Salisbury
NHS Foundation Trust

Salisbury NHS Foundation Trust Annual Report and Accounts
1 April 2024 to 31 March 2025

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Annual Report and Accounts 2024 to 2025

Presented to Parliament pursuant to
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PERFORMANCE REPORT

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Context and Overview of Performance

As we write this annual report it allows us to reflect on the difference our staff have made to many thousands of patients during this year. Whilst 2024-25 has been challenging in the NHS, Salisbury NHS Foundation Trust has a lot to be proud of. During the year the Trust saw over 304,107 people in outpatients, we treated 27,378 patients in our Day Case unit, 78,594 people attended our Emergency Department and 30,823 attended the hospital as an emergency admission.

With a change in government, financial pressures, and workforce challenges we are very proud of the way our teams have continued to respond and drive improvement across our services. Our colleagues have been resilient, continue to find new ways to work around challenges, and offer expert and compassionate care to embody the spirit of *Improving Together*, the vision and values that underpin everything we do at the Trust.

We have asked a lot of our communities too as we continue to work to reduce the backlog of patients waiting for elective treatment. Our teams have worked tirelessly over the last year with colleagues, the independent sector, and partners in Bath and Northeast Somerset, Swindon, and Wiltshire to reduce waiting times in line with national requirements. The Trust ended the year achieving zero patients waiting longer than 65 weeks. It is recognised there is more work to do as strive to recover constitutional standards by the end of this parliament (2029).

We have always been proud to deliver excellent care and experiences for our patients and in addition to improving our waiting times for planned care, we saw a positive drop in our overall length of stay as an organisation, as a result of the changes in our Same Day Emergency Care (SDEC) and Acute Frailty services. These will continue to expand in scope throughout 2024/25. While demographic shifts in our population have placed pressure on acute and community providers, reducing hospital flow, our quality indicators show continued improvement with significant progress on sustaining a reduced number of falls as well as pressure ulcers. We continue to improve our management of patient deterioration and have seen reductions in ICU admissions as a result.

2024-25 has also seen the opening of our new state of the art Imber Ward with 24 additional beds. Imber provides elderly care in a modern environment, supporting the Trust's elective recovery programme.

We have continued to develop and embed our approach to continuous improvement as we build a culture and ways of working that champions those who know services best in the pursuit of improvement. Whilst there is more for us to do our colleagues are putting this into practice and delivering significant improvements for patients.

Our values – that we are *patient centred and safe, professional, responsive, progressive, and friendly* are at the heart of who we are and what we do at the Trust. Devised in collaboration with our staff we strive to be an inclusive, kind and welcoming organisation. More than 5,000 people work in our teams. We are a community where everyone plays a

vital role in our organisation. We are passionate in ensuring all our staff belong, and feel they belong.

We have fantastic colleagues, and their health and wellbeing continue to be a major focus in our recovery and reset, learning from measures and resources we have put in place to support them and empower them to deliver outstanding care for patients and their families. Listening and learning from them is crucial

As an organisation our staff survey results have been published showing the most improved organisation in England for 2024, two years in a row. I am delighted the investment in training and development, the move to reduce our vacancies, particularly in nursing, have shown a marked improvement. We are the top scoring acute Trust in England for staff wanting to come to work in the morning, a testament to the passion our teams have for providing outstanding care to our patients.

As a key partner in the Bath and Northeast Somerset, Swindon, and Wiltshire system (BSW), 2024-25 saw continued collaboration between partners to support and improve the quality of services and ensure resources are used effectively. We have formed BSW Hospitals Group, with our acute Trust partners in Bath and Swindon, and appointed a shared Chief Executive. We are working closely together to ensure patients have access to high quality, safe and sustainable services. We continue to make progress on our shared electronic patient record system (EPR), which is due to go live in 2026. This will be an exciting step forward and will enable our clinical teams to work more effectively with each other.

2024-25 has seen significant national and local change to decision makers, policy, and systems. Our vision to provide outstanding experience for our patients, their families, and the people who work with and for us has given us a north star as we deliver our strategy and do the best possible for our population.

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

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

Ian Green OBE

Chair
27 June 2025
(on behalf of the Trust Board)

Cara Charles Barks

Group Chief Executive
27 June 2025

Purpose and Activities of the Trust

Salisbury NHS Foundation Trust was formally established on 1 June 2006. The Trust delivers a broad range of clinical care to approximately 275,000 people in Wiltshire, Dorset and Hampshire which includes:

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

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

The Trust has more than 5000 staff who deliver over 60 different clinical services, providing care to the local population and beyond, making SFT one of the biggest employers in South Wiltshire.

Integrated Care system (ICS)

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

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

As part of the Integrated Care System (ICS) arrangements nationally, provider organisations have stepped forward in formal collaboratives to better enable them to work together to continuously improve quality, efficiency, and outcomes for the populations they serve together. SFT is now working in a Group model with Great Western NHS Foundation Trust in Swindon and The Royal United Hospitals in Bath as an evolution of our Acute Hospital Alliance (AHA) - together we represent the acute provision within the BSW ICS

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

Acute Hospitals Alliance and BSW Hospitals Group in 2024-2025

The Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust agreed to form a group in 2024.
This decision followed years of increasingly close working as part of a provider collaborative called the Acute Hospital Alliance, which in 2023 was selected as the only South West

representative to join the first wave of NHS England's new Provider Collaborative Innovators Scheme.

We decided to work together as a group because we want to deliver high quality care for our population. Through working as a group, we increase our ability to improve patient care and how we use our resources.

Becoming a group gives us an opportunity to build on the successes we had as an Acute Hospital Alliance, including introducing robotic surgery to our system, developing the Sulis orthopaedic hub and community diagnostics centres, a successful joint business case to purchase a shared Electronic Patient Record, and creating a joint procurement function.

In November 2024, Cara Charles-Barks began her role as Chief Executive of each of the three Trusts, and of the BSW Hospitals Group. Cara has worked in the BSW system for eight years, having been Chief Executive of both Salisbury and the Royal United Bath Hospitals (RUH)

The Chief Executive role is the golden thread between the three Trusts, working to ensure we realise our shared ambition and potential to make the care we provide truly exceptional. The appointment provides an opportunity to take a more strategic approach, plan further into the future, and ensure we make the best decisions for our population.

The Chief Executive is supported at each Trust by a Managing Director who will be involved in co-creating and designing the vision and strategy, and leading teams to implement it. The Managing Directors are responsible for the day-to-day leadership at the Trusts. Interviews for these substantive posts took place in April 2025.

Our leadership team will be values-based, and they will role model the behaviours we expect everyone to demonstrate – how we do things is just as important as what we do.

To realise the opportunities and make large-scale transformation we need to get the fundamentals right, with our organisational performance being critical. Getting this right will enable us to build the confidence that we can be truly transformative. In 2025-26 we plan to appoint a Joint Chair and establish a Joint Committee to help oversee our work together. We held our first Board to Board meeting in January, giving Board members from the three Trusts the opportunity to reflect on our collective challenges and opportunities, and agreed to hold further joint development sessions in 2025-26.

We are now focussing on establishing our group operating model and our shared Strategic Planning Framework, which provides clarity on our priorities and is an enabler to transform clinical and corporate services.

Our shared strategic priorities have been agreed under the vision 'Working Together, Learning Together, Improving Together' as:

- Shared Strategy and Planning
- Transforming our Model of Care for the population we serve
- Financial Recovery and Sustainability
- Group Mobilisation and Development
- Achieving Digital Maturity

Our Strategy 2022-26

2024-25 marked a critical year in the deployment of our strategy. The strategy is a key document for the hospital as the Trust sets out the future plans and priorities. It articulates the important commitments the Trust is making to the local communities, and is underpinned by our vision:

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

The strategy confirms three priorities:

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

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

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

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

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

- Breakthrough objectives. These are operational in nature and where improvement efforts are focused for 18-24 months. They are reviewed each year and can evolve when the targets have been achieved for 6+ months.

As in 2023-24, in 2024-25 the breakthrough objectives below were aligned to the Trust's quality priorities and further detail on progress against the Trust's quality improvement plans can be found in the Quality Account, published annually on the Trust's website. These priorities represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience).

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

Breakthrough Objectives 2024-25

In 2024-25 the Trust chose the following four breakthrough objectives:

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

Progress against the 2024-25 breakthrough objectives

Following sustained improvement in the 2023-24 reducing falls breakthrough objective our reducing harm focus turned to better managing patient deterioration through the timeline recording of patient observations on the wards. These are recorded within the 'POET' system and are referred to as 'NEWS2' observations. We have recorded a 14% improvement and are continuing this work into 2025-26

The time to first outpatient appointment breakthrough objective had seen a plateauing of the average time to first appointment throughout 2023-24. As such it was continued into 2024-25 with refreshed cross-divisional focus through workshops and an outpatient's transformation group as a sub-set of Planned Care Board. Individual specialities such as Cardiology and Gastroenterology, however, have seen some good improvement particularly through the use of improvement huddles and tools introduced and supported by the Improvement and Transformation Team. Further specialty level support has helped drive clear improvement in 2024-25 of 11%.

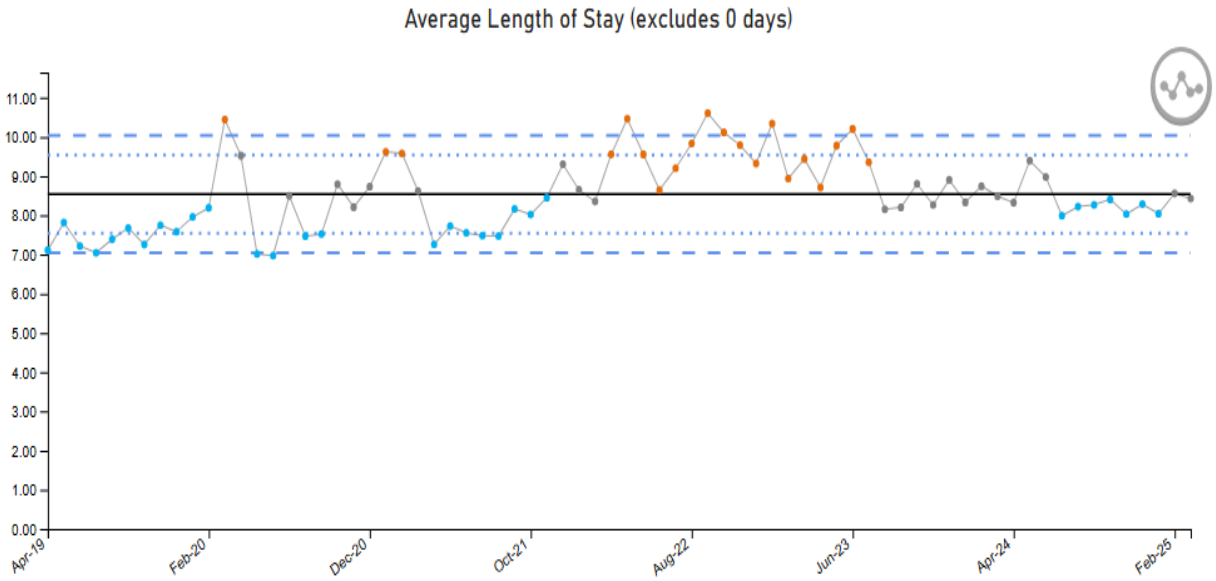
The 2023-24 staff availability breakthrough objective has reduced agency spend from 7.37% (April 23) to 3.77% (March 24). This improvement allowed this breakthrough objective to move to focusing to the retention of additional healthcare staff in 2024-25. Turnover in this group of Trust staff can be hugely impactful on the care we provide, thanks to dedicated work by our Organisational Development and People directorate a 16% improvement has been realised – allowing us to hold on to this critical group of staff as we improve our services.

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

Improving Patient Flow

The challenges with patient flow that were first emerging as a significant issue for acute providers in 2022- 23 continued to be a focus for improvement during 2023-24 and throughout 2024-25. We have leveraged our Improving Together methodology and Same Day Emergency care (SDEC) unit functions (including the introduction of an Acute Frailty Unit) to drive a improvements in flow. The new Adult Community Services contract awarded to HCRG in April 2025 will provide opportunities in the year ahead to further improve flow and in the interface of acute, community, and primary care services.

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



We continue to work with all our system partners and neighbouring systems (Dorset and Hampshire) to reduce the number of patients whose discharge is delayed (No Criteria To Reside). A local discharge/Flow hub went live in July 2023. This means that discussions regarding discharges of patients with complex needs take place with all partners in one room at the hospital site and as such can include patients and carers more readily.

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

The improvement work in relation to flow improvement, including improvement of the Emergency Department (ED) 4-hour quality indicator and reducing delayed discharges with system partners will be a continued focus for 2025-26 as we seek to recover constitutional standards and work with the new community services provider.

Elective Recovery

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

Theatre productivity has remained above nationally recommended utilisation levels and strong recruitment performance allowed us to open additional theatre capacity in 2024-25 as part of our three-year development plan for theatres. At the close of 2024-25 we have benchmarked as one of the top performing trusts in the South West for theatre utilisation.

We have developed a Community Diagnostic Centre within the Town Centre with CT and MRI scanning operational and plans to expand the diagnostic offer closer to home in the years ahead.

Our most significant challenge continues to be access to inpatient beds due to the volume of beds required to support non-elective demand, and additionally theatre capacity. However,

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

We recognise that despite steady improvement in waiting times for treatment, there is still much to do in our pursuit of an outstanding experience for our patients and population. We will continue to drive improvement, and leverage opportunities as part of our new Group model into 2025-26.

Improving our Maternity Services

The previous year has seen continued progress and embedding of improvements around process, culture and governance in maternity and Neonatal services.

The Care Quality Commission (CQC)carried out an unannounced inspection of Maternity Services in September 2024, a report was published in February 2025 with SFT being rated 'Good' in all domains and overall. This is progress from an overall rating of 'Requires Improvement', with 'Inadequate' for Leadership and requires Improvement' for safety in 2021 and recognises the positive improvements being worked through.

In November 2024, Salisbury Maternity Unit also received confirmation of formal exit from the National Maternity Safety Support Programme, which had been entered following CCQ in 2021. The Trust had met all exit criteria following significant work alongside NHSE Maternity support programme, and this was recommended and commended.

This year has also continued to see effective collaboration with the Maternity and Neonatal Voices Partnership to support an improvement in experiences for all and ensure that women and services users voices are heard, and services and changes are co-produced in collaboration with those who use them.

Continued presence and reporting at Trust Board and our Maternity Safety Champions meetings, which continue to include a broad selection of staff from all roles and levels, ensure concerns from staff are heard at Executive level, and that the Executive and Non-Executive Board members are fully appraised of Maternity and Neonatal services current position, outcomes for families, and any challenges within the service.

A focus has continued on staff communications to ensure everyone is informed of any developments or challenges with a number of focus groups and listening events held for all to encourage staff to influence decisions that are made within the service. This has meant a continued progression of the improvement in culture, leadership, and transformation within the service.

Responding to Staff Health and Wellbeing

Staff sickness in winter 2024-25 was particularly high with January 2025 a challenging month. The percentage of days lost as a proportion of all staff rose from 3.67% to 3.84% but did not reach the heights of 3.95% seen in 2022/23. Lower rates of short-term absences are often an indicator of improved morale, and it is pleasing to see that short term absence trends fell this year, commensurate with increased morale scores in the staff survey results.

This year, in response to data that shows both Anxiety and Musculo-Skeletal injury as two of our biggest causes of sickness absence, we have increased the hours of our in-house

physiotherapy services to cater for more staff appointments and also increased the number of counselling sessions available to staff. A new, more streamlined process for seeking mental health support has been launched under a single application with responses triaged to provide the best support for the individual. Through effective staff management, our occupational health team has improved its service across all its functions including recruitment support and case referrals, where 96% of referrals were achieved within 2 working days. Adjustments to the Trust induction programmer have been made to incorporate changes which has seen the introduction of a 'we are safe and healthy day' in the first week on site for all new staff.

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

National Staff Survey Results 2024

The NHS staff survey is conducted annually, with 2024 being the fourth year when the questions were aligned with the NHS People Promise to track progress against our ambition to make Salisbury Foundation Trust (SFT) workplace the 'best place to work'. The national Staff Survey reports against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

Details of the scores for each indicator, together with the average, best and worst scores in the benchmarking group across the NHS can be found in the Staff Report or on the NHS Staff Survey website: NHS Staff Survey 2024 Benchmark Report

In 2024, SFT was identified for the second year running as the most improved Trust, and we topped the list of acute trusts in England for staff wanting to go to work in the morning. A testament to the work of our improvement and Organisational Development and People teams as they seek to make SFT one of the best places to work in the country.

Our People Promise programme and the divisional action plans generated in response to staff survey results will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board. Further detail on our staff survey response can be found in the Staff Report.

Improving our digital capability

We continue on our journey to deliver the aims and objectives laid out in our five-year digital plan launched in 2022/23, with Improving Digital Care being a Strategic Initiative for the Trust. The programme to replace the Trust's main electronic patient record (EPR) has now commenced. The new Shared EPR will be a single solution with Royal United Hospitals Bath and Great Western Hospitals and aims to go live in 2026/27. Whilst the new core EPR is the main focus, we have continued to mature the use of digital over the last year including the introduction of a new maternity electronic patient record (EPR) system, improving the electronic discharge summary process and introducing digital Respect forms using the ICS wide Integrated Care Record.

