would have had to make daily trips to visit their newborn babies in hospital. The Stars Appeal raised over £350,000 towards the family accommodation part of the project with the remainder coming from the Trust's capital funds.

*Highlight
of the Year*



NEW CORPORATE STRATEGY

The Trust reviewed its long term strategy to meet the challenges faced by NHS reforms

The Trust will continue to work in partnership with existing stakeholders and develop good working relationships with new groups and bodies formed under the Health and Social Care Act 2012. In order to meet the challenge and the impact of proposed changes, the Trust carried out a review of its corporate strategy, which sets out how the Trust will adapt to the changing circumstances and how it can remain a thriving and independent Foundation Trust in the future. The strategy centres on the Trust's vision of offering an outstanding experience for every patient, so that it maintains its position as the local provider of choice. In summary, the strategy focuses on four strategic goals with a number of objectives applied to each. These goals are:

*Highlight
of the Year*



NEW NEONATAL INTENSIVE CARE UNIT AND FAMILY ACCOMMODATION

New expanded NICU with accommodation for parents so that they can stay close to their baby



Good patient care not only centres on treatment but also the prevention of accidents and illness. This year staff worked hard on providing additional support or advice through health promotion campaigns in a number of areas. This included breast care, breastfeeding and smoking awareness. The Trust also joined partners in highlighting key messages around alcohol and its impact on health. This complemented a new screening programme in A&E where patients are now asked about their alcohol use, so that the Trust can identify those who require advice and can be referred back to their GP for review.

Highlight of the Year



SPECIALIST OUTPATIENT VTE ASSESSMENT REDUCES AVOIDABLE ADMISSIONS

*People referred to hospital for VTE assessment
now receive this in a dedicated area*

The venous thromboembolism (VTE) team also continued to build on the excellent work they have been doing on blood clots. 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. People referred to hospital by their GP for an urgent diagnosis for venous thromboembolism can also now get faster assessment and treatment from a specialist team, in a dedicated area away from the Medical Assessment Ward. The aim was to provide a faster diagnosis, improved patient information and prevent avoidable admission to hospital and since it started in February 2012 the team has seen over 200 outpatients. The Trust is an 'Exemplar' site for VTE and is in the forefront nationally on VTE prevention.

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 Salisbury team has treated over 4,500 people and sold its products to 14 countries around the world and during the year they developed a more flexible wireless version of the stimulator. Examples of innovation this year could also be seen when the Trust launched its sunflower moisturising cream for public use. The cream, has been used effectively for patients who need a skin moisturiser following injury or surgery. Both initiatives generate additional money that can be reinvested in NHS services.

Highlight of the Year



COMMERCIALISATION OF SUNFLOWER CREAM

*Hospital develops new everyday skin moisturiser
which can be sold to the public*

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 40 projects this year, using many different methods including patient stories, focus groups and questionnaires. It is important that patients have the opportunity to tell us about 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 highlight emerging themes and issues so that we can focus attention on these and improve our services. For instance, in the national inpatient survey, noise at night, prompt answering of call bells and waiting times for people to take home medication were some of the themes which provided a



focus for improvements in the 2012/2013 financial year. Results from this year's national A&E survey showed that people needing emergency treatment rated the Accident and Emergency (A&E) Department at Salisbury District Hospital as one of the best in the country, with confidence in staff, privacy, and patient's experience rated highly. When compared with most other Trusts in the survey, Salisbury District Hospital was better in 32 of the 44 questions asked and about the same in the remaining 12.

Patients' views are invaluable and the Trust has a frequent feedback initiative which gathers regular feedback from wards and clinical areas. As part of the Government's plan to ensure that every patient has the opportunity to provide feedback on the quality of services they receive, the Trust also introduced the Friends and Family Test and from 1 April 2013 patients are asked a standard question about whether they would recommend the hospital to friends and family. This will be used to benchmark the quality of care across the country and make improvements where patient feedback has indicated that their experience is poor. 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. During the year the Trust strengthened its links with Clinical Commissioning Groups and met regularly with local GPs to discuss their ongoing and future needs. The Trust also 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 and the Trust also engaged with newly formed Health and Wellbeing Boards which take over the role of the Overview and Scrutiny Committees.

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. It also encourages alternative forms of travel through the Trust's Travel Plan.

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 a high rate of reporting and no harm incidents that reflect the value in its approach to this issue.



*Highlight
of the Year*

PATIENTS RATE A&E SERVICES HIGHLY
*Confidence in staff, privacy and dignity and
patients experience key positive findings
in national patient survey*

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. 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 the 2012/2013 year was challenging. The Trust continued to make efficiency savings to maintain the financial stability that it needs to ensure the long term viability of the hospital and respond to changes in the way patients access NHS services.

Despite the challenges, the Trust achieved its financial targets, finishing the 2012/2013 year with a £1.63m surplus and an overall Monitor financial risk rating of 3. This surplus is important, as it provides a degree of financial flexibility and enables the Trust to maintain existing services, whilst investing in new developments that benefit patients.

Key Financial Targets Met

- Planned surplus exceeded
- Achievement of Level 3 Financial Risk rating as planned
- £7.6m savings achieved

The year saw the transition to new commissioning arrangements under the NHS reforms, with the Trust working closely with outgoing Primary Care Trusts (PCTs) and the new Clinical Commissioning Groups (CCGs) on financial decisions that relate to 2012/2013 and to agree contracts and plan care for 2013/2014. This includes a continuing need to provide services more efficiently in both primary and secondary care. Like PCTs before them CCGs will be looking to provide more services in the community, which could impact on the Trust's own financial planning over the coming years. As in previous years the Trust continued to work with GPs and community services to reduce length of stay, avoid unnecessary admission to hospital and where possible provide more care and treatment in the community.

Nationally the NHS has to make £20 billion savings by 2014/2015 as part of an ongoing programme, which started in 2009/2010. The Trust has its own savings programme, which means we have to be more efficient and flexible in how and where we provide our services, while maintaining high standards of care. At the start of the 2012/13 year the Trust's savings target was £9.6m, driven mainly by a real terms 4% reduction in the national tariff which determines the amount we get paid for most of our work. Individual directorates identified savings in their own areas and at the end of the year the Trust achieved savings of £7.6m, with the balance made up from additional income from activity. The number of patients seen was broadly the same as the previous year. However, there are signs that demand management by GPs restricted the growth in activity that the Trust had been seeing over previous years. The Trust also reviewed its practices to achieve 'Best Practice Tariffs' that benefit the Trust and patients

and this also helped maximise income and the overall financial position.

In 2013/2014 the Trust will need to make further savings of 4%, due to the changes in the national tariff. There will also be an additional 0.5% for unavoidable cost pressures, giving the Trust an overall savings target of 4.5%. However, this will not be spread evenly across all Directorates, as the Board has agreed to protect ward nursing and midwife staff numbers.

Efficiency and Use of Resources

- High levels of efficiency maintained with overall costs 8% less than the national average.
- Management and administrative costs contained within 3.87% of turnover.

During the year the Trust brought in an external consultancy to see whether they could identify savings which would support future years. The Trust was one of a number of Trusts that joined the South West Pay Terms and Conditions Consortium. This was set up to respond to the financial and clinical service challenges facing the NHS, with the aim of identifying how taxpayer funding may be more efficiently used in order to protect both employment and the continued delivery of high quality healthcare in the future. The work of the Consortium took place in parallel with national negotiations on several elements of pay terms and conditions. Around 63% of expenditure comes from staff pay and this is under national terms and conditions, known as Agenda for Change and also the consultant contract. While nationally there was no cost of living staff pay rise during 2012/2013, incremental progression up pay scales still took place for eligible staff, with the cost met by the Trust. Because of the financial position, there is an agreed view across much of the NHS that there is a need to identify ways of reducing the overall 'pay bill' in line with reduced funding, whilst continuing to treat more patients. The Consortium looked at potential solutions outside the national negotiations. The NHS Staff Council signed off the national Agenda for Change Agreement on the areas covered in its review and the Consortium identified further recommendations to be considered by individual Trust Boards.



The Board's approach is to work in partnership with local unions to implement the national Agenda for Change Agreement and the recommendations from the Consortium report. It also proposes joint work to identify future opportunities to change national terms and conditions that should be explored at national level.

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 include: 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. 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 81.6% of non NHS bills and 74.1% 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 surplus 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.

Patients Treated			
	2012/2013	2011/2012	2010/2011
Elective inpatient (spells)	6,956	7,353	7,282
Day cases	18,845	19,559	20,082
Non elective (spells)	28,346	28,457	28,837
Regular day attendees	6,468	5,703	5,320
Outpatients (consultant led)	180,250	180,394	178,514
New attendances	(63,522)	(63,501)	(66,480)
Follow up	(116,728)	(116,893)	(112,034)
Accident and Emergency	42,919	42,453	40,749
New attendances	(41,939)	(41,453)	(39,827)
Follow up	(980)	(1,000)	(922)
<i>Spells are the main way in which hospital activity is recorded. A spell is the period of time from Admission to Discharge.</i>			

Capital Expenditure

Capital Expenditure of £7.5m million was incurred in 2012/2013 and spent on a range of service developments.

Capital projects included:

Medical Equipment	£1,478,000
Pharmacy Aseptic Suite	£ 595,000
Improvements to Neonatal Intensive Care Unit	£ 506,000
Improvements to Trust IT servers	£ 456,000

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

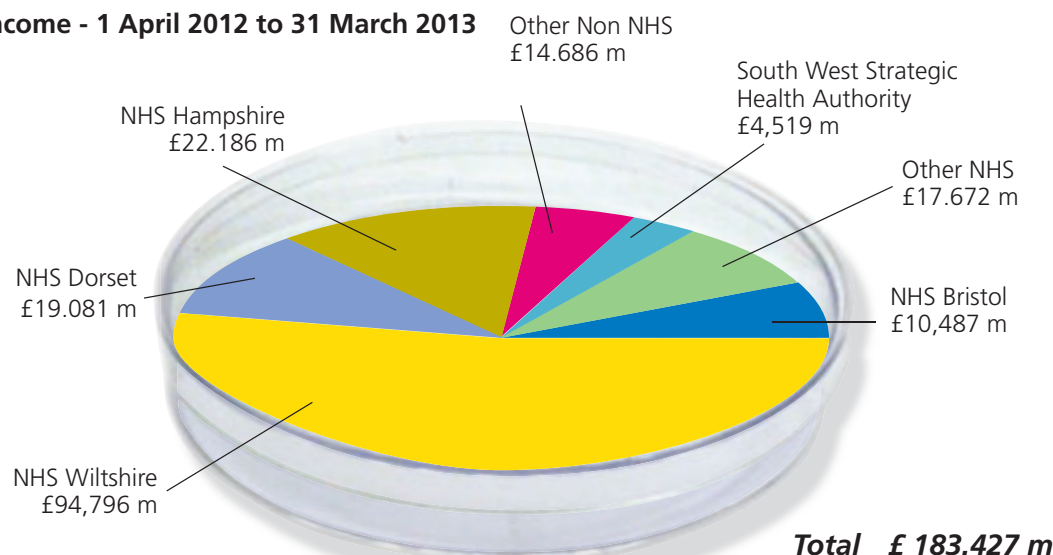


Staff receive regular monthly updates, with key operational and financial information cascaded throughout the organisation, as well as the day to day communications that take place at different levels of the Trust. The Trust also held open sessions for all staff on the financial position nationally and locally and the work of the South West Pay Terms and Conditions Consortium. The Executive Directors also visited departments and wards to discuss the issues and feedback staff views to the Consortium so that these could be used to influence any recommendations or proposals. The Trust also set up a separate page on its Intranet so that staff were fully kept up to date on progress and this linked into a dedicated Consortium website. The Chief Executive regularly sends out a personal message to all staff as part of the wider communication process. 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 treats private patients through a partnership with Odstock Private Care Limited (OPCL). To support this, the Trust has a designated unit called the Clarendon Suite, where private patients can be treated on the Salisbury District Hospital site. While (OPCL) is contracted to provide private care on site, income generated is used to benefit NHS patients by supporting our services. There are also a number of treatments offered that are not available on the NHS. These are provided privately within departments without compromising our own NHS service. A good example of this is the Laser Centre.

Good relationships and the flexibility to explore new business and commercial opportunities will again be key to the Trust in the coming year. This will include the launch of the Trust's sunflower cream for public use as a moisturiser. The Trust will also continue to monitor its performance around existing targets and the NHS Outcomes Framework.

Sources of Income - 1 April 2012 to 31 March 2013



PATIENT CARE AND STAKEHOLDERS

During the year the Trust introduced a number of developments and initiatives that have directly or indirectly improved patient's experiences and the quality of 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

Putting Pride Into Practice

Staff enjoyed a unique opportunity to share best practice, celebrate their achievements and highlight improvements to patient care at the Trust's Putting PRIDE Into Practice – Making Every Contact Count event. The local event reflected the Chief Nursing Officer for England's vision for staff who provide care to patients that centres on six key values and behaviours. It also complemented the key themes and recommendations in the Francis Report.

New Faster Service For Outpatient VTE Assessment And Treatment

People referred to Salisbury District Hospital by their GP for an urgent diagnosis for venous thromboembolism (VTE) are now getting faster assessment and treatment from a specialist team, in a dedicated area away from the busy Medical Assessment Ward. The aim was to provide a faster diagnosis, improved patient information and prevent avoidable admission to hospital. Since it started only three patients from the 178 outpatients seen needed to be admitted.

Breast Cancer Patients Benefit From New Lymph Node Technique

Patients who need an operation to remove breast cancer that has spread can now have this carried out during the first procedure thanks to a new machine that gives an instant result which is available to the surgeon while the patient is under anaesthetic. Previously surgeons would have had to wait for the results of a biopsy and patients who had a positive test would have had to come back for a second operation.

National Dementia Audit 2012

As part of its commitment to improve the care it gives to people with dementia, the Trust took part in the second round of the national dementia audit. The aim of the audit was to test the care we provide and identify areas for further improvement. In recognising achievement in this area, Chilmark Ward achieved a silver award and Redlynch, Pitton and Farley bronze for improvements that staff.

Successful Recruitment And Education Day For Psychology Volunteers

Over 100 people came along to a successful recruitment and education day for existing psychology volunteers and people who are interested in volunteering on the Engage programme. As part of Engage, volunteers provide additional stimulation and interaction for older people through memory puzzles, discussion groups and reading.

Improvements To Discharge Planning

The Discharge Team set up a project to ensure that patients receive their diagnosis, treatment and rehabilitation quickly, reducing their hospital stay. This was achieved through a more coordinated approach to daily patient reviews, with social care and hospital teams meeting jointly at ward level to discuss each patient's progress.

Introduction of Hospital at Night Co-ordinator Role

The Critical Care Outreach team respond to the immediate needs of patients and expanded on the success of the Hospital at Night (H@NT) project by introducing leadership, coordination and additional clinical expertise through a H@NT clinical Coordinator role. This has reduced delays and improved continuity of care.

New Nurse - led Urology Telephone Clinic for Follow up Patients

Nurses in the Urology Department wanted to find a safe and effective alternative to follow up appointments that met the needs of their patients. The team set up three telephone clinics each month for appropriate patients, which reduced the number of clinics and individual hospital visits and increased patient satisfaction.



Successful Staff Flu Vaccination Programme

Over 1,800 staff received flu vaccinations last winter as part of a successful campaign to protect patients and staff from the virus. Comprehensive staff vaccination helped reduce the risk of flu spreading across patient areas, affecting vulnerable patient groups. It also reduced the impact on staff sickness within the Trust.

PROMOTING BETTER HEALTH AND SUPPORT FOR OUR PATIENTS

Breastfeeding Support For Mums

As part of Breastfeeding Awareness Week, mums had an opportunity to learn more about the support that is available to them at a special family picnic organised by the Salisbury Breastfeeding Peer Support Network. This gave successful breastfeeding mums an opportunity to share their experiences and encourage others who may be experiencing difficulties with breastfeeding.

Eye Talk For Hospital Members

Local people had an opportunity to find out more about the eye and common conditions and injuries treated by our specialists in a presentation given by Consultant Ophthalmologist Roger Humphry. The talk was part of the Medicine for Members series, and gave people an insight into how the eye works, highlighted the clinical conditions that are treated and provide some practical tips to keep safe and healthy.

Dying Matters Awareness

As part of Dying Matters Awareness Week Hospital and Hospice staff held their own local campaign to highlight the work that they do to support patients, carers and relatives and provide key messages for people who are nearing the end of their life. This centred on simple steps which could make a big difference to people when they are dying, such as sharing their wishes with someone close to them, registering to be an organ donor or simply talking about their situation.

Organ Donation Awareness

As part of Organ Donation Week, staff were on hand to provide information and key messages to local people at the Salisbury library. With only a third of the population on the organ donor register, one objective was to increase this further. The other was to ensure that people tell family and friends they are on the register, so that they are aware of their wishes when they become involved in discussions about donation.

People can register by calling the donor line on 0300 123 23 23.

Members Learn About Heart Problems And Prevention

Consultant cardiologist Tim Wells gave local people an opportunity to find out more about heart disease and how they can look after their own health. The talk gave us an opportunity to highlight the causes of coronary heart disease, prevention and the treatment that we can offer people in the new purpose built Cardiac Suite in Salisbury.

Talk About Cancer Care And Support From Salisbury Specialists

As part of the popular Medicine for Members lectures, specialists gave local people an opportunity to find out more about cancer care, the support that is available for people with the disease and the importance of effective teamwork and communication.

Patient Information at Salisbury District Hospital

The Trust recognises the value of good quality information and continues to build up and update its information library. All our information can be found on the Trust's website. A working group looks at different types and styles of patient information, and works on themes identified through real-time feedback, concerns, complaints and the patient surveys. Volunteers comment on all patient information including leaflets, web pages and DVDs as part of the work carried out by the Readership Panel. A number of new Easy Read leaflets have been written by a group of adults with learning disabilities helped by a support worker and member of staff. There are plans for a new information centre in the hospital in 2013/14 where information will be available to patients and visitors and information prescriptions can be rolled out to all patient groups.



LISTENING AND LEARNING FROM OUR PATIENTS

Patients Rate A&E Staff And Services Among Best In Country

People needing emergency treatment rated the Accident and Emergency Department at Salisbury District Hospital as one of the best in the country, with confidence in staff, privacy, and patient's experience rated highly in an independent Care Quality Commission (CQC) survey. Around 850 people were asked their views on facilities, waiting times, the quality of care and the way they were treated. When compared with most other Trusts in the survey, Salisbury was better in 32 of the 44 questions asked and about the same in the remaining 12.

Inpatient Survey

In the national inpatient survey respect and dignity and quality of care were two examples of the positive findings from patient's comments. Salisbury was also amongst the best performing Trusts on questions relating to delays for medicine, to see a doctor or for an ambulance. However, there were areas where the Trust does need to make improvements. These include noise at night and answering of call bells. A full action plan is monitored at Board level.

Patients Rate Outpatient Services Highly

Patients rated the outpatient services highly as part of a national survey carried out in all general and specialist hospitals by the independent Care Quality Commission. Patients were asked questions relating to their appointment, care and treatment, the hospital environment and their overall impression of the service. The Trust was amongst the top 20% of best performing hospitals in most of the questions covered, with privacy and dignity, cleanliness, confidence in staff and satisfaction with outpatient services key findings in the survey.

Salisbury Cancer Patients Rate Their Care Highly In National Survey

Over 90% of cancer patients who were asked their views on the care they received at Salisbury District Hospital rated it as excellent or very good in a national survey carried out on behalf of the Department of Health. The questionnaire covered the patient's diagnosis and treatment, confidence in staff, hospital information and the support that they received at home.

Good Day Surgery Survey

Day surgery patients rated staff and the quality of services highly, with respect and dignity, confidence in staff and overall patient satisfaction key findings in a survey. Around 99% of patients who responded to the survey said they had confidence and trust in the doctors and nurses, that they were treated with respect and dignity and that toilets and clinical areas were clean. They also said they would recommend the hospital to friends and family.

Comments, Concerns, Complaints and Compliments

Last year the Trust treated 60,607 people as inpatients, day cases and regular day attendees. Another 42,919 were seen in A&E and 180,250 as outpatients. The Chairman, Chief Executive and Customer Care Department received 2,301 thank you letters/cards, with many more sent directly to staff on wards and units. There were 450 general enquiries, 328 comments, 544 concerns and 320 complaints. The overall number of comments, concerns and complaints responded to in 0-10 working days was 1,139 (70%), in 10-25 working days 217 (13%) and above 25 working days 280 (17%). All comments, concerns and complaints were acknowledged either verbally or in writing within three working days. Nine complaints were referred to the Parliamentary and Health Service Ombudsman for independent review and, to date eight have not been upheld. The Trust is awaiting a decision on one case.

The Trust welcomes feedback as this is used to improve the quality of its services. Areas where improvements were made following complaints include:

- The perioperative anticoagulation policy has been updated to provide procedural clarity and the perioperative care pathway for patients on Warfarin has been reviewed.
- A new proforma was introduced, which triggers the correct response and management in the event of an eclamptic seizure.
- An information leaflet has been written, detailing the screening and investigations the hospital offers women who are expecting twins.
- The Trust patient property policy has been reviewed.
- To help reduce waiting times in the Eye Clinic, expansion work is underway, a new consultant has been appointed with another appointment to made in the near future and clinic booking patterns are being reviewed.

More detail about improvements can be found in the Trust Board quarterly reports.



MAINTAINING PERFORMANCE FOR OUR PATIENTS

Positive CQC Inspection

The Care Quality Commission (CQC) found that Salisbury District Hospital met essential care and cleanliness standards following a routine unannounced inspection. The CQC carry out spot-check reviews of compliance in all areas of health and safety including the care and welfare of people who use the services, the cleanliness of the hospital, standard of infection control and the monitoring of service provision. The Trust was assessed in seven standards, with action required in just two areas, staffing and records management.

Excellent Dementia Peer Review

The Trust received a positive review on the care it provides to patients with dementia from a peer review team of experts from the south west region. The review team were impressed with the enthusiasm and professionalism of staff. They also singled out a number of areas of good practice that they will be looking to share across the region, building on the key strengths of leadership and widespread engagement from the first review last year.

Successful Bowel Cancer Screening Peer Review

As the lead organisation which manages the Bath, Swindon & Wiltshire Bowel Screening programme the Trust received a positive peer review from the national Quality Assurance Reference Centre. The assessment team carried out site visits at Salisbury District Hospital, Royal United Hospital in Bath and the Great Western Hospital in Swindon, where they found excellent management by the Trust of the three-site centre and overall standards of facilities and care.

Hospital Receives Excellent Cleanliness Rating

The Trust has received an excellent rating for cleanliness from the Department of Health following a Patient Environment Action Team (PEAT) inspection. Salisbury is the only general hospital in the country to have received the highest rating for cleanliness each year since PEAT inspections started in 2000. The Trust also received an excellent rating for food, privacy and dignity.

Positive Environmental Health Inspection

The Trust received a 5 star rating for food safety following a routine inspection of general catering facilities and ward kitchens by the local authority Environmental

Health Department. The inspector reviewed staff training, cleaning and temperature control records, and the processes we have in place to manage food safety. They also observed staff practices, checked food production and food storage areas.

Gold Rating in National Audit Of Laparoscopic Theatre

Salisbury District Hospital has achieved the maximum score and a Gold rating in the national audit of laparoscopic theatre equipment. The Trust is one of only 15% of hospitals in the audit that has fully integrated theatres with High Definition imaging equipment. This is considered to be the highest standard for laparoscopic surgery which is hugely beneficial to staff and to patients who undergo this type of surgery.

Education Department Receives National Accreditation

The Education Department received accreditation from the Learning and Performance Institute (LPI). This assures the Trust that the education team conform to a professional code of practice, that individuals involved in learning provision are technically competent and have a recognised teaching qualification and that our facilities are up-to-date and of industry standard.

Successful External Assessment For Hospital Library

Following an external assessment to test compliance against the NHS Libraries Quality Assurance Framework (LQAF), the Hospital's Healthcare Library achieved an overall score of 95% against a national average of 85%. The framework is designed to ensure there are a number of core services offered by NHS health care libraries and consistent standards across the country.

Trust Retains Patient Information Standard

The Trust has retained the Information Standard from its external assessors, the Royal Society for Public Health. This ensures that the Trust continues to provide high quality health and social care information. Salisbury is one of only 34 hospital Trusts across the country that has been accredited with the Information 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 and can be trusted.



IMPROVING SERVICES AND FACILITIES FOR OUR PATIENTS

New Sleep Service for People from South Wiltshire

People from south Wiltshire with suspected obstructive sleep apnoea can now access a new sleep service at Salisbury District Hospital. The Respiratory Team has provided a sleep service for Dorset patients since 1998 and has extensive experience in the assessment, investigation and treatment of sleep disorders.

New Equipment Keeps Salisbury In Forefront Of Genetics Diagnosis And Testing

Salisbury scientists can now obtain more complete genetic information to diagnose a wide range of conditions, thanks to a new £100,000 state-of-the-art DNA decoding machine. This new 'next-generation sequencing' equipment helps them identify genes associated with specific hereditary conditions, so that doctors can make an accurate diagnosis, provide advice, support and improved management of the condition for patients and their families.

Opening Of New Neonatal Intensive Care Unit And Family Accommodation Suite

The new Neonatal Intensive Care Unit (NICU) and additional Family Accommodation Suite opened and, together are now known as the Neonatal Unit. The family accommodation provides parents with on-site accommodation. The new clinical areas within the Neonatal Unit have high and low dependency facilities and special rooms where mothers can stay close to their babies in privacy. Both projects received additional support from the Stars Appeal.

Patients Benefit From Opening Of New Infusion Suite

Patients who need intensive treatment for rheumatic diseases such as osteoporosis and inflammatory arthritis now benefit from a fully equipped infusion suite at Salisbury District Hospital thanks to a £2,500 donation from the Salisbury Hospital League of Friends. Some patients need frequent treatment and drugs are delivered directly into the veins through a drip over a 4 to 6 hour period.

Opening Of Horatio's Garden

Horatio's Garden opened, giving spinal patients recovering from life-changing injuries an opportunity to enjoy the fresh air in a beautiful area designed by award winning gardener Cleve West. The garden was made possible through generous donations to the Southern Spinal Injuries Trust (SSIT) and the Hospital's charitable funds. It will serve as a lasting tribute to Horatio Chapple who was a volunteer on the spinal unit and the inspiration behind the creation of the garden.

New League Of Friends And Stars Appeal Shops

Following extensive renovation new League of Friends and Stars Appeal shops opened in the main reception area of the hospital. The League of Friends shop sells hand made sweets, confectionery and ice cream, with the Stars Appeal selling its books, jigsaw puzzles, DVDs, cards and Stars Appeal merchandise. Both areas are staffed by a team of volunteers with all profits generated going to fund extra care and equipment at Salisbury District Hospital.

Improvements To Endoscopy Unit Facilities

Patients who need diagnostic internal investigations can now benefit from improved facilities in more comfortable surroundings following a redesign and refurbishment of the Endoscopy Unit. The redesign provides a clear flow through the unit from admission, recovery to discharge and enables patients to be admitted and discharged in a quiet room.

Haematology Consultants Develop Generic E-Mail Advice For GPs

Addressing queries about abnormal laboratory results and possible patient referrals and increased demand on laboratory services had become time consuming. The team developed a generic email address to run alongside a clinical guidelines webpage that speeded up responses and improved satisfaction rates for GPs.



IMPROVING EFFICIENCY TO SUPPORT PATIENT CARE

Odstock Private Care

Odstock Private Care Ltd (OPCL) marked the first five years of supporting NHS services when it donated over £140,000 it had generated this year from private care provided on the Salisbury District Hospital site to the Trust. Since it started in 2007, OPCL has given over £500,000 to the hospital which has been used to support NHS services and buy additional medical equipment.

Trust Payroll Team Win New Contracts

The payroll team won a tender to provide payroll services to Oxford Health NHS Foundation Trust for another three years. The Trust already provides a service for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and this money is used to develop and improve NHS services for patients in Salisbury.

Energy Efficiency Awareness

The Trust held an Energy Awareness Day. Estates staff and the EDF energy team provided useful tips on how to save energy at work and at home as part of its 'Small Change Can Make a Big Difference' campaign. As part of the campaign staff were encouraged to generate energy saving ideas themselves with an opportunity to win a prize.

Facilities Improve Efficiency Of Working Practices

Following a workforce review, the team set out to improve communication and engagement with facilities staff in order to increase their understanding of current issues, generate ideas and introduce new ways of working. The resulted in improved staff feedback, reductions in absence and a better service for staff and patients.

RECOGNISING INNOVATION THAT IMPROVES PATIENT CARE

Innovations Awareness

Trust innovation leads held an Innovations Day to help create awareness of the type of ideas that could lead to the development of a commercial product and the support that they can provide to maximise its potential and protect the rights of the person who had the original idea. The Trust has a long tradition of innovation and creativity and currently has a range of products at the final commercialisation stage.

New Wireless Equipment To Improve Pioneering Salisbury Walking Aid

Clinical engineers at Salisbury have developed a more flexible wireless version of their pioneering Odstock Dropped Foot Stimulator walking aid which has transformed the lives of thousands of stroke patients. The new wireless version takes away the wires that run between the foot switch and the control box making it more convenient and easier to use. Money generated is used to further research, improve existing aids and develop new products that benefit NHS patients.

New Electronic Discharge Summaries

With substantial clinical input, staff in informatics have developed electronic discharge summaries which have improved the service we provide to primary care. The summaries include information on To Take Out (TTO)

drugs, follow up outpatient appointments and actions for primary care and provide a timely, high quality, electronically transmitted discharge summary to GPs.