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

Key operational and financial risks

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

In summary, the Trust's main priorities and risks for 2025-26 remain the safe implementation of the new electronic patient health record, increasing levels of elective activity and operational productivity, controlling finances and improving delivery of efficiencies and supporting the workforce. In addition to these, and critical to core business, is the continued delivery of quality care.

Joint ventures

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) and joint venture created between Salisbury NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire.
Salisbury NHS Foundation Trust, along with Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust are working with local third sector, end of life, primary care, community services and mental health services to consider how we can work together to support transformation of community services in future.
The Wiltshire Health and Care contract was moved and ceased trading on the 1st April 2025.

Going Concern

Our Board considered an assessment of the Trust as a going concern at its meeting on 1 May 2025. A number of risks to this position were identified.

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

Looking forward to 2025-26

In 2025-26 the Trust will continue to deliver its 2022-26 strategy. The annual plan and strategic planning framework are aligned to deliver reduced waiting times to first outpatient appointment, increasing staff retention, managing patient deterioration, and creating value for our patients. The Trust has made a commitment to make progress against our priorities of People, Population and Partnerships delivered through the drive for improvement through the Improving Together programme.

As we enter 2025-26, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and making the most of our new Group model. The focus will be on the delivery of NHS England Operational Planning Priorities 2025-26 and engaging with the nation three year planning process beginning in June 2025. The key elements of the Trust's plan are delivered through an improved No Criteria to Reside (NCTR) position, working with system partners to reduce demand on acute services, and ensuring the appropriate number of beds are open in the hospital including the expansion of our Same Day Emergency Care (SDEC) service. Delivery of this plan is reliant on the interdependencies with system partners, particularly in relation to NCTR whilst we continue to work at pace to progress internal improvements around discharge.

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

Due to the Trust's deficit position and of the wider system going into next year, there will be significant external financial oversight during 2025-26. The most significant risks to our strategy are the financial sustainability of the organisation and the demographic shifts within our geography. Therefore, next year will see a heightened focus and work with system partners to develop a financial plan to enable sustainable delivery of services and demand growth mitigation.

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

Ian Green OBE

Chair
27 June 2025
(on behalf of the Trust Board)

Cara Charles Barks

Group Chief Executive
27 June 2025

PERFORMANCE ANALYSIS

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

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

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

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

Performance overview

The Trust has made progress this year in delivering key priorities as part of the recovery and restoration of services following the pandemic. Unparalleled levels of Industrial Action in 2023- 24 and increases in non-elective demand this year have made the year a challenging one, but the progress has been meaningful.

National objectives influencing our plan for 2024-25 were to:

- improve ambulance response times and A&E waiting times.
- reduce elective long waits and cancer backlogs and improve performance against the core diagnostic standard.
- Reduce the number of patients waiting longer than 65 weeks for elective treatment.

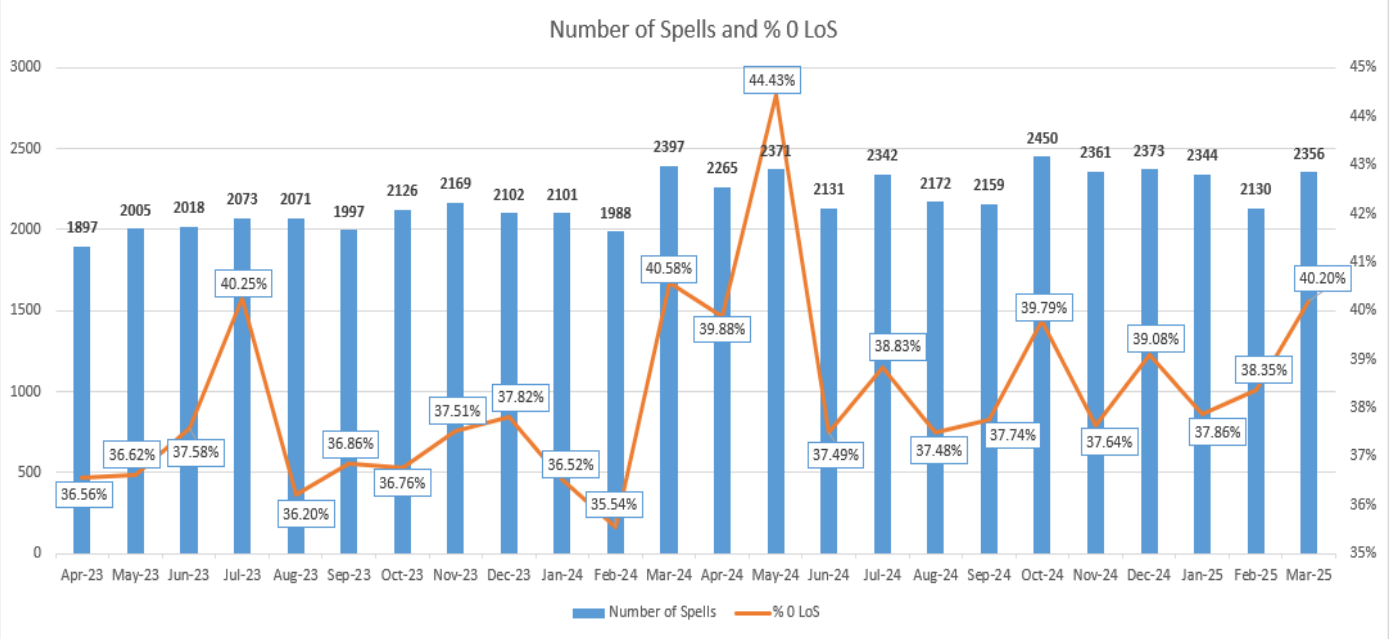
Our local plans included focusing on improving care of deteriorating patients, reducing waits to first outpatient appointments, increasing productivity and reducing vacancies.

Operational Performance

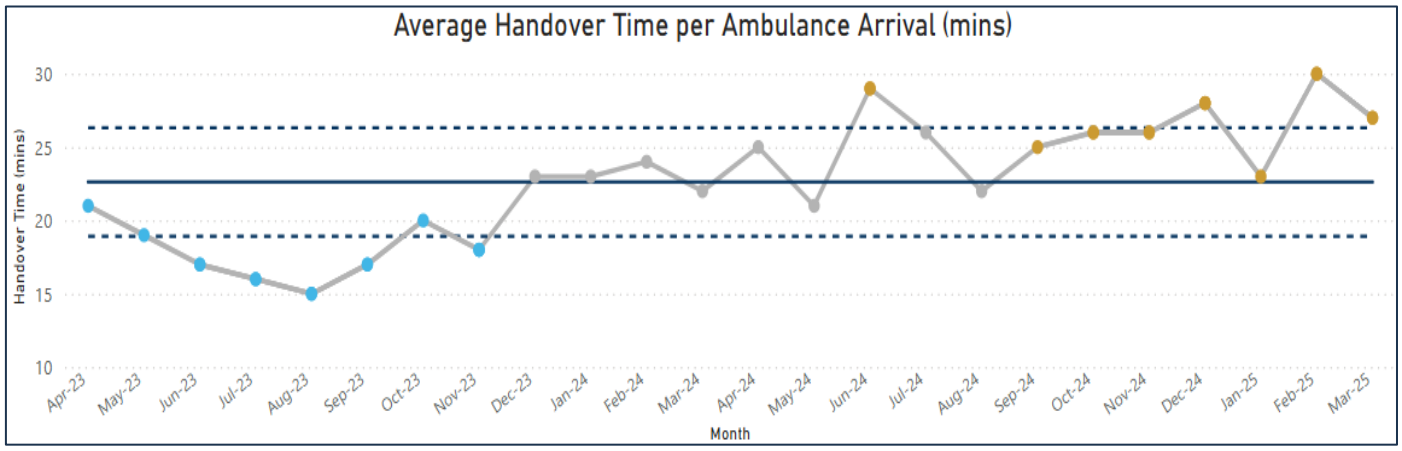
Urgent and Emergency Care

We continue to see increasing demand for urgent care service, with attendances to our Emergency Department services increasing by 6% in comparison to 2023-24 and our Non elective admissions (NEL) admissions have grown by 9% Performance against the 4-hour standard decreased slightly from an average of 74% in 23-24 to 71%. The Emergency Department have responded to the increased level of challenge and delivered several improvement initiatives – a new triage process increasing the number of patients assessed within 15 minutes of arrival from 39% to circa 88%, review of physical space and redesign of the flows in the department and have developed Minors and Majors areas improvement workstreams.

Further development of Same Day Emergency Care (SDEC) services has enabled our average length of stay to decrease by around half a day in comparison with the previous year with more patients receiving care and returning home on the same day.



Despite seeing a small increase in the average handover time for ambulances arriving at the Emergency Department we continue to benchmark as one of the best in the region for this important metric.

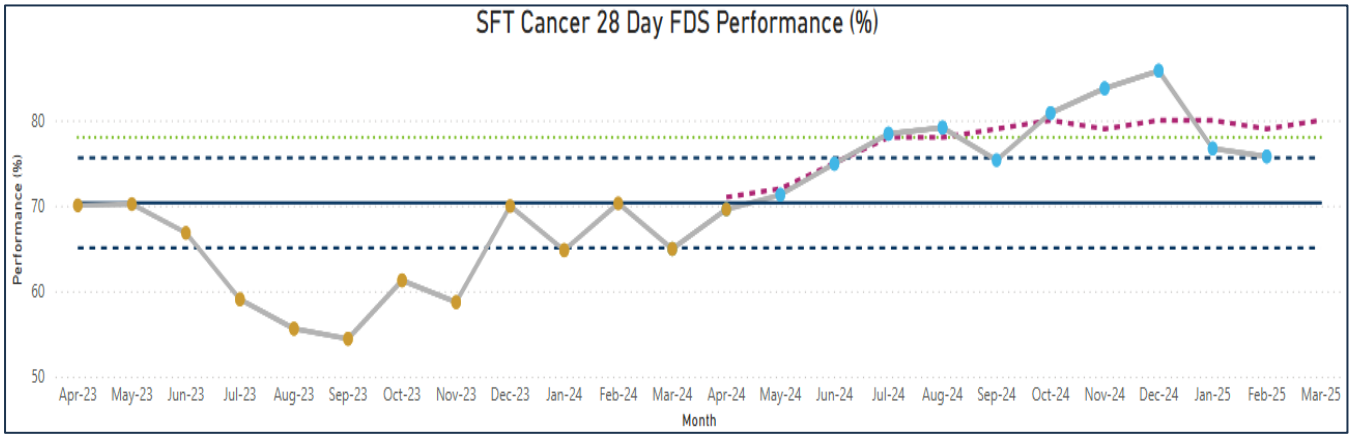


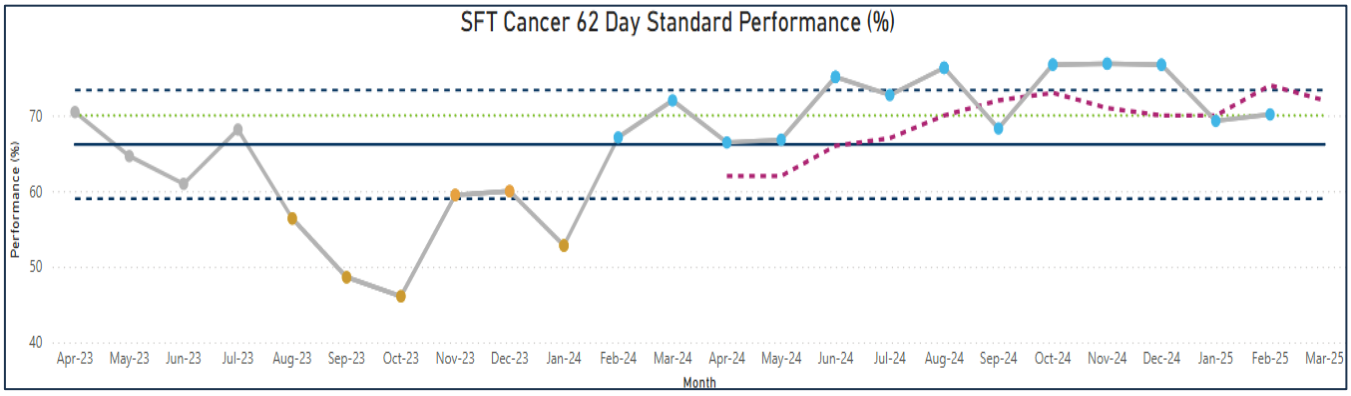
Flow into the hospital remains a challenge, affecting our ability to treat and admit or discharge patients within 4 hours. Our plans relied on this number of beds occupied by patients no longer requiring reducing but instead this increased from around 68 at the start of the year to 93 by March 25. Providing the right capacity for patients requiring further care remains a difficult and complex issue, and despite the clear challenges there have been examples of excellent collaborative working across the system to try and tackle this significant issue.

Elective Care

Cancer pathways

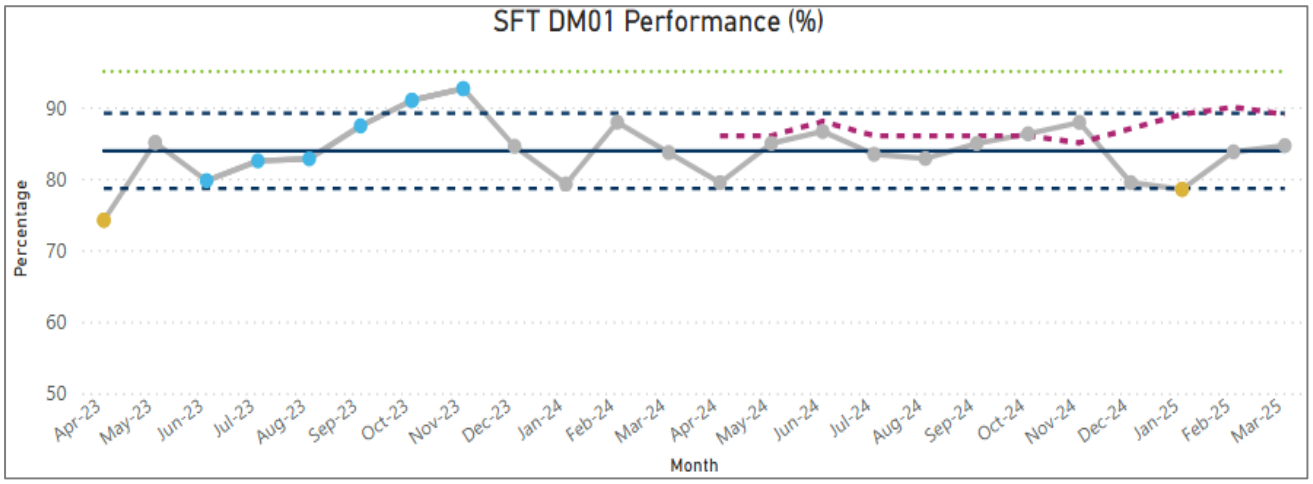
Recovery of the Cancer standards has been a clear and important priority for us this year and we have delivered beyond the plans that we set at the start of the year. We have made consistent and sustained improvement in delivery of both the 28 Day Faster Diagnosis and the 62 Day Referral to Treatment standards. This improvement enabled us to exit the tiering process providing enhanced support as part of the Oversight Framework from NHS England. Cancer remains a priority for us, and we continue to focus on the pockets of challenge despite our good performance – in particular Urology and Lower GI pathways are areas we strive to continue to provide timely cancer treatments during 25/26.





Diagnostics

We recognise that to support delivery of the Urgent and Elective care standard delivery of timely diagnostic services is key. We have maintained the progress that we made in 2023-24 and continue to achieve over 80% of patients receiving their diagnostic test within 6 weeks which benchmarks us slightly above the England average, this has included expansion of capacity through the Salisbury Community Diagnostic Centre.