New Screening For Women To Identify Antenatal Distress

'Mums to be' often find it difficult to express their worries about pregnancy, which can lead to anxiety and depression. Maternity and Psychology staff worked together to develop a staff training programme to recognise, manage and sign-post women to appropriate psychological support.

Abdominal Aortic Aneurysm (AAA) Screening

The Trust was successful in its bid to provide Abdominal Aortic Aneurysm (AAA) screening in Wiltshire and Dorset and AAA screening is now offered to men aged 65 and over. Appointments take place at Salisbury District Hospital and Warminster Hospital.

Sunflower Cream

The hospital launched its Sunflower Cream with new labels and a range of promotional materials. The pharmacy has been making and supplying this moisturising cream for use in the hospital for many years.



RECOGNISING AND REWARDING THE BEST

Staff Rewarded For Services To Patients

Staff were rewarded for their professionalism and commitment and the way in which they have improved services for patients as part of the Striving for Excellence Awards. There were 10 categories in all, and award nominations were made by patients, staff and volunteers, with Governors, staff and members of the public voting for the winners in the Service Improvement categories.

Orthopaedic Team Wins National Award

Orthopaedic staff have won a national award from the Clinical Leaders Network (CLN) recognising their position as one of the leading teams in the country that treat people with broken hips. The award, which was judged by leading UK health professionals, highlights the team's performance against six key national standards. These include fast access to a specialist consultant, early review by multidisciplinary teams, and timely assessment and surgery.

Junior Doctors Receive National Recognition For Safety Improvements

Junior doctors working on out-of-hours medical ward cover received national recognition from the UK Foundation Programme for their work in improving safety and cover at weekends and bank holidays. Junior doctors have to cover a large number of beds during these periods and as part of the improvements they devised a new priority based bleep system. The team were highly commended for their work which they presented at the national UK Foundation conference.

Laverstock Ward Wins Help For Heroes Award

Staff on Laverstock Ward won a Hero Award from national charity Help for Heroes for the outstanding medical and nursing care they have given to military patients. The multi-disciplinary team and support staff in plastic surgery and on Laverstock Ward provide a wide range of care to soldiers who have been injured in Afghanistan and Iraq.

Senior Nurse Wins Leadership Award

Directorate Senior Nurse Colette Martindale won the Chief Executive's Striving for Excellence Leadership Award. Colette is a natural born leader who has risen successfully through the ranks since she started working at Salisbury over 20 years ago. She is a great ambassador for the Trust and a tremendous advocate for her patients.

Cancer Lead Wins Outstanding Contribution Award

Helena Bridgman, Clinical Lead for Cancer Services, won the Chairman's Outstanding Contribution Award. In addition to her role as clinical lead for cancer, Helena played a significant part in improving care for patients with dementia. Since she started in 1986, countless people have benefited from her involvement and energy.

Salisbury Team Wins Award for Work with Nepalese Patients

The Retinal Screening Team, which runs the Salisbury and North Hampshire Diabetic Eye Screening Programme, covers a large Nepalese population. Take up of screening for this group was low, so the team worked closely with primary care to involve this group break down barriers and increase the take up rate by 26%.

CELEBRATING ACHIEVEMENTS

Salisbury Patients Win Inter Spinal Unit Games

Patients from across Southern England have won the 2012 Inter Spinal Unit Games for Salisbury District Hospital at the Stoke Mandeville Stadium in Aylesbury. The six strong team was pitted against 11 other teams from spinal units across Great Britain and Ireland and the games included swimming, table tennis, hand cycling, fencing, shooting, archery and wheelchair rugby.

Spinal Patients Capture Own Sporting Achievements For London 2012

Spinal patients had a unique opportunity to capture their own sporting achievements on camera as part of the London 2012 Olympic and Paralympic Games celebrations. The patients worked with the hospital's ArtCare team on its Beyond the Line project which supported activities and events that highlight the sporting and artistic skills and abilities of people with a spinal cord injury.



Trust Young Volunteer 2012

Eighteen-year-old Bishop Wordsworth School student Daniel Stevens was rewarded for his dedication and commitment to patients when he was presented with the Trust's Young Volunteer Award. Daniel, spent one day a week helping patients and physiotherapy staff with weekly hydro sessions for children and providing additional support to staff in motivating children who need to complete their exercises.

NHS Heroes

Dave Cates, Director of Fundraising and Philip Blackman, Chemotherapy Scheduler were given NHS Hero Awards as part of a national recognition scheme for staff. Anyone in the NHS who demonstrated real commitment and compassion in care or support work could be put forward for an award which coincided with the 64th Anniversary of the NHS.

Salisbury Nurse Supported British Paralympic Team

Lead nurse Anne Seaman who works on the Duke of Cornwall Spinal Treatment Centre provided specialist support to ParalympicsGB at the Paralympic Games in London. She was selected as a member of the team because of the range of skills she developed working with spinal cord injured patients and the way in which these skills are used to support people across a range of disabilities.

Unsung Hero Rewarded

Linda Harris, Vascular Unit Manager, won the Trust's Unsung Hero Award. Her commitment and dedication was the driving force behind the development of vascular outpatient services and a key factor in the successful tender for abdominal aortic aneurysm screening.

Endoscopy Unit Wins Customer Care Team Award

The Endoscopy Unit received a customer care award from patients who highlighted the professional, friendly and compassionate care they provided in often difficult personal and sensitive circumstances.

Surgeon Recognised With Customer Care Individual Award

Consultant plastic and oral maxillo facial surgeon Ian Downie won a customer care individual award from patients who complemented him for his high standards and the way in which he looked after his patients.

Volunteer Rewarded For Friendliness And Humour

Volunteer Shirley Howson was rewarded for her work on the Nunton Unit. Shirley provides invaluable support to staff, greeting patients, making tea and putting them at ease. Her friendliness and humour is mixed with a quiet efficiency in everything that she does.

Staff Nurse Wins Mentoring Award

Staff nurse Shantimole Mathew won the Pinder Award, which recognises the role experienced nurses play in supporting students throughout their training programme. Shantimole was nominated by a student who highlighted her kindness and dedication in supporting her through her placement.

Hospital IT Manager Celebrates Master's World Cup Hockey Win

IT Support Manager and national over 50s hockey goalkeeper Linda Dunham celebrated success following England's win over New Zealand in the Inaugural Lady Master's World Cup. Linda has a good track record in international hockey having represented England for the last five years in the over 45s category.

Long Service Awards 2012

Twenty eight members of staff were rewarded for their loyalty and commitment to patients when they received long service awards for completing 25 years continuous service. This included staff from a broad range of roles across a range of hospital services. The Trust held a special ceremony, and those who were able to attend were presented with their certificate, flowers and a gift from the Trust's Chairman and Chief Executive.



WORKING WITH OUR STAKEHOLDERS, PARTNERS AND LOCAL COMMUNITY

New Mobile Chemotherapy Unit For Salisbury Hospital Patients

Some patients who travel up to 60 miles a day for chemotherapy and related treatments on the Pembroke Suite are now able to have this closer to their home thanks to the launch of a new Mobile Chemotherapy Unit. The new unit was been donated by national charity Hope for Tomorrow and is being used for Salisbury District Hospital patients from Wiltshire, Hampshire and Dorset.

Hospital Liaison Carer Support Worker

The Trust worked closely with Carer Support Wiltshire who now have a Salisbury District Hospital Liaison Carer Support Worker (HLCSW) to help staff identify carers and ensure that as many carers within the hospital are aware of the support services that are available to them. Carers play a vital part in the support, rehabilitation, recovery and timely discharge of patients and the HLCSW attends daily whiteboard meetings and gives help and advice to professionals and carers.

Alcohol Awareness

The Trust worked with Wiltshire Council to promote the Government's new message that all people should have at least two alcohol free days each week to give the liver time to recover. As part of Alcohol Awareness week, there was a online pledge, an alcohol awareness event

in Springs Restaurant and a mobile roadshow which visiting a number of towns in Wiltshire.

Nurses Celebrate Black History Month

Hospital staff joined the Royal College of Nursing to celebrate Black History Month. The aim was to promote knowledge of black history, culture and heritage and champion the many positive contributions that black and ethnic minority communities make to society. Events were held in hospital and the community.

Hospital Consultants Give Trees To Mark Queen's Diamond Jubilee Year

Hospital consultants gave a range of trees to be enjoyed by patients, staff and visitors to mark the Queen's Jubilee. Across the country people planted trees to celebrate the Diamond Jubilee, as part of the Woodland Trust project. At Salisbury District Hospital 17 trees were planted on the Green at Entrance B creating a lasting legacy and a fitting tribute to the celebrations.

Radio Odstock Opens New Studio

Patients are able to enjoy a wider choice of programmes on hospital radio thanks to the introduction of a second £4,000 state-of-the-art studio funded by the Salisbury Hospital League of Friends. Radio Odstock has been broadcasting to patients for over 60 years providing a range of music, dedications and chat.

SUPPORTING OUR STAFF TO PROVIDE BEST CARE

Staff Salary Sacrifice Scheme

The Trust introduced a salary sacrifice scheme for staff who choose to pay for their parking monthly from their salary. By adopting the scheme, staff who buy monthly parking permits, and who opt to "salary sacrifice" for this service, will have their salary reduced by the cost of their monthly permit which can save income tax, National Insurance and pension contributions on the sacrificed salary.

Shape Up @ Salisbury - Staff Health And Wellbeing

The Trust held a number of events to support staff in their work and promote staff health wellbeing and safety as part of its Shape Up @ Salisbury campaign. This

included free classes in the staff club and opportunities for advice on a number of health issues. There is evidence to show that the health and wellbeing of our staff can have a positive impact on the care that they are able to give to our patients.

Staff Stop Smoking Course

The Trust gave staff an opportunity to take an 11 week stop smoking course as part of its health and wellbeing initiative. Smokers are four times more likely to quit smoking with support and the course included two weeks free nicotine replacement therapy (NRT), assessment and treatment, as well as helpful talks on stop smoking support, behavioural change, peer group support and general encouragement.



Staff And Children Enjoy Opening Of New Garden And Play Area

Staff and children at the Salisbury District Hospital Day Nursery celebrated the opening of a new £25,000 garden and play area. The garden, which includes new grassed and woodland areas, sandpit, raised planting and outside seating, was made possible thanks to money raised through the hospital's staff lottery and the Salisbury Hospital League of Friends, together with support and help from parents, local people and organisations.

NUMBER OF EMPLOYEES IN POST AT 31 MARCH

	2013	2012	2011
Medical and Dental	417	381	379
Administration and Estates	900	862	889
Other Support Staff	357	348	343
Nursing and Midwifery	1,567	1,562	1,609
Scientific, Therapeutic & Technical Staff	711	707	697
Total	3,952	3,860	3,917
<i>At 31 March 2013 the Trust employed 3,952 full and part-time staff (Equivalent to 2,666.11 full-time posts)</i>			



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 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

Name	Role	Attendance from four meetings
Luke March	Chairman	4
Nigel Atkinson	Member	4
Lydia Brown	Member	3 from 4
Barry Bull	Member	2 from 3
Ian Downie	Member	3 from 4
Andrew Freemantle	Member	1 from 1
Stephen Long	Member	4
John Stokoe	Member	1 from 2

The Remuneration Committee reviews the salaries and individual reward packages of the Executive Directors. These are set in comparison with packages given to holders of similar posts within the NHS. In setting, monitoring and reviewing salary ranges, the Committee uses survey material and receives independent advice and guidance as and when required from an organisation specialising in this work. During the year the Chief Executive and Director of Human Resources and Organisational Development provided advice to the committee. The Head of Corporate Governance provided administrative support.

The personal performance of the Executive Directors was assessed against their job descriptions 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 the 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 line with the two-year pay freeze for NHS staff earning more than £21,000 per year, no cost of living pay rise was awarded to the Executives for the year starting 1 April 2012.

Responsibility for setting the terms and conditions of Non Executive Directors rests with the Council of Governors. This was determined when the Trust was authorised, on the basis of independent advice. 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 Directors' pay and this was repeated in 2011 and 2012.

There is no bonus scheme for Executive Directors and any in-scale annual increment is based solely on individual performance as noted above. 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	
	2011/12	2012/13	2011/2012	2012/2013	2011/2012	2012/2013
Luke March Chairman	40-45	40-40	0	0	0	0
Peter Hill Chief Executive	140-145	130-135	0	0	4,300	4,000
Nigel Atkinson Non Executive	15-20	10-15	0	0	0	0
Christine Blanshard Medical Director	90-95	160-165	0	0	0	0
Lydia Brown Non Executive	10-15	15-20	0	0	0	0
Barry Bull Non Executive	10-15	5-10	0	0	0	0
Malcolm Cassells Director of Finance	115-120	120-125	0	0	4,000	4,000
Alan Denton Director of Human Resources	95-100	15-20	0	0	4,000	4,000
Ian Downie Non Executive	10-15	10-15	0	0	0	0
Andrew Freemantle Non Executive	0	0-5	0	0	0	0
Clare Fuller Acting Medical Director	70-75	0	0	0	0	0
Stephen Long Non Executive	10-15	10-15	0	0	0	0
Tracey Nutter Director of Nursing	100-105	100-105	0	0	0	0
Jim O'Connell Interim Chief Operating Officer	75-80	0	0	0	0	0
Sean O'Kelly Medical Director	0-5	0	0	0	0	0
Alison Kingscott Director of Human Resources	0	45-50	0	0	0	0
Michele Romaine Non Executive	10-15	0	0	0	0	0
Caspar Ridley Chief Executive	10-15	140-145	0	0	400	2,200
John Stokoe Non Executive	10-15	5-10	0	0	0	0

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

Caspar Ridley resigned on 5 September 2012. Alan Denton retired on 31 May 2012. Alison Kingscott took up her post on 8 October 2012. Peter Hill was Chief Operating Officer until 4 September 2012, Interim Chief Executive from 5 September 2012 to 14 January 2013 and Chief Executive from 15 January 2013 onwards. Barry Bull's term of office came to an end on 31 December 2012. Major General John Stokoe's term of office came to an end on 31 October 2012. Andrew Freemantle took up his post on 1 January 2013.



Pension Benefits 1 April 2012 – 31 March 2013

	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 2013 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 1 April 2012 £000	Real increase in Cash equivalent Transfer Value £000	Employers contribution to Stakeholder pension To nearest £100
Peter Hill	0-2.5	0-2.5	205-210	155-160	990	981	-42	0
Christine Blanshard	2.5-5	12.5-15	225-230	170-175	1,060	907	106	0
Malcolm Cassells	0-2.5	2.5-5	220-225	165-170	1,242	1,127	56	0
Alan Denton	0-2.5	0-2.5	150-155	110-115	885	826	3	0
Alison Kingscott	0-2.5	0-2.5	80-85	60-65	334	291	13	0
Tracey Nutter	0-2.5	0-2.5	160-165	120-125	737	682	19	0
Caspar Ridley*	0-2.5	0-2.5	10-15	0	122	117	0	0

* Mr C Ridley is a member of the 2008 pension scheme and therefore the benefits are calculated at age 65 years.

Notes to Remuneration and Pension Tables

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

* Please note that these tables have been subject to audit.



Cash Equivalent Transfer Values

Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The factors used to calculate the 2013 CETVs have increased; therefore the value of CETVs for some members has increased by more than expected since 31 March 2012.

Median Remuneration that Relates to the Workforce

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director and the lowest paid director in their organisation and the median remuneration of the organisation's workforce. The mid-point of the banded remuneration of the Trust's highest paid director in 2012-13 was £162,500 (£2011/12, £162,500. This was 6.7 times (2011/12, 7.3 times) the median remuneration of the workforce, which was £24,400 (2011/12, £22,400). In 2012-13, one (2010-11, Nil) employee received remuneration in excess of the highest paid director. Remuneration ranged from £7,200 to £190,000, (2011/12, £6,600 to £167,000). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments.

It does not include employer pension contributions and the cash equivalent transfer value of pensions. The pay multiplier between the median remuneration of the workforce and the highest paid director fell in 2011-12. Based on annualised pay, the Medical Director was the highest paid director in both years. Please note that this information has been subject to audit.

Statement on Pay Policy

Most staff within the NHS have contracts based on Agenda for Change national terms and conditions. Agenda for Change is the single pay system in operation in the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists, very senior managers (optional) and directors.

Pay Circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change.

Directors contracts are based on local terms and conditions and pay is set by the Remuneration Committee, which is covered earlier in this Remuneration Report

Expenses for Directors and Governors

A total of £9,522.99 was reimbursed to Directors and Governors for expenses incurred during the course of their duties during 2012/2013. This included expenses related to travel, accommodation and subsistence.



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 three years for all new appointments. This can be renewed for a second three-year term with the agreement of both parties. The Council of Governors can terminate the appointment at any time during this period of office.

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 months 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
Chief Executive
24 May 2013



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.

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 2012/2013 year the Trust has been fully compliant.

Details on the NHS Foundation Trust Code of Governance can be found on the Monitor website at www.monitor.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 six Non-Executive Directors and five Executive Directors, making thirteen 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 printed form on request.

The Directors have collective responsibility for:-

- Following regulatory guidance issued by Monitor and the 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 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. The Trust's services were registered by the Care Quality Commission without conditions on 1 April 2010. The Board's role is to ensure ongoing compliance with the regulations.

Council of Governors

The Council consists of 25 Governors:

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

The Chair of the Trust Board is also the Chair of the Council of Governors and is a key conduit between the two bodies. The full Council of Governors meets in public four times a year and also holds an Annual Members' Meeting. 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:-

- Hold the Non-Executive Directors to account
- Advise the Board on the effect on the provision of NHS services of non NHS provision
- 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.
- To undertake training in the role

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 2012/2013 these covered:

- Communications and Membership
- A Commentary to the Care Quality Commission
- Performance of Chairman and Non Executive Directors
- The Trust's Annual Plan for 2012/2013 prior to submission to the regulator
- Patient experience
- Governor's self assessment
- The strategic direction of the Trust
- Volunteers

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. 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 Chief Operating Officer 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. Up until 31 March 2013, these were Wessex Community Action, a body that provides an over-arching voluntary presence at local level; Wiltshire Council that provides the main local authority link; NHS Wiltshire and NHS Dorset which are two of the main health commissioning bodies for the Trust. From 1 April 2013, the NHS bodies mentioned above are to be replaced with representatives from Wiltshire, West Hampshire and Dorset Clinical Commissioning Groups.

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

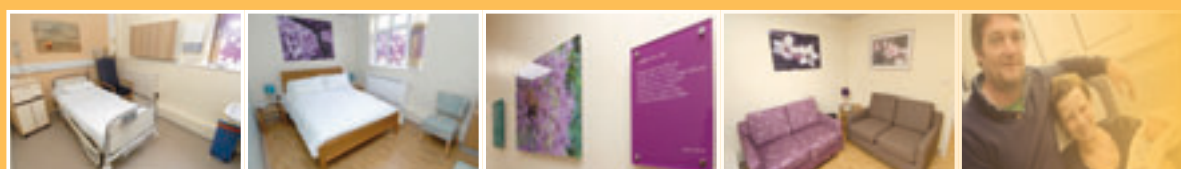
In addition to the AGM, and the joint meeting with the Trust Board to review the Annual Plan, the Trust held six meetings of the Council of Governors during the 2012/2013 year.

Elected Governors – Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 6 meetings
John Carvell	Salisbury City	May 2012	Three years	5
Celeste Collins	Salisbury City	May 2011	Three years	4
Chris Wain	Salisbury City	May 2012	Three years	6
Robert Coate	South Wiltshire Rural	May 2011	Three years	6
*June Griffin	South Wiltshire Rural	May 2012	Three years	4 from 5
*Sir Raymond Jack	South Wiltshire Rural	May 2012	Three years	3 from 5
Dr Alastair Lack	South Wiltshire Rural	May 2011	Three years	6
Beth Robertson (Lead Governor)	South Wiltshire Rural	May 2012	Three years	6
Paul Goldman	North Dorset	May 2011	Three years	4
**Andrew Freemantle	North Dorset	May 2012	Three years	3 from 4
Sarah Bealey	New Forest	May 2012	Three years	4 from 5
John Markwell	Kennet	May 2012	Three years	5
Carole Noonan	West Wiltshire	May 2012	Three Years	5
*Nicholas Sherman	East Dorset	May 2012	Three years	4 from 5

**In elections held in May 2012 Kate Beaumont and Sara Willan (both South Wiltshire Rural), Mary Hutcherson (North Dorset), Wayne Arnett (New Forest) and Elizabeth Connock (East Dorset) did not stand for a further term. All replacements are listed in the box above*

***Andrew Freemantle (North Dorset) stood down in December 2012 to become a Non Executive Director of the Trust. The by-election for this constituency was held in 2013 and Madeleine Hewitt was elected.*



Elected Governors – Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 6 meetings
Andrew Farrow	Patient/Carer	May 2012	Three years	4

Elected Governors - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 6 meetings
*Mandy Cripps	Clerical, Administrative and Managerial	My 2012	Three years	5 from 5
*Brian Fisk	Volunteers	May 2012	Three years	5 from 5
Shaun Fountain	Medical & Dental	May 2012	Three years	6
Colette Martindale	Nurses & Midwives	Nov 2012	Three years	5
Lynda Weeks	Hotel & Property Services	May 2012	Three years	5
Christine White	Scientific & Therapeutic	May 2012	Three years	5

* In elections held in May 2012, Eric Gould (Volunteers) did not stand and Louise Arnett Clerical, Administrative and Managerial) was not re-elected.

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance from 6 meetings
William Moss	Wiltshire Council	May 2011	Three years	5
Anita Pheby	Wessex Community Action	May 2011	Three years	5
*Elizabeth Stevens	NHS Dorset	May 2011	Three years	5
*Lis Woods	NHS Wiltshire	May 2011	Three years	6

*Primary Care Trusts were replaced by Clinical Commissioning Groups on 1 April 2013, resulting in new organisations and representatives for Nominated Governors from this date onwards.

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 David Seabrooke, 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.

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 six 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.

The strategies developed at the time of the Trust's application for Foundation Trust status have been revised to meet the changing demands on healthcare providers. These are undergoing further development following the implementation of the Health and Social Care Act 2012. 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 2011/2012, the Board undertook a further external assessment of the effectiveness of the Board as a whole. A self assessment exercise was undertaken in the spring 2013 in relation to Board effectiveness.

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 2011/2012, the Trust engaged the Kings Fund to help the Board of Directors undertake the evaluation of the Board and its sub committees. This included observation of the Trust Board in public meetings and one-to-one interviews with the Trust Board and the Lead Governor. An action plan was agreed to address minor shortcomings and the findings of the report presented to the Council of Governors which is responsible for the appointment and reappointment of the Non Executive Directors.

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. As mentioned above a self assessment exercise also took place in 2013 on Board effectiveness.



The Board of Directors

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. This second period was extended for a further year and will be completed on 31 December 2013. 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. He is currently Chairman of the National Churches Trust, and a trustee of other charities. Luke lives in Great Durnford near Salisbury.

Peter Hill – 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 lives in Salisbury in Wiltshire.

Nigel Atkinson – Non Executive Director (Independent)

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

Dr. Christine Blanshard – Medical Director

Christine Blanshard graduated in Medicine from Cambridge University in 1986 and has over 25 years NHS experience. She trained in East Anglia and London, and became a consultant gastroenterologist and general physician in 1998. She has undertaken a variety of managerial roles alongside her clinical work and before joining the Trust was Director of Strategy and Associate Medical Director at Homerton University Hospital NHS Foundation Trust. She lives in Winchester.

Dr. Lydia Brown MBE – (Vice Chairman and Senior Independent Director)

Lydia Brown joined the Trust on 1 November 2008 and is now a second 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 a Director of a number of local voluntary organisations. Lydia lives in West Gomeldon in Wiltshire.

Malcolm Cassells – Director of Finance and Procurement

Malcolm Cassells is a qualified accountant with extensive financial experience gained through over 35 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.

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.

Andrew Freemantle – CBE Non Executive Director (Independent)

Andrew Freemantle joined the Trust on 1 January 2013 for a three year term. He has wide range of experience as a former Chief Executive of the Scottish Ambulance Service NHS Trust and Chief Executive Officer of the Royal National Lifeboat Institution. This followed a distinguished army career. Andrew lives in Tarrant Monkton in Dorset

Alison Kingscott – Director of Human Resources and Organisational Development

Alison Kingscott has a wide range of HR experience in both the NHS and private sector. She has held senior NHS positions in the south west of England and was Director of Human Resources and Corporate Lead for Estates and Facilities at Weston Area Health NHS Trust before joining the Trust.

Stephen Long – Non Executive Director (Independent)

Stephen Long joined the Trust on 1 November 2008 and is now in a second 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

Tracey Nutter joined the Trust in April 2003 from Southampton University Teaching Hospitals NHS Trust where she was Associate Nurse Director. She has over 28 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. She lives in Poole in Dorset.

*Dame Sarah Mullally DBE – Non Executive Director (Independent)

*Revd. Dame Sarah Mullally DBE was appointed Non Executive Director with effect from 1 April 2013.

Barry Bull – Non Executive Director until 31 December 2012

Alan Denton – Director of Human Resources until 31 May 2012

Caspar Ridley - Chief Executive from 1 March 2012 to 5 September 2012

Major General John Stokoe CB CBE – Non Executive Director until 31 October 2012

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.

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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.

BOARD OF DIRECTORS ATTENDANCE

	Trust Board (8 meetings)	Audit Committee (4 meetings)	Remuneration Committee (4 meetings)	Finance Committee (12 meetings)	Clinical Governance Committee (6 meetings)
Luke March	7	N/A	4	11	N/A
Peter Hill	7	N/A	N/A	10	5
Nigel Atkinson	8	4	4	N/A	5
Christine Blanshard	7	N/A	N/A	N/A	6
Lydia Brown	7	3	3	N/A	6
Malcolm Cassells	7	N/A	N/A	11	N/A
Alan Denton	2 from 2	N/A	N/A	N/A	N/A
Ian Downie	6	1 from 1	3	9	1 from 1
Andrew Freemantle	1 from 1	N/A	1 from 1	2 from 3	N/A
Alison Kingscott	3 from 3	N/A	N/A	N/A	N/A
Stephen Long	7	N/A	4	N/A	6
Tracey Nutter	8	N/A	N/A	N/A	4
Barry Bull	6 from 7	3 from 3	2 from 3	9 from 9	N/A
Caspar Ridley	3 from 4	N/A	N/A	4 from 5	3 from 3
John Stokoe	3 from 6	1 from 3	1 from 2	7 from 7	1 from 4



THE AUDIT COMMITTEE

	Committee Role	Attendance out of four meetings
Nigel Atkinson	Chairman	4
Lydia Brown	Non Executive Director	3
Barry Bull	Non Executive Director	3 from 3
John Stokoe	Non Executive Director	1 from 3
Ian Downie	Non Executive Director	1 from 1

The Work of the Audit Committee in Discharging its Responsibilities

The Audit Committee is in place to provide the board with assurance as to the effectiveness of the processes overseen by the board itself and by the Finance, Workforce and Clinical Governance Committees.

The Committee has an annual work programme as well as dealing with other items that arise during the year.

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 receipt, discussion and follow-up of completed internal audit reports is a key driver of its activity in relation to the system of internal control. The Committee pays special attention to reviewing the annual financial statements and the external auditor's review and opinion on the accounts. It received the Auditor's opinion on the Quality Account 2012-13.

KPMG, who became the Trust's appointed External Auditors from 1 April 2012 attended the July 2012 meeting. At the same time, the Audit Commission formally notified its cessation of office.

The Committee reviewed and approved the Head of Internal Audit (South Coast Audit) Opinion and the Governance Report prepared by the Audit Commission. The Head of Internal Audit report concluded there was Significant Assurance as to the Trust's system of internal control. The committee received the Annual Management Letter, which is submitted to the Board.

Reports from the Internal Auditors, South Coast Audit, covered their conclusions on a range of Trust activities within their 2011/2012 work plan as agreed by the Committee. The Committee received a report on the framework governing Payments by Results for 2011/12

results and a follow-up report.

The Committee also oversees the work of the Local Counter-Fraud Specialist on proactive work to strengthen the Trust's counter-fraud awareness arrangements and also the small amount of case-work associated with this.

The Committee meets with the Trust's auditors separately from the Trust so there is an opportunity for them to disclose any matters of concern. The committee has reviewed its effectiveness in relation to its terms of reference and the Audit Committee handbook.

It sought assurances about audit reports where limited assurance was given, and the actions underway to address these. It has reviewed the operation of the Trust's Assurance Framework, sections of which are reviewed throughout the year by other committees of the board.

The Director of Finance & 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.

Financial Audit

The external auditors for the Trust are KPMG. During the 2012/2013 period, the Trust has incurred the following costs on external audit:

- Audit services: £63,000
- Further assurance services: None
- Other services: £2,000 - Facilitating Board effectiveness self assessment and facilitating a pension seminar following changes to pension rules.
- 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 Executive's 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 COMMITTEES

During the year the Trust established three Nominations Committees (NCs) to oversee recruitment exercises. The first for the appointment of a new Director of Human Resources and Organisational Development, the second for a new Chief Executive. The third started the process to appoint a Chief Operating Officer.

In all cases the Trust used an external search consultancy to assist the committees with candidate selection. The committees reviewed the job descriptions, personal

specifications and the candidate briefs, which were then used by the consultancy to promote awareness of the roles, which were also advertised on the NHS Jobs website.

A list was established with recommendations, which the committees reviewed and established a shortlist. In both cases an interview and assessment took place to choose the successful candidates.