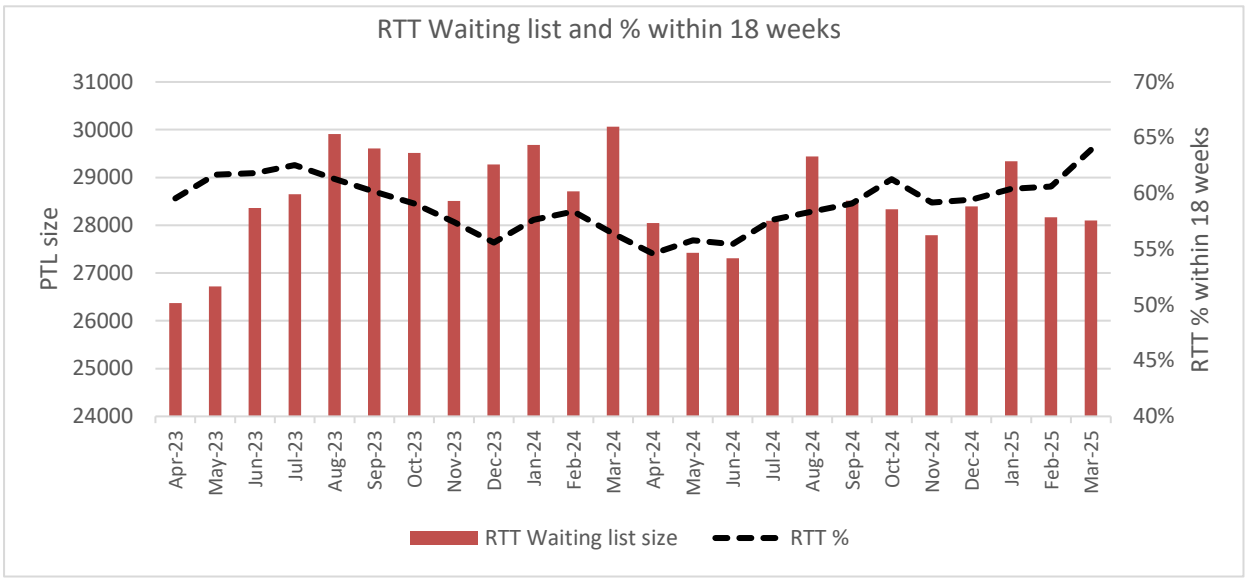


Referral to Treatment (18 weeks)

We have focused this year on reducing our longest waits for elective treatment and in March 2025 eliminated any patients waiting longer than 65 weeks for treatment – one of the first providers in the South West region to achieve this. Our efforts in reducing waits to first outpatient are evident in the increase in the percentage of patients receiving their first treatment within 18 weeks, by almost 10% from 54.6% in April 24 to 63.9% in March 25. We were able to deliver this by focusing on;

- theatre productivity – by the end of 24/25 the Trust was benchmarking within top quartile nationally
- time to first outpatient – which had reduced to 127 days, the lowest it's been since the pandemic
- increased operational management

Our aim for 2025-26 is to reduce this to no patients waiting longer than 52 weeks for treatment and increase further the percentage within 18 weeks as we aim towards achieving 92% by the end of Parliament.
As part of this we have seen the total waiting list size reduce beyond our anticipated levels, with increases in both admitted and non admitted stops driving this reduction.



Overview of financial performance in 2024-25

In 2024-25 the NHS had a continued focus on the recovery of elective pathways and addressing waiting times combined with managing emergency pathways. Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, impacted length of stay reductions.

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

The Group, encompassing Charity, Subsidiaries and Trust before adjustments for Annually Managed Expenditure (AME) Impairments and Capital donations, closed the year with a deficit of £14.127 million. Following required adjustments for national reporting, the Trust reported a position of £5.513m deficit.

Group Statement of Comprehensive Income	2024/25 £'000	2023/24 £'000
Income		
From clinical activities	373,347	332,928
Other operating income	43,530	51,908
Total Operating Income	416,877	384,836
Operating Expenses	(423,525)	(373,779)
Operating Surplus/(Deficit)	(6,648)	11,057
Finance income	1,635	1,565
Public Dividend Capital payable	(5,242)	(4,928)
Other finance costs	(3,586)	(5,425)
Net Finance Costs	(7,193)	(8,788)
Revaluation gains (+) / losses (-) on assets	126	895
Fair value gains (+) / losses (-) on investments	(168)	31
Discontinued operations gains (+) / losses (-)	(163)	
Corporation tax expense	(81)	(80)
Total Retained Surplus / (Deficit)	(14,127)	3,115
Adjusted Surplus / (Deficit) SFT only	(5,513)	(4,475)

Group Statement of Comprehensive Income	2024/25 £'000	2023/24 £'000
Total Retained Surplus / (Deficit)	(14,127)	3,115
Remove loss on disposal of discontinued operations	(163)	
Remove impact of consolidating NHS Charitable fund	(637)	(1,167)
Remove net impairments not scoring to Departmental expenditure limit	9,009	669
Remove impact of capital grants and donations	67	(9,815)
Remove impact of PFI revenue costs on IFRS16 basis	338	2,420
Remove net impact of DHSC centrally procured inventories		303
Adjusted Surplus / (Deficit) SFT only	(5,513)	(4,475)

The Trust delivered £18.6m savings in year (£15.3m 23/24) , which was £2.5m below plan, with the non-recurrent element of £7.9m achieved (£3.8m 23/24). Key workstreams underpinning the delivery included:

- Non recurrent vacancies (£3.3m)
- Elective productivity (£2.8m)
- Divisional Cost Improvement Programmes (CIPs) (£2.7m)
- Procurement (£2.5m)
- Bed occupancy and length of stay (£1.3m)

Capital Investment

The Trust invested £26.0m (including £2.2m Right of Use assets) in infrastructure and equipment during 2024-25 (£48.3m in 2023-24). The most significant projects were the purchase and refurbishment of South Newton (£5.3m), continuation of the Electronic Patient Record project (£2.8m) and the completion of Imber ward (£1.9m).

The £26.0m was funded internally through depreciation and cash, donations, IFRS16 leasing funds and additional Public Dividend Capital (PDC) from the Department of Health primarily for EPR and Elective Care centre funding. The capital programme continues to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk and improving patient experience.

Significant in-year programmes included expenditure of:

- £6.7m on building and critical infrastructure schemes including the conclusion of the Imber ward, Decarbonisation and CT scanner installation schemes, Breamore ward improvements, Energy efficiency and works for the Automatic number plate recognition for car parks
- £5.3m for the South Newton development including the purchase costs
- £2.8m on the EPR programme
- £2.7m on the digital programme, including £0.6m investment in Network kit, £0.4m implementation of the Badgernet (Maternity IT) system, £0.3m on South Newton IT works and equipment and £0.3m on the Pathology Laboratory Information Management System
- £1.5m on the Elective Care Centre; and
- £1.2m on leased items including replacement and additional medical equipment, including Fluoroscopy C-arm, Holmium laser, Hystroscopic flexiscopes, Endoscopy stack and scopes and Ultrasounds for Spinal, Urology and Neuraxial imaging.

Tackling Health Inequalities

Health inequalities are unfair, avoidable, and systemic differences in health outcomes from different groups of people. The **CORE20PLUS5** approach guides our work on health inequalities. The 'Core' references the 20% most deprived communities in England. In Wiltshire we have eight geographical areas in the poorest 20% nationally, and three of these are in Salisbury.

The **'PLUS'** represents defined groups that experience disparities in health outcomes within our local geography. In the case of BSW this is Gypsy, Roma, Traveller, and Boater communities, as well as routine and manual workers. Military populations are considered here too. For children there is a focus on mental health, and the children of Gypsy, Roma, Traveller, and Boater families. The **'5'** represents the key clinical areas of focus – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. Smoking cessation is a theme through all five.

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

To support our work at Salisbury NHS Foundation Trust (SFT), the Wiltshire Health Inequalities Group (WHIG) meet monthly, and this group is co-chaired by a Public Health Consultant from Wiltshire Council and the Health Inequalities Lead at SFT. The terms of reference of this group were revised during 2024/25 to ensure that there is an even greater focus on the national CORE20PLUS5 priorities throughout the annual cycle.

This year, a further £863,195 was allocated to Wiltshire to help fund projects that will reduce health inequalities. A series of workshops were held with key stakeholders across Wiltshire to

determine how funds should be spent to address health inequalities in 2025. The specific priorities agreed are outlined below and funded projects will be required to focus on these specific areas.

Children and Young People	Adults
• Poorer mental health in children with adverse childhood experiences • High number of children from Core20 areas not brought for outpatient appointments.	• Low uptake of cancer screening and late presentation of symptoms for Core20 populations and routine and manual workers/Gypsy, Roma, Traveller and Boater communities. • Physical health checks for people with Severe Mental Illness (SMI) in Core20 populations and routine and manual workers/Gypsy, Roma, Traveller and Boater communities.

In addition to addressing the above, there are a range of projects that are currently being supported by our staff across the organisation. A sample of some of these projects have been highlighted below.

- SFT staff have been attending a local Farmers Market and providing education around skin cancer awareness.
- New staff have continued to be recruited to roles that will help support our work in reducing health inequalities. Two EDI Cancer Leads were recruited to work with communities to improve early diagnosis and awareness of presenting signs and symptoms of cancer, and secondly to improve staff education around cultural awareness and reasonable adjustments. There will a focus on manual workers and the boating community.
- A new operations group was established in 2024/25 with specific focus on health inequalities. Our policies were reviewed, and as result of some process changes, we have seen a significant reduction in the average wait time to first outpatient appointment for people with LD and autism. Further work is underway to establish where there may be further opportunities for improvement.
- The smokefree group are working in close collaboration with Wiltshire Council to provide written resources to our hospital inpatients. There is a visible TTD (treating tobacco dependency) service with good input from pharmacy ward-based teams and pre-operative assessment teams, with an average of 120 referrals/month.
- We have continued a virtual diagnostic partnership with a company to support Children and Young People (CYP) with asthma and have established Asthma Friendly Schools in collaboration with Wiltshire, BANES and Swindon local authorities. We are making every contact count within clinic consultations (using Smokerlyzer CO monitors on smoking/vaping parents and giving brief advice about cessation).

Environmental Sustainability Performance

Following the implementation of our Board-approved Green Plan 2021–2025, we continue to progress towards a Net Zero carbon healthcare service by 2040. Our strategy is rooted in real, measurable carbon reductions and excludes reliance on offsetting. It reflects our

ambition to deliver sustainable healthcare while addressing broader environmental, health and wellbeing outcomes.

Updated Targets and Strategic Objectives

- Achieve Net Zero for our Carbon Footprint (Scopes 1 and 2) by 2040, with an interim ambition of 80% reduction between 2028–2032.
- Achieve Net Zero for our Carbon Footprint (Scopes 3) by 2045, with an interim ambition of 80% reduction between 2036–2039.
- Align with NHS England's sustainability targets and comply with HM Treasury's TCFD-aligned disclosure requirements.

Progress to Date

We have built on the momentum of 2023/2024 by accelerating delivery across Green Plan objectives. Key achievements this year include:

- Delivery of our £10.5m Salix-funded decarbonisation project, including full installation of air source heat pumps, solar PV arrays, and LED lighting upgrades across the Hospital including the Spinal Unit and Odstock Health and Fitness Centre. The heat pumps are due to be commissioned in July 2025.
- Successful implementation of 'Foodsteps' carbon impact assessment tool for all items on the retail menu. Foodsteps uses lifecycle assessment data to provide accurate figures on the carbon impacts of meals, breaking these down from farm to fork.
- Switching food waste disposal (patient meals and retail outlets) from macerator to an offsite Anaerobic Digestion plant, a process that provides biofuel.
- Sustainability inclusion in the 'My First 90 Days' Induction programme.
- Adaptation Risk Assessment completed, with key climate risks identified. It is planned for these to be incorporated into the Trust's corporate risk register by the end of 2025.
- Expansion of our safer disposal of inhalers scheme, to Respiratory Outpatients.
- Increased our Cycle to Work scheme salary sacrifice limit to £4,000.
- Launch of the staff sustainability engagement platform 'OnHand' shared with the Acute providers within our group.
- Internal and external engagement and communications to highlight and promote the Sustainability agenda.
- Inclusion of consideration for 'People-Planet-Profit' in the Improving Together A3 Thinking template. And an optional SusQI e-learning course.
- Procurement supplier scope 3.1 review/baseline across the Acute Hospital Alliance.
- Geothermal Feasibility - a seismic study was undertaken in June 2024 to explore the viability of deep geothermal energy to provide low-carbon heat for the main campus. Early modelling suggests the potential to offset heating demand of SDH North, Spinal Unit, SDH Central Corridor, and the Odstock Health & Fitness Centre.

Taskforce on Climate-related Financial Disclosures (TCFD) – Year 2.

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as

interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications

Governance

The governance structure (Figure 1) remains robust and unchanged from 2023/2024. Oversight of climate-related issues continues to be led by:

- Trust Board – The Trust Board has strategic oversight and receives a report from TMC by exception.
- Chief Finance Officer – Board-level Net Zero Lead.
- Trust Management Committee (TMC) - Annual Progress Report
- Head of Facilities – Sustainability Lead, reporting annually to the TMC.
- Sustainability Committee – Subject matter experts monitoring progress against the Green Plan.

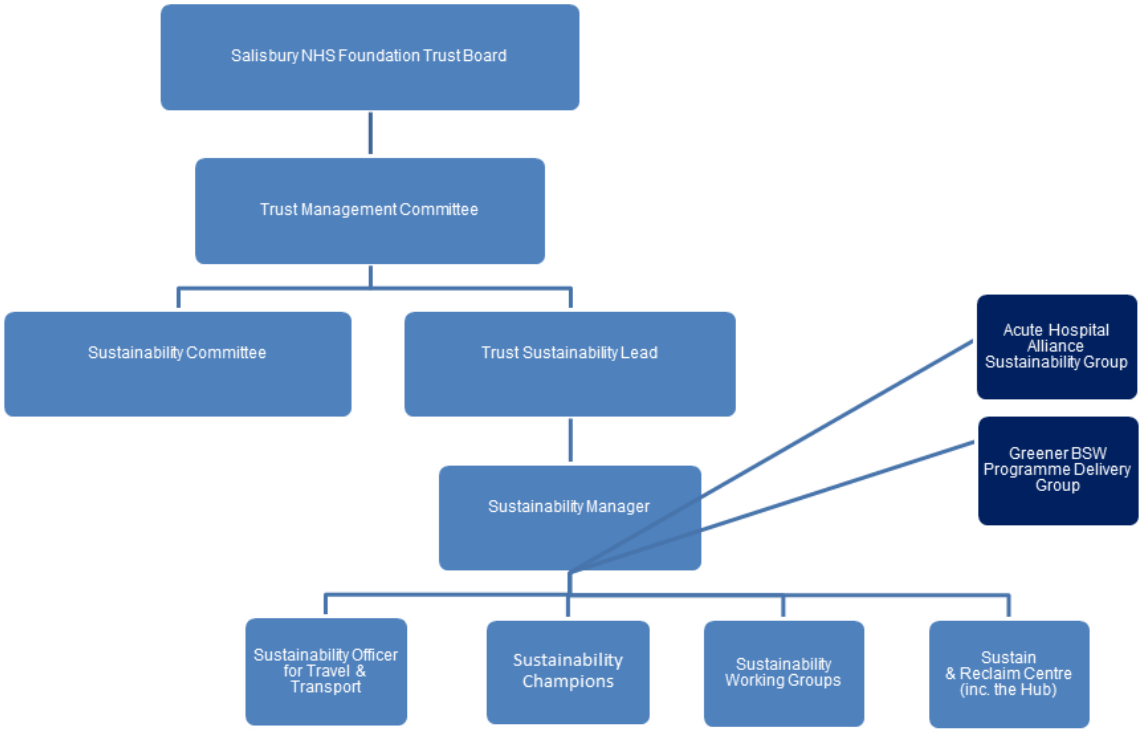


Figure 1. Green Governance Structure

Strategy

- Our updated Estates Strategy embeds climate resilience as a core design principle for all refurbishments and new builds.

- Investment planning now highlights projects with both sustainability and financial ROI, supporting long-term resilience and emissions reductions.
- Continued integration of climate considerations into service redesign, notably in digital outpatient care to reduce emissions and travel.

Risk Management

Identifying, Assessing and Managing Risks

A project is underway to develop an Acute Hospital Alliance (AHA) Adaptation Plan, informed by Trust level Climate Risk Assessments. The risks are aligned to the UK Climate Projections, NHS guidance, UKCCRA risks, and other evidence such as EA flood data. From this, we will:

- Assess physical risks such as heatwaves, flooding, and storm events across clinical and infrastructure assets.
- Evaluate transition risks, including policy changes, supply chain constraints, and reputational risks from failure to meet Net Zero goals.
- Integrate climate risk scenarios into major investment decisions and business continuity planning.
- Screen high-emission suppliers, supported by Procurement's use of the Evergreen framework that checks a supplier's climate risk resilience and net zero plans.
- Embed a climate risk lens into corporate risk registers and board assurance frameworks.

Metrics and Targets

Key Metrics Used

Metric	2023/24	2024/25	% change
Scope 1 & 2 Emissions (tCO2e)	8,498	8,008	-5.76%
Scope 3 Emissions (tCO2e) NHS Carbon Footprint	2,040	2,169	+6.3%

The increase in Scope 3 emissions is largely due to higher water consumption, greater business travel mileage, and increased Transmission & Distribution (T&D) and Well-to-Tank (WTT) emissions resulting from higher electricity usage. While the electricity itself is reported under Scope 2, these associated upstream and downstream emissions fall under Scope 3, in line with GHG reporting standards.

Targets

To align with the NHS Net Zero commitments and meet TCFD expectations for credible, time-bound decarbonisation planning, we've modelled a linear annual reduction pathway from our current emissions levels. This provides a clear trajectory toward net zero by the required NHS deadlines:

Scope 1 & 2 (target: net zero by 2040)

- From 8,008 tCO2e in 2024/25 to 0 tCO2e by 2039/40.
- Target reduction: ~535 tCO2e per year.

Scope 3 (target: net zero by 2045)

- From 2,169 tCO2e in 2024/25 to 0 tCO2e by 2044/45
- Target reduction: ~108 tCO2e per year.

Looking Ahead: 2025/2026 and Beyond

We will develop a new Green Plan 2025–2028, setting out our pathway to 2040 and embedding updated national targets from NHS England and the Greener NHS programme. Key areas of focus will include:

- Deepening supplier engagement and Scope 3 emissions management.
- Investing in digital solutions to enable smarter energy use.
- Embedding adaptation strategies into capital planning.
- Collaborating regionally through the Acute Hospital Alliance and Integrated Care Boards (ICB) Green Boards.

Major in-year risks in 2024/25

The Board of Directors has identified, and manages the principal risks to the delivery of its strategy and objectives through its Board Assurance Framework (BAF) The principal risks to the delivery of its strategy and objectives identified by the Trust during 2024/25 were

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

- BAF 1 - Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model
- BAF 2 - Due to the size of our catchment population there is a risk that some services are not sustainable
- BAF 3 - Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff
- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
- BAF 5 - There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.
- BAF 8 - Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.

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

- BAF 6 - There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.
- BAF 7 - Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.

PARTNERSHIPS - Working through partnerships to transform and integrate our services

- BAF 9 - An irreversible inability to reduce the scale of financial deficit
- BAF 10 - Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.

- BAF 11 - Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan
- BAF 12 - Risk of sustained deterioration across key performance metrics (new risk)

Overseas operations

The Trust does not have any overseas operations

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

The Board of Directors consists of Executive and Non-Executive Directors. Executive Directors are appointed by the Board and Non-Executive Directors are appointed by the Council of Governors. The Board is responsible for overseeing the strategic direction and performance of the Trust and is accountable to the local communities through the members and governors, NHS England and the Care Quality Commission. The Board has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

Directors of Salisbury NHS Foundation Trust during 2024-25

Ian Green	Chair
Cara Charles-Barks	Joint Chief Executive (from 1st November 2024)
Dr Peter Collins	Chief Medical Officer (Left July 2024)
Duncan Murray	Chief Medical Officer (interim Chief Medical Officer from August 2024, and substantive from October 2024
Judy Dyos	Chief Nursing Officer
Mark Ellis	Interim Chief Finance Officer
Lisa Thomas	Interim Managing Director from 1st November 2024 (Interim Chief Executive Officer from February 2024)
Niall Prosser	Interim Chief Operating Officer
Melanie Whitfield	Chief People Officer
Michael von Bertele CB, OBE	Non-Executive Director (left 30 October 2024)
Tania Baker	Non-Executive Director (Left 31 May 2024)
Margaret (Eiri) Jones	Non-Executive Director (Senior Independent Director)
Rakhee Aggarwal	Non-Executive Director
David Buckle	Non-Executive Director (left 30 October 2024)
Debbie Beavan	Non-Executive Director
Richard Holmes	Non-Executive Director
Paul Cain	Non-Executive Director (from 1 June 2024)
Kirsty Matthews	Non-Executive Director (from 1 June 2024)
Anne Stebbing	Non-Executive Director (from 1 July 2024)

Register of Directors' Interests

NHS employees are required to be impartial and honest in the conduct of their business. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. There is an annual review of the Register of Interests and compliance with the Fit and Proper Persons Requirements. As a standing agenda item, the Directors declare any interests before each Board and Board Committee

meeting which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust Board considers that all its Non-Executive Directors are independent in character and judgement.

The Register of Declared Interests is made available to the public by contacting the Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ. This can also be found on the Trust website following the link below:
https://www.salisbury.nhs.uk/about-us/corporate-governance/

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

The Care Quality Commission (CQC) undertook a well-led inspection in December 2019 and rated the Trust as 'Good'. The CQC stated that 'There was effective, experienced, and skilled leadership, a strong vision for the organisation and embedded values. The leadership had the capacity and capability to deliver high-quality sustainable care. Leaders understood the challenges to quality and sustainability and they were visible and approachable. There was a clear vision for the Trust and strong values.'

During 2024-25, the Trust welcomed Paul Cain, Kirsty Matthews and Anne Stebbing who joined the Trust as Non-Executive Directors.

An external well-led review started in April 2023 for a period of 3 months. This was a developmental review with the key aim to understand the Trust's strengths and also areas that require improvement from a well-led perspective. The outcomes of this report were shared with the Board and wider Trust and recommendations to take forward are underway.

The Annual Governance Statement (AGS) describes in further detail the Trust's approach to ensuring services are well-led and quality governance.

Other disclosures

Modern Slavery Act 2023-24 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

Cost allocation and charging guidance issued by HM Treasury

Salisbury NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.
Political Donations

The Trust has made no political donations of its own.

Better Payment Practice Code

The Trust conforms to the principles of the Better Payment Practice Code and aims to pay its bills promptly. Performance against the code can be viewed below. No interest was paid under the late Payment of Commercial Debts (Interest) Act 1998.

Performance against the Code for 2024-25 is set out below:

Better payment practice 2024-25	Foundation Trust Number	Foundation Trust £'000
Non-NHS		
Total bills paid in the year	58,188	142,556
Total bills paid within target	44,811	110,863
Percentage of bills paid within target	77.0%	77.8%
NHS		
Total bills paid in the year	1,829	7,618
Total bills paid within target	1,501	5,817
Percentage of bills paid within target	82.1%	76.4%
Total		
Total bills paid in the year	60,017	150,174
Total bills paid within target	46,312	116,680
Percentage of bills paid within target	77.2%	77.7%

Performance against the Code for 2023-24 is set out below:

Better payment practice 2023-24	Foundation Trust Number	Foundation Trust £'000
Non-NHS		
Total bills paid in the year	68,222	157,615
Total bills paid within target	64,102	144,576
Percentage of bills paid within target	94.0%	91.7%
NHS		
Total bills paid in the year	1,657	9,000
Total bills paid within target	1,407	8,020
Percentage of bills paid within target	84.9%	89.1%
Total		
Total bills paid in the year	69,879	166,615
Total bills paid within target	65,509	152,596
Percentage of bills paid within target	94.0%	91.6%

Information on fees and charges

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

		2024-25	2023-24	2022-23
	Expected sign			
Income	+	18,782	19,602	17,753
Full cost	-	15,659	15,239	15,561
Surplus/Deficit	+/-	**3,123**	**4,363**	**2,192**

Income Disclosure

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

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff, and external bodies that generate income which cover the cost of the service. These services are self-funded with their own staff and do not distract from the core service of patient care. Surpluses generated from these income generating activities are used to enhance patient care. Services that generate income include payroll services, accommodation, catering, car parking, private patient treatment, pharmacy products. The total income from all these areas amounted to around £10.6 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £10.4 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £3.5 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.

Cara Charles Barks
Group Chief Executive (Accounting Officer)
27 June 2025 (on behalf of the Trust Board)

REMUNERATION REPORT

Chair of the Remuneration Committee's Annual Statement on Remuneration

In accordance with the requirements of NHS England and NHS Improvement, this remuneration report consists of the following parts:

- An Annual Statement on remuneration
- The Senior Manager Remuneration Policy
- The Annual Report on remuneration

Remuneration/ Nominations Committee

As the Chair of the Remuneration Committee, I am pleased to present our remuneration report for 2024-25.

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors. One of the Trust's Non-Executive Directors is chair of the Remuneration Committee and all Non-Executive Directors, and the Trust Chair are members of the committee.

The Remuneration Committee reviews the salaries and where relevant, the individual reward packages of the Executive Directors. Most other staff within the NHS have contracts based on Agenda for Change national terms and conditions, which is the single pay system in operation in the NHS. Doctors, dentists, senior managers and directors have separate terms and conditions. Pay circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change. The Trust follows these nationally set pay polices in negotiating with Trade Unions on areas of local discretion.

Attendance at the Remuneration Committee for 2024/25 is shown below;

Remuneration Committee Attendance		
Name	**Role**	**Attendance / possible attendance**
Ian Green	Trust Chair	6/6
Rakhee Aggarwal	Chair of the Committee / Non-Executive Director	5/6
Tania Baker	Non-Executive Director	0/0
Michael von Bertele	Non-Executive Director	4/5
David Buckle	Non-Executive Director	2/5
Margaret (Eiri) Jones	Non-Executive Director	6/6
Debbie Beaven	Non-Executive Director	5/6
Richard Holmes	Non-Executive Director	5/6
Kirsty Matthews	Non-Executive Director	2/6
Paul Cain	Non-Executive Director	3/6
Anne Stebbing	Non-Executive Director	4/5

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

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2024 -25. Salaries are set in comparison with those given to holders of equivalent posts within the NHS. Advancement within the individual salary scales of Executive Directors is based on successful appraisal outcomes and this is the only performance-related element of the Executive Director's remuneration. The Remuneration Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chair advises the committee on the performance of the Chief Executive.

Senior managers have the authority or responsibility for directing and controlling the major activities of the Trust and for Salisbury NHS Foundation Trust this covers the Chair, the Executive and Non-Executive Directors. It is important to note that the Remuneration Committee of the Board has responsibility for setting the terms and conditions for the Executive Directors, while responsibility for setting the terms and conditions for the Chair and Non-Executive Directors lies with the Council of Governors, which is advised by the Performance Committee.

2024-25 major decisions on remuneration

During 2024-25, the Remuneration and Nominations Committee conducted the following business.

- Recognised the annual pay increase for Very Senior Managers VSM as laid out in guidance shared from NHS England by 5% with effect from 1 April 2024.
- Approved the process for the Group CEO Recruitment, the appointment of Cara Charles - Barks (CCB) as Group CEO and the remuneration package.
- Approved the creation of the Managing Director post and the recommendation to appoint Lisa Thomas as the Interim Managing Director for Salisbury NHS Foundation Trust.
- Approved the process, appointment and salary of the CMO.
- Appraisal and remuneration of Executive Directors.
- Approved the creation of a Group Transformation & Innovation Officer and a Group Strategy Officer, the job descriptions and the remuneration.
- Approved the extension of the secondment agreement for the Chief Finance Officer for a further six months in lieu of the move to a group structure pending legal advice.
- Approved the extension to the secondment agreement for the Chief Operating Officer to March 2025.
- Approved the promotion of the Associate Director of Transformation for 12 months fixed term to Board level (non-voting)

The changes to the Trust's Executive team during 2024-25 were:

- Appointment of Cara Charles - Barks as Group Chief Executive Officer from 1st November 2024.
- Appointment of Lisa Thomas as Interim Managing Director from 1st November 2024.

- Appointment of Duncan Murray as the substantive Chief Medical Officer from October 2024

Rakhee Aggarwal
27 June 2025
Non-Executive Director / Remuneration Committee Chair

Senior Managers' Remuneration Policy

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

The remuneration of the Chief Executive and Executive Directors (with the exception of the Chief Medical Officer*) is determined by the Board of Directors' Remuneration Committee considering market levels, key skills, performance, and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

*The pay, terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer. The Chief Medical Officer is eligible to apply for discretionary performance-related pay under Medical Terms and Conditions.

The Trust's overarching approach to remuneration is designed to ensure that senior managers' remuneration supports its strategy and business objectives. The approach has been developed to support the provision of high-quality services for patients through its strategic aim of delivering an outstanding experience for every patient, financial stability, and improved service performance. The Trust is mindful of a broad range of factors in setting this approach including reference to the Trust Equality and Diversity and Inclusion policy the aim of which is to foster a more equitable, diverse, and inclusive environment, enhancing the sense of belonging for all staff and empowering them to thrive at work and reach their full potential with dignity and respect.

There is particular mention of the Trust Board of Directors responsibilities for ensuring that the organisation complies with its legal and regulatory obligations under the Equality Act and the public sector equality duty.

This includes ensuring that the Trust:

- Provides equal opportunities for all employees and service users, regardless of their protected characteristics.
- Promotes diversity and inclusion in the workplace and in the delivery of services.
- Eliminates discrimination and harassment.

The Chief Executive Officer has ultimate responsibility for equality, diversity and inclusion, but this responsibility has been delegated to the Chief People Officer.

The Trust Board will receive for assurance and ratification, a range of equality, diversity and inclusion reports to ensure that the Trust is meeting its legal obligations and to identify any areas for improvement, these include the publication of annual NHS workforce race equality standard (WRES) and workforce disability equality standard (WDES) and Gender pay reports in May and October respectively.

The Trust's remuneration principles are that rewards to senior managers should enable the Trust to:

- Attract, motivate, and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients.
- Align remuneration with objectives that match the long-term interests of the Trust.
- Drive appropriate behaviours in line with the Trust's values.
- Focus senior managers on the business aims and appraise them against challenging objectives.
- Comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS Constitution and Care Quality Commission and meet the standards set within the Trust Equality, Diversity and Inclusion Policy.

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership.	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs

	Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: • Improving the health and wellbeing of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work	payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and benchmarked against the NHSI Guidance for pay for senior managers.	between 1 April and 31 March.
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short- and long-term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic goals stated in the basic salary component.	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

The components above apply generally to all Executives and there are no arrangements that are specific to an individual Executive Director. The Remuneration Committee adopts the principles of the Agenda for Change framework when considering Executive Director's pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale, even if individual directors meet their annual objectives.
The performance measures were chosen to reflect the Trust's adopted values and behaviours alongside its strategic goals which form the basis for Directors' performance objectives. Objectives for each Executive are agreed at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). The objectives / performance measures, alongside the refreshed national leadership competencies, are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-Executive Directors does have the authority to decide on whether any pay or remuneration increase should be awarded each year based on performance.

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

Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSE guidance for pay for senior managers.

Remuneration of Non-Executive Directors

Element of pay (Component)	How component supports short- and long-term strategic objective of the Trust	Operation of the component	Performance metric used and time period
Basic remuneration	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of: • Improving the health and wellbeing of the population we serve.	It is one single pay point based on research of NHS remuneration for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee

	• Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work.		
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A
Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

*Non-Executive Directors Fees: Responsibility for setting the terms and conditions for the Chair and Non-Executive Directors lies with the Council of Governors. The policy on remuneration is that the Non-Executive Directors are paid a basic salary (see Salary Scales). No additional duties which require a fee are carried out by the Non-Executive Directors.

Statement of consideration of employment conditions elsewhere in the Trust

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

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

Annual Report on Remuneration

Service contracts obligations

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

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

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

Name	Role	Current term of office	Notice Period (months)
Ian Green	Chair	Commenced February 2023 (3-year term)	3
Rakhee Aggarwal	Non-Executive Director	Commenced January 2023 (3-year term)	3
Tania Baker	Non-Executive Director	Commenced May 2022 (2-year term) Left on 31/05/2024	3
Michael von Bertele	Non-Executive Director	Commenced October 2022 (2-year term) Left on 30/10/2024	3
David Buckle	Non-Executive Director	Commenced January 2023 (3-year term) Left on 30/10/2024	3
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2022 (3-year term)	3
Richard Holmes	Non-Executive Director	Commenced January 2023 (3-year term)	3
Debbie Beavan	Non-Executive Director	Commenced January 2023 (3-year term)	3
Paul Cain	Non-Executive Director	Commenced June 2024(3-year term)	3
Kirsty Matthews	Non-Executive Director	Commenced June 2024(3-year term)	3
Anne Stebbing	Non-Executive Director	Commence July 2024(3-year term)	3
Peter Collins	Chief Medical Officer	Commenced October 2020 Resigned October 2024	6
Duncan Murray	Chief Medical Officer	Commenced October 2024	6
Judy Dyos	Chief Nursing Officer	Commenced June 2020	6
Mark Ellis	Interim Chief Finance Officer	Commenced August 2022	6
Lisa Thomas	Interim Chief Operating Officer Interim Chief Executive Officer Interim Managing Director	Commenced August 2022 Commenced February 2024 Commenced November 2024.	6
Niall Prosser	Interim Chief Operating Officer	Commenced February 2024	6
Melanie Whitfield	Chief People Officer	Commenced September 2021	6
Cara Charles Barks	Group Chief Executive	Commenced November 2024	6

The remuneration and expenses for the Trust Chair and non-executive directors are determined by the Council of Governors, taking account of any National guidance.

Disclosures in accordance with the Health and Social Care Act

Expenses for Senior Managers and Governors

Year	Number of Directors in Office	Number of Directors Reimbursed	Amount Reimbursed to Directors	Number of Elected Governors in Office	Number of Elected Governors Reimbursed	Amount Reimbursed to Elected Governors
2024/2025	19	10	£12,920	13	1	£54
2023/2024	15	5	£4,575	22	0	£0
Expenses incurred during the course of their duties relate to travel, accommodation and subsistence. Directors include those who were in post in an interim capacity during the year						

Salary and Pension Entitlement

Set out below is a table disclosing the single total figure of remuneration for each person occupying a director post. This includes all remuneration paid by the Trust to the individual in respect of their service for the Trust, including remuneration for duties that are not part of their management role. There have been no payments made to directors relating to non-management roles in 2024-25.