THE NOMINATIONS COMMITTEE FOR THE APPOINTMENT OF DIRECTOR OF HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT

	Committee Role	Attendance out of two meetings
Luke March	Chairman	2
Nigel Atkinson	Non Executive Director	2
Lydia Brown	Non Executive Director	2
Caspar Ridley	Chief Executive	2

THE NOMINATIONS COMMITTEE FOR THE APPOINTMENT OF A CHIEF EXECUTIVE

	Committee Role	Attendance out of three meetings
Luke March	Chairman	3
Lydia Brown	Non Executive Director	3
John Carvell	Governor	3
Ian Downie	Non Executive Director	2
Alison Kingscott	Director of HR and OD	3
Beth Robertson	Governor	3

THE NOMINATIONS COMMITTEE FOR THE APPOINTMENT OF A CHIEF OPERATING OFFICER

	Committee Role	Attendance out of one meeting*
Luke March	Chairman	1
Peter Hill	Chief Executive	1
Alison Kingscott	Director of HR and OD /Adviser	1
Steve Long	Non Executive Director	1
Tracey Nutter	Director of Nursing	1

A Chief Operating Officer was appointed and takes up this post in 2013/2014



MEMBERSHIP

The Trust has traditionally had strong links with the local community, attracting over 500 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.

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 2013 the membership for Salisbury NHS Foundation Trust was as follows:

Public Constituency	Number
Salisbury City	2,830
South Wiltshire Rural	4,870
Kennet	1,637
North Dorset	1,815
East Dorset	955
New Forest	1,368
West Wiltshire	1,252
Patient/Carer Constituency	849
Staff Constituency	3,032
Total	18,608

Ownership of the Trust's membership strategy rests with the Governors with support from the Trust and is currently in the process of being reviewed. This will help ensure that membership involvement is encouraged in the Trust's governance and decision making process, and 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.

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 18,608 members at 31 March 2013, 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. A Governor's working group has been set up to look at the Trust's Constitution, and as part of this exercise, the Trust is considering making changes to the current catchment area in 2013/2014.

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

Membership Size and Movements

Public Constituency	2012/2013	2013/2014 (Estimated)
At year start (1 April)	14,798	14,727
New members	324	649
Members leaving	395	450
At year end (31 March)	14,727	14,926
Staff Constituency		
At year start (1 April)	2,801	3,032
New members	351	297
Members leaving	120	155
At year end (31 March)	3,032	3,174
Patient Constituency		
At year start (1 April)	838	849
New members	46	72
Members leaving	35	21
At year end (31 March)	849	900
Overall Total	18,608	19,000



The Trust used its in-house database to monitor and increase the membership in line with demographic and statistical information and continued to use induction as a membership gathering point for staff.

The Trust uses its public meetings to highlight the benefits of membership and encourage recruitment. Members' newsletters are also 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 over 133,000 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 and Quality Account. They have been working on patient and public involvement initiatives, for instance, End of Life Care and Dementia Care. The End of Life Care Group covers a wide range of work which includes dedicated education and training for staff, and greater support and assistance for families where patients prefer to die at home. Both groups have made significant improvements which have been covered in more detail earlier in this report.

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 Governors 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 100 patients a month 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 includes the development of the popular Medicine for Members series of lectures. These talks aim to give people an insight into how the body works, highlight the clinical conditions that are treated and provide some practical tips to keep safe and healthy. Talks that took place within the year covered cancer care, organ donation and eye care.

A dedicated section on the Trust's website and Intranet provides details of each Governor, their interests and a means for members to communicate with them. There are also members' newsletters for staff and people in the public and patient/carer constituencies. Further opportunities are planned for Governors to meet their members in the 2013/2014 financial year.



QUALITY REPORT

Introduction

This is our annual report which looks at the quality of our services over the previous year and also includes plans for quality improvement next year.

Quality accounts, which are also known as quality reports, cover three components; patient safety, clinical effectiveness and patient experience. These reflect the quality of care a patient receives and each of our priorities is linked to one of these three components.

Part 1

Our commitment to quality - the Chief Executive's view

I feel that it is essential that our patients have confidence in our staff and the hospital and that they have good quality, safe care when they come in for treatment. It is also important that our patients are treated with compassion and care and that they have a positive experience. Patients across the country, quite rightly, will want to be reassured of the quality of care they receive in their own hospital following publication of the Francis Report into the care and treatment of patients in Mid Staffordshire. Quality is, and must remain, the main priority for us and I am pleased with the progress we have made over the last year in so many areas that affect the quality of care that we give to our patients, their families and visitors.

This can be seen in patient surveys, assessments and reviews and was highlighted again by the Care Quality Commission (CQC), which carried out an unannounced inspection of Salisbury District Hospital. The CQC found that we met all care and cleanliness standards, with minor concerns in just two areas. These related to staffing and management of records. The Trust has action plans in place to work with staff to address the minor concerns. Because of its impact and the way it reflects their findings, the CQC used the following comment from a patient to open up its report on the Trust: "No one likes staying in hospital, but the time comes when we might end up here. I've been fortunate. It's the best conditions and food that anyone could wish for. The staff are most pleasant and helpful".

Good quality care is also reflected in a number of positive improvements that have taken place across the hospital and a key area for us is care of the elderly. We have developed an innovative programme of stimulating activities for patients which was praised by a peer review team of experts who looked at the care

we provide for patients with dementia. The Trust has also continued to maintain high standards of cleanliness and reduced the number of serious pressure ulcers.

We have worked hard to ensure that we carry out our patients' wishes and their preferred priorities for end of life care and more health professionals in hospital now have access to this information. We have developed a rapid discharge process for patients in the last 72 hours of their life which ensures that care and equipment can be provided at home, with support from community teams.

High quality care is the key priority for the Trust and the Trust Board is committed to improving quality through a 'whole organisation approach'. The Trust developed a 'trigger tool' for each service, which is a method that enables teams to self assess against key quality performance criteria. This helps the Trust and Directorates focus on key areas for improvement.

The Trust also uses clinical audit results, patient feedback and information from complaints and safety reports. These show where improvement is needed. For example all wards develop an action plan based on feedback from their patients. 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 'walk rounds', which enable staff and patients to talk directly with members of the Trust Board and raise any quality or safety issues in their own areas with them. 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 a patient story is heard at every Clinical Governance Committee meeting. 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 work that covers their own areas. A good example of this can be seen in general surgery where patients undergoing hernia operations worked with us to improve patient information and follow up care.

While the Trust Board has overall responsibility for quality, safety and patient experience, leadership for these areas is delegated to the Director of Nursing and the Medical Director.



Our emphasis on Quality will continue through a number of priorities for 2013/2014. Views and comments from clinical staff, local people, commissioners and the Trust's Governors have been used in the development of these priorities which will be addressed later in the Quality Account.

Our staff work hard to provide excellent standards of care, and constantly assess their practices in order to make any changes that could benefit their patients. On behalf of the Board, I want to thank them for their hard work and professionalism in 2012/2013 and the positive contribution they make to the Trust and our patients.

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



Peter Hill
Chief Executive
24 May 2013

On behalf of the Trust Board
24 May 2013

Part 2

This section provides a review of the progress we have made in our 2012/2013 priorities as published in the last Quality Account and sets out our priorities for 2013/14.

The Trust's priorities in 2012/2013 were:

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 Enable patients to receive timely and effective hospital treatment.

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

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

Our priorities for quality improvement in 2013/2014 and why we have chosen them

Looking forward to 2013/2014 we have used a broad range of methods to gather information and determine our quality priorities. These include:

- Speaking to patients and asking them to give us feedback on their experience of care during their hospital
- Information from the national inpatient and outpatient surveys
- Themes from comments, compliments, concerns and complaints are used to identify trends.
- We have also used risk reports and listened to what staff have told us during Executive Safety and Quality walk rounds. These rounds give staff the opportunity to talk face-to-face about safety or quality concerns with Executive Directors and Non-Executive Directors.

This process confirmed that the current priorities are the areas where we need to continue to focus our quality improvement. The Board has decided to carry them on for a further year. This decision has been confirmed by feedback from other stakeholders.

We have consulted widely on the priorities and involved Age UK, Warminster Health and Social Care Group, our staff, governors and members to help us make the final decisions on our priorities for 2013/2014. This also included our equality objectives. The priorities have been discussed with clinical teams as part of the service planning process. Our newly formed Clinical Commissioning Groups have also helped us work out what our priorities should be and the work we need to do together. Some of their comments are included in this report.

The Trust has made good progress on last year's priorities however there are still further improvements that can be made and additional work has been identified for 2013/2014. A number of these areas are required for our Commissioning for Quality and Innovation (CQUIN) programme and support the Care Quality Commission (CQC) regulations.

As part of the NHS reforms a new NHS Outcomes Framework 2013/2014 has been published which focuses on patient outcomes and experience. The framework sets out five domains where health improvement can be achieved over a number of years. These domains are:



Domain 1 Preventing people from dying prematurely – we plan to link this to our work in priority 1.

Domain 2 Enhancing quality of life for people with long term conditions - we plan to link this to our work in priority 2

Domain 3 Helping people to recover from episodes of ill health or following injury - we plan to link this to our work in priority 3

Domain 4 Ensuring that people have a positive experience of care - we plan to link this to our work in priority 4

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm - we plan to link this to our work in priority 5

This year we have reported our performance against four of these domains. You can find this in Part 3.

Our priorities for 2013/2014 are unchanged from 2012/13 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 Ensure that patients receive timely and effective hospital treatment.

Priority 4 Ensure patients are able to rate the quality of care they received in 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 quality governance process. To enable the Trust Board, the Clinical Governance Committee and Clinical Management Board to do this they will receive monthly reports and ask for further work where further work is needed. The Trust Board minutes and reports can be viewed on the Trust website.

Both the Director of Nursing and the Medical Director have responsibility to lead in these priority areas. The Medical Director leads on Domain 1, 2 and 3 and the Director of Nursing leads on Domain 4 and 5. The following sections describe the work undertaken in 2012/2013 to achieve or improve the priority areas.

Domain 1 Preventing people from dying prematurely

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

Description of the issue and reason for prioritising it:

The Trust has continued its work to reduce the number of deaths in hospital. We have done this by monitoring the Hospital Standardised Mortality Ratio (HSMR) the Summary Hospital Level Mortality Indicator (SHMI) and the actual number of deaths.

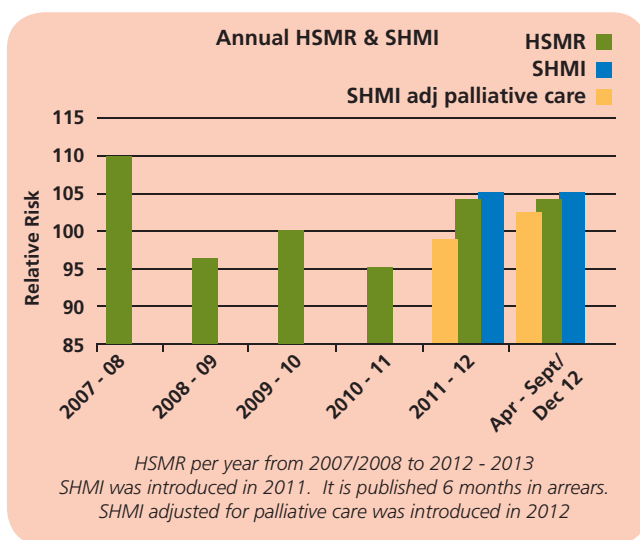
HSMR compares the number of deaths in hospital with the expected number, taking into account factors such as the age of the patient, their complicating medical problems and whether they were admitted for end of life care. SHMI compares the number of deaths in hospital or within 30 days of discharge with expected levels. It is not "corrected" for patients admitted for end of life care, for example to Salisbury Hospice. Currently 26% of our deaths are in patients admitted for palliative or end of life care.

If the number of deaths was exactly as expected the HSMR and SHMI would be 100. However, some natural variation is to be expected, and a number above or below 100 can still be within the expected range. Our HSMR for April 2012 to December 2012 is 104 and our SHMI for October 2011 to September 2012 is 105. Both these levels are within the expected range.

We routinely examine our mortality rates and analyse the data in detail to see what factors are contributing, including carrying out detailed case note reviews. We can look at specific groups of patients or audit a random sample of deaths. For example we have recently reviewed 100 patient deaths and have found that some patients chose to be admitted to hospital for end of life care, whilst for others there was not the care available in the community to keep them comfortable at home in their last days. We are working with colleagues in the community to improve provision of palliative care at home.

As well as reducing mortality rates, patients, carers and their families told us that it is important to ensure they receive high quality care as they approach the end of life and that they want a choice of where to be cared for and where to die. Keeping patients and their families involved and informed is key to our work in improving end of life care.





What we did last year to support this improvement priority:

- Last year we said we will continue to work together with GPs to ensure we respect individual choice about where people want to die.

GPs have continued to improve their recording of people's wishes at the end of their life and their preferred priorities for care using advance care plans. This ensures doctors and nurses have up-to-date information about a patient's wishes. However, further work needs to be done to make sure that this happens for all patients at the end of their life. It is a key piece of work which the GP's are currently taking forward. Progress this year includes the Emergency Department and Medical Assessment Unit doctors and nurses being able to see GP records to ensure a patient's care is continued in hospital and their end of life care plan is respected.

- We said we would continue to provide staff education so that they are able to care for dying patients and talk sensitively with them, their relatives and carers.

A redesigned education programme is now in place which is aimed at doctors and nurses teaching them about the specific needs of patients at the end of their life. Staff report they feel more confident in how to care for these patients and communicate with families and relatives.

As a result we have seen an improvement in our local audit of end of life care in 2013. The results showed that we sustained improvements made in 2012 within the hospital in recording resuscitation status, in prescribing pain relief and caring for patients on the end of life care pathway (Liverpool Care Pathway). It was also clear that the communication about a patient on the LCP with

their GP's had declined. More work needs to be done to improve this.

- For patients who prefer to die in hospital we said we will give compassionate, good quality care and maintain their privacy and dignity.

The ward sister is the day to day guardian of good quality, compassionate care. She/he is supported by an end of life care link nurse who makes sure that the whole team has up to date information about good quality end of life care.

- For patients who wish to die at home or in a nursing home we said we will ensure they are able to leave hospital as soon as they can and that they have everything they need in good time. Our care teams will continue to work with community and social care partners to deliver care and support where patients and families need it.

As part of a pilot scheme we developed a rapid discharge pathway with the Neighbourhood Teams for patients in the last 72 hours of their life. This ensures that care and equipment needs can quickly be put in place so that the patient can quickly leave hospital. So far this year 20 patients have been successfully discharged home using the improved process. As a result the programme has been introduced for use by every ward in the hospital.

- Last year we said we will continue to work with clinical teams to ensure mortality reviews are held and ensure that lessons are learnt across the Trust.

A senior doctor has worked with clinical teams across the hospital to improve how we review the care of patients who die in hospital. Teams have reviewed a percentage of deaths in hospital in 2012/13. The reviews did not find any serious failings in care but have found areas where we could improve. For example, there was a common theme found around the need for better communication with the patient and their families. This theme is being addressed as part of the education programme for end of life care.

- We said we will work with clinical teams to ensure we communicate clearly with patients and their families with regard to plans for their care.

As part of our education programme a nurse on each ward has received training and is providing the training to the rest of team. This also includes gaining experience of palliative care by working alongside nurses in the hospice and in the community.



What the patients & public told us?

"We recently visited an elderly uncle who sadly was in the last few days of his life. It was a difficult and harrowing time but the staff who looked after him in those precious moments cared for him with such dignity and respect. The quality of care and facilities provided were more than we could have expected".

hospital to review a further 100 deaths. The care before admission, in hospital and discharge arrangements will be included to see if there are any improvements we need to make.

- We will introduce a bereavement and palliative care team to provide support for families who have lost a baby.
- We will continue to ensure the themes from child death reviews across Wiltshire are used to learn and improve.

How will we report progress throughout the year?

We will monitor and report our progress through the Trust's End of Life Care Strategy Steering Group and the Mortality Working Group. These groups report to the Clinical Management Board every six months and to the Clinical Governance Committee annually.

What will we do in 2013/2014

- We will continue to work with GPs to ensure patients who wish to record their wishes about their end of life care have an advanced care plan which is used and respected by the doctors and nurses.
- We will review the use of the Liverpool Care Pathway and other end of life care documentation to improve patient care and communication with families.
- We will work in partnership with local people to talk about death and dying and take part in the national dying awareness week in May 2013.
- We will continue to provide education for the link nurses in an extensive training programme planned to last to March 2014 and we will introduce an education programme for senior doctors.
- We will expand our community and hospital palliative care service from 5 to 7 days a week.
- We will investigate the care of patients who were admitted at weekends and who later died, to see if there are any changes or improvements to be made.
- We also plan to work with GPs and clinicians in the

Domain 2 Enhancing quality of life for people with long term conditions

"My father spent a week in hospital and died peacefully. He wasn't conscious for much of the time but was cared for with compassion and good humour by a team of dedicated and amiable nurses. I arrived anticipating the worst, and witnessed the best. The hospital was a friendly and compassionate place".

"I didn't get the information I needed as the only time I found out what was wrong with my mother was from the medical certificate".

"A member of Warminster health and social care group told us 'make a list of friends and family in end of life planning so that people know who needs to be contacted'".

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

Description of the issue and reason for prioritising it:

We expect all our patients to be treated with compassion, dignity and respect and with care that is personal to their individual needs. We have worked with local GPs, Age UK and Governors who have all told us that the care of older people, people with dementia and people with learning disabilities need to be key priorities. In particular giving priority to ensure that all patients have help to eat and drink, that staff have time to meet relatives and that all patients know what is happening in their care.



The Trust was assessed by a regional dementia peer review team in February 2013. The feedback from the assessment team was very positive and they were impressed by the progress we have made since the last peer review.

They noted a number of areas of good practice particularly the strength of leadership and widespread engagement with staff and the Alzheimer's Society. The team were impressed with the positive culture within the Trust in the overall care we provide for our patients with dementia. They highlighted real enterprise both in the development of stimulating activities and programmes such as our 'Young at Heart' project and the 'Engage' programme. They felt the staff were well supported and there was strong internal and external links which had a positive impact on the care provided.

In particular, they highlighted our partnership with the Alzheimer's Society who had produced an excellent staff training programme. They were impressed with the level of staff engagement and the way in which links are made between general hospital services and staff involved in palliative and end of life care. They applauded our approach to audit and the way we used patient feedback to measure whether we are making a difference to patients with dementia and how we used the feedback to improve services in this area.

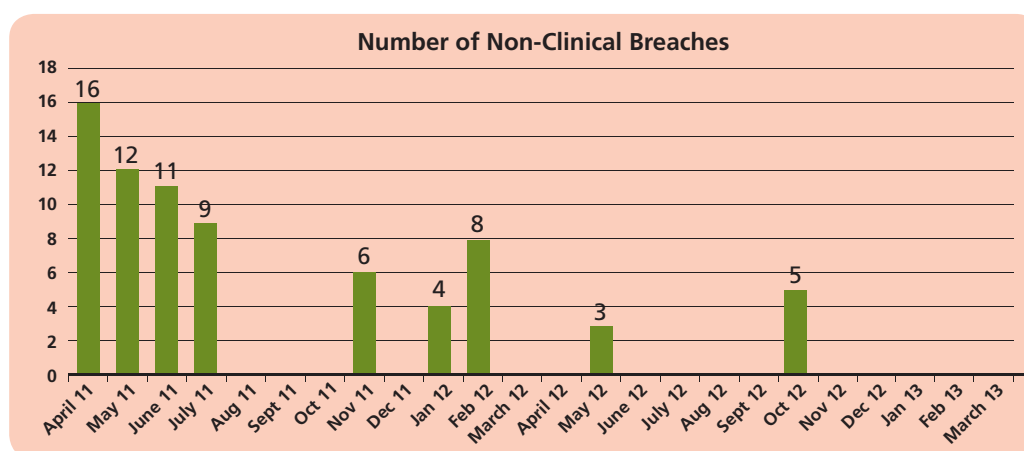
What we did to support this improvement priority:

- We will continue to work hard to eliminate mixed sex accommodation in our ward areas.

The staff have worked hard to eliminate times when men and women share sleeping accommodation. We monitor all breaches and ensure action is taken so that patients do not have to share sleeping accommodation with someone of the opposite sex. The table below shows the times when we have not been able to do this (known as a non-clinical breach); this has improved since last year. Most of the breaches in 2012/2013 relate to the clinical need of the patient to be cared for in the coronary care unit and the stroke unit.

- We said we will introduce the identification and risk assessment of patients with dementia when they come into hospital and refer them on to their GP or specialist mental health services when appropriate to ensure that they receive effective care and treatment.

In July 2012 we started to screen all patients over the age of 75 who were admitted to hospital as an emergency for their risk of dementia. The aim is to identify patients with dementia as early as possible so they, their families or carers can access support and services.



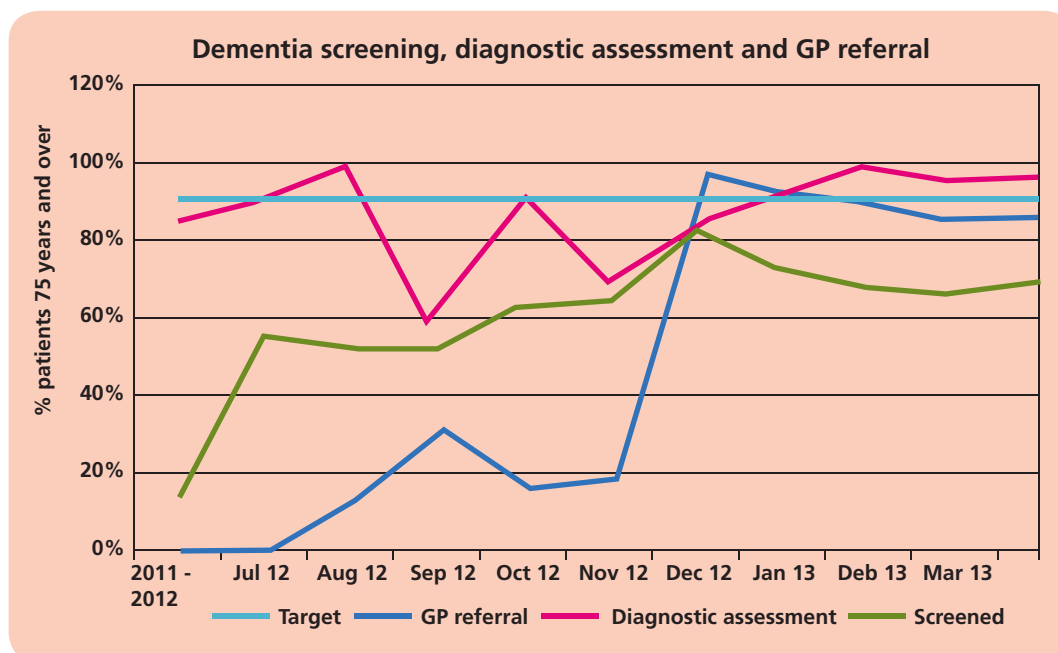
There was a reduction in the percentage of patients who said they were cared for in mixed sex accommodation in the national inpatient survey from 11% in 2011 to 7% in 2012.

There were some areas for further improvement. These centred mainly around the continuation of our programme to create a truly dementia friendly environment, such as better signage and coloured crockery. The team also felt we needed to better identify patients on admission who have dementia. They complimented our training programme and said it was important to increase the take-up rate of training across the Trust.

Patients are asked ten questions about time, place and people, in the past and present. If a patient scores 6 or less the screening test is considered positive. In the case of a positive score an assessment is done. This includes an assessment by a doctor using a more detailed mental test and investigations such as blood tests or a brain scan. If needed the patient is referred to the mental health specialist nurse whilst in hospital or referred to their GP for further investigation when the patient leaves hospital.



The table below shows our progress in screening, diagnostic assessment and referral to the GP



Dementia screening is only counted if it is done within 72 hours of admission. Some patients were screened after 72 hours which is the reason why there is a higher percentage of patients having a diagnostic assessment.

- We will continue to expand the support patients with dementia receive through the use of coloured crockery and picture menus. We will introduce specific aids to orientate patients such as easy read clocks. We will support activities and lunch clubs on the wards to increase social interaction and interest for patients creating a friendlier environment.

This work is being progressed as part of a wider Trust initiative which incorporates the Kings Fund Enhancing the Healing Environment and Point of Care programmes. These programmes focus on developing a common theme throughout the hospital to assist in orientating patients and improving the environment of care for older people. Our aim is to create an elderly care and dementia friendly hospital.

- The ArtCare team will work with the staff on Winterslow ward to improve the day room to make it more comfortable for all patients.

This work to make the day room more cheerful with art work and better lighting is planned to take place early in 2013/2014.

- We will continue with our audits of observation at mealtimes and will involve senior staff and volunteers who are trained to help patients to eat and drink at meal times.

A team of clinical staff, governors and non executive directors have continued a programme of audits of observation of mealtimes on every ward in the hospital. The team observe the preparation for mealtimes, serving of food, and assistance given to patients who need help with eating and drinking. The team give instant feedback to the ward leader so improvements can be made straight away. Further work is planned to improve on the themes arising from the audits.

Since July, clinical and non clinical staff, who have received specific training in communication, feeding, eating and drinking, have been working as volunteer mealtime assistants on the wards to help patients eat and drink. Mealtime assistants also report back on their experiences so that any changes needed can be made by the ward teams.

There was an increase in the percentage of patients who said they had enough help from staff to eat their meals in the national inpatient survey from 63% in 2011 to 74% in 2012.

- We will improve the nursing assessment documentation to better highlight those patients at high risk of malnutrition and how we are helping them.

Following an audit carried out in 2011 a new food chart was introduced to help staff record how much a patient eats.



The 2012 audit confirmed that since then there has been an improvement in the amount that patients are eating and better recording on the food chart. However, we need to do more work to make sure that the results on the patient's chart are considered by the doctors and nurses when planning their patient's care. A new way of doing this is currently being piloted in the surgical unit.

- We will work with social care teams to improve the assessment of the needs of carers who are looking after people with dementia.

A carer's survey was undertaken in July 2012 to understand their needs so that we can give the right support. The survey told us that we needed to increase the availability of help for patients, particularly at mealtimes, and to continue providing the dementia awareness training for all staff. This is provided by the hospital training leads with the Alzheimer's Society throughout the year. A hospital liaison carer support worker was appointed in August 2012 who takes part in a weekly dementia ward round to raise staff awareness and direct carers to support and carer assessments in the community.

- We said we will improve access to the mental health specialist service for older people.

We introduced a weekly dementia ward round in September 2012. The ward round is supported by an elderly care consultant/dementia lead, mental health nurse specialist, hospital liaison carer support worker and a social worker. The ward round is aimed at identifying as soon as possible the physical, social and emotional needs of people with dementia and, if required, their palliative care needs. During the ward round carers are given information and contact details for different agencies for support and advice about carer assessments in the community.

- We will continue to train our dementia champions and staff in dementia care.

The Trust has a well established dementia awareness training programme provided as study days, ward based teaching and through computer-based training. 78% of staff have completed computer-based mental capacity training and 81 staff have attended the one-day mental health training. This includes nurses, nursing assistants, doctors, therapists, porters, administration staff and managers.

- We will continue with the improvements we are making for patients with learning disabilities

The Easy Read group are working to produce accessible information on topics that are chosen by adults with learning disabilities. An initiative to produce appointment letters in an easy read format was approved by the IT Department and is currently being worked on. We aim to have easy read menus for patients early in 2013/2014.

We are beginning work to improve the transition process for patients with learning disabilities as they move from children's to adult services. These patients frequently have complex health and social care needs. Our aim is to ensure that there is excellent communication between children's and adult services and, if possible, a single point of contact from a named consultant to co-ordinate care and communicate with the patient, their carers and GPs.

- We will use the learning developed from the work with the Kings Fund and run the programme ourselves in Redlynch, an acute medical ward, and Winterslow that specialises in the care of older people. The following improvements have been made on Redlynch ward:

› A relative attended a ward meeting to share her concerns with nursing staff and to let them hear first hand what they could do to improve.

› Staff training on preventing pressure ulcers has been held to ensure staff use their knowledge to prevent pressure ulcers developing on the ward.

› Bedside handover is in progress to ensure patients are involved in their care plan.

› Visiting times have been changed to enable nurses to help patients at meal times and medicine rounds are completed before visiting. This has freed up more time to speak to relatives.

› Whiteboard meetings now occur daily. At these meetings the patient's care and discharge plan is reviewed by relevant members of the team to make sure that the plan of care is followed and that patients can return home as soon as they are able.

› Doctor's ward round times have been changed to ensure a nurse can attend the round.

The programme started on Winterslow ward in January 2013 and the following improvements have been made;

› Patients are being encouraged to get dressed every day and the hospital is offering a personal on-sitelaundry service for a small cost.



› Information is on bedside lockers to encourage relatives and carers to provide washing, shaving and personal items. This is to ensure that the daily routine that a patient follows at home is respected whilst in hospital.

› We have introduced a drinks monitoring tool to ensure patients have at least 7 drinks a day.

› We are monitoring call bell response times using a computerised audit tool for staff and real time feedback experience from patients.

- We said we will expand the 'Young at Heart' creative time for older people on the wards.

This involves activities such as singing, dancing, music and storytelling which provides physical and mental stimulation during the recovery phase and helps to lift patients' moods. These sessions continue to go well and have been extended from four wards every week to 6 wards. The sessions receive very positive feedback from patients, their families and carers. This can be seen at www.communitydance.org.uk/animate.

In addition, a project called 'Engage' uses specially trained volunteers who spend time in conversation with patients. The project has been expanded to cover 9 wards with 47 volunteers supported by the psychology team. They are trained in issues they may come across on the wards such as anxiety and depression, cognitive and communication difficulties, dementia and communication skills. Patients give very positive

commented award for equality and diversity as part of our Striving for Excellence awards in November 2012.

What will we do in 2013/2014?

- We will continue to improve the identification and diagnosis of patients with dementia in hospital and outpatients and refer them on to their GP or specialist mental health services when needed to ensure they receive effective care and treatment.
- We will improve the support of carers of people with dementia by giving advice and information. We will ask carers whether they feel supported and take action to improve what we provide where needed.
- In partnership with the Alzheimer's Society we will continue to train our dementia champions and staff in dementia care.
- We will continue to expand our 'Engage' project which uses volunteers to spend time in conversation with older people and patients with dementia to help improve patient's moods.
- We will introduce finger foods which are small bite size portions to make it easier for older patients and patients with dementia to eat and picture menus to make it easier to choose what they would like to eat.
- We will continue to involve senior staff and volunteers who are trained to help patients eat and drink at meal times.

What the patients & public told us?

"My stay was very short but I was treated kindly and sensitively having regard for my wishes".

"When engaging with staff they were polite and respectful. Being a regular patient I always feel that I am being taken seriously".

"One night I had been very worried and fearful but a nurse had spent 30 minutes with me reassuring me".

feedback of this service and there is some evidence to suggest that the initiative helps patients leave hospital sooner. The project won a highly

- We will introduce a 'Keep active' campaign for older people on Winterslow ward to help them maintain their independence.

- In partnership with the Patients Association we will continue our in depth observations of how staff interact and care for patients on their ward. We will continue to use this to improve care.

- We will provide psychological screening for anxiety and depression for all women in the antenatal period and offer advice on services to support them.

- We will introduce an improved care pathway for children with diabetes.



How will we report progress throughout the year

We will monitor and report progress through the Dementia Steering Group, Learning Disabilities Working Group and Food and Nutrition Steering Group. They report to the Clinical Management Board every six months and to the Clinical Governance Committee annually.

Domain 3 Helping people recover from episodes of ill health or following injury

Priority 3 Ensure patients receive timely and effective hospital treatment

Description of the issue and reason for prioritising it:

The length of stay in hospital can vary between patients with similar conditions and the main reasons for delays are the way in which we manage ward rounds and arrange tests and medicines. There can also be delays when patients are ready to be discharged, but the support they need at home is not always available.

Reducing length of stay and preventing unnecessary admission to hospital are key aims of the NHS reforms. We are working with our community and social care colleagues to integrate services and to make changes which will benefit our patients. Key to achieving this will be better management of their care while in hospital and providing care closer to home.

What we did last year to support this improvement priority:

- We will continue to increase the number of conditions suitable for same day assessment and treatment so more patients can go home sooner.

The Emergency Department and Acute Medical Unit have introduced a new and more sensitive blood test to diagnose a heart attack earlier. This test means that patients can be referred to a cardiologist earlier than before or safely discharged home, avoiding a hospital admission.

Patients diagnosed with a deep vein thrombosis (blood clot) who have a positive scan are now seen by the anticoagulant outpatient team instead of attending the Acute Medical Unit. Since February 2012 410 patients have been seen in the clinic. Of these only 7 patients required an assessment in the Acute Medical Unit. Results show this has reduced the time patients spend in hospital by two hours for each patient.

- We want to ensure that patients are involved in deciding their expected date of discharge within 12 hours of arriving in hospital so that plans for going home are focused around their needs.

The Medical Directorate are piloting a scoring system to predict how long a patient will stay in hospital. This will help identify a discharge date that the patient and the clinical team can work towards. In particular, it means that early arrangements can be made for patients with social care or therapy needs.

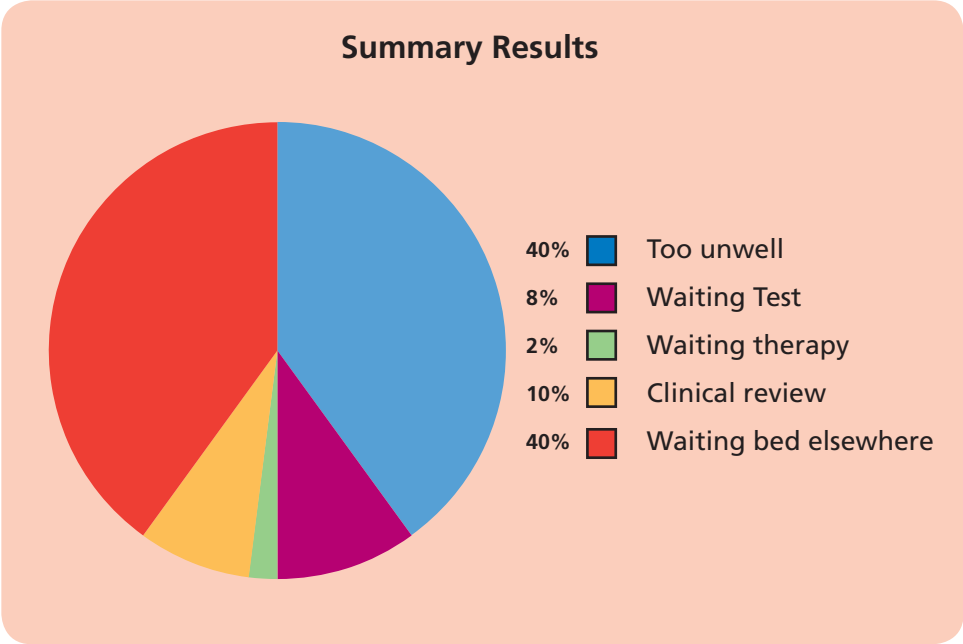
- Through a well designed treatment and discharge plan, we want to focus on reducing the number of patients who have been in hospital for 14 days.

The Trust carried out an audit in April 2012 to understand why patients had been in hospital for more than 14 days. The results showed that 41% of patients were still undergoing treatment and were not fit to go home, 39% were waiting for a bed in another hospital or nursing home and 20% were waiting for their clinical team to take some action such as a diagnostic test or medical review.

A further audit was undertaken in August 2012 to understand why 20% of patients were waiting for their clinical team to take some action. The results showed 40% of patients were too unwell to have the further tests that they needed. However, for some patients delays were due to waiting to see a therapist, for medicine, transport or for a bed in another location. The discharge team make sure that these areas are discussed and progressed at the daily whiteboard rounds. The Medical Directorate has set up a similar programme of monthly bed occupancy audits on each medical ward to identify the reasons why patients stay longer than expected.



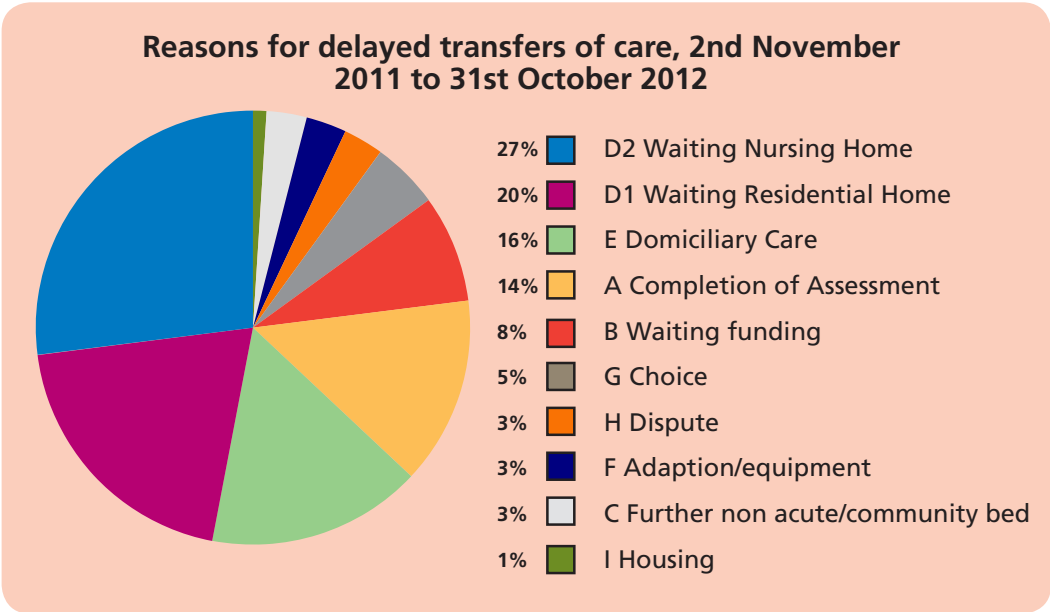
This table shows the reasons for 20% of patients waiting for their clinical team to take some action.



- We said we would move our social care team to work in the same place as the hospital discharge team. This will enable them to support patients with complex needs better and more quickly.
- We want to reduce the delays some patients experience who are medically fit to leave hospital but are waiting for a nursing home assessment.

The co-location of the hospital discharge team and the social care team happened in November 2012. This means that the health and social care team can talk to each other much more easily and work together to make sure those patients can leave hospital as soon as they are medically fit to do so.

Since November 2011 we have undertaken a weekly analysis of the reasons why patients are delayed in hospital. The hospital discharge and social care team have worked to reduce these delays. Initiatives have included a simpler social care assessment and use of STARR beds (these are short stay beds available in nursing homes to enable a patient to have further recovery time or adaptations made at home) prior to the patient returning to their own home or a residential home.



- We said we would continue to work on ensuring patients are able to go home seven days a week. There will be a particular focus on weekend discharges in partnership with GP's and community services.

In March 2012 our therapists started a pilot to provide a 7-day service and this has shown some improvements in the number of patients going home at the weekends. In addition, a discharge co-ordinator is now on duty at weekends to make sure that there are no delays. In April 2012 14.8% of patients who stayed more than 2 days in hospital were discharged at the weekend. In March 2013 this improved to 16.24%.

- We will introduce a mobile chemotherapy unit so patients can have their treatment closer to home.

The new mobile unit was funded by charitable donations and in May 2012 was initially sited in the hospital car park. This allowed the team time to test and understand the issues of working in a mobile unit. In September 2012 Murray Walker opened the mobile unit in Fordingbridge. The service has been enthusiastically received by patients and the local community. The unit is now delivering treatments in Shaftesbury Abbey View Medical Centre and in Westbury. The feedback we have received tells us that people are keen to receive this service closer to home and want us to expand the areas we cover.

- We said we will progress the enhanced recovery programme for knee replacement patients.

The enhanced recovery programme is about improving patient outcomes and speeding up a patient's recovery after surgery. It results in benefits to both patients and staff. The programme focuses on making sure that patients are active participants in their own recovery process. It also aims to ensure that patients always receive the right care at the right time. Patients on the enhanced recovery programme can go home one or two days after their surgery. Patients on the programme attend an education session before the operation where they to learn about how quickly they will be able to get up and what they need to do to support their own recovery. After the patient leaves hospital a physiotherapist telephones the patient and from this, either visits them at home or invites them to a clinic. Since this work started the team have discharged 70 patients within 2 days of their knee replacement. The average length of stay has reduced from 6.55 days in June 2011 to a mean length of stay of 4.9 days in February 2013.

- We would like to reduce the time stroke patients spend in hospital through the use of an early supported discharge service.

The service is provided by the community Neighbourhood Teams with input from the community neurological team. This enables patients to be safely discharged secure in the knowledge that they will continue to receive a high level of therapy and care at home. Each patient has an individual rehabilitation programme. Between April 2012 and February 2013 we referred 33% of stroke patients to this service which meant that they could leave hospital sooner.

- Last year we said we wanted to introduce a self management plan for patients with long term breathing conditions so that when they start to feel unwell they can start medication early.

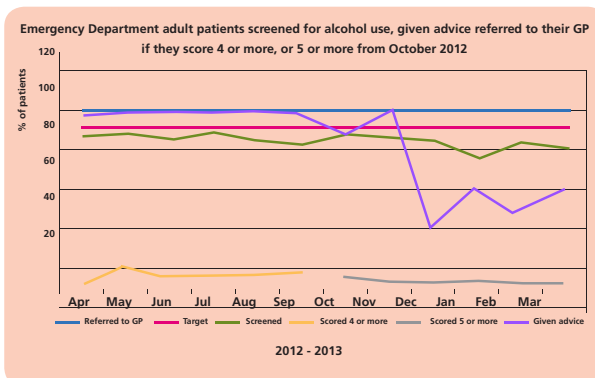
The respiratory team have introduced a self management plan which allows the patient to take greater responsibility for their care. Patients are taught how to take control of their own condition and what to do if they become unwell.

- We will encourage diabetic patients to take their own insulin in hospital if they are able to do so in order to promote and maintain independence.

We introduced a new diabetes treatment chart which prompts the clinical team to ask patients if they would like to manage their own insulin whilst in hospital. This allows patients to continue being responsible for their own insulin regime.

- We said we would introduce an alcohol screening programme for patients attending the Accident and Emergency Department.

Since April 2012 all patients who go to the Emergency Department have been asked about their alcohol use. This helps us to identify patients who may need some advice and to refer them to their GP or specialist nurse. The table below shows the progress we have made:



What the patients & public told us?

"After being referred to the hospital by my GP I was amazed at how quickly things progressed and I was treated for my condition".

"I attended the A&E department and was admitted to a ward where I received superb care and medical treatment by the doctors, physiotherapist and the cheery nursing staff".

"There was poor communication about my treatment".

How will we report progress throughout the year?

Data showing progress against length of stay and other performance indicators are displayed to the teams in the form of a 'dashboard'. These are monitored and reported on by each directorate and by the Operational Management Board every month.

Domain 4 Ensuring that people have a positive experience of care

Priority 4 Ensure patients are able to rate the quality of care they received in hospital as very good or better.

Description of the issue and reason for prioritising it:

It is important the Trust does everything it can to provide high quality care for all our patients and make sure that the care is effective, personal, safe and patients are treated with compassion, dignity and respect. Patients have told us that we do not get everything right every time and we must therefore find out what happened, learn from it, and work to improve care.

The table below shows the percentage of patients who rated their care as excellent or very good in the National Inpatient Survey from 2010 to 2012

National Inpatient Survey question Overall, how would you rate the quality of care you received?	2010	2011	2012
Average Score	79	78	81

- With GPs we will continue to reduce the number of children and young people admitted to hospital as an emergency with diabetes, asthma and epilepsy.
- With our community partners we want to concentrate efforts on providing better support for patients at home who are frequently admitted to hospital.
- To help older people remain safe and independent at home we will continue to work with Wiltshire Council and Wiltshire Medical Services to increase the number of patients we refer to Telecare.
- We will continue to encourage the uptake of the measles, mumps and rubella (MMR) immunisation for women who have had a baby.

We recognise that these results show we need to make improvements. Further analysis of these results with patients tell us that:

- Not all patients liked the food offered on the summer choice menu.
- Patients were concerned about the cleanliness of toilets and bathrooms in the evening and at night time.
- They did not know what was happening next in their treatment or care plan.
- We improved our response times to call bells but we need to continue to be vigilant about answering them.



The real time feedback chart below shows patient responses to the question 'Overall how would you rate the quality of care you received?' in this hospital from September 2011 to March 2013.



What we did last year to support this improvement priority:

- Patients at high risk of falls will be seen by a nurse or carer at least every hour to ensure they are comfortable and they have everything they need. This is known as intentional rounding and we will increase the number of wards doing this.

We have piloted the use of intentional rounding on three wards and doing this has helped to reduce the number of patients who have fallen. We have continued to extend intentional rounding across all the wards.

Other benefits have also been seen since the introduction of the skin bundle (a set of practices which reduce the likelihood of the patient getting a pressure ulcer). This has resulted in a reduction of hospital acquired grade 3 and 4 pressure ulcers (the most severe) with 7 patients developing this type of ulcer between April to March 2013 a reduction from the previous year of 12 patients.

- It is important our patients know what is planned for their care and treatment and so we will continue to make sure that information discussed and decided at the daily whiteboard meetings is discussed with the patient. We will monitor progress through real time feedback.

At the daily whiteboard meetings a doctor, nurse, therapist, social worker and discharge team plan the next steps for all patients to make sure their treatment and care is delivered. Improvements have been made by ensuring the nurse leading the whiteboard review has up-to-date information about all the patients and any decisions that are made at the review are shared with the patient. The discharge team were recognised for their significant contribution to improving the way that patients are admitted and discharged; winning the 2012 Striving for Excellence service improvement award.

- Where patients have identified call bells and

noise at night are an issue these will be included in ward action plans to ensure staff remain active in reducing noise. We want to try a new call bell system and pilot it on one medical ward. We will survey patients to find out the exact cause of noise, especially at night. We will continue to work with an independent noise specialist to reduce environmental causes where possible.

In our work monitoring environmental noise, bins have been shown as one of the causes of noise, especially at night. In February 2013 we started to use a new quieter bin on Redlynch ward. In the 2012 national inpatient survey results patients have told us that noise at night from staff has reduced.

All the medical wards have set measurable call bell response time standards. Patients have told us that our response times have improved in the 2012 national inpatient survey results and we will continue to remain vigilant. Response times are monitored by the ward sisters and matrons. We hope to trial a new call bell system on a medical ward as we refurbish it.

- Where patients have told us staff do not introduce themselves or could be more welcoming we will ensure customer care training is provided.

Customer care training sessions are held every two months and all staff can attend. The training sessions focus on the principles of good customer care and use real life scenarios so that staff can learn how to deal with different situations.

- We said we would introduce a 'Patient Day' board on Farley Stroke Unit as a pilot project. This will explain the ward routine and will include the time the senior nurse 'matron' visits the ward, the times relatives can see staff, and advertise the various social activities. For example singing, crafts and Pat Dogs.

This work has been completed and feedback from patients has been positive.

- We will continue with improvement work in the Outpatient services to reduce wasted appointments and improve communication and information if patients are kept waiting.

We have continued to roll out a partial booking service for follow up appointments. This means the patient books the appointment a few weeks ahead rather than months ahead, which avoids the likelihood of cancellation. We have also continued to refine text messaging to remind patients the day before their appointment.



Our wasted appointment rates have reduced over the last 2 years from 5.1% in 2010/11 to 4.26% in March 2013. Salisbury is one of the best performing hospitals in reducing wasted appointments.

What the patients & public told us?

"I was pleasantly surprised. The care and treatment was very good and the nurses were very kind".

"All the staff were kind and helpful and I felt very safe in their hands".

"When I left hospital it felt rushed".

What we will do in 2013/2014?

- We will continue to review the numbers and skill mix of staff available on wards to make sure that patients receive compassionate and competent care.
- We will continue to support staff to take pride in the care they give to all their patients by holding a celebration day.
- Real time feedback from all the wards is collected from patients by volunteers and governors. We will continue to use this feedback and use themes from the national patient survey, incidents and complaints to take action and make improvements when issues are identified.
- We will introduce the Friends and Family test for all inpatients and patients discharged from the Emergency Department in April 2013 to monitor the quality of care.
- We will introduce the Friends and Family test for all women who have had a baby in the maternity unit from October 2013.
- We will ask our staff if their friends or family needed inpatient or emergency care whether they would recommend Salisbury District Hospital.
- We will redesign the two key public entrances in the hospital to provide modern, bright and a friendly welcome to the hospital.

- We will continue to improve the support of vulnerable families by better liaison between midwives and health visitors in the antenatal and postnatal period.
- We want to improve the transition process from child to adult services for young people with long term conditions.

How will we report progress throughout the year?

Real time feedback is reported to the Trust Board, Clinical Management Board, Operational Management Board and our commissioners monthly and every two months to the Clinical Governance Committee. The other work programmes will be reported through the Clinical Management Board and then to the Clinical Governance Committee.

Domain 5 Treating and care for people in a safe environment and protecting them from avoidable harm

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

Description of the issue and reason for prioritising it:

The safety of our patients is a key aim in our quality improvement work. We continue to run a patient safety programme. Our aim is to reduce levels of harm to patients whilst in hospital and we measure this through things like pressure ulcer rates, infection rates, thrombosis events, and the number of patients falling in hospital. All of these can lead to pain and distress for our patients and extra days or weeks in hospital. This fits with a national priority this year across the NHS to measure the incidence of pressure ulcers (sores), falls, urine infections from catheters, and blood clots through a system called the Safety Thermometer.

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. We will continue to focus on infection prevention and control as an important area of care.

What did we do last year to support this improvement?

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

- Complete the final phase of the bedpan washer replacement programme and sluice room upgrade



on every ward as well as reviewing macerators, which are bedpan disposal units. In addition we will review outpatient areas.

We have made progress in the following areas:

- Dirty utility room upgrades have been completed in the main hospital. The final replacement of bedpan washers and dirty utility room upgrades for the Spinal Unit wards is expected to be completed by June 2013.
- Work to review outpatient facilities and plan a work programme will be completed by June 2013.
- Continue to review Trust infection prevention and control policies to ensure the Trust remains compliant with current best practice.

We have:

- Worked to make sure that all our policies are current and reflect best practice. The work is directed by a Trust infection control action plan and monitored by the Director of Infection Prevention and Control.
- Completed a successful trial of an alternative hand wash soap. This will be brought into use in 2013/2014.
- Reviewed the public alcohol hand rub gel dispensers. These will be replaced in 2013/2014.
- Continue to reduce our infection rates, particularly related to venous and arterial lines ('drips'), through the implementation of care bundles.

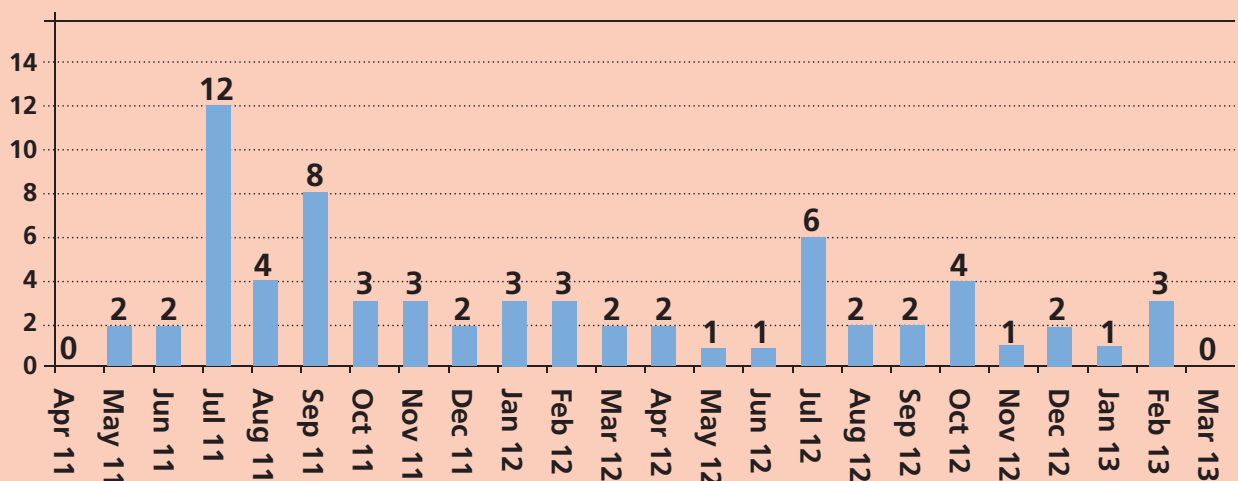
We have:

- Focused work on the introduction of care bundles which are a group of essential practices that must be used when inserting a cannula (drip). The work is being done within the Emergency Department and on Whiteparish ward.
- Continued to monitor our infection rates. From April 2012 to March 2013 there were 3 MRSA blood stream infections and 25 cases of Clostridium difficile.
- Continue to monitor the cleanliness of equipment and the environment, using the hygiene monitoring system (this is called ATP and monitors the effectiveness of our cleaning regimes and will detect if there are any microorganisms). This will also be used to monitor good hand hygiene practice.

We have continued to use the ATP monitoring equipment:

- By the Housekeeping Department before and after a 'deep clean' as a training aid. This has highlighted the need for equipment and furniture replacement such as bedside tables.
- As a testing method on specific equipment or items such as pillows and equipment blades and handles to identify levels of contamination. This has proved to be a useful educational tool and has resulted in improving cleaning methods and techniques.
- ATP has also been used to identify levels of contamination of specialist mattresses before and after cleaning.

Clostridium Difficile - Trust Apportioned



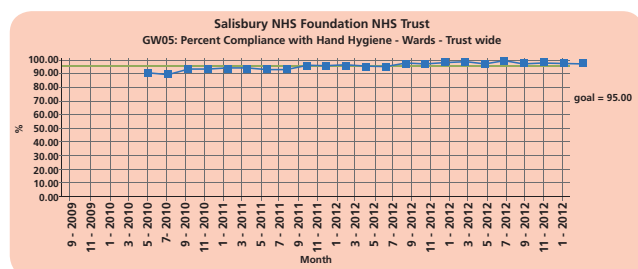
› Results and outcomes of ATP monitoring are presented at the Infection Prevention & Control Working Group and Matrons Monitoring Group.

- We will continue to monitor practice through the audit programme and report these to the Infection Control update meetings and matrons monitoring group meetings.

We continue to audit:

› Hand hygiene and other infection prevention and control practice. These are reported at the monthly Infection Prevention and Control working group.

The table below shows continued good hand hygiene practice



- Compliance with the implementation of action plans is monitored and feedback via the Matrons' Monthly Monitoring Group. Additionally the audit reports are presented to the Clinical Management Board 4 times a year.
- We will continue to review up-to-date innovations and technologies to ensure best practice in infection prevention and control.

Following a visit to a large acute hospital that has successfully used a room decontamination system (called Glosair) we are undertaking a trial of it.

What the patients & public told us?

"The hope is that safety is always in the mind of everyone who treats patients".

"Not heard of so much infection, keep it under control, I think cleanliness has improved".

"The toilets and bathrooms are not as clean in the evening as the day".

We said we will work with our staff and patients to continue our safety work:

- We have introduced the NHS Safety Thermometer. Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure our progress. The Safety Thermometer measures the following events on one day each month across the hospital – pressure ulcers, falls, urinary tract infections in patients with a urinary catheter, and blood clots. This will allow us to monitor our own work in reducing patient harm.

Data collection is done by the staff on their own ward, and we have now had a full year of consecutive reliable data. Reporting results of harm free care will begin in April 2013.

What will we do in 2013/2014?

- We will start to report the level of harm free care in the Safety Thermometer to our commissioners and NHS England.
- We will continue to reduce the number of patients who develop grade 2, 3 and 4 ulcers and work with our partners in the community to reduce the number of pressure ulcers.
- We will reduce the number of catheter acquired urine infections.
- We will continue our work to make sure that all patients are assessed for their risk of developing a blood clot in hospital. We will conduct a detailed enquiry into any patient who develops a blood clot in hospital to ensure we learn and improve.
- We will continue to reduce the number of preventable falls whilst acknowledging that active rehabilitation for some patients will involve an element of risk and that some patients may still fall.
- To support effective parenting we will continue to make sure there is a multiagency plan in place for all babies born into vulnerable families.
- We want to make sure we manage the care of young people with eating disorders effectively.

Infection prevention and control

- We will continue to maintain low numbers of patients with avoidable MRSA blood stream infections and avoidable C difficile.



- To ensure we treat patients with severe infections within an hour of their arrival in hospital we will introduce the 'Sepsis Six' campaign.
- We will review cleaning products in housekeeping to ensure that we continue to use the best available.
- As a result of ATP monitoring (our hygiene monitoring system) we will have a programme of replacement of bedside tables.
- Following a successful trial of the Glosair system we will introduce it as standard practice in the decontamination of all rooms.
- We will continue to monitor hand hygiene practice following the introduction of a new type of soap. We will also continue to review hand wash stations to encourage staff and visitors to wash their hands.
- We will review outpatient dirty utility rooms to make sure they are up to the required standard.

How will we report progress throughout the year?

Infection control, blood clot assessment, pressure ulcers, falls resulting in harm are all reported every month to the Trust Board, Clinical Management Board and Operational Management Board and to the Clinical Governance Committee every two months as well as our commissioners.

Statements of Assurance from the Board

Review of Services

During 2012/2013 Salisbury NHS Foundation Trust provided and/or subcontracted 46 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to them on the quality of care in these 46 relevant health services. The income generated by the relevant health services reviewed in 2012/2013 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2012/2013.

The Trust has published a Quality Strategy 2012 – 2015 which sets out a quality governance framework for the review of individual services. This includes the completion of the Salisbury Organisational Trigger Tool which alerts us to risks relating to quality of care. Where risks are identified, plans are put in place for improvement. It also includes a review of quality information to provide assurance of effectiveness, safety and a good patient experience in each individual service. Information

reviewed includes a Directorate Quality Indicator report, clinical audit results, patient survey feedback, real time patient feedback, comments, complaints and compliments and a risk report highlighting adverse events. This information is discussed quarterly at Directorate performance meetings and the Department Executive Safety and Quality walk rounds. The Directorate Management Team present their quality and safety outcomes and improvement work to the Clinical Governance Committee every year as part of the assurance process.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the Clinical Management Board or Clinical Governance Committee. Many of the reports are also reported to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Each year the Trust has a number of external agency and peer review inspections. The reports, recommendations and action plans are discussed at one of the assuring committees. For example, the Trust had a cancer peer review inspection of the acute oncology team, chemotherapy and skin cancer services in February 2013. The review team found a safe chemotherapy service. The review team said our service was one of the best chemotherapy services they had seen. The pre-assessment chemotherapy clinics, the patient diary and clinical psychology service for patients were also mentioned as examples of good practice. Some improvement actions were required to ensure improved co-ordination of data input into the electronic prescribing system.