Name and Title	Remuneration Year to 1 April 2024 - 31 March 2025					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ian Green - Chairman	45-50	0	0	0	0	45-50
Tania Baker - Non-Executive	0-5	0	0	0	0	0-5
Michael von Bertele - Non-Executive	5-10	0	0	0	0	5-10
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15

Name and Title	Remuneration Year to 1 April 2024 - 31 March 2025					
	Salary (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Annual Performance Related Bonus (bands of £5000) £000	Long-Term Performance Related Bonus (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Margaret (Eiri) Jones - Non-Executive	15-20	0	0	0	0	15-20
David Buckle - Non-Executive	5-10	0	0	0	0	5-10
Richard Holmes - Non-Executive	10-15	0	0	0	0	10-15
Debbie Beavan - Non-Executive	10-15	0	0	0	0	10-15
Paul Cain - Non-Executive	10-15	0	0	0	0	10-15
Kirsty Matthews - Non-Executive	10-15	0	0	0	0	10-15
Margaret Stebbing- Non-Executive	10-15	0	0	0	0	10-15
Cara Charles-Barks (33%)	40-45	0	0	0	15-20	55-60
Lisa Thomas - Interim Chief Executive and Managing Director	180-185	0	0	0	160-165	340-345
Peter Collins - Chief Medical Officer	110-115	0	0	0	0	110-115
Duncan Murray – Chief Medical Officer	150-155	0	0	0	285-290	435-440
Judy Dyos - Chief Nursing Officer	140-145	0	0	0	85-90	225-230
Mark Ellis - Interim Chief Finance Officer	130-135	0	0	0	55-60	185-190
Niall Prosser – Interim Chief Operating Officer	130-135	0	0	0	27.5-30	155-160
Melanie Whitfield - Chief People Officer	145-150	0	0	0	40-45	185-190

This table is subject to audit

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

Name and Title	Remuneration Year to 1 April 2023 - 31 March 2024					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Ian Green – Chairman	45-50	0	0	0	0	45-50
Tania Baker - Non-Executive	10-15	0	0	0	0	10-15
Michael von Bertele - Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones - Non-Executive	15-20	0	0	0	0	15-20
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Richard Holmes - Non-Executive	10-15	0	0	0	0	10-15
Debbie Beavan - Non-Executive	10-15	0	0	0	0	10-15
Stacey Hunter - Chief Executive	165-170	0	0	0	0	165-170
Lisa Thomas - Interim Chief Operating	155-160	0	0	0	0	155-160

Name and Title	Remuneration Year to 1 April 2023 - 31 March 2024					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Officer/ Interim Chief Executive						
Peter Collins - Chief Medical Officer	195-200	0	0	0	0	195-200
Judy Dyos - Chief Nursing Officer	125-130	0	0	0	7.5-10	135-140
Mark Ellis - Interim Chief Finance Officer	115-120	0	0	0	0	115-120
Niall Prosser – Interim Chief Operating Officer	20-25	0	0	0	30-32.5	50-55
Melanie Whitfield - Chief People Officer	130-135	0	0	0	35-37.5	165-170

This table is subject to audit

- *Stacey Hunter left the Trust on 31st January 2024*
- *Lisa Thomas commenced as Interim Chief Executive Officer on 1st February 2024*
- *Niall Prosser commenced as Interim Chief Operating Officer on 5th February 2024*

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

Pension related benefits in 23/24 were affected by 'rollback' (see notes to remuneration tables).

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 31 March 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2024	Employers Contribution to Stakeholder Pension
	(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000	To nearest £100
Peter Collins Chief Medical Officer*	2.5-5	0	70-75	190-195	0	10	1,563	0
Judy Dyos Chief Nursing Officer*	2.5-5	5-7.5	45-50	115-120	1,020	88	858	0
Lisa Thomas Interim Chief Operating Officer/ Interim CEO *	7.5-10	15-17.5	55-60	150-155	1,213	147	977	0
Niall Prosser Interim Chief Operating Officer	0	0	25-30	70-75	522	0	592	0
Melanie Whitfield Chief People Officer	2.5-5	0	20-25	0	342	35	270	0
Cara Charles-Barks Group Chief Executive Officer	2.5-5	2.5-5	55-60	125-130	1219	39	982	0
Duncan Murray Chief Medical Officer	12.5-15	32.5-35	80-85	220-225	2,008	307	1,415	0
Mark Ellis Interim Chief Finance Officer*	2.5-5	2.5-5	30-35	80-85	634	47	535	0

**Individual affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero (see further details below). This table is subject to audit.*

Notes to Remuneration and Pension Tables

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.
The accounting policies for pensions and other retirement benefits and key management compensation are set out in the Note 1.6 to the accounts

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

Cash Equivalent Transfer Values

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Group Chief Executive Officer

It has been agreed that each Trust will put the full amount of pension benefits for Cara Charles-Barks and each Trust needs to disclose all of the pension in the remuneration table.

Pay ratio information

This section is subject to audit

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024-25 was £210-215,000 (2023-24 £195-200,000). This is a change between years of +20%, this is due to a change in Medical Director in 2024-25 and the resulting difference between points on Consultant pay scales.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2024-25 was from £14,000 to £240,000 (2023-24 £14,000 to £249,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 3.2% (2023-24 6.3%). One employee received remuneration more than the highest-paid director in 2024-25 (2023-24 fifteen employees).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

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

2023/2024	25th percentile	Median	75th percentile
Salary component of pay	24,336	34,581	42,618
Total pay and benefits excluding pension benefits	25,839	36,242	48,865
Pay and benefits excluding pension: pay ratio for highest paid director	7.55	5.38	3.99

The banded remuneration of the highest paid director was 5.38 times the median remuneration of the workforce in 2023-24. The Trust's median remuneration increased in 2024-2025 compared with the previous year due to National pay awards.

Payments for loss of office

There were no payments made to senior managers for loss of office in 2024-25.

Payments to past senior managers

None to report in 2024-25.

The Remuneration Report has been approved by the Trust Board.

Cara Charles - Barks
Group Chief Executive (Accounting Officer)
27 June 2025 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs

Analysis of Average Staff Costs	Total 2024-245 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	229,503	229,426	78
Social security costs	21,269	21,269	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	23,352	23,352	0
Paid by NHSE on provider's behalf (6.3%)	10,231	10,231	0
Pension cost – other	20	20	0
Temporary staff/agency contract staff	15,473	0	15,473
Apprenticeship levy	1,006	1,006	0
TOTAL STAFF COSTS	300,854	285,303	15,551
Less: Costs capitalised as part of assets	2,621	2,621	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	298,233	282,682	15,551

Analysis of average staff numbers (subject to audit)

	Total 2024-25	Permanently employed 2024-25	Other 2024-25	Total 2023-24	Permanently employed 2023-24	Other 2023-24
Medical and Dental	550	508	42	654	358	297
Administration and Estates	1,448	1,361	87	1526	1294	233
Healthcare assistants and other support staff	765	663	102	843	675	169
Nursing, midwifery & health visiting staff	1,305	1,180	125	1261	1115	146
Scientific, therapeutic and technical staff	502	477	25	606	525	81
Total	**4,570**	**4,189**	**381**	**4890**	**3965**	**925**

The figure shown under the other column relates to other staff engaged on the objectives of the organisation such as, short term contract staff, agency/temporary staff, locally engaged staff overseas and inward secondments where the organisation is paying the whole or most of their costs.

The comparative numbers have been restated to bring them in line with the occupation codes within the electronic staff record, the NHS human resource and payroll database system.

The number of male and female directors, senior managers and employees

31 March 2025

Head Count	Female	Male	Total
Directors	8	6	14
***Senior managers**	16	8	24
All other staff	4,256	1,479	5,735

**Senior managers are defined as members of the Trust Management Committee which provides a forum for the Chief Executive, supported by the Executive Directors and Clinical Directors, to advise on the strategic direction of the Trust and the Trust's involvement in the wider health economy. Senior managers in this context include members of the Trust Management Committee who are not included in the two remaining groups.*

Staff Turnover

Staff turnover information can be found on the NHS Digital website:

NHS Workforce Statistics, March 2025 - NHS England Digital

Sickness Absence

Year April March	Overall absence days lost	% of total available days	% Short term <28 days	% Long term >28 days	Absence Recorded with No reason given
23/24	30,263	3.67%	1.3%	2.37%	0.41%
24/25	56,559	3.84%	1.42%	2.42%	0.07%
25/26 Forecast	*33,544*	*3.5%*	*1.4%*	*2.1%*	*0.07%*

The total number of days lost due to sickness rose in the period between April 2024 and March 2025 largely due to an increase in overall workforce size and a higher rate of short-term sickness absence instances. The percentage of days lost as a proportion of all staff increased from 3.67% in 2023/24 to 3.84% this year, reducing staff availability across the Trust. The single most prevalent reason for sickness absence has continued to be

anxiety/stress/depression which accounts for c25% of all sickness absence. Services have been impacted due to the increase of short-term intermittent absence, through cough/cold/flu which during the winter months accounted for c.30% of absence. This is despite SFT still achieving some of the highest % for staff flu vaccinations in the South West. Finally, Musculo skeletal injuries make up the third highest contributing factor at c 9% of all absences, these often tend to be longer term problems, hence the numbers of staff are lower, but days lost generally higher. Throughout the year, the proportion of long term (60%) and short-term sickness absences (40%) has been broadly consistent. The overall proportion of sickness absence remained above the Trust target of 3% but has benchmarked positively against peers in the SW region.

The data for absence recorded with no reason fell to nominal levels (0.4% to 0.07%) reflecting an improved management system and greater accuracy of absence recording from Line Managers. Absence data being recorded on E-roster has contributed to this improvement, and support has also been provided via the Employee Relations team to deliver management training on improving attendance management, encouraging staff wellbeing and how to support staff who require reasonable adjustments in the workplace.

The 2025/26 Forecast assumes a 4% reduction in workforce (Staff in post) and an average 3.5% absence rate, with improved actions to reduce short term sickness absences.

The ‘we are safe and healthy’ working group continues to promote and develop activities and initiatives to support the wellbeing of our workforce. Our Trust Staff, Access, Learning, Information (SALi) intranet site has a dedicated portal which provides line managers and staff with a single entry point to resources and guidance to support physical and mental health and financial wellbeing, this portal was subject to a significant overhaul this year, which has made access when away from a Trust computer easier, broadened and updated the content and made navigation on the site simpler. The ‘my first ninety days’ induction programme includes a safe and healthy day, providing improved guidance and advice for new members of staff. With generous funding from The League of Friends we have continued to refurbish rest rooms for staff, involving them in their design and layout, to enable our staff with the opportunity to take a more comfortable break away from the busy working environment.

We have continued to provide a physiotherapy service for staff and have continued to enable a single self-referral process for staff seeking support with Anxiety, Stress and Mental Health conditions to access talking therapies and clinical psychological support.

Training interventions to support line managers to hold skilful wellbeing conversations with their staff have continued and financial webinars continue to be delivered throughout the year. The uptake on all these sessions is good, and feedback positive. We have recently regenerated a community of practice to support our Mental Health First Aiders with training, peer encouragement and trends analysis, seeking to improve this key voluntary service within the Trust.

The Trust continues to monitor health intelligence through a series of quarterly meetings which enables the triangulation of data between stakeholders, including our Occupational Health team, Health and Safety Manager, Employee relations lead, Patient safety team and Freedom to Speak Up Guardian, which in turn supports the identification of improvement plans. The wellbeing plan will be refreshed in the early part of next year, alongside the delivery of a women’s health strategy for the Trust.

People Policies

Our People policies are crucial to ensure we provide a structured framework for managing our staff in a consistent, fair, and legally compliant manner. In 2024/25 we continued the cyclical and important work to review, refresh, publish and communicate new and updated policies for our workforce. Part of the communication plan has been a series of breakfast clubs designed to support line managers in their understanding of the detail and implementation of key polices.

Not only do our People policies provide vital information for our workforce they support the development of a positive, respectful and inclusive workplace culture aligned with our Trust values. Key policies that have either been introduced or updated this year have included:

- **Sexual Safety Policy.** This new policy supported the implementation at SFT of the NHS Sexual Safety Charter. We are committed to a zero-tolerance approach to sexual misconduct in the workplace to create a workplace where everyone feels safe and the policy aims to ensure that everyone understands what actions to take when someone in the organisation discloses or reports sexual misconduct.

- **Supporting People with Disabilities Policy.** We updated this policy to reflect the supportive nature required for staff with disabilities and introduced an SFT Health Passport which is a user-friendly, proactive tool which can be used to ensure line managers are able to support staff in fulfilling roles at work.

- **E-Roster Policy.** A complete re-write has streamlined policy to complement the work the E-roster team lead with the wider workforce in relation to staff management and reporting on the E-Roster platform.

- **Bank & Agency Use Policy**. Policy re-written as part of the Temporary Staffing improvement project, recommendations for the Temporary staffing audit and the changes to the NHSE Agency use and rules.

- **New Parent Policy** – updated to reflect the introduction of neo-natal leave. Neonatal Care leave is a new statutory right giving eligible employees up to 12 weeks of paid leave if their baby requires neonatal care within the first 28 days after birth. The leave is in addition to existing entitlements such as maternity, paternity, adoption and shared parental leave.

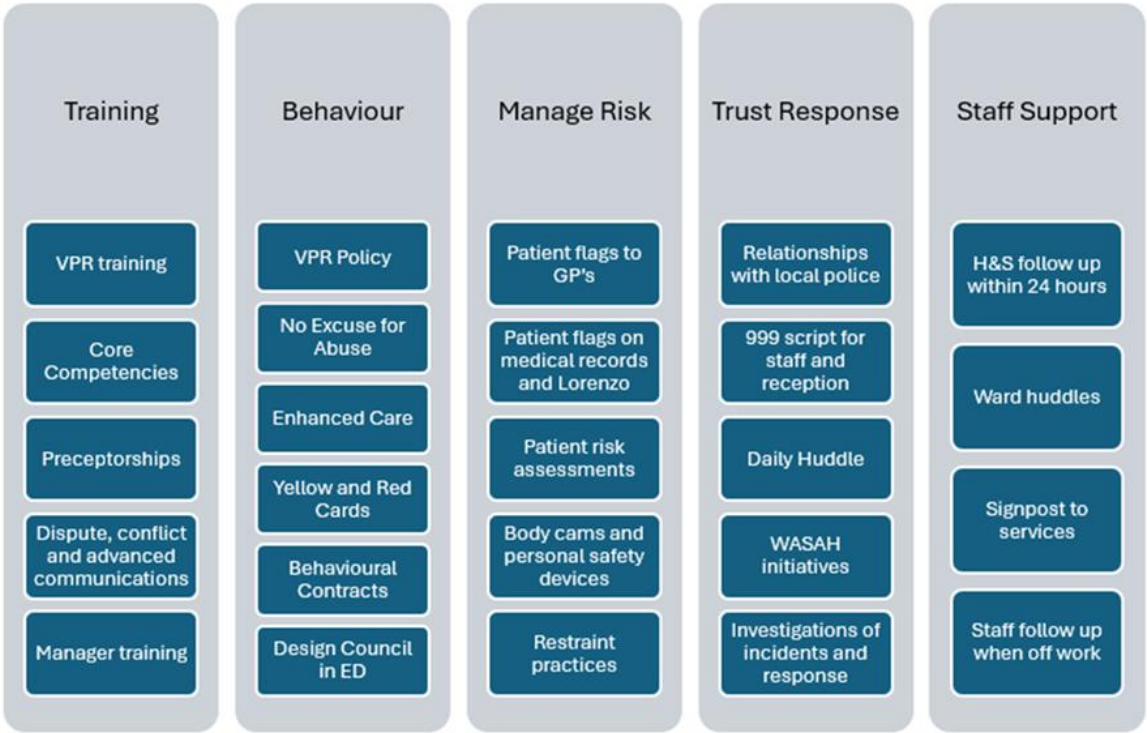
Our plan for 2025/26 seeks to continue our journey in embedding a restorative, just and learning approach to our key people policies with particular emphasis on new disciplinary and performance management policies which help mitigate risks like harassment and discrimination by clearly defining acceptable behaviour and processes to follow. Development of our policies continues in partnership with our Joint Consultative Committee colleagues to ensure our policies are not only legally compliant, but improve readability, ease of implementation and support updated ways of working.

Health and Safety (H&S)

The H&S team provides an assurance, response and technical support function for each Division. Their first function remains the implementation of a formal H&S management system developed against internationally accredited standards. H&S Activity is supported by a published schedule of risk, inspection and audit activity. During 2024-25, to increase audit capacity, members of the H&S team completed formal H&S audit training. Audits against the management system schedule included; Medical Devices, Medical Engineering, Wessex Rehabilitation and Sarum Ward. Task analysis activity continued as scheduled throughout the year to formally review the management of risks to the H&S of staff and annual ward inspections were introduced having been paused as part of the response to Covid.

More than 600 incidents, hazards, injuries and near misses were reported in 2024-25. The H&S team is tasked with responding to 90% of H&S related incident reports on Datix within 1 working day. This Key Performance Indicator (KPI) was met in year with over 560 incidents followed up within this timeframe (92%). The Trust also has a legal obligation to report all reportable injuries (RIDDOR) to the Health and Safety Executive (HSE) within a prescribed timeframe. RIDDOR incidents, of the type recorded at the Trust (incapacity greater than 7 days) must be reported to the HSE within 14 days. The H&S team has committed to reporting within 10 days. In year, all injuries that fall under the definition of a RIDDOR were reported within 10 days of being reported on Datix.

Incidences of violence and aggression remain the most reported incident and injury causation. Over the past 18 months the Trust, with the support of the Violence Prevention and Reduction Working Group (chaired by the H&S Manager), has taken a significant number of steps to reduce the risk of violence and aggression against staff and improve the support offered to our colleagues. An overview of the tools, resources and actions available to manage violence and aggression in the workplace are seen below.



Finally, the H&S team provides a fit test function to ensure respiratory protection is provided to staff exposed to, or likely to be exposed to infections transmitted via respiratory route. Standard practice for named pathogens is to ensure staff have an FFP3 mask that is fitted to the size and shape of an individual's face. Fit testing is conducted by way of smell and taste testing and computerised testing on a Portacount machine. 2024-25 saw several challenges with masks being discontinued by manufacturers and subsequently rationed. The Fit Test Team continued to provide a testing service and ensured the availability of masks for staff to use by reducing appointment waiting times, daily ordering of stock and fit testing staff in departments when unable to attend appointments in the fit testing suite. Scheduling of appointments was moved to our Managed Learning Environment (MLE) (Learn) where ward compliance can be measured and reported. The Fit Test Team continue to work with local wards to improve overall compliance now that better suited masks, with improved compliance results, are available to staff.

The Fit Test Team complete, on average, 204 appointments a month which has recently increased to 278 a month including extra days undertaken to complete fit tests for new medical students and weekend appointments to cover shift workers who work weekends, nights and evenings only.

Staff Survey

Reporting year 2024 was the fourth year when the Annual NHS Staff Survey questions were aligned to the NHS People Promise, seeking to track progress against our ambition to make Salisbury Foundation Trust (SFT) the 'best place to work'. The 2024 Staff Survey reported against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

Our response rate for the 2024 survey was 59% (2622 responses) compared with 54% for the 2023 survey. By comparison the median response rate in 2024 for our benchmarking group[1] was 48.6%. This represents a positive increase in responses, and it was pleasing to also see a broader spread of staff groups engaged with the survey, ensuring that results were more equitable across the trust.

In the 2023 NHS Staff Survey, a particular concern was the response rate from Healthcare Assistants and others in the Additional Clinical Services staff group. Particular attention was paid to these colleagues with added incentives to complete the survey. The result was a spectacular 20% increase which saw the number of Additional Clinical Services staff responding increase from 20.4% in 2023 to 41% in 2024.

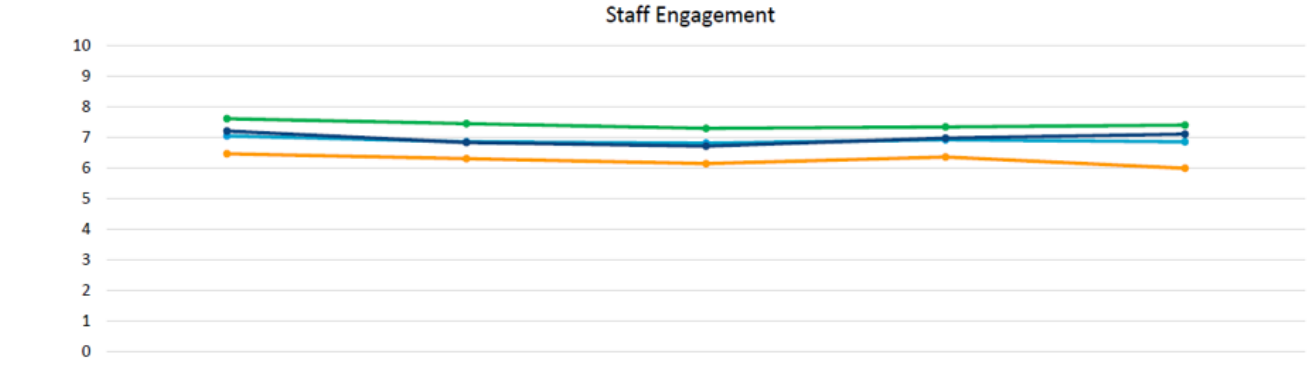
At the start of the year, we set clear ambitions about the scores we aspired to in the 2024 survey, progressing towards an ambition of reaching the upper quartile in all areas in the 2025 survey. It was therefore pleasing that in the 2024 survey seven of the nine core indicators were ranked in the top quartile of acute trusts. Notably within our benchmarked group, SFT was, for the second year running, identified as the most improved Trust in England and England's top acute Trust for staff who look forward to coming to work.

Scores for each indicator together with the average, best and worst scores in the benchmarking group across the NHS are presented below for 2024:

[1] Acute and Acute and Community Trusts

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

Theme: Staff Engagement



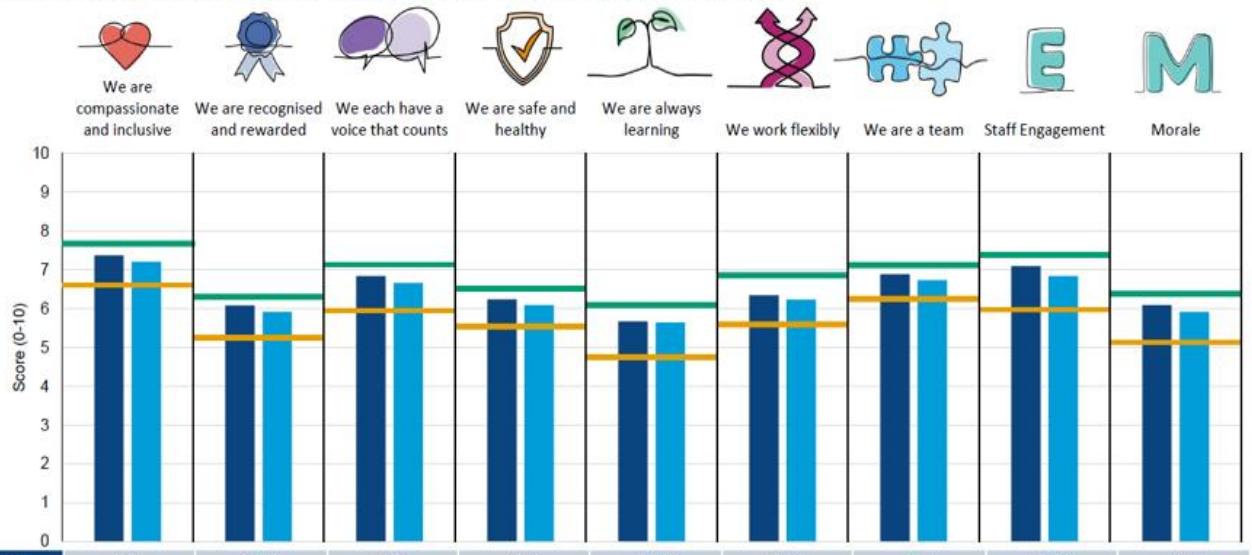
	2020	2021	2022	2023	2024
Your org	7.19	6.82	6.70	6.96	7.09
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	2041	1858	1859	2254	2640

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

People Promise elements and themes: Overview

Survey Coordination Centre NHS

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



Your org	7.38	6.09	6.85	6.24	5.67	6.35	6.89	7.09	6.09
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2639	2637	2613	2622	2505	2626	2637	2640	2640

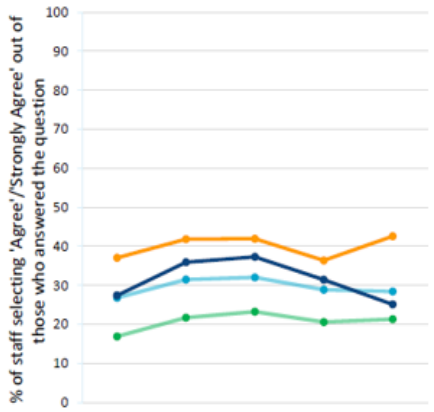
Retention: More people stay within our workforce and take up opportunities of promotion or changes of role

NHS Salisbury NHS Foundation Trust

Vision metric

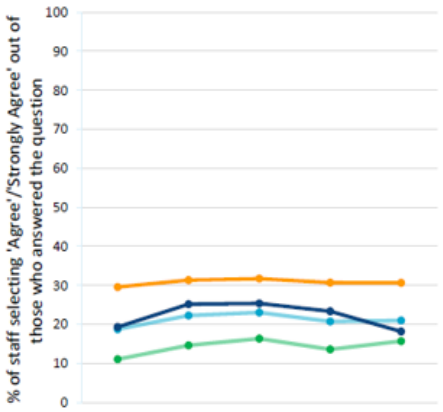
Measurement: Reduction of unwanted turnover (people leaving the Trust or the NHS. All questions are better than average – this is better than last year when SFT's position on all scores was worse than the national average

Q26a I often think about leaving this organisation.



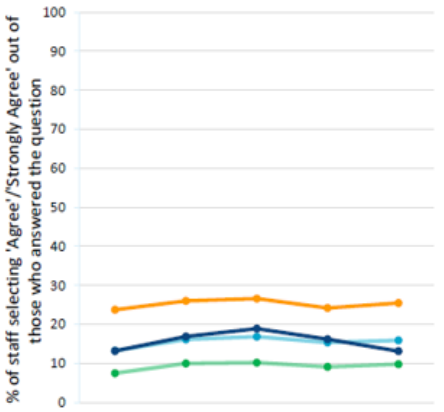
	2020	2021	2022	2023	2024
Your org	27.39%	35.90%	37.28%	31.43%	25.09%
Best result	16.88%	21.69%	23.23%	20.56%	21.30%
Average result	26.80%	31.47%	32.02%	28.87%	28.43%
Worst result	37.07%	41.84%	41.90%	36.37%	42.58%
Responses	2001	1790	1845	2250	2634

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



	2020	2021	2022	2023	2024
Your org	19.30%	25.14%	25.36%	23.33%	18.16%
Best result	11.04%	14.62%	16.33%	13.58%	15.68%
Average result	18.73%	22.25%	23.04%	20.73%	20.98%
Worst result	29.56%	31.32%	31.70%	30.70%	30.62%
Responses	1996	1789	1844	2251	2633

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



	2020	2021	2022	2023	2024
Your org	13.16%	16.87%	18.88%	16.19%	13.10%
Best result	7.47%	9.95%	10.19%	9.10%	9.76%
Average result	13.23%	16.15%	16.83%	15.32%	15.87%
Worst result	23.73%	25.99%	26.60%	24.17%	25.47%
Responses	1997	1784	1839	2245	2625

Future priorities and targets

SFT has now transitioned from being one of the first People Promise Exemplar Sites to incorporating all the elements of the people promise into our people plan workstreams. By outlining clearly our long-term and in-year ambitions we have used a series of projects and identified workstreams to improve the staff experience at SFT.

The People Promise is designed to encourage the retention of our staff by addressing the key challenges experienced by our staff. We aim to reduce numbers of staff leaving the Trust and to develop more coherent talent management plans to support the careers of those who stay with us. We are paying attention to the employee journey at every step from work experience, attraction, induction, recruitment, job satisfaction and promotion through to retirement. Of note this year has seen a continued increase in skills and knowledge of our line managers and leadership teams – and this has been reflected in the National Staff Survey results.

We want to be recognised as an inclusive employer. We have identified some areas within our staff survey results relating to disability and race that warrant further work in the coming year. Action plans are in place to continue to improve the sense of belonging and equity for all staff in the Trust, these include improved Cultural Awareness training, specific induction activities and support for internationally recruited staff as well as increased vigilance to support a more equitable recruitment process. The launch of our Health Passport is expected to enable staff who are living with a long-term condition to identify reasonable adjustments required to support their work more effectively.

Steps have been taken to increase the profile of staff networks and their members with events such as South East Asia day, a celebration of Pride and a groundbreaking Bhangra Night. Attendance at the prestigious staff awards evening has become more representative of the whole workforce.

Following the launch of our monthly listening events, including the '*Hearing It'* sessions led by the CPO and CEO and the 100-day and one year anniversary events hosted by our Chief People Officer (CPO) and Organisational Development ad People (OD and P) senior team, we recognise the positive impact that listening and working with colleagues to resolve issues has within the organisation. Our listening report, launched in 2024 has been well received.

Our People Promise programme and the divisional action plans generated in response to staff survey results will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board.

Staff engagement

Identified as a vision metric within the Improving Together methodology, Staff Engagement is a priority with the Trust aiming to achieve top quartile status against peer organisations in our staff survey results. In 2024 the National Staff Survey score of 7.09 placed SFT as 18th overall for staff engagement, a very positive result reflecting the work of the Trust to engage staff more effectively.

In addition to our *Hearing it* events, we also introduced a Staff Council this year and so widening our Staff participation alongside the more formal partnership working with our union and professional body representatives. In addition to the annual staff survey we host a quarterly Pulse Survey, making good use of the local questions option. Board safety walks - "Learning from you" and 'go and see' visits by members of the Executive team also continue to give staff the opportunity to engage directly with the senior management team. These occur regularly, visiting patient and non-patient facing areas, speaking to staff and listening to their concerns. Our regular Cascade briefings give the Trust the opportunity to share information and to take views from staff on a wide range of topics. We have maintained our regular daily Bulletin, a weekly Chief Executive message and a line manager's round up every Friday via e-mail.

The annual Staff 'Thank You' Week included the staff awards, family fun day and staff comedy night. Awards are presented covering a mix of categories from a Chair's award and the CEO Award to Best Team, Unsung Contribution and Sharing Outstanding Excellence (SOX) of the Year. In addition, we held a volunteer's lunch to recognise the contribution of our volunteers and we also held a Long Service Awards event. We continue to have regular peer to peer SOX Awards and SOX of the month that enable staff, patients and families to recognise the contributions made by their colleagues.

Following analysis of the 2023 Staff Awards guest list we looked to make changes to the organisation of the Awards to ensure that attendance was equitable. Changes made to the process saw a 34% increase in staff attending from a BME background, a 23% increase in additional clinical services staff and 42% increase in medical and dental staff. This prestigious event is now more representative of the SFT workforce.

2024 also saw the second Hospital Open Day. With over 1000 members of our local community visiting the hospital to meet staff and partner organisations. We held our second '*Tent Talks'*, supported by the Stars Appeal, a two-day festival of learning, wellbeing and fun for staff, volunteers, and partner organisations. This year, with family and friends invited, Tent Talks also included a groundbreaking Bhangra Night.

We are committed to being an active 'anchor' organisation within the Salisbury area. This requires our long-term sustainability to be aligned to the wellbeing of the population we serve. As such our Communications, Engagement and Community Relations team represents the Trust at the city Place Partnership (Chaired by John Glenn MP), are active within Experience Salisbury and are members of the city Cultural Pillar. It is this engagement with the community which has realised the 'beyond blue light' discount scheme now in place for our staff – this has included an exclusive discount with new department store Bradbeers.

Equality, Diversity & Inclusion (EDI)

This year has seen positive actions to continue to build a more inclusive and equitable workplace for all our staff. We value the diversity of our workforce, which includes individuals from over 85 countries, their global perspectives enrich our expertise and enhance the care we provide to our local community.

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

Ethnicity	Disability	Gender
Black and Minority Ethnic: 28%	Disabled 4%	Female 75%
White: 69.4%	Undeclared Disability Status: 4.2%	Male 25%
Undeclared Ethnicity: 2.5%		

Our seven staff networks[2] play an important role in amplifying diverse voices and fostering a supportive environment in which everyone feels they belong. We actively promote these networks and areas of shared interest through our comprehensive inclusion and wellbeing calendar. The calendar raises awareness, enabling the celebration of significant events, including exhibitions in the Healthcare Library; a bhangra evening; a South Asian Heritage event where over 250 staff enjoyed food and cultural performances; Black History Month celebration featuring powerful storytelling including the history of reggae and percussion rooted in African rhythms; and a summit on Menopause Support for all genders.

We have made steady progress against our 2023-24 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans, which include four WRES and three WDES objectives. Furthermore, the 2024 staff survey results relating to WRES and WDES metrics indicate that, with only one exception, all metrics show an improved experience for our Black Asian Minority Ethnic (BME) and disabled staff since 2023. Importantly, SFT performs at or better than the benchmarked average for peer trusts across all 13 metrics. Although this is a welcome improvement, we recognise that the gap in positive experience between our BME staff and White staff, and between our disabled staff and non-disabled staff, remains significant and we continue to implement the actions identified in our long term EDI plan to improve this situation. Data trends contained in the WRES/WDES and Gender Pay Gap reports are available on the Trust website (https://www.salisbury.nhs.uk/about-us/equality-diversity-and-inclusion/edi-reports/.)

[2] Ability Confident; Armed Forces; Carers; Men's Health; Multicultural; Pride Community; and Women's

As noted in our policies section, to enhance support for disabled staff, we have updated our "Supporting Disabled Staff at Work" policy and launched Health Passports. We delivered a neurodiversity awareness workshop in the autumn, and in March 2025, the Trust achieved validation as a Disability Confident Scheme Leader (Level 3). These and other initiatives support our ambition for the Trust to be an inclusive and equitable employer of choice for those with a disability and/or long-term condition.

We continue to collaborate within the Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS) to support the promotion of inclusion and wellbeing across the wider region.

Freedom to Speak Up

In conjunction with the wider OD&P team, our Freedom to Speak Up Guardian has worked hard to maintain improvement across all elements of the People Promise. 'We are Compassionate and Inclusive', 'We Each have a Voice that Counts' and 'We are Safe and healthy' remain the primary areas of focus for Freedom to Speak Up (FTSU), though their data and insights contributes across all elements of the people promise. Actions have included socialising and promoting the refreshed FTSU Policy in conjunction with supporting the development of people policies that now have a restorative approach when dealing with work related issues, leading to a less punitive culture. Anonymised data is now triangulated across the Trust to create thematic analysis to inform interventions and work alongside staff networks to identify barriers to speaking up. These areas of work have had a significant positive impact on our Staff Survey results.

The Trust's Guardian has direct access to all senior leaders including the newly appointed group Chief Executive and all Board members and also delivers training at a variety of events, including Trust Induction and Resident Doctors Core Training. This involvement helps to influence the creation of psychological safety in order that colleagues can raise concerns with confidence and assurance that they will be listened to and acted upon.