The Trust had three Health and Safety Executive improvement notices served on it in 2012. These were related to violence and aggression towards staff and two on dermatitis prevention. Improvements have been made in all three areas and the notices have now been lifted. Examples of improvements made have been better staff training in how to handle violence and aggression, a rapid response team to support staff in these situations and an increase in security guard presence within the Trust.

Areas where problems or concerns have been identified have action plans for improvement and these are monitored through the Trust Directorate performance management meetings. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or the following year's Quality Account priority areas.



Participation in Clinical Audits

During 2012/13, 42 national clinical audits and 2 national confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides.

During 2012/13, Salisbury NHS Foundation Trust participated in 38 (90%) national clinical audits, and 2 (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 2012/2013 are listed in the table below. The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust participated in during 2012/2013 are listed in the same 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 2012/2013, 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
Acute			
Adult community acquired pneumonia (British Thoracic Society)	Yes	No*	N/A
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100%
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
1. Alcohol Related Liver Disease			
2. Subarachnoid Haemorrhage	Yes	Yes	100%
National Joint Registry (NJR)	Yes	Yes	100%
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Yes	100%
Renal colic (College of Emergency Medicine)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	93.4% (April to Dec 12)
Blood and Transplant			
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:			
a) O Negative blood use (2010/11)			
b) Medical use of blood (2011/12)			
c) Bedside transfusion (2011/12)			
d) Platelet use (2010/11)	Yes	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100%
Cancer			
Bowel cancer (NBOCAP)	Yes	Yes	100%
Head and neck oncology (DAHNO)	Yes	Yes	100%
Lung cancer (NLCA)	Yes	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%
Heart			
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%



Adult cardiac surgery audit (ACS)	No	N/A	N/A
Cardiac arrhythmia (HRM)	Yes	Yes	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A
Coronary angioplasty	Yes	Yes	100%
Heart failure (HF)	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	No	ongoing local audit as part of safety work stream
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	100%
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	No*	N/A
Long term conditions			
Adult asthma (British Thoracic Society)	Yes	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	No*	N/A
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%
Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services (previously listed separately on 2010/11 quality accounts list)	Yes	Yes	100%
National Review of Asthma Deaths (NRAD)	Yes	Yes	100%
Pain database	Yes	Yes	100%
Renal replacement therapy (Renal Registry)	No	N/A	N/A
Renal transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
Mental Health			
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	N/A	N/A
National audit of psychological therapies (NAPT)	No	N/A	N/A
Prescribing Observatory for Mental Health (POMH) (Prescribing in mental health services)	No	N/A	N/A
Older People			
Carotid interventions audit (CIA)	Yes	Yes	100%
Fractured neck of femur (College of Emergency Medicine)	Yes	Yes	100%
Hip fracture database (NHFD)	Yes	Yes	100%
National audit of dementia (NAD)	Yes	Yes	100%
Parkinson's disease (National Parkinson's Audit) Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	Yes	Yes	100%
Other			
Elective surgery (National PROMs Programme)	Yes	Yes	Variable across 4 procedures



Women's & Children's Health			
Child health programme (CHR-UK)	Yes	Yes	Variable across 7 consultants
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	100%
Maternal, infant and newborn programme (MBRRACE-UK)			
This programme was previously also listed as Perinatal Mortality (in 2010/11, 2011/12 quality accounts)	Yes	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	Yes	100%
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	100%
Additional national clinical audits the Trust participated in			
Heavy Menstrual Bleeding	Yes	Yes	100%
UK-wide Insulin Pump Audit	Yes	Yes	100%
Accidental Awareness during General Anaesthesia	Yes	Yes	100%
National Audit Cardiac Rehabilitation	Yes	Yes	100%
Audit of Complex Urological Operations	Yes	Yes	100%

*Salisbury NHS Foundation Trust did not participate in these audits as they were from similar topic areas where audits were already planned or underway. We may participate in them in 2013/2014.

The reports of 14 (100%) national clinical audits that were published in 2012 were reviewed by Salisbury NHS Foundation Trust in 2012/2013. Of these 9 (64%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in practice and Salisbury NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.



The table below shows examples of national clinical audit reports reviewed during 2012/2013 and examples of resulting action being taken by Salisbury NHS Foundation Trust.

Audit report	Reviewed by whom	Action taken or required to improve
National Hip Fracture database annual report 2012	Clinical Management Board in April 2012	The appointment of an orthogeriatrician, nurse practitioner, additional theatre capacity for trauma surgery and active leadership by senior doctors achieved dramatic improvements in compliance with standards. By 2012 80% of patients reached an orthopaedic ward within 4 hours, 92% had surgery within 48 hours (and 84% within 36 hours), incidence of pressure ulcers fell from 5.4% to 1.2%, pre operative assessment by an orthogeriatrician rose from 1.5% to 95% and bone protection and fall assessments rose from 6.2% and 3.2% respectively to 100% in both. Mortality fell from 10.1% to 8.4% and length of stay fell from 27.6 days to 19.8 days. Salisbury were ranked 98th out of 100 NHS Trusts in 2011, by 2012 the Trust were ranked in the top five nationally.
NCEPOD Cardiac Arrest Procedures Time to Intervene?	Clinical Management Board in July 2012	Extensive training has led to earlier recognition of the deteriorating patient and an increase in referrals to the Critical Care Outreach team. This has resulted in a decrease in the numbers of cardiac arrests. Local audit to ensure all patients are reviewed by a consultant within 12 hours of admission.
National Lung Cancer audit (LUCADA)	Clinical Management Board in January 2013	Time from referral to first treatment 44 days (46 days nationally). Patients in lung cancer trials 10.5% (2.6% national average)
Sentinel Stroke National Audit Programme	Clinical Management Board in February 2013	Access to a 7 day TIA clinic started on 3 March 2013 linked with Royal Bournemouth Hospital and Poole Hospital. Improvements in stroke care information for patients and carers attending outpatient appointments.



The Trust expects to formally review all national audits at the Clinical Management Board within 2 months of publication. This gives clinical teams time to discuss the findings and to develop an action plan which is presented to the Board for approval and support where actions are needed.

Action plans have been developed for all national audits and confidential enquiries published during the year. Monitoring of these actions is through the Trust's quality performance management structure or through designated working groups. For example the NICE Quality Standard on End of Life Care action plan is monitored through the End of Life Strategy Steering Group and reported to the Clinical Management Board. This shows an increase in the percentage of patients cared for on the Liverpool Care Pathway rose from 60% in 2011 to 86% in 2012 to ensure best practice at end of life care.

The reports of 130 (45%) local clinical audits were reviewed by the Trust in 2012/2013 and Salisbury NHS Foundation Trust intends to take or has already taken the following actions to improve the quality of healthcare provided:

- A report of all clinical audit results that demonstrate a risk to patients or the organisation is reported to the Clinical Risk Group. An example is the annual health care records audit. This has resulted in the introduction of new name stamps in some areas so that the name, grade and contact details of the doctor, nurse or therapist is recorded legibly.
- All infection control audit reports were reviewed by the Infection Control Working Group. Examples of this work are a continued focus on maintaining high standards of practice through compliance with hand hygiene, staff being bare below the elbow, making sure that commodes are cleaned properly and MRSA screening for patients admitted as an emergency. 87% to 92% of patients admitted as an emergency are screened for MRSA.
- Many ward-based audits have been carried out: for example a Dementia Charter Mark standards audit. This enabled the Dementia Steering Group to assess how each ward used their real time observation of patient care, standards of documentation and staff attendance at dementia training. The ward with the best score achieved an award with a small amount of money going to the ward. This money has been donated by the League of Friends and wards achieving the award can spend the money on improving care or the environment for people with dementia.

- Audits were also undertaken by individual services. An example is a nurse-led urology telephone clinic which follows up patients with urinary tract symptoms. The team set up three telephone clinics each month for patients which has reduced the number of times patients have to visit the hospital and increased patient satisfaction. This initiative won a Trust Service Improvement Award in 2012.

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 make sure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to benchmark our performance against others nationally and to determine the focus of improvement programmes. The annual programme also includes a number of audits agreed as part of the contract with our Clinical Commissioning Groups.

Research

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2012/2013 that were recruited during that period to participate in research approved by a research ethics committee was 611* into 45 studies. This compares to 659 into 52 studies in 2011/2012.

The level of participation in clinical research demonstrates Salisbury NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

*End of year recruitment figures will not be finalised until later in the year. Please note that last year's account stated 614 patients recruited to trials but this increased to 659 once the full year figures were validated later in the year.

Goals agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust's income in 2012/2013 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 relevant health services, through the Commissioning for Quality and Innovation



payment framework. Further details of the agreed goals for 2012/2013 are set out in the table below. The planned income through this route for 2012/2013 was £3,623,180 (In 2011/12 it was £2,200,000). The amount the Trust received in 2012/2013 was £3,478,623 (in 2011/2012 it was £2,060,000).

CQUIN contracts were signed with our commissioners during 2012/2013 as part of their overall contract. The

Trust fully achieved the quality improvements as set out in the table below except for 3a dementia screening which achieved 73%. Dementia screening was a new initiative in 2012/2013 and has taken time to embed in practice. Goal 7 was to increase the number of patients discharged at a weekend proved challenging. We have worked with our community partners and improved by 1.44%. See priority 3 which explains improvements we have achieved.

Goals	CQUIN indicators	Domain	Target 12/13	Performance in 12/13
1a	Venous-thromboembolism (VTE) risk assessment & prophylaxis – reduce avoidable deaths, disability and chronic ill health from VTE	Safety	90%	98.6%
1b	Venous-thromboembolism prophylaxis to reduce avoidable deaths, disability and chronic ill health from VTE.	Safety	95%	97.7%
2	Improve responsiveness to personal needs of patients experience	Patient	69.2 mean score	71.4 Mean score
3a	Dementia screening for patients 75 years and over admitted as an emergency	Outcomes Experience	90%	73% (70% of this CQUIN achieved)
3b	Dementia diagnostic assessment of those screened at risk of dementia	Outcomes Experience	90%	96%
3c	Dementia referral for specialist diagnosis	Outcomes	90%	92%* *2 patients remain in hospital (30/4/13) and will be referred to their GP on discharge.
4	Safety Thermometer	Safety Experience	3 full submissions of 3 surveys for 3 consecutive months	Achieved



Goals	CQUIN indicators	Domain	Target 12/13	Performance in 12/13
5	<p>High impact innovations</p> <p>3 schemes:</p> <p>1) Assistive Technology – improved uptake of Telecare.</p> <p>2) Oesophageal Doppler Monitoring (optimal fluid management during surgery) – sustain current level.</p> <p>3) BNP blood test – increase uptake by GPs to rule out heart failure</p>	Outcomes Safety	<p>1) 6 referrals in Q4 12/13.</p> <p>2) Sustain High risk patients & high risk surgery = 22%. High risk surgery alone = 25%.</p> <p>3) 10% increase on 165 GP BNP blood tests in Q3 & Q4 combined</p>	<p>1) 9 referrals in Q4 12/13</p> <p>2) High risk patients & high risk surgery = 58%. High risk surgery alone = 41%</p> <p>3) 260 blood tests requested in Q3 and Q4</p>
6	<p>Reduced length of stay in planned and emergency admissions</p> <p>3 work streams:</p> <p>1) Reduction in length of stay for 4 cardiac diagnoses (heart failure with and without complications and cardiac angiogram).</p> <p>2) Reduction in length of stay for emergency hand trauma admissions.</p> <p>3) Review of pneumonia pathways to agree a specific outcome for quarter 4 to be implemented in 2013/14</p>	Effectiveness	<p>1) 3.46 days</p> <p>2) 0.83 days</p> <p>3) Agree pathway</p>	<p>1) 3.37 days</p> <p>2) 0.61 days</p> <p>3) Pathway agreed at CMB in March 13.</p>
7	7 day a week working to help patients return home promptly without delays in discharge (weekend discharges).	Effectiveness Experience	Baseline 14.8% increase to 17.8%	16.24% 95% of CQUIN achieved
8	<p>Rapid access to specialist advice and guidance through improved same day and appointments within 48 hours for GP referrals.</p> <p>4 work streams:</p> <p>1) 10% reduction in emergency admissions to the Surgical Assessment Unit for less than 2 hours.</p> <p>2) Increase GP uptake of hot joint rheumatology clinics.</p> <p>3) Agree pathway for clinic specific focus on gastroenterology, jaundice and hepatitis for next day/24 hour access.</p> <p>4) Agreed pathway for clinic specific focus on elderly care for next day/24 hour access.</p>	Effectiveness Experience	<p>1) Expected volume to be an outpatient appointment full year effect of 95.</p> <p>2) Increase GP referrals</p> <p>3) Agree pathway</p> <p>4) Agree pathway 90% of vulnerable women referred to appropriate agencies</p>	<p>1) 99 patients had an outpatient appointment in 12/13.</p> <p>2) 20 patients from Nov 12 – March 13.</p> <p>3) Pathway agreed at CMB in March 13.</p> <p>4) Pathway agreed. Clinic started 4/2/13</p>



Goals	CQUIN indicators	Domain	Target 12/13	Performance in 12/13
9	Maternity services – access to flexible services that focus on the needs of the individual, particularly vulnerable women	Safety	90% of vulnerable women referred to appropriate agencies	98.4% to 31/12/12

Specialist Commissioning CQUIN indicators 2012 – 2013

The Trust achieved the quality improvements as set out in the table below except for Goal 8 and 9. Goal 8 was to ensure premature babies are screened for retinopathy. The Trust achieved 86% as three babies missed the screening test but were examined by a senior eye specialist. The Trust achieved 28% of premature babies being exclusively breast fed. This proved particularly challenging as 3 sets of premature twins all needed formula milk to gain weight and grow.

Goals	CQUIN indicators	Domain	Target 12/13	Performance in 12/13
1 – 4	Same as CQUIN table above			See table above
5	To introduce quality dashboards for the following services: <input type="checkbox"/> Burns care <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Neonatal care <input type="checkbox"/> Bone Marrow Transplant <input type="checkbox"/> Haemophilia <input type="checkbox"/> Cystic Fibrosis	Outcomes	Q1 identify overall lead and speciality leads. Q2 plan for implementation. Q3 commence data entry	Q1 – leads identified Q2 – plans agreed Q3 – data entry commenced
6	Spinal cord injury 3 work streams: 1a and 1b) Acute outreach team to visit newly injured patients in other hospitals within 7 days of referral. 2a and 2b) Acute outreach team to ensure newly ventilated patients in other hospitals have a plan within 7 days of referral.	Outcomes	1a) 25% of patients to be visited between April to September 2012. 1b) 75% of patients to be visited from October 2012 to March 2013 2a) 25% of patients have a plan within 7 days of referral between April to September 2012 2b) 90% of patients have a plan within 7 days of referral	1a) 48% 1b) 94% 2a) 82% 2b) 100%



Goals	CQUIN indicators	Domain	Target 12/13	Performance in 12/13
	3) Specialist commissioners receive a waiting list report within 15 days of the end of the month.		between October to March 2013 3) Monthly updated list	3) Reported monthly
7	Neonatal care – total parenteral nutrition of babies under 30 weeks or less than 1500g receive it by day 3.	Outcomes	80%	100%
8	Neonatal care – to achieve 95% screening of retinopathy of prematurity	Outcomes	95%	86%
9	Neonatal care – increase the proportion of low birth weight babies (less than 33 weeks) fed exclusively on mother's milk at discharge	Outcomes	80%	28.6%
10	Neonatal care – simple nurse led discharge	Outcomes	60%	82%

Our quality priorities in 2013/2014 reflect the need to continue to work with our partners to improve these aspects of care. The Trust has agreed CQUINs for 2013/2014 as set out in the table below:

CQUIN indicators (Wiltshire, Hampshire, Dorset, Bournemouth Poole, Somerset, Southampton City, Isle of Wight, Portsmouth) 2013 - 2014

Goal name High Impact Innovations	Description of goal Gateway to the rest of	Target 50% of each scheme	Quality domain
3 million lives	Increase the planned use	a) Increase referrals in orthopaedics from 24 in of Telecare technology 2012/13 to 36 in 2013/14 b) Roll out to general medicine and surgery to achieve 12 referrals in 2013/14	Innovation
Intra-operative fluid management (IOFM)	Optimise fluid management during surgery in high risk patients and major surgical cases	Reach 80% by Q4 of a group of relevant high risk patients defined by OPCS codes	Innovation
Digital First	Telephone clinic for follow up for urology post surgery patients. Haematology consultant daily email and telephone advice for GP	Increase in the number of patients reviewed at the weekly telephone clinic. Monitor activity	Innovation



Goal name High Impact Innovations	Description of goal Gateway to the rest of	Target 50% of each scheme	Quality domain
Post gateway			
Friends and Family Test	Phased expansion (all adult patients discharged from hospital and the Emergency Department) Maternity services – all women who have had a baby – to start by the end of October 2013	Q1 response rate must be 15% of total discharges	Safety
Friends and Family Test	Increased response rate	By end of Q4 achieve a response rate that improves on Q1 and is 20% or over	Safety Effectiveness Patient Experience
Friends and Family Test	Improved response rate on the staff response to the friends and family test.	The hospital to remain in top quartile of Trusts	Safety Effectiveness
NHS Safety Thermometer	Data collection	Maintain monthly data collection	Patient Experience. Effectiveness
NHS Safety Thermometer	Reduction in the prevalence of hospital acquired new pressure ulcers.	By end of Q4 30% reduction in new pressure ulcers Collaborative working with the health community to contribute towards reduction of old pressure ulcers	Patient Experience. Effectiveness
Dementia - find, assess, investigate and refer	90% of patients admitted as an emergency over 75 years to be screened for dementia. If a positive screen 90% of patients had a diagnostic assessment and referred to their GP for further review	90%	Effectiveness
Dementia – clinical leadership	Named lead clinician for dementia and a training programme for staff	Clinical lead already in place. Outcome is based on the planned training programme being delivered	Effectiveness
Dementia – supporting carers of people with dementia	Ensuring carers feel supported .	Monthly audit will find out if carers feel supported, were given advice and information	Effectiveness



Goal name High Impact Innovations	Description of goal Gateway to the rest of	Target 50% of each scheme	Quality domain
Venous Thromboembolism risk assessment	All adult inpatients must have a VTE risk assessment on admission to hospital	95%	Safety
Venous Thromboembolism root cause analysis	The number of root cause analysis carried out on patients who develop a hospital associated thrombosis (blood clot)	95%	Safety
Out of hospital care Emergency Department non elective emergency admissions	1) Reduce emergency admissions to hospital for patients with a long term condition. 2) Reduce emergency paediatric admissions for epilepsy, diabetes, asthma. 3) Hospital consultants to engage with locality professionals to provide advice and support in managing individual patients and on a population basis. 4) Support GPs in managing patients in care homes and link with care co-ordination services	For 1, 2 and 3: <ul style="list-style-type: none">Establish a baseline by 30/6/13Identify patients and agree action plan by 30/7/13Produce activity report by 31/9/13Update action plan by 31/3/14Undertake an Interqual audit in year.Ensure clinical time is available to support pathway development.Monitor referrals to Neighbourhood teams.Provide 8 training events for GPs in management of agreed conditions	Safety Patient Experience
Out of hospital care Emergency attendances – follow up of frequent attendees	1) Identify and provide acute and community actions for frequent adult and paediatric attendees to hospital emergency services with a view to reducing frequent attendees. 2) Achieve an increase in the number of frequent attendees referred to appropriate community services	For 1 and 2: <ul style="list-style-type: none">Establish a baseline by 30/6/13Identify patients and agree action plan by 30/7/13Produce activity report by 31/9/13Update action plan by 31/3/14	Safety Patient Experience
Functional movement in hospital for elderly care patients	To reduce the functional decline of elderly patients whilst in hospital through increased mobilisation	Q1 baseline audit of number of patients appropriate to mobilise and frequency of mobility during the day. Q2 implement a mobility plan and staff education Q3 increase numbers of patients with a mobility plan.	Safety Patient Experience



Goal name High Impact Innovations	Description of goal Gateway to the rest of	Target 50% of each scheme	Quality domain
7. Rapid access to specialist advice and guidance through improved same day and appointments within 48 hours for GP referrals to reduce emergency admissions	a) Gastroenterology clinic specific for patients with jaundice and hepatitis clinic slots next day/24 hour access b) Elderly care specific clinic for next day/24 hour access	For a) and b) Available number and utilisation of clinic slots per week.	Safety Patient Experience Effectiveness Innovation
8. Maternity services - to support vulnerable families	To improve support for vulnerable families through monthly liaison meetings between community midwives and health visitors	90% of vulnerable women/families referred to a health visitor or other health professional in the antenatal period. 90% of vulnerable women have a formal written discharge summary written by the midwife to the health visitor 6 days after the birth of the baby.	Safety Patient Experience

The Trust is currently having positive discussions to agree Specialist Commissioning CQUIN indicators for 2013/2014. Further details of the agreed goals for 2013/2014 are available from the Finance Department, Salisbury NHS Foundation Trust, Salisbury District Hospital, Wiltshire. 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 without conditions.

The Care Quality Commission has not taken enforcement action against Salisbury NHS Foundation Trust during 2012/2013.

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2012/2013.

In February 2013 the CQC made a routine unannounced inspection and found that we meet all care and cleanliness standards. The CQC visited a wide range of clinical areas, talked to our staff and patients and observed the care we provide. The inspection team were clearly impressed with the motivation and professionalism of our staff and the report opens with the following comment that they recorded from an older patient: "No one likes staying in hospital, but the time comes when we might end up here. I've been fortunate. It's the best conditions and food that anyone could wish for. The staff are most pleasant and helpful"

In its report the CQC found that we met the following essential standards:

Respecting and involving people who use services

CQC judgement: People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care

Care and welfare of people who use the service

CQC judgement: People experienced care, treatment and support that met their needs and protected their rights

Meeting nutritional needs

CQC judgement: People were protected from the risks of inadequate nutrition and dehydration.



Cleanliness and infection control

CQC judgement: People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean hygienic environment.

Assessing and monitoring the quality of services

CQC judgement: The Trust had an effective system to regularly assess and monitor the quality of service that people receive. The Trust had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others

The CQC identified that action was needed in the following areas:

Staffing

CQC judgement: At the time of the visit the CQC were not sufficiently assured patients were being cared for by enough suitable, skilled, qualified and experienced nursing and health care staff. The CQC judged this to have a minor impact on people who use the service. (The CQC have the option of rating this impact as minor, moderate or major). The CQC also found that the Trust was aware of the situation and was already taking the necessary action.

Records

CQC judgement: People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained. However, paper records were not always kept securely to protect patient confidential information. The CQC judged this to have a minor impact on people who use the service.

Salisbury NHS Foundation Trust are planning to take the following actions to improve in these areas:

- Recruit to all nursing vacancies through a one off initiative to recruit approximately 40 registered nurses from Portugal and attend a local health care recruitment fair to seek newly qualified nurses.
- Ensure our ward nursing establishment and skill mix match the needs of our patients. We will continue to undertake a skill mix and establishment review at least annually and monitor patient dependency over time on wards. We will continue to review the 'headroom' allocated to each ward to cover sickness and annual leave and monitor staffing levels at twice daily bed meetings. A board level report will be regularly presented on workforce indicators, including vacancy rates, bank and agency use and sickness rates.

- The Trust will introduce a privacy sheet to cover patient charts at the end of the bed to prevent casual viewing of confidential and private information.
- The Information Governance department will continue with audits of the security of patient records, ensure action plans are in place and progress is monitored through the performance quality meetings.

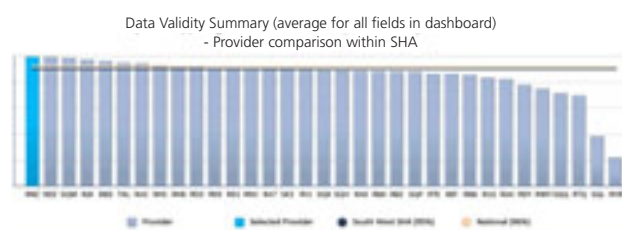
Data quality

Good quality information (data) underpins the effective delivery of patient care and is essential if improvements in the quality of care are to be made. Improving data quality will improve the delivery of patient care and improve value for money.

Salisbury NHS Foundation Trust will continue to take the following actions to improve data quality:

- To focus on the process of data collection to encourage a 'getting it right, first time' culture.
- Continue with an audit programme and peer review of data and change practice accordingly.
- Staff inputting data will be automatically notified when they have made a mistake, so that it can be corrected.
- To design and adjust data collection systems to prevent collection of poor quality data.
- Continue with the data quality improvement group where issues regarding data collection and reporting are discussed and improved upon.

We know the above actions are effective as Salisbury NHS Foundation Trust has improved our general data quality of our commissioning data submitted to the Secondary Uses Service. This is shown in the table below which compares Salisbury NHS Foundation Trust with other acute hospitals within the Strategic Health Authority.



RNZ = Salisbury NHS Foundation Trust
(selected provider).

All other acute hospitals (provider)



To ensure our data quality is able to support the assurance of overall care quality the Trust manages a Data Quality Service. The Data Quality Service aims to ensure staff record clinical information accurately on every occasion. The service achieves this by supporting good practice in the process of data collection, this ensures the person coding the episode of care has the right information about the care given and the appropriate training to ensure accurate data capture. The Data Quality Service staff spend time working with doctors and administrative staff to demonstrate best practice as well as correct errors made. Errors are detected through the use of automatic electronic data quality reports and rectified by the person who recorded the data incorrectly. Data quality reports include volumes and types of errors and are reported to the Data Quality Improvement Group, Directorate performance meetings and the Information Governance Steering Group. The Data Quality Service continually monitors and audits data quality locally and participates in an external audit which enables the Trust to benchmark its performance against other Trusts.

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

Salisbury NHS Foundation Trust submitted records during 2012/2013 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The table below shows the percentage of records in the published data which includes the patient's valid NHS number and General Practitioner Registration code. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Practitioner Registration code is essential to enable the transfer of clinical information about the patient.

Data item	Salisbury District Hospital 11/12*	National benchmark 11/12*	Salisbury District Hospital 12/13 As at M11	National benchmark 12/13 As at M11
% for admitted patient care with a valid NHS number	99.4%	98.9%	99.5%	99.1%
% for outpatient care with a valid NHS number	99.6%	99.1%	99.6%	99.3%
% for Emergency Department care with a valid NHS number	98.2%	93.6%	98.1%	94.9%
% for admitted patient care with a valid General Practitioner Registration code	100%	99.9%	100%	99.9%
% for outpatient care with a valid General Practitioner Registration code	100%	99.7%	100%	99.9%
% for Emergency Department care with a valid General Practitioner Registration code	99.9%	99.4%	99.9%	99.7%

* 2011/12 month 11 data was reported in the quality account.



Information Governance Toolkit Attainment levels

Salisbury NHS Foundation Trust's Information Governance Assessment report overall score for 2012/2013 was 83% and was graded as satisfactory (green). The assessment provides an overall measure of the quality of data systems, standards and processes within the organisation. The Trust's score was the same as in 2011/2012*. The Trust achieved the necessary standard for all areas assessed.

* Please note the score of 85% was reported in 2011/2012. The correct score was 83%.

Clinical Coding Error Rate

Clinical coding translates the medical terminology written in a patient's health care record to describe a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and underpins payments and financial flows within the NHS. The Trust introduced new coding software in 2012. This has improved consistency of coding and provides an audit tool which enables local improvement actions to be taken.

Salisbury NHS Foundation Trust was subject to an external Information Governance coding audit during 2012/2013 by an independent audit company and the error rate reported in the latest published audit for that period for diagnoses and treatment coding were:

Primary diagnosis incorrect 1.5%
Secondary diagnoses incorrect 3.5%
Primary procedures incorrect 4.2%
Secondary procedures incorrect 1.5%

The services reviewed within the sample were Trauma and Orthopaedics, Emergency Department Short Stay Emergency Unit, Dermatology, Rheumatology and Gynaecology. The results should not be extrapolated further than the actual sample audited.

The following improvement actions were progressed in 2012/2013:

- The quality of the filing within the case notes folder. This work has been led by the Health Care Records Committee at ward level to encourage complete filing before the case notes leave the ward. The senior doctor who leads this work has demonstrated the correct procedure to junior staff and at staff induction.

Salisbury NHS Foundation Trust will be taking the following improvement actions to improve data quality for 2013/2014:

- Ensure discharge letters contain information regarding active co morbidities and other conditions treated whilst an inpatient.
- Improve information for excision of lesions and detail what type of graft was used.
- Continue to improve the coding of co-morbidities of patients.
- Continue to improve the quality of the filing in the case notes folder and the secure storage in the clinical area.

NHS Outcomes Framework – Overarching indicators

Summary Hospital Level Mortality (SHMI)

Salisbury NHS Foundation Trust considers that the SHMI data is as described for the following reasons:

- See explanation under description of the issue and reason for prioritising it in priority one.

Salisbury NHS Foundation Trust has taken the following actions to improve the SHMI of 105 to improve the quality of its services by:

- A senior doctor has led and has worked with clinical teams across the hospital to improve mortality reviews. Teams have reviewed a percentage of deaths in hospital in 2012/2013. The reviews did not find any serious failings in care but have found areas where we could improve. For example a theme emerged concerning the need for improved communication with the patient and their families. This theme is being addressed as part of the education programme for end of life care.

Salisbury NHS Foundation Trust intends to take the following actions to improve the SHMI of 105 to improve the quality of its services by:

- We will investigate the care of patients who were admitted at weekends who later died to see if there are any changes or improvements need to be made.
- We also plan to work with GPs and clinicians in the hospital to review 100 deaths. The care before the patient is admitted to hospital, care in hospital and discharge arrangements will be included to see if there are any improvements that we need to make.



NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average	Highest average other Trusts 2012/13	Lowest average other Trusts 2012/13
Domain 1: preventing people from dying prematurely	a) SHMI value	Not available	105	105 (to Sept 2012)	100	125	71
	a) SHMI banding	Not available	As expected	As expected	As expected	Higher than expected	Lower than expected
	b) Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust.	28.6%	29.5%	26%			

Patient Reported Outcomes Measures (PROMs)

Salisbury NHS Foundation Trust considers that the Patient Reported Outcomes Measures (PROMs) are as described for the following reasons:

- We introduced PROMs in 2010 for patients who had hip and knee replacement surgery, groin hernia and varicose vein surgery. These measure a patient's health gain after surgery. The information is gathered from the patient who completes a questionnaire before and after surgery. The responses are analysed by an independent company and benchmarked against other Trusts. Salisbury

NHS Foundation Trust has taken the following actions to improve the health gain of patient's having groin surgery to improve the quality of its services by:

- The senior doctor for groin hernia repair commissioned a focus group in January 2012 to better understand why patients reported their health state as worse after the operation. Changes were then made to improve patient information about what to expect after the operation and patients are now given a choice to delay surgery if they have no symptoms when they attend an outpatient appointment.



NHS Outcomes Framework Domain	Indicator	2010/11	2011/12 Provisional	2012/13 Provisional	National average 2012/13	Highest average other Trusts 2012/13	Lowest average other Trusts 2012/13
Domain 3: helping people to recover from episodes of ill health or following injury	Patient reported outcome scores (PROMs) of total health gain as assessed by patients for elective surgical procedures:				Average health gain where full health = 1		
	i) groin hernia	0.128	0.148	0.042	0.091	0.310	-0.115
	ii) varicose vein	0.065	0.078	0.070	0.093	0.273	-0.056
	iii) hip replacement	0.390	0.418	0.484	0.437	0.690	0.155
	iv) knee replacement	0.277	0.300	0.337	0.312	0.527	0.031

Emergency readmissions within 28 days of discharge

Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge from hospital is as described for the following reasons:

- Every time a patient is discharged and readmitted to hospital the staff code the episode of care. The Data Quality Service continually monitors and audits data quality locally and we participate in external audit which enables the Trust to benchmark its performance against other Trusts.

Salisbury NHS Foundation Trust has taken the following actions to reduce readmissions of patient's within 28 days of discharge to improve the quality of its services by:

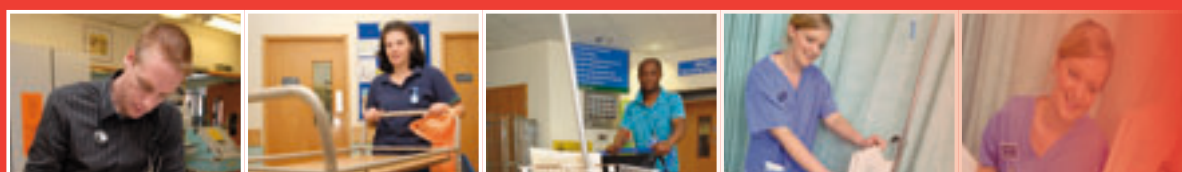
- In 2011/2012 knee replacement readmissions were above the national average. These cases were reviewed. It was thought that some of the

re-admissions might have been avoided if the patient had been given more support when they left hospital. A telephone contact, visit or outpatient appointment with an orthopaedic therapist was put in place to reduce this number. In September 2012 re-admissions were as expected.

- In 2012 we undertook an audit with our community partners to understand why patients are re-admitted to hospital. We found a number of patients were re-admitted after surgery because they were unable to pass urine.

Salisbury NHS Foundation Trust intends to take the following actions to reduce readmissions to improve the quality of its services by:

- We will continue to review groups of patients with diagnoses and procedures where readmission rates are higher than expected and take improvement actions.



NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average 2012/13	Highest average other Trusts	Lowest average other Trusts
Domain 3: helping people to recover from episodes of ill health or following injury	Percentage of emergency readmissions within 28 days of discharge from hospital of patients aged:						
	i) 0 to 14	5.93%	4.88%	5.11%	4%	Not available	Not available
	ii) 15 or over	6.05%	5.89%	5.87%	6.3%		

Responsiveness to the personal needs of patients

Salisbury NHS Foundation Trust considers that the mean score of responsiveness to inpatient personal needs is as described for the following reasons:

- Each year the Trust participates in the National Inpatient Survey. A random sample of 850 patients are sent a nationally agreed questionnaire and the results are analysed independently by The Patient Survey Co-ordination Centre.

Salisbury NHS Foundation Trust has taken the following actions to improve responsiveness to inpatient personal needs and improve the quality of its services by:

- Eliminating mixed-sex sleeping accommodation.
- Improving our responsiveness to call bells.
- Reducing noise at night
- Improving the help we give patients to eat and drink at mealtimes.

Salisbury NHS Foundation Trust intends to take the following actions to improve responsiveness to inpatient personal needs and improve the quality of its services by:

- See 'what we will do in 2013/2014' in priority two.
- We will review the recommendations in the Francis enquiry and the Government's response in Patients First and Foremost and take improvement actions where needed. Progress will be reported to the Clinical Governance Committee and the Board.

NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average in 2012/13	Highest average other Trusts 2012/13	Lowest average other Trusts 2012/13
Domain 4: ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs (mean score)	68.8	69.2	71.4	71.1	85.6	56.6



Staff who would recommend the hospital to friends and family needing care

Salisbury NHS Foundation Trust considers that the percentage of staff who would recommend the hospital to friends and family needing care is as described for the following reasons:

- Each year the Trust participates in the National Staff Survey. A random sample of 800 staff are sent a nationally agreed questionnaire by an independent company. The results are analysed by the Staff Survey Co-ordination Centre.

Salisbury NHS Foundation Trust has taken the following actions to improve the percentage of staff who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Overall staff engagement in the 2012 staff survey showed the Trust in the highest (best) top 20% of acute Trusts. This included the staff feeling able to contribute towards improvement and feelings of motivation at work.

Salisbury NHS Foundation Trust intends to take the following actions to improve the percentage of staff who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Reviewing the Trust's values and beliefs and embed them in day-to-day business.
- Developing the Trust strategy so that we provide each patient with an outstanding experience.

NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average In 2012/13	Highest average other Trusts	Lowest average other Trusts
Domain 4: ensuring that people have a positive experience of care	Percentage of staff who would recommend the hospital to friends or family needing care	75%	77%	76%	60%	Not available	Not available

Venous thromboembolism

Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were risk assessed for venous thromboembolism (blood clots) is as described for the following reasons:

- Patient level data is collected monthly by the ward pharmacist from the patient's prescription chart. The data is captured electronically and analysed by a senior nurse linked to the Thrombosis Committee.

Salisbury NHS Foundation Trust has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism to improve the quality of its services by:

Salisbury NHS Foundation Trust intends to take the following actions to improve the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism and improve the quality of its services by:

- Develop the role of a ward based anti-coagulant nurse to provide patient and staff education in the light of new anti-coagulant medicines coming onto the market.

- Ongoing education of staff, patients and raising awareness with members of the public.
- Feedback of the monthly audit results to the wards and clinical leads to drive improvement.
- In-depth analysis of patients who develop a thrombosis in hospital to learn and improve.



NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average 2012/13	Highest average other Trusts 2012/13	Lowest average other Trusts 2012/13
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of admitted patients risk assessed for Venous Thromboembolism	91%	92%	98%	94.2% to 31/12/12	100% to 31/12/12	84.6% to 31/12/12

C.difficile infection

Salisbury NHS Foundation Trust considers that the rate per 100,000 bed days of cases of C.difficile infection are as described for the following reasons:

- The Trust complies with Department of Health guidance against which we report positive cases of C difficile. We submitted our data to the Health Protection Agency and are benchmarked nationally against other Trusts. C.difficile data is subject to external audit for assurance purposes.
- Maintaining and monitoring standards of cleanliness and taking actions to improve.
- Designated ward rounds to ensure best practice in antibiotic prescribing.
- In depth analysis of patients who develop C difficile in hospital to learn and improve.

Salisbury NHS Foundation Trust intends to take the following actions to reduce the rate per 100,000 bed days of cases of C.difficile infection to improve the quality of its services by:

- Salisbury NHS Foundation Trust has taken the following actions to reduce the rate per 100,000 bed days of cases of C.difficile infection to improve the quality of its services by:
- Continued vigilance through the above actions
- See 'what we will do in 2013/2014' in priority 5.
- Maintaining and monitoring good infection control practice including hand hygiene and taking action to improve.

NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	National average 2011/12	Highest average other Trusts 2011/12	Lowest average other Trusts 2011/12
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	*Rate of C. difficile per 100,000 bed days	20.0	30.0	16.9	21.8	51.6	1.9

* Rate calculated on Trust apportioned cases only of patients aged 2 years and over.



Patient safety incidents

Salisbury NHS Foundation Trust considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken.
- The Trust submits patient safety incident data to the National Reporting Learning System. We are ranked against other Trusts in respect of the rate of reporting and category of harm.
- We work in partnership with our commissioners to share learning and improvement actions.
- The Trust complies with the duty of candour.

Salisbury NHS Foundation Trust has taken the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that have resulted in severe harm or death to improve the quality of its services by:

- Investigating clinical incidents and serious incidents and sharing the lessons learnt across the Trust and ensured recommendations are implemented through the Directorate quality performance meetings.

Salisbury NHS Foundation Trust intends to take the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that resulted in severe harm or death to improve the quality of its services by:

- Continuing to actively promote reporting, investigation of clinical incidents and serious incidents, sharing learning across the Trust and with our commissioners to ensure improvement in the Trust and outside the organisation.

NHS Outcomes Framework Domain	Indicator	2010/11	2011/12	2012/13	Median for small acute organisations	Highest average other Trusts	Lowest average other Trusts
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	Rate of patient safety incidents reported.	6.05 incidents per 100 admissions	7.7 incidents per 100 admissions	7.9 incidents per 100	6.5 incidents per 100 admissions (to 7/9/2012)*	Not available	Not available
	The percentage of such incidents that resulted in severe harm or death	1.2%	1.7%	0.8%	0.9%		

*The number of incidents per 100 admissions is taken from the National Reporting Learning System (NRLS) report. This shows the latest actual figures reported nationally for the Trust which are always 6 months in arrears.



Review of Quality Performance

This section gives information relating to the quality of services that Salisbury NHS Foundation Trust provides through a range of selected measures of patient safety, effectiveness and experience. 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, such as cleanliness and infection prevention and control. Our commissioners measure a number of these areas and our CQUIN contract supports improvement measures.

These indicators are included in monthly quality indicator and measures report that is reported to the Board and Clinical Governance Committee.

Patient Safety Indicators	2008/09	2009/10	2010/11	2011/12	2012/13	National average	What does this mean?	Source of Measure
1. Mortality rate (HSMR)	96	100*	95*	104	104 to 31/1/13	100	Lower than 100 is good	Based on the national definition of Dr Foster's HSMR. Based on the national definition in the NHS Information Centre
SHMI (new measure 2011/12)	n/a	n/a	n/a	105	105 to 30/9/12	100		
2. MRSA notifications**	2 (5)	4 (5)	0 (5)	4 (5)	3 (3)	Not available	0 is excellent	National definition
3. C. difficile infection per 1,000 bed days	0.3	0.45	0.32	0.51 Trust and non Trust apportioned 0.29 Trust apportioned only	0.25 Trust and non Trust apportioned 0.16 Trust apportioned only	Not available	Lower than national average	National definition
4. Global Trigger adverse events rate	44	42	31***	41	33 (to 28/2/13)	40	Lower score the better	Definition based on Patient Safety First Campaign
5. 'Never events' that occurred in the Trust.****	0	0	2 (These were associated with surgery & rectified with	1 (This was associated with surgery with no patient harm)	2	Not available	0 is good	Definition from National Patient Safety Agency



Patient Safety Indicators								
			no long term harm)					
6. Patient falls in hospital resulting in a fracture or major harm Clinical Effectiveness indicators	Not measured	24	21	32	32	Not available	Low number is good	Definition from National Patient Safety Agency
Clinical Effectiveness indicators								
7. Patients having surgery within 36 hours of admission with a fractured hip	60%	75%	74%*** **	87%	80%	90%	Higher number is good	Based on national definition with data taken from hospital system and national database.
8. % of patients who had a risk assessment for VTE (venous thromboembolism)	57%	72%	91%	92%	98%	90%	Higher number better	Based on national definition with data taken from hospital system and national database.
9. % patients who had a CT scan within 24 hrs of admission with a stroke	56%	89%	90%	92%	94.6%	Not available	Higher number better	Based on national definition with data taken from hospital system and national database.
10. Compliance with NICE Technology Appraisal Guidance published in year Patient experience indicators	83%	92%	80%	70%	72%	Not measured	Higher number better	Local indicator



Patient Safety Indicators	2008/09	2009/10	2010/11	2011/12	2012/13	National average	What does this mean?	Source of Measure
Patient experience indicators								
11. Number of patients reported with grade 3 & 4 pressure ulcers	45	58	19	12	7	Not available	Lower number is better	National definition with data taken from hospital reporting systems
12. % of patients who felt they were treated with dignity and respect	81%	80%	81%	79% Yes always 19% Yes some-times	83% Yes always 15.5% Yes some-times	Not available	Higher number is better	Data taken from national inpatient survey
13. Means score of patients stating the quality of care was very good or better.	79 #	74 #	79 #	78 #	81 #	Not available	Higher number is better	Data taken from national inpatient survey
14. % of patients in mixed sex accommodation	19%	14%	11%	11%	7%	Not available	Lower number is better	Data taken from national inpatient survey
15. % of patients who stated they had enough help from staff to eat their meals	60%	55%	67%	63%	74%	Not available	Higher number is better	Data taken from national inpatient survey
16. % of patients who thought the hospital was clean	61%	65%	66%	65%	66%	Not available	Higher number is better	Data taken from national inpatient survey

* In previous annual reports the HSMR was reported as 101 in 2009/10 and 97 in 2010/11. However, in 2011/12 HSMR was rebased and our figures were rebased to 100 in 2009/10 and 95 in 2010/11.

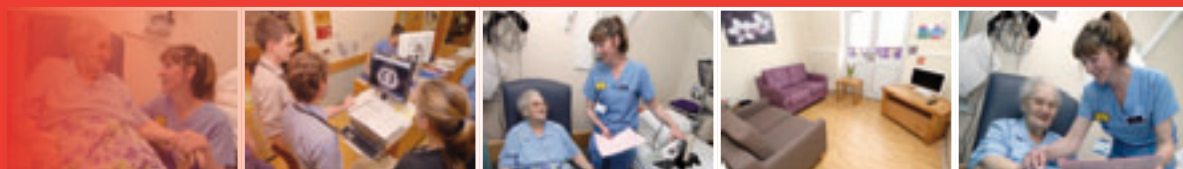
** In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA notifications as a total figure. This will have included community hospital and GP patients. The total figure is quoted in brackets in the table.

*** The Global Trigger/adverse events rate was published as 33 up to 31 Jan 2011 in the 2010/11 quality report. The total figure for the full year in 2010/11 was 31.

**** Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The never events list increased from 8 to 25 on 1 April 2011.

***** In 2010/2011 Quality Account the Trust quoted 80% of patients having surgery within 36 hours of admission with a fracture neck of femur (hip). The National Hip Fracture report 2011 indicated the Trust achieved this with 74% of patients based on full year figures.

In the national inpatient survey in 2012 the way patients were asked to answer the question was changed. To enable a year on year comparison the average score has been substituted for the percentage of patients asked the question.



National Targets and Regulatory Requirements

	2008/09	2009/10	2010/11	2011/12	2012/13	Target for 2013/14
C.difficile year on year reduction (from 10/11 positive samples taken within 72 hrs of admission are reported as non Trust apportioned)*	73	79	52 (31 Trust apportioned, 21 non Trust apportioned)	111 (44 Trust apportioned 67 non Trust apportioned)	39 (25 Trust apportioned 14 non Trust apportioned)	21
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half of the 03/04	2 (5)	4 (5)	0 (5)	4 (5)	3 (3)	0
All cancers: 31 day wait for second or subsequent treatment	n/a	97.1% Surgery + drugs	99.1% Surgery + drugs	99.5% Surgery + drugs	99.4% Surgery + drugs	94%
All cancers: 31 day wait for second or subsequent treatment – surgery	n/a	98.1%	98.5%	98.9%	98.9%	94%
All cancers: 31 day wait for second or subsequent treatment – anti cancer drug treatments.	n/a	99.4%	100%	100%	100%	98%
All cancers: 31 day wait for second or subsequent treatment – radiotherapy	n/a	n/a	n/a	n/a	n/a	n/a
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	96.1%	85%	92.7%	93.3%	90.5%	85%
All cancers: 62 day wait for first treatment from NHS cancer screening service referral	n/a	93.8%	100%	97.2%	100%	90%
Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted	90.8%	90%	94.9%	93.5%	93.4%	90%
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.1%	95%	98.6%	98.2%	97.9%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	n/a	n/a	92.9%	91.5%	94.5%	92%
All cancers: 31 day wait from diagnosis to first treatment	99.3%	96%	98.5%	97.9%	97.9%	96%
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	100%	94.5%	94.7%	94%	94.4%	93%
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)	31.5%	89.2%	96.6%	97.3%	97.9%	93%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	98.2%	98.3%	97.8%	97.86%	96.9%	95%
Self certification against compliance with requirements regarding access to health care for people with learning disabilities	Not measured	Not measured	Compliant	Compliant	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 inpatients. This is reflected in the figures above from 2008 to 2010. From 2010/2011 the definition changed and this reflects the number of positive Trust in-patient cases split between Trust apportioned (over 72 hrs after admission) and non-Trust apportioned (less than 72 hrs of admission).



Statement from Wiltshire Clinical Commissioning Group for Salisbury Foundation Trust Quality Account - 29 April 13

We have reviewed the information provided by Salisbury NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and 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.

Our view is that Salisbury NHS Foundation Trust provides, overall, high quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust continues to achieve good results in national surveys of patient experience, their score for 2012 is one of the highest in the South West. Its hospital standardised mortality ratio remains within national averages, and it has achieved significant reductions over time in Clostridium difficile levels.

Salisbury NHS Foundation Trust provides a very wide range of general and specialised services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. NHS Wiltshire CCG welcome the specific priorities for 2013/14 which the Trust has highlighted in this report all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities.

The Francis report and ongoing actions for the Winterbourne View reviews will form a key part of our assurance in 2013/14.

Transforming community service and out of hospital care is a priority for Wiltshire CCG 2013/14. We are reviewing the models of care, environment, accident and emergency attendance and admissions. We are also working with Salisbury NHS Foundation Trust to ensure the right clinical balance of services between hospital clinics and community settings closer to patients' homes

NHS Wiltshire CCG is fully committed to continuing its close co-operation with the Trust over the coming year on these important issues.

Statement from Wiltshire Council Health and Adult Social Care Select Scrutiny Committee – 26 April 2013

Wiltshire Council have elections in May 2013 for the whole of Wiltshire Council and, as the Health and Adult Social Care Select Scrutiny Committee is now not due to meet until after the elections, the Committee will

not be commenting on any Quality Accounts this year. Wiltshire Council hope to engage with Salisbury NHS Foundation Trust throughout the coming year to ensure that we will be able to comment next year.

Hampshire County Council – 26 April 2013

The Health Overview and Scrutiny Committee of Hampshire County Council does not contribute to the Quality Account of any of the providers it works with. It is not required to do so and its members are satisfied that they have direct methods of raising concerns and discussing issues with Salisbury NHS Foundation Trust.

Dorset County Council -10 May 2013

Comments were received and taken into account from the Quality Assurance and Performance Officer of Dorset County Council.

Statement from Healthwatch – 1 May 2013

Healthwatch Wiltshire have received and noted the report and will be following up once the new Healthwatch organisation has been properly established.

Patrick Wintour
Acting Chair

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 Directors Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 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 2012/2013;
- 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 2012 to May 2013;
 - Papers relating to quality reported to the Board over the period April 2012 to May 2013;
 - Feedback from the commissioners dated 29 April 2013.
 - Feedback from the governors dated 29 April 2013.
 - Feedback from Local Healthwatch organisations dated 1 May 2013.
 - 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 on 2 April 2012, 6 August 2012, 3 December 2012 and 8 April 2013.
 - The 2012 national patient survey dated 16 April 2013..
 - The 2012 national staff survey dated 28 February 2013.
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 April 2013.
 - Care Quality Commission quality and risk profiles. Presented to the Clinical Management Board dated 25 April 2012, 27 June 2012, 31 October 2012, 23 January 2013 and 27 March 2013. The quality and risk profiles were not presented to the Clinical Governance Committee between 2012 to 2013.

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
24 May 2013



Peter Hill
Chief Executive
24 May 2013



Independent Auditor's Report to the Council of Governors of Salisbury NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Salisbury NHS Foundation Trust to perform an independent assurance engagement in respect of Salisbury NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile - All cases of Clostridium Difficile positive diarrhoea in patients aged 2 years or over that are attributed to the trust; and
- 62 Day Cancer Wait - the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

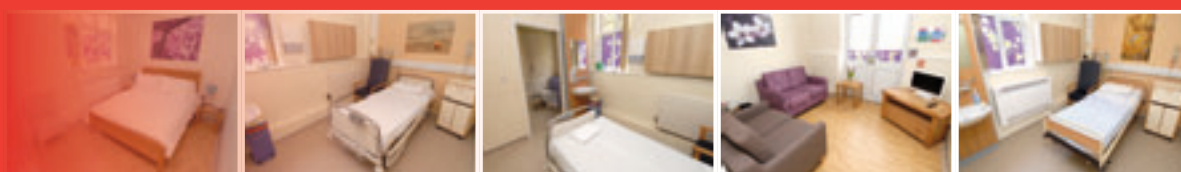
We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to March 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
- Feedback from the Commissioners dated 29 April 2013;
- Feedback from local Healthwatch organisations dated 01 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012 national patient survey dated 16 April 2013
- The 2012 national staff survey dated 28 February 2013;
- Care Quality Commission quality and risk profiles, 2012/13; and
- The 2012/13 Head of Internal Audit's annual opinion over the trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Salisbury NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.



Assurance work performed

We 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’). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller 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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by *Salisbury NHS Foundation Trust*.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.



**Jonathan Brown KPMG LLP,
Statutory Auditor,
Bristol
Date 24 May 2013**



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 is currently on track to achieve this target reduction. The Trust uses the NHS Carbon Reduction Strategy "Saving Carbon, Improving Health" and the SDU's Good Corporate Citizen (GCC) Self Assessment Tool as a framework for its own Sustainability and Carbon Reduction Strategy to assess the Trust's impact on the environment.

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

Summary Performance

Area		Non Financial data	Non Financial data		Financial data	Financial data
		2011/2012	2012/2013		2011/2012	2012/2013
Greenhouse Gas Emissions	Scope 1 (Direct) GHG Emissions	Gas: 6122 Tonnes CO _{2e} 33,051,027 kWhs Transport; 184 tonnes CO _{2e}	Gas: 7790 Tonnes CO _{2e} 42,058,334 kWhs Transport; 148 tonnes CO _{2e}		*Gas; £1,116,261 Transport; £137,701	*Gas; £1,374,820 Transport; £105,434
	Scope 2 (Indirect) GHG Emissions	5665 tonnes CO _{2e} 10,392,068 kWhs	2997 tonnes CO _{2e} 5,537,606 kWhs		£1,026,330	£1,584,494
	Scope 3 ** Official Business Travel Emissions	186 tonnes CO _{2e}	197 tonnes CO _{2e}		£329,167	£339,063
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust Methods of disposal	1,184 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	1,287 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	Expenditure on waste disposal	£275,242	£294,892
Finite Resources	Water & Sewerage	151,407 m3	156,023 m3	Water & Sewerage	£370,608	£385,572

Source: Final Estates Return Information Collection (ERIC) information for 2011/2012 and 2012/2013

*Includes £1,290 annual CRC subsistence fee and £151,393 CRC allowances for 2011/2012 and £1,290 annual CRC subsistence fee and £148,647 CRC allowances for 2012/2013

** Please note that Scope 3 reporting includes business mileage rates but not public transport travel



Future Priorities and Targets

In 2011 the Government implemented the Carbon Reduction Commitment Scheme (CRC). This is the UK's mandatory climate change and energy saving scheme for large energy users. The hospital is part of this scheme and has reported to the Environment Agency the amount of CO₂ that it produced during the last two years. This figure is used to measure the performance of the hospital against itself year on year and against other organisations in the national CRC scheme. The Trust will continue to use this information as one of the key external indicators of environmental performance and has achieved year on year carbon reduction.

The Trust will continue to use the GCC together with CRC information as the basis for its own internal priority areas for the future. This will be monitored through the Environmental Management Committee, and Facilities management reports together with a reporting process that includes the Operational Management and Trust Board. The priority areas and targets are summarised below:

Travel

Policies and performance:

The Trust set itself an objective to reduce the carbon that it is responsible for from the vehicle fleet it has. In line with this objective, the new vehicles which have been leased for the courier fleet have Euro 5 engines which have the lowest emissions in their class. In addition, a vehicle review ensured that the correct sized vehicle appropriate for the workload were leased, which contributed to further savings.

Active Travel:

The Trust had a vision to engage with staff and the local community and develop a plan to encourage active travel with supporting facilities. Following the introduction of staff car parking charges the Trust has seen a reduction in the use of private vehicles owned by staff parking in the staff car parks, therefore reducing vehicle congestion on site and our carbon footprint. The Trust has continued with the commitment to run the cycle to work schemes for staff. Which saw a take up of around 30 cycles. As part of these objectives, the Trust has worked with a cycle company which enables staff cycles to be repaired and maintained on site while they are at work. This has been a private arrangement between the cycle owner and the company.

Traffic management:

The Trust's objectives in this area are: to work with partners and stakeholders; develop plans to reduce traffic impacts; promote public transport and active travel supported with information and incentive schemes. Also, on site car parking is now strictly managed through the use of enforcement measures by the Trust and the extension of prohibited local parking by the Council.

Procurement

Policies and performance:

Work is ongoing to develop a sustainable procurement policy that supports local community and minimizes environmental impacts.

Procurement skills:

Work is ongoing to provide staff with accessible information on sustainable procurement; provide training and review the learning and development needs of staff against key sustainable development objectives.

Engaging suppliers:

Work is ongoing to assess the impact of key suppliers on our sustainable development objectives and also create an understanding of our objectives and help improve their understanding of sustainable development.

Sustainable procurement:

We have added sustainable development clauses in tendering documents and contracts. When bids are evaluated we now include a Carbon Reduction Strategy and Sustainability weighting. The next stage is to benchmark the impact of CO₂ from a procurement perspective and agree an action plan to reduce this.

Facilities Management

Minimising waste:

The Trust has an active campaign to recycle unused or unwanted office equipment and furniture through a scheme run by volunteers. This has proved very popular with staff and has directly reduced the waste from the site going to landfill by sorting and streaming of the waste to suitable recycling operators and has avoided the cost of buying new equipment.



Energy and water usage:

The Trust has made use of specific funding set aside internally and government-backed loans to invest in energy efficient equipment. These schemes include the replacement of an older Combined Heat and Power unit (CHP), with a modern unit which is twice the size. This generates half of the power for the site. Low energy lighting LED, high efficiency condensing boilers and the site building management system controlling energy use on site has been upgraded. Applications for additional funding for further efficiency schemes utilising renewable energy has been made in 2013.

Workforce

Healthy workplace:

The trust objective is to provide incentives and facilities to promote active low carbon travel, healthy and sustainable food choices and regular exercise. The Trust has an on-site fully equipped leisure facility which promotes fitness programmes and healthy activities. This is being upgraded during 2013 to increase the number of staff who can benefit from this. Catering staff are building on existing links with local suppliers to increase use of fresh, locally sourced food and ingredients. Staff and trade unions are involved in developing initiatives to support healthy lifestyles and provide accessible areas for staff rest and reflection.

Community Engagement

Policy and performance:

The Trust developed a community engagement action plan with clear social, economic and environmental objectives. The Trust continues to work in partnership with other bodies and links in with Sustainability South West, local government and climate change adaptation teams.

Community participation:

The Trust has gathered views on sustainable development. In addition, local volunteers have started a ground-breaking initiative for the NHS forming voluntary equipment recycling and reclamation project. The aim is that this will continue to build on the success of last year. This initiative links in with the site Waste management group.

Healthy and sustainable food choices:

Plans for healthy and sustainable food choices, a system to track sourcing, transportation, consumption and disposal of food and drink products is ongoing together with targets to increase healthy and sustainable food choices.

Assets and resources:

The trust has worked with local charities to improve and landscape several garden areas for the benefit of the hospital users, The spinal center now has a garden specifically designed for people with restricted mobility.

Facilities and New Buildings

Policies and performance:

During the year a review of the south side of the Salisbury District Hospital site took place. A partnership with development companies is being sought to explore possibilities for this section of land.

Design:

Work to minimise whole life costs of building and refurbishment projects through design has continued, with ongoing work to produce design briefs that encourage low carbon, low environmental impact proposals from suppliers and partners.