Themes and trends are reported quarterly through the People and Culture Committee to Board for assurance and to highlight lessons learned from concerns that have been raised. This year 129 concerns have been raised to the FTSU Guardian, a 20% decrease on the previous year. Of these, 35 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action. Themes from reporting are identified in the table below.

	Themes	Cases Q1 (24/25)	Cases Q2 (24/25)	Cases Q3 (24/25)	Cases Q4 (24/25)
1	Element of Patient Safety/Quality	2	9	11	13
2	Worker Safety	4	13	21	19
3	Element of other inappropriate attitudes or behaviours	11	21	20	28
4	Bullying/Harassment	6	7	7	4
5	Disadvantageous and/or demeaning treatment (detriment as a result of raising concerns)	2	2	3	3

**Please note that some cases record more than one theme*

Of the 129 concerns raised, 26.5 % were raised by staff from a Black, Asian or Minority Ethnic background which is a proportional representation of the BAME workforce. The FTSU Guardian works closely with the Multicultural Network to ensure that speaking up is promoted and any barriers that this particular staff group may face are discussed and addressed.

Of note, disability issues were connected to 6% of staff who raised concerns, a significant drop compared with 2023-24 at 12%. The reinvigorated staff networks and wellbeing offers that have been introduced will give more support and guidance in the future.

The total amount of concerns raised having an element of poor line manager competency, behaviours, or both is 53 (49%) compared to last year which was 63%, this reduction has been influenced by the management and leadership training packages that are offered by the OD&L team.

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, business cards are handed to every new member of staff.

Education and Apprenticeships

SFT supports the aim of creating a highly skilled workforce through a combination of three approaches.

- Mandatory, statutory, and additional valued core training is delivered via our on-line Managed Learning Environment (MLE).
- Core clinical skills and targeted situational clinical event management is delivered through our Practice Education Team, our clinical Simulation Team and several specialist Practice Educators based in service areas across the Trust.
- Additional training for continued professional development (CPD) has this year been provided through two routes, both coordinated by the Education Team. Firstly, the distribution of the NHSE CPD fund targeting Nurses, Midwives and Allied Health Professionals (AHPs), and secondly through an SFT-provided fund aimed at other staff groups who are not eligible for NHSE funding.

Funding source	Amount distributed	Total Number of staff who accessed funds
NHSE CPD fund	£459,504.00	519
SFT Trust funded CPD	£113,698.00	103

In total 622 clinical and non-clinical staff received funded support for training and development delivered by external trainers / providers.

The apprenticeship levy is an alternative source of funding for training and development and is a significant element in the Trusts commitment to a sustainable workforce and our role as an anchor institution. The levy funds are allocated direct to training providers to deliver

Apprenticeship Standards for our existing staff, potential new staff and can also be transferred to support local organisation that are non-levy contributors.

Apprenticeships have been taken up across all academic levels from Level 2 (GCSE Grade C/4) to Level 7 (Masters) across 29 different standards in both clinical and non-clinical specialities. There were 128 apprentices on programme across the organisation as of March 2025. 37 staff members completed their apprenticeship in 2024-25.

The table below shows the uptake of apprenticeships, and the monies provided to support our apprentices from the national levy.

	2022-23	2023-24	2024-25
Total Number of apprentices	143	160	165
Current Funds	£1,575,253	£1,788,691	£2,077,075
Total paid into levy	843279	£986,317	£1,073,735
Total Spend in Year	£579,197.20 Of which £71,377.58 (12.32%) was transferred to other organisations	£608,083 Of which £67,349 (11.1%) was transferred to other organisations	£621,054 Of which £48,857 (7.8%) was transferred to other organisations
Annual Expired Levy	£136,370.30	£148,666	£222,675

Qualifications gained by SFT staff include: Registered Nurse, Nursing Associate; Advanced Clinical Practice, Operating Department Practitioner, Senior Leader, Project manager, Cyber Security Technologist, Business Administration and Commercial Procurement and Supply.

The Apprenticeship Levy is used to pay the training providers to deliver training which makes up a minimum of 20% of the apprentices' time. SFT currently pays 0.5% of its total pay bill into the Apprenticeship Levy per month, with a cumulative total of £2.08 million available for us to access. Levy utilisation slightly increased this year compared to last. In 2024-25 the Trust spent £621,054, a 2.1% increase of spend. Any Levy not utilised within 2 years of being paid into the fund will expire and we recognise the opportunity to encourage further take up.

We continue to engage in apprenticeship offers with our partners at Coventry University and Wiltshire College to deliver Nursing Associate and Registered Nurse Degree Apprenticeships.

Leadership and Development

A key component of our leadership development is the Leadership Behaviours Framework, which integrates the principles of Improving Together methodologies alongside core NHS initiatives such as civility, compassion and inclusivity. This framework serves as the foundation for our leadership and management development programmes and is central to our team development efforts. Teams are supported in creating bespoke team charters that align with the behavioural framework, fostering a culture of shared responsibility and mutual respect. Furthermore, the framework has been embedded in our recruitment processes, with specially

designed interview questions and integration into our talent pathways through a tailored 360-degree feedback mechanism and performance appraisals.

The Organisational Development and Leadership (OD&L) team has further expanded its portfolio of leadership development initiatives, designing and implementing two new programmes to add to the development portfolio. The Rising Team Player Programme, which focuses on self-leadership, is specifically targeted at individuals who are not yet in formal leadership positions; and the Clinical Leads Programme has been introduced to support senior clinicians in their transition to leadership roles. These programmes align with our strategic objectives of fostering a compassionate and inclusive work environment, contributing to the overarching People Plan vision of making Salisbury the 'Best Place to Work'. Participation across the portfolio of leadership interventions has seen a significant increase, with attendance rising from 144 individuals in 2023/24 to 442 this financial year.

Our ongoing efforts in leadership development are yielding positive outcomes, as evidenced by the results of the Staff Survey. All areas associated with our initiatives have shown an upward trajectory. Moreover, the Trust has been recognised as the highest nationally for the response to the statement, 'I enjoy coming to work', which underscores our success in developing our leaders to foster a culture of engagement and satisfaction.

This year, OD&L team has also significantly expanded its suite of management development workshops, increasing the number of available workshops from 13 to 30. This expansion has led to a substantial increase in participation, with attendance rising from 503 individuals to 911. Looking ahead, we will continue to mature our offer with the introduction of our 'Licence to Manage' programme. This initiative focuses on core management competencies aligned with NHS England's leadership and management framework. Early indications suggest that this approach is already delivering positive outcomes, with a 50% reduction in Freedom to Speak Up cases related to poor management practices.

Salisbury NHS Trust recorded 57 active coaching relationships, of which 28 were directly linked to our leadership development programmes. Coaching provides valuable support for the application of learning in operational contexts. Following a successful pilot phase, coaching has now been fully integrated into our programmes, and we anticipate a 33% increase in participation over the coming year. Engagement with the internal coaching community remains strong, and bi-monthly activity reports reflect our ongoing commitment to fostering leadership capabilities. This year also saw a significant achievement in coaching skills training, with the Trust surpassing the key performance indicator (KPI) target of 420 colleagues trained. This investment in developing coaching capability is integral to the cultural shift from traditional, transactional leadership approaches to more transformational and developmental leadership styles.

Finally, the OD&L team continues to operate in a consultancy capacity across the Trust, assisting teams with performance challenges. By collecting data from a range of sources and triangulating this information, we can produce diagnostic reports that offer a clearer understanding of the complex issues facing teams. This enables the development of targeted action plans, led by senior leaders, that are tailored to specific needs. Over the past year, the team has supported 27 services, with those teams most engaged in leadership development programmes and continuous improvement initiatives experiencing the greatest improvements in staff survey scores.

Consultancy Expenditure Off Payroll Payments

Table 1: Highly paid off-payroll worker engagements as of 31 March 2022 earning £245 per day or greater	24/25	23/24	22/23
Number of existing engagements as of 31 March 2025	**22**	44	25
Of which:			
Number that has existed for less than one year at the time of reporting	**11**	22	6
Number that has existed for between one and two years at the time of reporting	**11**	15	13
Number that has existed for between 2 and 3 years at the time of reporting	**0**	3	3
Number that has existed for between 3 and 4 years at the time of reporting	**0**	4	2
Number that has existed for 4 or more years at the time of reporting	**0**	0	1
Totals	**22**	44	25

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater.	24/25	23/24	22/23
Number of off-payroll workers engaged during the year ended 31 March 2025	**375**	745	692
Of which:			
Not subject to off-payroll legislation	**375**	743	682
No. assessed as caught by IR35	**0**	0	0
No. assessed as not caught by IR35	**5**	2	4
No. of engagements reassessed for consistency / assurance purposes during the year	**0**	2	0
No. of engagements that saw a change to IR35 status following the consistency review	**0**	0	0

Table 3: Off-payroll board member/senior official engagements for any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024	24/25	23/24	22/23
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	0	0	0

Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	**19**	15	18

Staff Exit Packages

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2024-25 included in this table. The 2023-24 figure is in brackets.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Under £10,000	0(0)	0(3)	0(2)
£10,000 - £25,000	0(0)	1(1)	1(16)
£25,001 – £50,000	0(0)	0(0)	0(0)
£50,001 - £100,000	0(0)	0(0)	0(0)
£100,001 - £150,000	0(0)	0(0)	0(0)
£150,001 - £200,000	0(0)	0(0)	0(0)
Total number of exit packages by type	0(0)	1(4)	1(18)
Total resource cost	£0(£0)	£13,809(£18,000)	£13,809(£18,000)

This table is subject to audit.
The other departures shown above relate to contractual payments in lieu of notice.

Trade Union Facility

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

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

Salisbury NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently updated in April 2023 replaces the version revised and published in 2014.

The Board considers that for the 2024/25 year, the Trust has been fully compliant with the provisions of the Code.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this code through the arrangements that it puts in place for our governance structures, policies, and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Integrated Governance and Accountability Framework.
- Terms of reference for the Board of Directors, the Council of Governors, and their committees
- Annual declarations of interest
- Annual Governance Statement
- Fit and Proper Persons Requirements

Council of Governors

The Trust's Governors are the representatives of members, staff, our stakeholders, and public interests, and are an integral part of advising us on how best to meet the needs of patients and the wider community. Our Governors have a number of statutory duties, but their key role is to hold the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors. Other statutory duties of the Council of Governors' role include:

- Appointing the Chair and Non-Executive Directors
- Approving the appointment of the Chief Executive
- Deciding on the remuneration of the Chair and Non-Executive Directors
- Receiving the Trust's Annual Accounts, Auditors Report and Annual Report
- Reviewing the Membership and Public Engagement Strategy

The Council of Governor have the following committees and trust led working groups over which they can have an influence. In 2024- 25 these covered:

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

- Staff Governors Committee
- Patient Experience Group

The Governors review their work programme and the make-up of their committees and working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. Governors are also party to discussions about elements of the Trust's strategy when items are taken at meetings of the Trust Board and Council of Governors.

The public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election, but they may not serve for more than nine years in total.

In addition, some of the organisations we work most closely with nominate stakeholder Governors. An appointed Governor may hold office for three years and can be re-appointed in line with elected Governors.

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

The Council of Governors hold four meetings a year, in addition to the Annual General Meeting (AGM). The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. However, membership engagement has been highlighted as a priority in the Membership Strategy and more meetings will be scheduled to take place in 2025-26.

Elected Governors - Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
Kevin Arnold	Salisbury City	June 2023	Three years	4 / 5
Joanna Bennett[1]	Salisbury City	June 2024	Three years	3 / 3
Lucinda Herklots (Deputy Lead)	Salisbury City	May 2021	Three years	2 / 2
Frances Owen	Salisbury City	June 2023	Three years	4 / 5
Frank Cunnane	South Wiltshire Rural	June 2023	Three years	5 / 5
William Holmes	South Wiltshire Rural	June 2023	Three years	4 / 5
Anthony Pryor-Jones[2]	South Wiltshire Rural	June 2020	Three years	2 / 4
Angela Milne	South Wiltshire Rural	June 2021	Three years	1 / 2
Andrew Rhind-Tutt	South Wiltshire Rural	June 2024	Three years	4 / 5
Peter Russell	South Wiltshire Rural	June 2024	Three years	5 / 5
Sara Willan	South Wiltshire Rural	June 2024	Three years	3 / 3
John Parker	North Dorset	June 2021	Three years	0 / 2
Matthew Swift[3]	North Dorset	June 2023	Three years	3 / 3
Dr Susan Snoxall	North Dorset	June 2024	Three years	3 / 3
David Tucker[5]	North Dorset	February 2024	One year three mths	0 / 1
Barry Bull	East Dorset	June 2023	Three years	4 / 5
John Mangan	New Forest	June 2021	Three years	2 / 2
Jacqueline Hartas	New Forest	June 2024	Three years	3 / 3

Peter Kosminsky[4]	Kennet	June 2021	Three years	2 / 4
Mary Clunie	Rest of England	June 2021	Three years	1 / 2
Salil Ray-Chowdhury	Rest of England	June 2024	Three years	3 / 3

[1] Joanna Bennett re-elected to her second term.
[2] Anthony Pryor-Jones resigned his post in December 2024.
[3] Matthew Swift resigned his post in October 2024
[4] Peter Kosminsky resigned his post in February 2025
[5] David Tucker elected on a by-election to complete Matthew Swifts term of Office

Elected Governor - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance
Paul Russell	Clerical, Administrative and Managerial	June 2021	Three years	4 / 5
Jane Podkolinski	Volunteers	June 2021	Three years	5 / 5
Benita Florence[1]	Medical & Dental	June 2024	Three years	1 / 2
Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	3 / 5
Jayne Sheppard	Nurses & Midwives (Lead Governor)	June 2021	Three years	4 / 5

[1] Benita Florence resigned her post December 2024

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance
Cllr Richard Rogers[1]	Wiltshire Council	March 2022	Three Years	0/2
Cllr Pauline Church	Wiltshire Council	June 2024	Three Years	2 / 2
Vacant*	Wessex Community Action	N/A	N/A	N/A
Vacant*	Dorset Integrated Care Board (ICB)	N/A	N/A	N/A
Vacant*	Bath and Northeast Somerset, Swindon, and Wiltshire ICB	N/A	N/A	N/A
Jason Goodchild	Military	March 2024	Three years	4 / 4

[1] Richard Rogers resigned his post in April 2024
* Vacant positions were acknowledged by the Council during the year. Work to review the nominated governor category is ongoing and will be completed during 2024-25

During the year our executive team have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chair of the Trust and these meetings are attended by the Chief Executive, who is there to provide clarifications on the Integrated Performance Report

(IPR); and the Chief Nursing Officer who presents the Patient Experience Reports. There is an opportunity for Governors to express their views and raise any other issues, so that members of the Board, including Non-Executive Directors can respond.

There have been no formal requests for Director attendance at the Council of Governors meetings, but it has been standard practice for the Chief Executive and the Chief Nursing Officer to attend. Other executives attend as and when required dependent on the topics raised as part of the agenda.

An informal meeting is normally held between the Governors and the Non-Executive Directors a week after a public board meeting approximately four times a year.

The Trust Board is aware of the work carried out by the Governor committees and information is fed back to the directors.

In 2024 - 25, the Trust Board met regularly in public and, as part of its commitment to openness, Governors and members are invited by the Chair to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board.

Public Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.

The Trust Board has invited Governor observers to attend the meetings of the Board's Audit Committee, the Finance and Performance Committee, its Clinical Governance Committee and the People and Culture Committee.

Register of Governor Interests

A register of interests is held in the Trust Offices. Information regarding the Governors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting:

Head of Corporate Governance,
Trust Offices,
Salisbury NHS Foundation Trust,
Salisbury
SP2 8BJ

Dispute Resolution

There are several mechanisms in place that allow an issue or concern to be discussed and escalated. Informally, there are meetings between the Lead Governor and the Chair. There are also regular meetings between the Governors and the Non-Executive Directors. A formal procedure is in place (see point 51, Dispute Resolution in the Trust's Constitution) should there be a dispute between the Council of Governors and Trust Board. There have been no disputes during 2024- 25

FOUNDATION TRUST MEMBERSHIP

The membership of the Trust is made up of local people, patients and staff who have an interest in healthcare and their local hospital. Public members have to be aged 16 and over.

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

- Medical and Dental
- Nurses and Midwives
- Scientific, Therapeutic and Technical
- Administrative, Facilities and Managerial
- Voluntary

Public members (including volunteers) can only be a member of one constituency. Staff members can only be a member of the staff constituency. Eligibility requirements for joining different membership constituencies, including the boundaries for public membership, are shown in the Trust's Constitution, which is available on the Trust's website.

During the year the Trust sought to broadly maintain membership. The membership for Salisbury NHS Foundation Trust at 31st March 2025 is:

Public Constituency	Number
Salisbury City	2,304
South Wiltshire Rural	4,131
Kennet	1,105
North Dorset	1,219
East Dorset	529
New Forest	931
Rest of England	1,081
Staff Constituency	1,836
Total	**13,136**

Ownership of the Trust's Membership Strategy sits with the Governors with support from the Trust. A key objective of the strategy is to maintain an engaged membership of Salisbury NHS Foundation Trust which broadly represents the population it serves, taking account of age, ethnicity, and diversity in the population of the catchment area.