EQUALITY AND DIVERSITY REPORT

Approach to Equality and Diversity

We respect and value the diversity of our patients, their relatives and carers, and our staff and are committed to meeting the needs and expectations of the diverse communities we serve, providing high quality care.

The Trust has undertaken a considerable amount of work on Equality and Diversity (E&D), which helps improve better patient services and promote equality of opportunity for staff. The Equality and Diversity Steering Group reports to the Trust Board and determines the strategic direction on E&D, based on current legislation and national initiatives.

The group reports to the Trust Board twice a year on its work and progress against action plans and provides information on the make up of staff and patients. The Trust also has several equality forums:

- REACH (Reaching Equality Aspiring Confident Hope) group for Black Asian Minority Ethnic (BAME) staff
- LGBT (Lesbian, Gay Bisexual and Transgender) network (Rainbow SHED) for staff to discuss issues that relate to their employment experiences and hospital services
- Disability Employees Network (DEN) which covers disability issues and policies. For instance, the Trust has the 'Positive About Disabled' people 'two ticks standard' and has policies that apply to the recruitment, retention, training and development of staff with disabilities.

We have used the Equality Delivery System (EDS) to engage with local and national interest groups who have offered feedback and involvement in the Trust's EDS assessment.

Public Sector Equality Duties (PSED)

The Trust has to prepare and publish one or more objectives that help the organisation further the three aims of the Equality Duty. The Trust used the NHS equality assessment tool (EDS Equality Delivery System) to support the collection of evidence on equality

practices and measure its progress for the different equality groups: age, gender, religion/or belief, sexual orientation, marriage/ civil partnership, race, disability, pregnancy and maternity, gender reassignment.

The Trust also carries out equality analysis to ensure that Trust policies, procedures, developments or activities do not have an unintentional adverse impact on patients or staff from equality groups.

The Trust is compliant with its PSED duties and has published its Equality Delivery System gradings, equality objectives and supporting documents. This can be found at www.salisbury.nhs.uk/about-us/equality and diversity along with other E&D information.

Priorities and Targets Going Forward

We have adopted the EDS (Equality Delivery System) model and are working with local interest groups on four equality objectives for 2012/13 :

Objective 1 - To develop a fundraising campaign that will raise awareness of the community of the needs of the elderly and result in improved environments in our medical wards

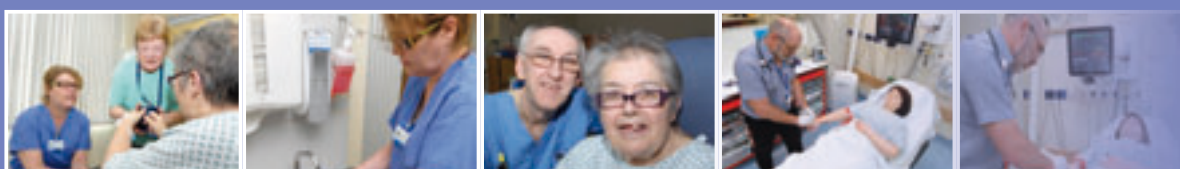
Objective 2 - Through the fundraising campaign to challenge the views of the community in how much we should do as a society to improve the profile of the elderly

Objective 3 - To design and implement a programme of positive action for our staff to ensure that they are able to perform their duties free from abuse, harassment, bullying, violence from patients, other members of the public and colleagues

Objective 4 - To develop and implement a plan to enable and encourage managers and staff to understand the benefits of diversity in the workplace which will ensure our work environment is free from discrimination

In addition we are also:

- holding two events a year to highlight Equality and Diversity within the Trust
- working with PPI (Public, Patient and Involvement) and the Director of Nursing to ensure we are meeting our equality objectives for patients and visitors



- publishing a quarterly Equality and Diversity newsletter for internal and external organisations
- applying for the Stonewall Top 100 Index a national LGB (Lesbian, Gay & Bisexual) organisational benchmarking tool

These priorities are regularly reviewed, 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 well established 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. 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 'quality and safety walk rounds', as well as the national staff survey. The 2012 staff survey included a 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.

	2011/2012		2012/2013		Trust Improvement/ deterioration
Response rate	Trust	National average	Trust	National Average	
	59%	54%	53%	50%	6% deterioration



	2011/2012		2012/2013		Trust Improvement/ deterioration
Top 5 ranking scores	Trust	National Average	Trust	National Average	
Staff job satisfaction	3.56	3.47	3.67	3.58	0.11% Improvement
support from immediate manager	3.77	3.61	3.71	3.61	0.06% deterioration
Percentage of staff suffering work related stress in last 12 months	24%	29%	32%	37%	8% Deterioration
Percentage of staff having equality and diversity training in last 12 months	64%	48%	71%	55%	7% Improvement
Percentage of staff able to contribute to improvements at work	66%	61%	71%	68%	5% improvement
Bottom 5 ranking scores	Trust	National Average	Trust	National Average	
Percentage of staff reporting errors, near misses or incidents in the last month	98%	96%	87%	90%	11% deterioration
Percentage of staff experiencing physical violence from staff in the last 12 months	-	-	4%	3%	No comparison with previous years available
Percentage of staff working extra hours	67%	65%	73%	70%	6% Deterioration
Percentage of staff agreeing that their role makes a difference to patients	91%	90%	88%	89%	3% deterioration



Percentage of staff receiving job relevant training or development in last 12 months	-	-	79%	81%	No comparison with previous years available
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In addition to the top and bottom ranking scores above, there had been significant changes in the scores from the previous year in the following areas.

	2011/2012		2012/2013		Trust Improvement/ deterioration
	Trust	National Average	Trust	National Average	
Percentage of staff having equality and diversity training in last 12 months	64%	48%	71%	55%	7% Improvement
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	98%	96%	87%	90%	11% deterioration
Percentage of staff suffering work related stress in last 12 months	24%	29%	32%	37%	8% deterioration
Percentage of staff working extra hours	67%	65%	73%	70%	6% deterioration

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 seven 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 2013 staff survey.

Appraisals:

Our results showed we had broadly sustained the significant improvements in our performance since

2010, reflecting the targeted work in this area. Whilst our scores had improved more than the average acute Trust we are now below the national average and need to continue to work to improve our performance in both the quality and quantity of appraisals, together with associated personal development plans - seeking to move our overall Trust performance to above average by the time of the next staff survey.

Job relevant training, learning or development;

Our results vary considerably in relation to some training subjects and we need to see how we can ensure staff can access job relevant training in all areas equally, ensuring they see the link between training and development and helping them do their job more effectively.



Experience of violence from other staff, or patients, relatives or the public in last 12 months,

It is difficult to see if our results have changed over recent years because the wording of the questions have changed and are not therefore directly comparable. Both are worse than average for an acute Trust and this is an area the Trust wishes to improve, in keeping with our Trust value of Respect. The Target for 2012/13 is to reduce the number of instances of violence.

Percentage agreeing their role makes a difference to patients:

Ensuring everyone, whatever their role, can see that they have an impact on patient care is important in making sure we achieve an outstanding experience for every patient.

Percentage of staff working extra hours:

Our score places us in the 'worst 20%' in this area when benchmarked against acute Trusts, particularly in

relation to unpaid hours. Whilst undoubtedly reflecting the high level of commitment from staff to their jobs we need to ensure staff are not working an excessive number of hours.

Percentage witnessing and reporting potentially harmful errors, near misses or incidents:

Our results in these areas have reduced and placed us below average when compared to other acute trusts. We will take action with the intention of improving these scores to at least average by the next national staff survey.

Percentage suffering work related stress:

This score has increased significantly over the last 2 years and despite our score still being in the best 20% of acute Trusts it is unacceptable. We would aim to improve our score to at least average by the 2013 survey.

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 five governance elements which are:

- performance against national measures
- compliance with third party requirements (Care Quality Commission, NHS Litigation Authority)
- declared risk of, or actual, failure to deliver mandatory or commissioner requested services
- any other certification failures (not included in bullet points 1, 2 and 3 such as non cooperation with NHS bodies local authorities or the cooperation and competition panel)
- Any other factors not covered above that the regulator may regard as a breach of the Trusts terms of authorisation

NHS Foundation 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 areas of governance and for supplying any required exception reports.

Monitor assesses the Risk Rating against four measures - 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 2011/12 and 2012/2013 are set out below.

	Annual Plan 2011/2012 forecast	Q1 2011/2012 actual	Q2 2011/2012 actual	Q3 2011/2012 actual	Q4 2011/2012 actual
Financial Risk Rating	3	3	3	3	3
Governance Risk rating	Green	Amber-Green	Amber-Green	Amber-Green	Amber-Red
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Amber-Green	Amber-Green	Green

For quarters 2 and 3 in 2011/12, the Trust self-assessed itself Green. Monitor initially accepted this for Q2, but in reviewing the Q3 return, it indicated (i) that Q2 should have been amber-green and (ii) that Q3 was reassessed by them as amber-green. This was due to the Trust not meeting its in-year trajectory for the control

of Clostridium Difficile (C.diff) infections attributed to the Trust. It has met the full year target for C.diff. and its Governance Risk Rating for Quarter 4 returned to green.

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

PUBLIC INTEREST DISCLOSURES

Income Disclosure

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service 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. Income generated from its subsidiary company Odstock Medical Limited also contributed towards supporting patient care. The total income from all of these areas amounted to around £ 8.4 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.

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	70,673	60,779
Total Non-NHS trade invoices paid within target	57,645	48,542
Percentage of Non-NHS trade invoices paid within target	81.6%	79.9%
Total NHS trade invoices paid in the period	2,056	5,958
Total NHS trade invoices paid within target	1,524	4,727
Percentage of NHS trade invoices paid within target	74.1%	79.3%
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 (excluding subsidiary)	
	£000
Total Trust Management Costs	£7,037
Total Trust Income	£181.918
% of total Income	3.87%



Patient and Public Involvement Initiatives

Patients were involved in over 40 projects this year, using many different methods including patient stories, focus groups, questionnaires, real time feedback along with the results of the National Patient Survey . We have worked closely with the Patients Association to observe staff interactions with their patient on the ward Projects have been carried out within a wide range of wards and departments and have included close working with people with Multiple Sclerosis and working towards improving support for transitional care for young adults with learning disabilities, all of 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 2012/2013 year the sickness absence rate was 3.30%. This represents an improvement from the previous year, which stood at 3.42 %.

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 2011 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 19,527
- The total number of FTE years available 2,675
- Average number of days sickness absence per FTE 7.30

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 2012/2013 there were no reported Serious Untoward Incidents involving data loss or confidentiality breaches.

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 24 May 2013.



Peter Hill
Chief Executive
24 May 2013



SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2013

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2013 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 2013 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 - Chief Executive

Date: 24th May 2013

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 NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS 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 Salisbury NHS Foundation 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 NHS Foundation 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 NHS Foundation 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 - Chief Executive

Date: 24th May 2013

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 reduce 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 2013 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). This mechanism allows the organisation to identify, learn from, and share good practice.

4. THE RISK AND CONTROL FRAMEWORK

The Trust recognises the need for a robust focus on the identification and management of risks and therefore places risk within an integral part of our approach to quality.

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 licence 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 licence.

- 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 NHS South West Quality and Safety Programme.
- 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 the 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. The Policy 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. This clearly outlines the leadership, responsibility and accountability arrangements which are then taken forward through the Assurance Framework, Risk Registers and performance management processes enabling the coherent and effective delivery of risk management throughout the organisation.

Capacity is developed across the Trust through training commensurate with staff duties and responsibilities. Sharing learning through risk related issues and incidents is an essential component to maintaining the risk management culture within the Trust.

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 the costs of managing a risk and the benefits to be gained. New risks identified for inclusion on the Organisational Risk Register are assessed for their likelihood and consequence using a 5x5 risk matrix in accordance with the Risk Management Policy. In order to ensure a standardised approach the same method of risk assessment documentation and scoring is used for all risks at all levels (clinical, health and safety and strategic risks).

The Head of Risk Management reports to the Assurance Committees (Sub Committees of the Trust Board) on a quarterly basis those risks scoring 12 or above on the Trust Risk Register. The designated Assurance Committees of the Trust Board are the Clinical Governance Committee (Clinical Risk), the Finance Committee (Financial Risk), and the Joint Board of Directors (Organisational Risk including workforce, Health and Safety, IT). The Audit Committee monitors the Assurance Framework process overall on a biannual basis. It is the responsibility of the Assurance Committees to review the Trust Risk Register to ensure breadth and depth of information and for assurance that actions are being taken to control and mitigate the risks cited. They subsequently report to the Trust Board on a quarterly basis any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this is reported immediately via the Executive. The appropriate Assurance Committee or the Trust Board can recommend whether an extreme risk should be transferred on to the Assurance Framework.

The Trust Risk Register (risks scoring above 12) is reviewed by the Trust Board twice a year, firstly through the summer Assurance Framework and Risk Register workshop, and secondly at the public meeting when the Assurance Framework is presented in its entirety.

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.

The Trust has identified the following risks which are being highlighted due to their potential impact on the delivery of the Trust's business plan but also the detrimental impact they could have on its reputation.

The potential for poor compliance with infection control policies leading to an increase in hospital acquired infection rates, loss of reputation and failure to meet targets is recognised and included within the Assurance Framework. This is monitored by the Director of Nursing in her role as Director of Infection Prevention and Control (DIPC) and a high level of scrutiny maintained at all levels of the organisation including root cause analysis of any cases of hospital acquired reportable infection.

One of the Trust's highest reported incidents is slips and falls and therefore the potential for this to result in patient injury. Securing patient safety is recognised within the Assurance Framework and specifically slips and falls within the Medicine Directorate Risk Register. Any fall resulting in major harm or fracture is subject to root cause analysis which is utilised to identify trends and themes and support the change of practice or identification of equipment requirements to prevent recurrence. The Trust has a falls group and the Falls report is also presented to the Clinical Risk Group and Clinical Management Board.

The Trust has identified that ongoing work is required to ensure that savings plans are robustly identified, described and enacted throughout the year. The Trust needs to be able to respond to the changing local healthcare priorities whilst achieving the Trust's own plans. A Programme Management Office has been established to drive forward savings within the Trust and external assistance was sought from Newton to help identify schemes to achieve savings targets. Positive assurance has also been received from Internal audit.

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 Security Policy defines how the Trust manages information risk and how the effectiveness of the policy is assessed and measured.

The Information Risk and Security 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 2012/13 there has been a comprehensive and robust evidence assurance programme linked to the work of information asset management. The Trust continues to ensure that the Information Asset Owners and Information Asset Administrators evidence is reviewed and updated on a regular basis. Any changes to processes and procedures are appropriately documented, risk assessed and approved prior to implementation.

Information Governance arrangements within the organisation have continued to improve in 2012/13. All laptops are encrypted, and all computers have been 'locked down' so users cannot save data to unencrypted memory sticks.

The Trust completed self assessment against version 10 of the IG toolkit maintaining an 83% compliance level and a Satisfactory rating across the entire Toolkit. A satisfactory rating is only achieved by the Trust maintaining level 2 or above in all 45 requirements.

There have been no serious breaches of the Data Protection Act (level 3 and above) in 2012/13 which required reporting to the Information Commissioners Office (ICO).

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. All departments and staff groups within the Trust report incidents and The National Reporting Learning System (NRLS) report (April 2012- September 2012) showed that the Trust is in the top half of the middle percentile for reporting of incidents. 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 signage within the Trust and the EDS Scheme was launched for external stakeholders. 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 unannounced visit by CQC Inspectors on 18th to 21st February 2013 identified minor concerns in relation to staffing and records outcomes. These have been addressed by action plans submitted to the CQC.

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. The Trust has put in place an alternative pension provider to cater for employees who are not eligible to join the NHS Pension Scheme.

Control measures are in place to ensure 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 UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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 risks 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. 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 are overviewed by the Trust Board 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 an opinion of significant assurance given.

The Assurance Framework

The Trust produces an Annual Governance Statement and has the evidence to support the statement. The Assurance Framework brings together this evidence.

The Assurance Framework is kept under quarterly review by the assuring committees and 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 and reporting on the overall risk, controls, gaps, and actions being taken to mitigate 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.

At the committees 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 principal 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 and compliance with Dementia standards. These are all being managed/mitigated through a comprehensive programme of controls and reporting arrangements such as monthly PEAT audits, implementation of the Salisbury Organisational Trigger Tool, ongoing close involvement with the regional safeguarding boards and the Trust Dementia Steering Group. 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 integrated governance processes, performance ratings, centralisation of services, planning of activity, procurement of IT systems and meeting equality duties. Actions are in place to mitigate these risks which are monitored and evaluated through internal groups such as the Operational Management Board, Information Strategy Steering Group, and Joint Board of Directors who receive regular performance reports across these activities in order to consider adequacy of the actions in place. External monitoring is also in place with the Commissioning PCT/CCG and compliance with CQC outcomes.

(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 the maintenance of an appropriately skilled workforce to maintain staff well being during the implementation of changes in organisational size and structure. Workforce plans are developed across the Trust to inform any service change. The staff well being project and a workforce redesign steering group is in place 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, budgetary control, efficiency of services, activity levels and cost reduction. 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 organisation's savings programme which have been clustered into several key schemes with performance indicators reported at each monthly meeting. Delayed transfer of care metrics are in place and progress is monitored at JBD. All financial information is ultimately reported up to the Finance Committee on a monthly basis.

Emerging risks will continue to be identified through the Annual Plan process as required by Monitor. In the current climate future risks to the organisation include, restructure of commissioning services external to the Trust and the potential impact of this and continued emphasis on cost reductions and savings plans. Two visits from the Health and Safety Executive in 2012 resulted in improvement notices in two emerging risk areas concerned with processes around violence and aggression and the management of dermatitis, which have been actioned and closed.

These emerging risks will be managed and controlled within the established risk management framework. 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.

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 key Assurance Committees regularly receive and discuss their respective risk registers, for high level risks within the organisation. The Audit Committee has sought assurance that the Assurance Framework appropriately reflects the level of risk and incorporates mitigating action. Independent assurance on the effectiveness of risk management and internal control has been provided through Internal Audit reviews.

A wide internal audit programme encompassed (amongst others) the following areas:

- Assurance Framework & Risk Management
- Critical Financial Assurance – Financial Accounting (core work)
- Ward/Unit Compliance Visits
- Processing Controls – Other Trusts Payroll
- Service Line Reporting & Management
- Contract Income
- Integrated Governance – Board & Committee Structure
- NHS Contract (SLA Monitoring)
- Odstock Medical Limited
- ITIL Gap Analysis (Computer Audit)
- IG Toolkit Review (Computer Audit).

The Board has maintained an active programme of fraud prevention in accordance with the core activities required by NHS Protect.

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

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. 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.

The Trust's Reference Costs shows it to be approximately 8% below the national average costs, based on the last published data, which relates to 2011/12.

6. ANNUAL QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 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 Informatics Department.
- The Quality Report process is coordinated by the Head of Clinical Effectiveness. 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 and issues raised through executive led Safety and Quality walk rounds. 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 KPMG.

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 given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. The main reason for this decision was the significant level of assurance that we could provide over all the Trust's key financial systems and robust arrangements in place for the Assurance Framework and Risk Management processes. However, some weaknesses in the design of controls and/or inconsistent application have been identified in the Internal Audit Annual Report. These include management of accommodation deposits, timely reporting of adverse events to risk management, implementation of NICE quality standards, completion of induction checklists and mandatory training within specified timeframe and finalisation of disaster recovery plan for the data warehouse and testing. However, the positive findings outweighed these weaknesses and action plans have been put in place to address these and are monitored by the Audit Committee.

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 (KPMG), the assurance committees (including the Audit Committee), the self assessment process against the CQC essential standards of quality and safety (unannounced visit March 2013), NHSLA Risk Management assessments (revalidation of Level 2 achieved in April 2011 for a further 3 years), 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 2013.

Signed:



Peter Hill
Chief Executive

Date: 24th May 2013

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

We have audited the financial statements of Salisbury NHS Foundation Trust for the year ended 31 March 2013 on pages 1 to 35. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

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

Respective responsibilities of the Accounting Officer and Auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page (ii) the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us 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 accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion:

- give a true and fair view of the state of Salisbury NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Salisbury NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

Date

24th May 2013

STATEMENT OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2013

		Group		Trust	
		2012/13	2011/12	2012/13	2011/12
	Note	£000	£000	£000	£000
Revenue from patient care activities	3	166,734	168,330	166,734	168,330
Other operating revenue	5	16,693	16,195	15,185	14,694
Operating expenses	7	(176,927)	(178,252)	(175,403)	(176,779)
OPERATING SURPLUS		6,500	6,273	6,516	6,245
FINANCE COSTS					
Finance income	12	219	172	219	172
Finance costs - financial liabilities	13	(1,820)	(1,838)	(1,820)	(1,838)
Finance costs - unwinding of discount on provisions	13	(13)	(16)	(13)	(16)
PDC Dividends payable		(3,254)	(3,452)	(3,254)	(3,452)
NET FINANCE COSTS		(4,868)	(5,134)	(4,868)	(5,134)
RETAINED SURPLUS FOR THE YEAR		1,632	1,139	1,648	1,111
OTHER COMPREHENSIVE INCOME					
Revaluation gains/(losses) on property plant and equipment	17	(2,275)	(5,179)	(2,275)	(5,179)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		(643)	(4,040)	(627)	(4,068)
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		(5)	10	-	-
(ii) Owners of Salisbury NHS Foundation Trust		1,637	1,129	1,648	1,111
TOTAL		1,632	1,139	1,648	1,111
(b) Total comprehensive income/(expense) for the year attributable to:					
(i) Minority interest, and		(5)	10	-	-
(ii) Owners of Salisbury NHS Foundation Trust		(638)	(4,050)	(627)	(4,068)
TOTAL		(643)	(4,040)	(627)	(4,068)

The notes on pages 5 to 35 form part of these financial statements.

All revenue and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION
31 MARCH 2013

		Group		Trust	
		31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
	Note				
NON-CURRENT ASSETS					
Intangible assets	16	752	284	752	284
Property, plant and equipment	17	125,345	130,061	125,335	130,041
Investments in subsidiaries	32	-	-	-	-
Total non-current assets		126,097	130,345	126,087	130,325
CURRENT ASSETS					
Inventories	18	2,393	2,517	2,323	2,457
Trade and other receivables	19	9,429	7,567	9,349	7,523
Cash and cash equivalents	20	17,113	21,058	16,911	20,880
Total current assets		28,935	31,142	28,583	30,860
Total assets		155,032	161,487	154,670	161,185
CURRENT LIABILITIES					
Trade and other payables	21	(16,378)	(19,789)	(16,206)	(19,693)
Borrowings	22	(2,277)	(2,263)	(2,277)	(2,263)
Provisions	23	(536)	(1,065)	(536)	(1,065)
TOTAL CURRENT LIABILITIES		(19,191)	(23,117)	(19,019)	(23,021)
TOTAL ASSETS LESS CURRENT LIABILITIES		135,841	138,370	135,651	138,164
NON-CURRENT LIABILITIES					
Borrowings	22	(21,310)	(23,595)	(21,310)	(23,595)
Provisions	23	(381)	(307)	(381)	(307)
TOTAL NON CURRENT LIABILITIES		(21,691)	(23,902)	(21,691)	(23,902)
TOTAL ASSETS EMPLOYED		114,150	114,468	113,960	114,262
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		62	67	-	-
Public dividend capital		51,554	51,229	51,554	51,229
Revaluation reserve		49,106	52,260	49,106	52,260
Income and expenditure reserve		13,428	10,912	13,300	10,773
TOTAL TAXPAYERS EQUITY		114,150	114,468	113,960	114,262

The notes on pages 5 to 35 form part of these financial statements.

The financial statements on pages 1 to 35 were approved by the Board on 24th May 2013 and signed on its behalf by:

Signed:



Peter Hill - Chief Executive

**CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS EQUITY
31 MARCH 2013**

	Public dividend capital (PDC) £000	Income and expenditure reserve £000	Revaluation reserve £000	Minority interest £000	Total taxpayers' equity £000
Balance at 1 April 2011	51,229	8,594	58,628	57	118,508
Changes in taxpayers' equity for 2011-12					
Net gain/(loss) on revaluation of property plant and equipment	-	-	(5,179)	-	(5,179)
Retained surplus/(deficit) for the year	-	1,129	-	10	1,139
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	1,189	(1,189)	-	-
Public dividend capital received in year	-	-	-	-	-
Balance at 31 March 2012	51,229	10,912	52,260	67	114,468
Changes in taxpayers' equity for 2012-13					
Net gain/(loss) on revaluation of property plant and equipment	-	-	(2,275)	-	(2,275)
Retained surplus/(deficit) for the year	-	1,637	-	(5)	1,632
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	879	(879)	-	-
Public dividend capital received in year	325	-	-	-	325
Balance at 31 March 2013	51,554	13,428	49,106	62	114,150

**CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 MARCH 2013**

	Note	2013 £000	2012 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Total operating surplus		6,500	6,273
NON-CASH INCOME AND EXPENSE			
Depreciation and amortisation charge		8,496	8,475
Impairments		795	-
Dividends accrued and not paid or received		-	298
(Increase)/decrease in trade and other receivables		(2,068)	5,746
(Increase)/decrease in inventories		124	(254)
Increase/(decrease) in trade and other payables		(3,411)	3,321
Increase/(decrease) in provisions		(455)	707
Tax (paid)/received		-	(7)
Net cash inflow from operating activities		9,981	24,559
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		219	172
Payments to acquire property, plant and equipment		(6,801)	(6,032)
Receipts from sale of property, plant and equipment		17	-
Payments to acquire intangible assets		(534)	(216)
Net cash inflow/(outflow) from investing activities		(7,099)	(6,076)
CASH FLOWS FROM FINANCING ACTIVITIES			
New public dividend capital received		325	-
Loans repaid		(1,565)	(1,528)
Loans received		-	500
Capital element of finance lease rental payments		(85)	(78)
Capital element of Private Finance Initiative obligations		(621)	(614)
Interest paid		(65)	(92)
Interest element of finance lease rental payments		(36)	(39)
Interest element of Private Finance Initiative obligations		(1,732)	(1,723)
PDC dividend paid		(3,048)	(3,891)
Net cash (outflow)/inflow from financing		(6,827)	(7,465)
(Decrease)/increase in cash and cash equivalents		(3,945)	11,018
Cash and cash equivalents at the beginning of the financial year		21,058	10,040
Cash and cash equivalents at the end of the financial year	20	17,113	21,058

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 2012/13 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 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.

1.2 Basis of Consolidation

Subsidiaries

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 as a separate item in the Statement of Financial Position.

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

Until 31 March 2013 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.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the Trust from the associate.

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

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.3 Income Recognition (continued)

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 2013 are based on estimates of invoices where services/goods were received but not invoiced at the year end. Included within these accruals is an estimated sum to cover invoices in the coming year where specific liabilities at 31 March 2013 had not been identified.

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'.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Intangible assets (continued)

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits, which is as follows:

Software 5 Years

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.

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 Property assets are valued every 5 years with annual desktop valuations and annual impairment reviews carried out in all other years. The 5 yearly revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A full revaluation was carried out at 1 March 2010. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost until 31 March 2013, 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

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) 3 - 69 years

Dwellings 44 - 80 years

Plant and Machinery 5 - 43 years

Transport equipment 5 - 10 years

Information Technology 4 - 10 years

Furniture and Fittings 5 - 25 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.

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'; and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

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.

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.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

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.

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.9 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 (except for Towels and Nightwear which have a two year life), in determining an approximation of net realisable value.

1.10 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.

1.11 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 rates of -1.8%, -1.0% and 2.2% in real terms where the expected payments would be in 0 - 5 years, 5 - 10 years and over 10 years respectively from the SOFP date, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35% 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.

1.12 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.12 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.

1.13 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.

1.14 Corporation Tax

The trust does not have a corporation tax liability for the year 2012/13. 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

1.15 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 2013. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.16 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.17 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.

1.18 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the 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.

1.19 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.20 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.

1.21 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.21 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.

1.22 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.

1. ACCOUNTING POLICIES (CONTINUED)

1.23 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

Value of land, buildings and dwellings £97.84 million: This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Untaken annual leave: salary costs include a £0.14m estimate for the annual leave earned but not taken by employees at 31 March 2013, to the extent that staff are permitted to carry leave forward to the next financial year. (2011/12 £0.17m)

Provisions: Assumptions around the timing of the cashflows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from the external advisors regarding when legal issues may be settled.

1.24 Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

IFRS 9 Financial Instruments	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
– Financial Assets	
– Financial Liabilities	
IFRS 10 Consolidated Financial Statements	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 11 Joint Arrangements	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 12 Disclosure of Interests in Other Entities	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 13 Fair Value Measurement	Effective date of 2013/14 but not yet adopted by the EU.
IAS 12 Income Taxes amendment	Effective date of 2012/13 but not yet adopted by the EU.
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)	Effective date of 2013/14 but not yet adopted by the EU.
IAS 27 Separate Financial Statements	Effective date of 2013/14 but not yet adopted by the EU.
IAS 28 Associates and joint ventures	Effective date of 2013/14 but not yet adopted by the EU.
IAS 19 (Revised 2011) Employee Benefits	Effective date of 2013/14
IAS 32 Financial Instruments: Presentation – amendment	Effective date of 2014/15 but not yet adopted by the EU
Offsetting financial assets and liabilities	
IFRS 7 Financial Instruments: Disclosures – amendment	Effective date of 2013/14 but not yet adopted by the EU
Offsetting financial assets and liabilities	

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

1.25 Accounting standards, amendments and interpretations issued that have been adopted early

The Trust has not early adopted any new accounting standards, amendments or interpretations.

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise 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. The activities of the subsidiary company, Odstock Medical Limited, are not considered sufficiently material to require separate disclosure.

3 Revenue

Group and Trust

3.1 Revenue by Type

	2013 £000	2012 £000
Elective revenue	34,253	37,165
Non-elective revenue	61,512	63,143
Outpatient revenue	25,128	27,837
A & E revenue	4,759	4,565
Other types of activity revenue	34,773	30,536
Total revenue at full tariff	160,425	163,246
Revenue from activities		
Private patient revenue	1,807	1,632
Other non-protected clinical revenue	4,502	3,452
	166,734	168,330

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

	2013 £000	2012 £000
Foundation Trusts	2,911	2,552
NHS Trusts	797	1,006
Strategic Health Authorities	-	-
Primary Care Trusts	156,468	159,705
Local Authorities	107	13
NHS Other	38	88
Non NHS:		
- Private patients	1,807	1,632
- Overseas patients (non-reciprocal)	106	58
- NHS Injury scheme (was Road Traffic Act)	1,298	1,306
- Other	3,202	1,970
	166,734	168,330

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 12.6% (2012: 10.5%) to reflect expected rates of collection. Other income includes £1.9m (2012: £1.6m) income from Salisbury Hospice Charity.

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:

	2013 £000	2012 £000
Mandatory services	160,425	163,246
Non-mandatory services	6,309	5,084
	166,734	168,330

NOTES TO THE ACCOUNTS

4. Private Patient Revenue

During 2012/13 the Health & Social Care Act 2012 removed the restriction on the amount a Foundation Trust could earn from private patient income as a percentage of total income, provided a ceiling of 49% is not exceeded for non-NHS income.

Salisbury NHS Foundation Trust private patient income in 2012/13 was substantially below the revised level permitted.

5. Other Operating revenue

Group	2013 £000	2012 £000
Research and development	743	1,311
Education and training	4,796	5,071
Charitable and other contributions to expenditure	1,042	336
Non-patient care services to other bodies	1,214	1,268
Other	8,898	8,209
	16,693	16,195

Included within 'Other' revenue above are amounts received from lodgings £1.2m (2012: £1.1m), car parking £1.1m (2012: £1.1m), catering £0.8m (2012: £0.9m), laundry £1.7m (2012: £1.4m), child care services £0.5m (2012: £0.5m) and trading revenue of the Trust's subsidiary company £1.5m (2012: £1.5m).

6. Revenue

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

6.1 Operating lease income**Group and Trust****6.1 As lessor**

The Trust has entered into short term commercial leases on buildings. During 2012/13 the Trust entered an agreement to lease an area within the hospital main entrance to a high street retailer on commercial terms.

6.2 Receipts recognised as income

	2013 £000	2012 £000
Rental revenue from operating leases - minimum lease receipts	189	125

6.3 Total future minimum lease income

	2013 £000	2012 £000
Receivable:		
Within 1 year	149	123
Between 1 and 5 years	365	64
After 5 years	25	-
Total	539	187

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

Group and Trust	2013 £000	2012 £000
Services from other NHS Foundation Trusts	1,307	1,007
Services from NHS Trusts	573	568
Services from PCT's	44	831
Services from other NHS bodies	242	170
Purchase of healthcare from non-NHS bodies	579	836
Executive directors costs	900	911
Non-executive directors costs	128	146
Staff costs	113,537	112,591
Drug costs	13,098	11,738
Supplies and services - clinical (excluding drug costs)	17,552	19,041
Supplies and services - general	3,085	2,597
Establishment	1,946	2,029
Transport	472	435
Premises	6,333	7,812
Provision for impairment of receivables	(184)	120
Increase in other provisions	(205)	763
Inventory write down	52	346
Depreciation and amortisation	8,496	8,475
Impairments of property, plant and equipment	795	-
Rentals under operating leases	177	215
Audit services - statutory audit	53	72
Fees payable to the Trust's auditor and its associates for other services:		
- further assurance services	10	-
- other services	2	-
Clinical negligence	3,272	3,002
Other	4,663	4,547
	176,927	178,252

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

Redundancy payments totalling £0.015m (2012: £0.078m) are included in staff costs and further details are disclosed in note 9.4.

There is a limitation on the Auditor's liability of £1.0m.

Other expenses include payments for course fees £0.3m (2012: £0.3m), patient's travel £0.1m (2012: £0.1m), the service element of the PFI contract £0.9m (2012: £0.6m), consultancy fees £0.4m (2012: £0.3m), insurance fees £0.1m (2012: £0.1m), legal fees £0.2m (2012: £0.1m), internal audit fees £0.2m (2012: £0.2m), contracted out services £0.1m (2012: £0.1m) and costs attributable to the Trust's subsidiary company £1.5m (2012: £1.5m).

8. Operating leases expenditure

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

	2013 £000	2012 £000
Minimum lease payments	177	215

8.3 Total future minimum lease payments

Payable:	2013 £000	2012 £000
Within 1 year	123	128
Between 1 and 5 years	265	213
After 5 years	52	65
Total	440	406

NOTES TO THE ACCOUNTS

9. Staff costs and numbers

9.1 Staff costs

Group	Total 2013 £000	Permanently Employed 2013 £000	Other 2013 £000	Total 2012 £000	Permanently Employed 2012 £000	Other 2012 £000
Salaries and wages	92,640	92,640	-	93,462	93,462	-
Social Security Costs	7,003	7,003	-	6,852	6,852	-
Employer contributions to NHSPA	10,681	10,681	-	10,759	10,759	-
Other pension costs	-	-	-	-	-	-
Agency and contract staff	4,441	-	4,441	2,720	-	2,720
	<u>114,765</u>	<u>110,324</u>	<u>4,441</u>	<u>113,793</u>	<u>111,073</u>	<u>2,720</u>
Less: costs of staff capitalised	(328)	(328)	-	(291)	(291)	-
	<u>114,437</u>	<u>109,996</u>	<u>4,441</u>	<u>113,502</u>	<u>110,782</u>	<u>2,720</u>

9.2 Average number of persons employed - WTE basis

Group	Total 2013 Number	Permanently Employed 2013 Number	Other 2013 Number	Total 2012 Number	Permanently Employed 2012 Number	Other 2012 Number
Medical and dental	327	308	19	347	336	11
Ambulance staff	10	10	-	14	14	-
Administration and estates	599	597	2	595	593	2
Healthcare assistants & other support staff	222	214	8	218	209	9
Nursing, midwifery & health visiting staff	1,247	1,166	81	1,250	1,208	42
Scientific, therapeutic and technical staff	384	383	1	393	392	1
Total	<u>2,789</u>	<u>2,678</u>	<u>111</u>	<u>2,817</u>	<u>2,752</u>	<u>65</u>

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

9.3 Directors' Remuneration

	2013 £000	2012 £000
Salaries and wages	839	869
Social Security Costs	95	87
Employer contributions to Pension Schemes	95	101
	<u>1,029</u>	<u>1,057</u>

The total number of Directors accruing benefits under pension schemes is 6 (2011: 6)

9.4 Staff departure costs

	2013 No. of compulsory redundancies	2013 No. of other agreed departures	2012 No. of compulsory redundancies	2012 No. of other agreed departures
Exit package cost band				
< £10,000	1	-	2	5
£10,001 - £25,000	1	-	1	4
£25,001 - £50,000	-	-	-	2
£50,001 - £100,000	-	1	1	-
Total number of exit packages by type	<u>2</u>	<u>1</u>	<u>4</u>	<u>11</u>
	£000	£000	£000	£000
Total resource costs	<u>15</u>	<u>52</u>	<u>78</u>	<u>148</u>

There were no compulsory redundancy costs relating to senior managers in the year.

In 2012 only, the Trust operated a Mutually Agreed Resignation Scheme (MARS) based on a Treasury approved scheme. Under the scheme staff could put themselves forward for MARS and, if the Trust accepted their resignation, recompense was paid based on their salary and length of service, in line with the scheme rules. These payments are disclosed under 'other agreed departures' above.

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 £10.68m (2012: £10.76m). As at 31 March 2013, contributions of £1.42m (2012: £1.36m) 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.

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

a) 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. The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ended 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform contribution rates to be used from 1 April 2015.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on detailed membership data as at 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pensions 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. From 2011-12 the Consumer Price Index (CPI) replaced the Retail Prices Index (RPI).

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment for the 1995 section and is optional for the 2008 section.

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 2013 there were 2 (2012: 4) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £0.184m (2012: £0.315m). 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 and Trust	2013 £000	2012 £000
Interest revenue:		
Bank accounts	219	172
Other loans and receivables	-	-
	<u>219</u>	<u>172</u>

13. Finance costs

Group and Trust	2013 £000	2012 £000
Interest on loans from Foundation Trust Financing Facility	52	76
Interest on obligations under finance leases	36	39
Finance costs on obligations under Private Finance Initiatives	1,383	1,425
Contingent finance costs	349	298
Total finance expense - financial liabilities	1,820	1,838
Other finance costs - unwinding of discounts on provisions	13	16
Total	1,833	1,854

14. The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts payable arising from claims made by businesses under this legislation (2012: £Nil).

15. Losses and special payments

Group and Trust	2013		2012	
	Number	Value £000	Number	Value £000
Losses	359	24	522	57
Special payments	58	91	38	36
	<u>417</u>	<u>115</u>	<u>560</u>	<u>93</u>
Total losses and special payments	417	115	560	93

There were no case payments that exceeded £0.1m.

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 2012	308	308
Additions - purchased	534	534
At 31 March 2013	842	842
Amortisation		
At 1 April 2012	24	24
Provided during the period	66	66
Amortisation at 31 March 2013	90	90
Net book value at 31 March 2012		
- Purchased at 31 March 2012	284	284
- Donated at 31 March 2012	-	-
Total at 31 March 2012	284	284
Net book value at 31 March 2013		
- Purchased at 31 March 2013	752	752
- Donated at 31 March 2013	-	-
Total at 31 March 2013	752	752

NOTES TO THE ACCOUNTS

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 2012	4,938	91,573	5,715	1,995	53,132	696	14,240	1,645	173,934
Additions - purchased	-	-	-	4,885	875	-	-	-	5,760
Additions - donated	-	-	-	1,041	-	-	-	-	1,041
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	2,687	-	(5,312)	1,089	14	1,302	220	-
Revaluation	(15)	(7,058)	-	-	-	-	-	-	(7,073)
Disposals	-	-	-	-	-	(12)	(5)	-	(18)
At 31 March 2013	4,923	87,202	5,715	2,609	55,095	696	15,537	1,865	173,644
Accumulated depreciation									
At 1 April 2012	-	-	-	-	32,635	639	9,981	618	43,873
Provided during the period	-	3,900	103	-	2,924	15	1,364	124	8,430
Revaluation	-	(4,695)	(103)	-	-	-	-	-	(4,798)
Impairments	-	795	-	-	-	-	-	-	795
Disposals	-	-	-	-	-	(1)	-	-	(1)
Accumulated depreciation at 31 March 2013	-	-	-	-	35,559	653	11,345	742	48,299
Net book value at 31 March 2012									
Owned	4,938	71,461	5,715	1,995	18,227	57	4,208	743	107,344
Finance leased	-	-	-	-	307	-	-	-	307
On balance sheet PFI	-	20,112	-	-	-	-	-	-	20,112
Donated	-	-	-	-	1,963	-	51	284	2,298
Total at 31 March 2012	4,938	91,573	5,715	1,995	20,497	57	4,259	1,027	130,061
Net book value at 31 March 2013									
Owned	4,923	67,854	5,715	2,609	17,435	43	4,148	770	103,497
Finance leased	-	-	-	-	246	-	-	-	246
On balance sheet PFI	-	19,049	-	-	-	-	-	-	19,049
Donated	-	299	-	-	1,855	2	44	353	2,553
Total at 31 March 2013	4,923	87,202	5,715	2,609	19,536	45	4,192	1,123	125,345

17.2 Analysis of property, plant and equipment

Net book value

Protected assets at 31 March 2013	2,375	81,793	-	-	-	-	-	-	84,168
Unprotected assets at 31 March 2013	2,548	5,409	5,715	2,609	19,536	45	4,192	1,123	41,177
	4,923	87,202	5,715	2,609	19,536	45	4,192	1,123	125,345

Protected assets are those required to provide either mandatory goods or services under Salisbury NHS Foundation Trust's terms of authorisation

On 31 March 2013 the District Valuer reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset 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 2013

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 2011									
At 1 April 2011	4,938	97,100	5,715	6,342	49,267	661	12,455	1,040	177,518
Additions - purchased	-	960	12	1,549	2,570	35	375	195	5,696
Additions - donated	-	15	-	-	242	-	5	74	336
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,062	33	(5,896)	1,060	-	1,405	336	-
Revaluation	-	(9,564)	(45)	-	-	-	-	-	(9,609)
Disposals	-	-	-	-	(7)	-	-	-	(7)
At 31 March 2012	4,938	91,573	5,715	1,995	53,132	696	14,240	1,645	173,934
Accumulated depreciation at 1 April 2011									
At 1 April 2011	-	-	-	-	29,763	633	8,907	550	39,853
Provided during the period	-	4,300	130	-	2,879	6	1,074	68	8,457
Revaluation	-	(4,300)	(130)	-	-	-	-	-	(4,430)
Disposals	-	-	-	-	(7)	-	-	-	(7)
Accumulated depreciation at 31 March 2012	-	-	-	-	32,635	639	9,981	618	43,873
Net book value at 31 March 2012									
Owned	4,938	71,461	5,715	1,995	18,227	57	4,208	743	107,344
Finance leased	-	-	-	-	307	-	-	-	307
On balance sheet PFI	-	20,112	-	-	-	-	-	-	20,112
Donated	-	-	-	-	1,963	-	51	284	2,298
Total at 31 March 2012	4,938	91,573	5,715	1,995	20,497	57	4,259	1,027	130,061

17.4 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2012	2,390	87,075	-	-	-	-	-	-	89,465
Unprotected assets at 31 March 2012	2,548	4,498	5,715	1,995	20,497	57	4,259	1,027	40,596
	4,938	91,573	5,715	1,995	20,497	57	4,259	1,027	130,061

17.5 Included within plant and machinery is the following held by the subsidiary company

	31 March 2013	31 March 2012
Cost	£'000	£'000
Accumulated depreciation	94	88
Net book value	(84)	(68)
	10	20

NOTES TO THE ACCOUNTS

Net Book Value of Assets Held Under Finance			
17.6 Leases	Plant & Machinery £000	PFI Arrangements £000	Total £000
Cost or valuation			
At 1 April 2012	616	20,112	20,728
Additions - Purchased	-	-	-
Revaluations	-	(1,063)	(1,063)
Disposals	-	-	-
At 31 March 2013	<u>616</u>	<u>19,049</u>	<u>19,665</u>
Accumulated depreciation			
At 1 April 2012	309	-	309
Provided during the period	62	523	585
Revaluation	-	(523)	(523)
Disposals	-	-	-
Accumulated depreciation at 31 March 2013	<u>371</u>	<u>-</u>	<u>371</u>
Net book value at 31 March 2013			
- Purchased	245	19,049	19,294
- Donated	-	-	-
Total at 31 March 2013	<u>245</u>	<u>19,049</u>	<u>19,294</u>
Cost or valuation			
At 1 April 2011	616	21,937	22,553
Impairments	-	-	-
Revaluation	-	(1,825)	(1,825)
Disposals	-	-	-
At 31 March 2012	<u>616</u>	<u>20,112</u>	<u>20,728</u>
Accumulated depreciation			
At 1 April 2011	247	-	247
Provided during the period	62	586	648
Impairments	-	-	-
Revaluation	-	(586)	(586)
Disposals	-	-	-
Accumulated depreciation at 31 March 2012	<u>309</u>	<u>-</u>	<u>309</u>
Net book value at 31 March 2012			
- Purchased	307	20,112	20,419
- Donated	-	-	-
Total at 31 March 2012	<u>307</u>	<u>20,112</u>	<u>20,419</u>

NOTES TO THE ACCOUNTS

18. Inventories

	Group		Trust	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Materials	1,707	1,692	1,637	1,632
Work-in-progress	-	7	-	7
Finished Goods	686	818	686	818
	<u>2,393</u>	<u>2,517</u>	<u>2,323</u>	<u>2,457</u>
Inventories recognised as an expense in the period	16,583	15,179	16,599	15,195
Write-down of inventories (including losses)	52	346	52	346
Reversal of write-downs that reduced the expense	-	-	-	-
	<u>16,635</u>	<u>15,525</u>	<u>16,651</u>	<u>15,541</u>

19. Trade and other receivables

	Group		Trust	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000

19.1 Amounts falling due within one year:

NHS receivables	3,298	2,320	3,298	2,320
Other receivables with related parties	87	41	87	41
Provision for impairment of receivables	(884)	(1,144)	(884)	(1,144)
Prepayments	800	648	800	648
PDC dividend receivable	92	298	92	298
Vat receivable	169	171	169	171
Other receivables	5,867	5,233	5,787	5,189
	<u>9,429</u>	<u>7,567</u>	<u>9,349</u>	<u>7,523</u>

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 17.4 days (2012: 14.2 days). No interest is charged on trade receivables

Other receivables include non-NHS trade debts £1.8m (2012: £1.7m), amounts due from Charitable Funds of £0.5m (2012: £0.2m) and £3.2m (2012: £3.0m) due from the Compensation Recovery Unit.

19.2 Movement in the provision for impairment of receivables

	Group		Trust	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Balance at beginning of year	1,144	1,024	1,144	1,024
Amount written off during the year	(184)	120	(184)	120
(Decrease)/increase in allowance recognised in income	(76)	-	(76)	-
Balance at end of year	<u>884</u>	<u>1,144</u>	<u>884</u>	<u>1,144</u>

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

19.3 Impaired receivables past their due date

	Group		Trust	
	31 March	31 March	31 March	31 March
	2013	2012	2013	2012
	£000	£000	£000	£000
By up to three months	271	698	271	698
By three to six months	78	-	78	-
By more than six months	535	446	535	446
Total	884	1,144	884	1,144

19.4 Non-impaired receivables past their due date

	Group		Trust	
	31 March	31 March	31 March	31 March
	2013	2012	2013	2012
	£000	£000	£000	£000
By up to three months	2,742	352	2,742	352
By three to six months	82	64	82	64
By more than six months	2,874	2,906	2,874	2,906
Total	5,698	3,322	5,698	3,322

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 12.6% (2012: 10.5%). 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	31 March	31 March	31 March
	2013	2012	2013	2012
	£000	£000	£000	£000
Balance at beginning of year	21,058	10,040	20,880	9,915
Net change in year	(3,945)	11,018	(3,969)	10,965
Balance at end of year	17,113	21,058	16,911	20,880
Made up of:				
Cash with Government Banking Service	16,714	20,651	16,714	20,651
Cash at commercial banks and in hand	399	407	197	229
Cash and cash equivalents as in balance sheet	17,113	21,058	16,911	20,880
Bank overdrafts	-	-	-	-
Cash and cash equivalents as in cash flow statement	17,113	21,058	16,911	20,880

NOTES TO THE ACCOUNTS

21. Liabilities

21.1 Trade and other payables

	Group		Trust	
	31 March	31 March	31 March	31 March
	2013	2012	2013	2012
	£000	£000	£000	£000
Amounts falling due within one year:				
NHS payables - revenue	1,049	3,340	1,049	3,340
Amounts due to other related parties - revenue	3,758	3,689	3,758	3,689
Non-NHS trade payables - revenue	4,224	4,454	4,052	4,358
Non-NHS trade payables - capital	652	792	652	792
Receipts in advance	2,451	2,702	2,451	2,702
Accruals and deferred income	519	1,179	519	1,179
Other	3,725	3,633	3,725	3,633
	16,378	19,789	16,206	19,693

NHS payables includes £1.4m outstanding pensions contributions due to the NHS Pensions Agency at 31 March 2013 (2012: £1.3m)

Amounts due to related parties includes income tax and national insurance contributions of £2.3m (2012: £2.3m). Included in 'Other' payables is £0.48m (2012: £0.34m) in respect of March enhancements earned in March but not paid until April, £0.26m (2012: £0.19m) payable to bank staff for work performed in March and £0.53m (2012: £0.12m) due for agency staff for the year to 31 March.

All Trade and other payables are current liabilities.

22. Borrowings

Group and Trust

	Current		Non-current	
	31 March	31 March	31 March	31 March
	2013	2012	2013	2012
	£000	£000	£000	£000
Obligations under finance leases	91	84	288	380
Amounts due under on-SoFP PFI (note 29)	621	614	20,166	20,794
Foundation Trust Financing Facility loan	1,250	1,250	625	1,875
Other loans	315	315	231	546
	2,277	2,263	21,310	23,595

The finance lease relates to the purchase of microbiology equipment and is for a term of 10 years. For the year ended 31 March 2013 the effective borrowing rate was 7.7% (2012: 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 three 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 payments	
	2013	2012	2013	2012
	£000	£000	£000	£000
Within one year	117	117	91	84
Between one and five years	321	439	288	380
After five years	-	-	-	-
	438	556	379	464
Less finance charges allocated to future periods	(59)	(92)		
	379	464		

Included within:

Current borrowings	91	84
Non-current borrowings	288	380
	379	464

NOTES TO THE ACCOUNTS

23. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Pensions relating to other staff	23	28	92	108
Legal claims	435	920	-	-
Other	78	117	289	199
	536	1,065	381	307
	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2012	136	920	316	1,372
Change in the discount rate	-	-	7	7
Arising during the year	4	247	169	420
Utilised during the year	(29)	(180)	(55)	(264)
Reversed unused	-	(552)	(79)	(631)
Unwinding of discount	4	-	9	13
At 31 March 2013	115	435	367	917
Expected timing of cash flows:				
Within 1 year	23	435	78	536
1 - 5 years	70	-	78	148
5-10 years	22	-	211	233
	115	435	367	917

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 and employee claims outstanding at 31 March 2012. These are based on valuation reports provided by the Trust's legal advisers.

Other provisions include the following:

- £0.310m the Trust has provided for injury benefits payable to former employees as a result of an injury suffered whilst in the Trust's employment (2012: £0.214m).
- £nil (2012: £0.102m) in respect of a compromise agreement reached with a former employee.
- £0.057m in respect of a supplier claim arising at the end of the contractual term.

£32.0m is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust (2012: £27.83m).

NOTES TO THE ACCOUNTS

24. Prudential Borrowing Limit

Trust	2013 £000	2012 £000
Total long term borrowing limit set by Monitor	25,700	27,800
Working capital facility agreed by Monitor	13,000	13,000
Total Prudential Borrowing Limit set by Monitor	38,700	40,800
Long term borrowing at 1 April 2012	25,858	27,783
Net actual borrowing/(repayment) in year - long term	(2,271)	(1,925)
Long term borrowing at 31 March 2013	23,587	25,858
Working capital borrowing at 1 April 2012	0	0
Net actual borrowing/(repayment) in year - working capital	0	0
Working capital borrowing at 31 March 2013	0	0

The Trust had a £10m (2011-12 £10m) approved working capital facility in place although this was unused during the period. The renewal date of this facility is 31 July 2013.

Financial Ratios	2013 Actual Ratios Ratios	2013 Approved PBL Ratios	2012 Actual Ratios Ratios	2012 Approved PBL Ratios
Minimum Dividend Cover	4	>1	4	>1
Minimum Interest Cover	9	>3	8	>3
Minimum Debt Service Cover	4	>2	4	>2
Maximum Debt Service to Revenue	0.02	<2.5%	0.02	<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.

Further information on the Prudential Borrowing Code for NHS Foundation Trusts and Compliance Framework can be found on Monitor's website.

25. Capital Commitments

Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £1.702m (2012: £3.229m).

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 £0.5m.

27. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year ended 31 March 2013 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities are listed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Bournemouth and Poole PCT	2,151	-	42	-
Bristol PCT	10,487	-	221	-
Dorset PCT	19,081	-	612	-
Hampshire PCT	22,186	80	361	65
Southampton PCT	1,006	-	23	-
West Kent PCT	2,395	-	247	-
Wiltshire PCT	94,796	-	24	-
South West Strategic Health Authority	4,519	-	-	-
NHS Litigation Authority	120	3,393	1	-

NOTES TO THE ACCOUNTS

27. Related Party Transactions (continued)

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies, further information is disclosed in note 31.

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.

	2013 £000	2012 £000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	921	609
Depreciation of PFI asset	523	586
Net charge to operating expenses	<u>1,444</u>	<u>1,195</u>

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

Imputed finance lease obligations comprise:	Minimum lease payments		Present value of minimum lease payments	
	2013 £000	2012 £000	2013 £000	2012 £000
Rentals due within one year	1,972	2,004	598	621
Rentals due within 2 to 5 years	7,284	7,460	2,166	2,297
Rentals due thereafter	31,799	33,372	18,023	18,490
	<u>41,055</u>	<u>42,836</u>	<u>20,787</u>	<u>21,408</u>
Less: interest element	(20,268)	(21,428)		
Total	<u>20,787</u>	<u>21,408</u>		

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:	2013 £000	2012 £000
Due within one year	754	669
Due within 2 to 5 years	3,540	3,122
Due after 5 years	21,026	20,455
	<u>25,320</u>	<u>24,246</u>

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

NOTES TO THE ACCOUNTS

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.

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	
	2013	2012	2013	2012	2013	2012
	£'000	£'000	£'000	£'000	£'000	£'000
Euro	-	-	379	464	-	-
GBP	9,429	7,567	40,503	46,555	17,113	21,058
	9,429	7,567	40,882	47,019	17,113	21,058

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 2013

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	Total
	%	£000	£000	£000	£000	£000	£000	£000	£000
Fixed rate									
Finance lease obligations	7.7	-	29	88	117	204	-	(59)	379
PFI obligations	6.5	250	250	1,472	1,896	5,388	31,799	(20,268)	20,787
Foundation Trust Financing Facility									
Loan	1.88	-	-	1,279	637	-	-	(41)	1,875
Salix Loan	0	-	-	315	231	-	-	0	546
Floating rate									
Trade and other payables	-	9,683	-	-	-	-	-	-	9,683

As at 31 March 2012

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	Total
	%	£000	£000	£000	£000	£000	£000	£000	£000
Fixed rate									
Finance lease obligations	7.7	-	29	88	117	322	-	(92)	464
PFI obligations	6.5	170	340	1,494	1,956	5,504	33,372	(21,428)	21,408
Foundation Trust Financing Facility									
Loan	1.88	-	-	1,303	1,280	636	-	(94)	3,125
Salix Loan	0.00	-	-	315	315	231	-	-	861
Floating rate									
Trade and other payables	-	14,756	-	-	-	-	-	-	14,756

NOTES TO THE ACCOUNTS

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 2013 are in receivables from customers, as disclosed in note 19.

29.6 Financial instruments by category

	At Fair value through income and expenditure account	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Financial assets				
Trade and other receivables excluding non financial assets	-	5,598	-	5,598
Cash and cash equivalents	-	17,113	-	17,113
Other financial assets	-	-	-	-
Total at 31 March 2013	-	22,711	-	22,711
Trade and other receivables excluding non financial assets	-	3,740	-	3,740
Cash and cash equivalents	-	21,058	-	21,058
Other financial assets	-	-	-	-
Total at 31 March 2012	-	24,798	-	24,798
	At 'Fair value through income and expenditure account'	Other	Total	
	£000	£000	£000	
Financial liabilities				
Borrowings	-	2,421	2,421	
Private Finance Initiative	-	20,787	20,787	
Finance lease obligations	-	379	379	
Trade and other payables	-	11,625	11,625	
Provisions under contract	-	917	917	
Total at 31 March 2013	-	36,129	36,129	
Borrowings	-	3,986	3,986	
Private Finance Initiative	-	21,408	21,408	
Finance lease obligations	-	464	464	
Trade and other payables	-	14,756	14,756	
Provisions under contract	-	1,372	1,372	
Total at 31 March 2012	-	41,986	41,986	

29.7 Fair values of financial liabilities at 31 March 2013

	Book Value £'000	Fair Value £'000
Provisions under contract	917	917
Loans	2,421	2,421
	3,338	3,338

NOTES TO THE ACCOUNTS

30. Third Party Assets

The Trust held £0.001m cash at bank and in hand at 31 March 2013 (2012: £0.003m) 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.

31. Intra-Government and Other Balances

	2013		2012	
	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	863	784	875	447
English NHS Trusts	255	185	207	193
Department of Health	92	-	-	5
English Strategic Health Authorities	2	-	-	-
English Primary Care Trusts	2,177	71	1,238	2,677
RAB Special Health Authorities	-	-	-	4
NHS CGA bodies	-	8	-	14
Other WGA bodies	256	3,758	212	3,689
Public Corporations and Trading Funds	-	-	-	-
Bodies External to Government	5,784	11,572	5,035	12,760
	<u>9,429</u>	<u>16,378</u>	<u>7,567</u>	<u>19,789</u>

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 2013 and 31 March 2012	<u>34</u>

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

33. Investment in associate

Salisbury NHS Foundation Trust has taken a one third share in a start up company, Replica 3dm Limited, which produces three dimensional models from scans and is marketing this capability to other NHS organisations. The company commenced trading in September 2012, but results from that date to 31 March 2013 are deemed to be immaterial and have not been incorporated into these consolidated financial statements.

34. Movements on Public Dividend Capital

	2013 £000	2012 £000
Public Dividend Capital at 1 April	51,229	51,229
New public dividend capital received	325	-
Public Dividend Capital at 31 March	<u>51,554</u>	<u>51,229</u>

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