The Trust's Membership Strategy was revised by the governor-led Membership and Communications Committee and approved by the Council of Governors in February 2023. The Trust should continually seek to communicate with its members, through a variety of effective means, i.e., governor newsletters, Medicine for Members meetings, constituency meetings, public Council of Governor meetings, the Annual General Meeting and through local and social media.

With an updated Membership Strategy, the Membership and Communications Committee is focusing on different methods of recruitment, including using the Trust's social media platforms. Furthermore, it is hoped that an updated membership page on the Trust's website and the continuation of constituency meetings and other events, for example, 'Medicine for Members' will attract a more representative membership

This year, the Trust continued to publish a digital summary of the Annual Review to enable a wider reach to the local population. This document was published on the Trust website, promoted to our members. This document provides a succinct and informative summary of the year's events, including our ambitions for the year ahead.

During 2024-25 Governors continued to join their committee's and groups in person and virtually to enable flexibility for those who are not always able to travel to the Trust. They have been focusing on their statutory duties and have also been involved in the development of the Trust's Annual Plan and Quality Account. Governors have been able to participate on Trust-led working groups, such as Food and Nutrition and the Transport Strategy, VTE, Clinical Ethics and any more Trust led working groups. Governors have also had the opportunity to be involved in the 'patient experience', including Real Time Feedback and PLACE assessments.

A dedicated section on the Trust's website and intranet provides details of each Governor, their interests, and a means for members to communicate with them. There are also members' newsletters for staff and people in the public constituencies

Nominations Committee

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

During the year the Committee met to recommend the appointment of three NEDs.

The Board of Directors

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

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust. All directors are equally accountable for the proper management of the Trust's affairs.

During 2024-25, the Trust appointed three new Non-Executive Directors after a rigorous and independently assessed process by recruitment consultants, Odgers Berndtson. All the new Non-Executive Directors were appointed in line with Fit and Proper Person guidance and the Trust.

All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

Board and Committee Effectiveness Review

During 2023-24, the Trust was of an external well-led assessment review, undertaken by Advancing Quality Alliance (Aqua). The outcome of this review was reported to the Board in July 2023. The Executive Directors reviewed the outcome of the review prior to a Board workshop in October 2023 which focussed on agreement of the key areas for improvement. Further details on the outcome of this review are provided in the Annual Governance Statement (AGS).

The Trust has Board approved Standing Financial Instructions and a Scheme of Delegation and Reservation of Powers, which outline the decisions that must be taken by the Board and the decisions that are delegated to the management of the hospital. These documents include, but are not limited to, instructions on budgetary control, contracts and tendering procedures, capital investment and security of the Trust's property, delegated approval limits, fraud and corruption and payroll.

The Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Trust Board Members

Non-Executive Directors

Ian Green OBE– Chair (Independent)

Ian Green joined the Trust as Chair in February 2023 for his first three-year term. Ian has held Non-Executive Director posts within the NHS over the past 15 years, including Non-Executive Director of South-Central Ambulance Trust Board. This broad experience has provided Ian with an excellent grasp of the challenges of healthcare delivery and of those specific to Salisbury. He is committed to ensuring services are delivered in accordance with best possible practice and emphasises the importance of working with partners to ensure population health needs are met, in a safe and effective environment. Most recently Ian has been Chief Executive of the Terrence Higgins Trust.

Rakhee Aggarwal – Non-Executive Director (Independent)

Rakhee Aggarwal joined the Trust in January 2020. Rakhee has been a mental health nurse since 1999; She has a BSc in Behavioural Studies (Psychology); and a Master's in Teaching and Learning for Health Professionals. She works at the University of Gloucestershire as an Executive Dean with responsibility for Equity, Diversity and Inclusion and is also the Head of School for Health and Social Care. Rakhee was appointed for her second term of office of three years in December 2022

Anne Stebbing Non-Executive Director (Independent

Dr Anne Stebbing joined the Trust in July 2024. Anne is chair of the Clinical Governance Committee and a member of the Charitable Funds Committee and Remuneration Committee

With over 30 years' experience as a consultant breast and general surgeon in the NHS, she has held many medical leadership roles from clinical director to deputy medical director at Hampshire Hospitals. She continues working part time in the breast surgery team.
Prior to joining SFT she was first a member of the East Berkshire CCG, and then served 6 years as a non-executive director at South Central Ambulance Service.

Debbie Beaven– Non-Executive Director (Independent)

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

Richard Holmes– Non-Executive Director (Independent)

Richard Holmes joined the Trust in January 2023 for his first three-year term as Non-Executive Director. Richard has had a wide range of senior appointments with responsibility for business services, including IT, HR, estates, and infrastructure. However, Richard's fundamental background is in finance and assurance as finance director and chief operating officer, and corporate governance as Company Secretary. Richard has long experience of serving on and chairing audit committees for large complex organisations and is also currently appointed to the audit committee of a charity that supports people to access higher education. He has been instrumental in improving organisational systems of control and assurance in organisations across many sectors ranging from both large corporate organisations to small charities, from public to private, and from education to manufacturing and construction.

Margaret (Eiri) Jones – Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019. Eiri is a registered adult and children's Nurse, has an MA in Professional Development and trained as a Quality Service Improvement and Redesign (QSIR) Practitioner. She has clinical, managerial, and executive leadership knowledge and skills gained during a career spanning over 45 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority, GIRFT), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her last UK Executive role was as the Director of Nursing for the United Lincolnshire Hospitals NHS Trust (2012 – 2014). Since then, she has held roles as an interim Quality Manager at NHS Crawley CCG; interim Director of Quality Governance at Barts Health NHS Trust; Regional Director of GIRFT in the Southwest of England and most recently as a Quality Improvement Director for Cwm Taf Morgannwg Health Board. Eiri is also Deputy Chair at Dorset County Hospital and a became a joint NED with Dorset Healthcare in September 2024 as part of the federated model in West Dorset. Eiri became Senior Independent Director as SFT (SID) in September 2023.

Dr Paul Cain - Non-Executive Director (Independent)

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

From being a Consultant in Occupational and Aviation Medicine in the Army with patient facing roles, he then focused entirely on healthcare leadership. This included leading

hospitals and pre-hospital trauma systems during conflicts and the military's integrated healthcare system during COVID 19. As DG Operations at the newly formed UK Health Security Agency, Paul was part of the senior leadership team directing the response to the Omicron variant and the Commonwealth Games. During these he implemented multi-million pound transformation programs delivering better organisational structures and modernising the health IT systems. Paul believes strongly in empowering and developing people to be the best they can and critically, not losing sight of delivering the kind of results that ensure organisations are doing their absolute best for patient

Kirsty Matthews – Non-Executive Director (Independent)

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

Executive Directors

Cara Charles-Barks Joint Chief Executive (from 1st November 2024)

Cara was appointed Chief Executive and Accountable Officer on 1 November 2024. This is a joint role with the Royal United Hospitals NHS FT and Salisbury Hospital NHS FT. Cara qualified as a Registered Nurse in 1990 in Australia. She has 30 years' experience in the public and private health care sector and has been named as one of the NHS's top 50 Chief Executives. Cara has been the Chief Executive Officer of the RUH since September 2020. Before that, she was CEO at Salisbury NHS Foundation Trust, during which time she received an MBE as part of the Queen's Birthday Honours for her leadership during the Novichok incident. In June 2019, she was appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Medical Services.

Lisa Thomas – Interim Chief Executive

Lisa joined the Trust in September 2017 as Chief Finance Officer before being appointed as Chief Operating Officer in August 2022 and Interim Chief Executive Officer in January 2024.

With the recent appointment of a Joint CEO across Salisbury NHS Foundation Trust (SFT), Great Western Hospitals, and Royal United Hospitals Bath, Lisa is responsible for the day-to-day leadership at SFT, working alongside the executive team as Interim Managing Director from 1st November 2024.

Lisa has over twenty-five years' experience of working in the NHS working across hospitals in Bath, Hampshire and Gloucestershire. Lisa is passionate about improving healthcare and has been involved throughout her career in service and patient care improvement projects. She is also enthusiastic about recognising the challenges of delivering healthcare for a rural population.

Judy Dyos – Chief Nursing Officer

Judy Dyos has been the Chief Nursing Officer and an Executive Director at Salisbury NHS Foundation Trust since 2020. She has an extensive nursing profile having been a registered

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

Mark Ellis – Chief Finance Officer

Mark has worked in the Trust as Deputy Chief Finance Officer and was appointed as Interim Chief Finance Officer in August 2022, responsible for the Trust's Finance, Payroll, and Procurement departments.

Mark has over 20 years' NHS finance experience, working in senior finance positions at a number of NHS Trusts across Hampshire and Berkshire until joining the Trust in late 2017.

Mark has an undergraduate master's degree in engineering science from the University of Oxford and obtained Chartered Management Accountant status as part of the NHS Graduate Training Scheme.

Melanie Whitfield – Chief People Officer

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

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

Melanie began her career in retail working for some of the best known brands on the high street including The John Lewis Partnership, Sainsbury's and Boots. She has continued both her formal academic studies and professional development and has a particular interest in the value and impact of team coaching. In joining the Trust Melanie expressed her wish to support all staff to be the best they could be, by helping create the kind of environment where everyone can thrive and in doing so, provide the best possible care to the community we serve.

Within SFT's executive team, she is the responsible leader for our Operational HR Services, Resourcing, Organisation design and Development, Education and Communication strategies alongside our Health and Safety and Occupational Health services. Outside of work she has a very understanding husband, two adult children who keep returning from university and always with their washing! Swimming at our Odstock health and fitness centre, yoga and rowing

Niall Prosser – Interim Chief Operating Officer

Niall Prosser joined the Trust in February 2024. He has over 18 years of senior NHS operational, transformation and commissioning management experience working within the

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

Duncan Murray - Chief Medical Officer

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

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

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

Directors who left the Trust during 2024-25

Tania Baker - Non-Executive Director (Independent)

Tania Baker joined the Trust in June 2016 for a three-year period. Her term of office was extended for a further two years in February 2019. She was Chief Executive Officer at health analytics company, Dr Foster where she was involved in developing the business nationally and internationally. Before this Tania held senior appointments in private healthcare and was Commercial Director at Aviva Health insurance. Tania was the Senior Independent Director (SID) until September 2023. She was appointed for her third term of office, for two years, in May 2022.

Michael von Bertele CB, OBE - Non-Executive Director (Independent)

Michael joined the Trust in November 2016 for a three-year period. His term of office was extended for a further three years in October 2019. As an army junior doctor, he trained in occupational and environmental medicine and became a consultant in 1992. Michael has served in the UN Protection Force in Croatia, was chief medical planner in the Ministry of Defence and was Director General of the Army Medical Services. He retired in 2012 and worked for Save the Children International until 2015. Michael was appointed for his third term of office, for two years in October 2022.He left the Trust on 30 October 2024.

Dr David Buckle – Non-Executive Director (Independent)

Dr David Buckle joined the Trust in January 2020. He is MB BS, DRCOG and MRCGP qualified and is a Fellow of the Royal College of General Practitioners. He was a practising GP until 2017 whilst latterly working part-time (until May 2018) as the Medical Director for Herts Valley Clinical Commissioning Group, where he was the Director of General Practice development. He has previously held other roles comprising various positions within Berkshire East and Berkshire West Primary Care Trusts and with NHS Berkshire West Primary Care Trust. David currently has a portfolio of non-Executive appointments, as the

President of the Society for Assistance of Medical Families, Non-Executive Director with Berkshire Healthcare NHS Foundation Trust, Non-Executive Director with East and North Hertfordshire NHS Hospitals Trust; and Vice Chair (clinical) of the Stroke Association. David became a voting member of the Board in May 2020. David was appointed for his second term of three years in January 2023.

Dr Peter Collins – Chief Medical Officer

Peter trained as a liver specialist and was the clinical lecturer at the Sheila Sherlock Liver Centre at the Royal Free Hospital prior to taking up a consultant post at University Hospitals Bristol Foundation Trust in 2005. He has a research interest in primary liver cancer and alcohol related liver failure and led the regional Primary Liver Cancer Service for the West of England. He has had a number of senior leadership positions in research, education and hospital care. In 2017, Peter was appointed to the role of Medical Director at Weston Area Health Trust where he played a key role in developing models of integrated care, reconfiguring services across Bristol and North Somerset and readying the organisation for a successful merger with University Hospitals Bristol. Since the merger Peter worked as a Deputy Medical Director for the large organisation focusing on the delivery of safe and effective COVID-19-19 care and the restoration of non-COVID-19 services for the Trust and the local Healthcare system. Peter joined the Trust as Interim Medical Director in October 2020 and was successfully appointed to the substantive position in March 2021.

Board of Directors' Attendance 2024/25

Board member	Title	Attendance rate
Tania Baker *(Left on 31 May 2024)*	Non-Executive Director	1/1
Michael von Bertele *(left 30 October 2024)*	Non-Executive Director	5/5
Lisa Thomas	Managing Director	8/8
Judy Dyos	Chief Nurse	8/8
Melanie Whitfield	Chief People Officer	8/8
Eiri Jones	Non-Executive Director/ SID	8/8
Rakhee Aggarwal	Non-Executive Director	8/8
David Buckle *(left 30 October 2024)*	Non-Executive Director	5/5
Peter Collins	Chief Medical Officer	5/5
Mark Ellis	Chief Finance Officer	8/8
Debbie Beaven	Non-Executive Director	8/8
Richard Holmes	Non-Executive Director	7/8
Ian Green	Trust Chair	8/8
Kirsty Mathews *(from 1 June 2024)*	Non-Executive Director	7/7
Paul Cain *(from 1 June 2024)*	Non-Executive Director	6/7
Anne Stebbing *(from 1 July 2024)*	Non-Executive Director	7/7
Duncan Murray *(Interim From August 2024, and substantive from October 2024)*	Chief Medical Officer	5/5
Niall Prosser	Chief Operating Officer	8/8
Cara Charles Barks *(1st November 2024)*	Group Chief Executive	1/3

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

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

	Attendance rate
Ian Green	4/4
Rakhee Aggarwal	2/4
Tania Baker	1/1
Debbie Beaven	2/4
David Buckle	2/2
Paul Cain	3/3
Richard Holmes	1/4
Margaret (Eiri) Jones	4/4
Kirsty Matthews	1/3
Anne Stebbing	2/3
Michael von Bertele	2/2
Cara Charles-Barks	1/1
Peter Collins	2/2
Judy Dyos	2/4
Mark Ellis	2/3
Duncan Murray	1/1
Niall Prosser	1/1
Lisa Thomas	3/3
Melanie Whitfield	0/3

Extraordinary meetings held on 18th April; 18th July; 15th August and 11th October 2024 were all held in private. They were all to discuss the joint CEO and Chair process for the joint structure of the BSW. (check wording with Fiona)
* Executive Directors will attend in rotation based on papers reporting to the meeting.

Board Committees

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

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

The Audit Committee

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

integrated governance, risk management and internal control systems, across the whole Trust.

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

Membership of the Audit Committee

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

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

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

Attendance Audit Committee 2024/25

Name	Title	attendance
Richard Holmes	Chair	5/5
Eiri Jones	Non- Executive Director	5/5
Michael von Bertele	Non- Executive Director	3/3
Kirsty Matthews	Non- Executive Director	3/3

Business conducted by the Committee in Discharging its Responsibilities

The Committee has an annual work programme as well as dealing with other items that arise during the year. It also agrees annual work programmes with the auditors and the Executive.

Risk Management

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

Annual Report and Accounts

As part of the year-end process and approval of the Annual Report and Accounts 2023/24, the Committee received and considered:

- The final draft of the Annual Report and Accounts 2023/24
- The Head of Internal Audit Opinion
- External audit opinion on the accounts and the Annual Auditor's Report.

- Letter of Representation to external audit
- The Going Concern assessment

External audit

The Committee reviewed the reports prepared by external audit and agreed external audit's plan for the 2024/25 accounts and the significant risk areas of focus in 2024/25. The Committee also approved the professional fees of £229,372 charged by Deloitte in the period from 1 April 2024 to 31 March 2025.

Internal audit

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

- Reviewed the internal audit plan for 2024/25
- Considered the major findings of internal audit which will form the basis of the Head of Internal Audit Opinion.
- Regularly reviewed outstanding audit actions and were assured that a robust progress monitoring process is in place.

Counter Fraud

The Committee approved the plan and reviewed the progress reports and the Annual Report

Clinical Governance

The Committee reviewed the implementation of the Patient Safety Incident Response Framework (PSIRF), the patient consent process prior to surgical intervention and Pharmacy Aseptic Stock Management.

Information Governance

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

Cost Control and Financial Governance

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

Governance documents

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

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

Clinical Governance Committee

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

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

Register of Attendance – Clinical Governance Committee 2024/2025

Committee Member	Title	attendance rate
Anne Stebbing	Non-Executive Director - Committee Chair	8/9
Eiri Jones	Non-Executive Director	3/3
Peter Collins	Chief Medical Officer	2/3
David Buckle	Non-Executive Director	4/4
Niall Prosser	Chief Operating Officer	7/9
Debbie Beaven	Non-Executive Director	9/9
Paul Cain	Non-Executive Director	7/9
Duncan Murray	Chief Medical Officer	5/6
Judy Dyos	Chief Nurse	8/9

Finance & Performance Committee

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

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

Attendance at the Finance & Performance Committee in 2024/25 was as follows.

Committee Member	Title	Attendance rate
Debbie Beaven	Non-Executive Director - Committee Chair	9/9
Lisa Thomas	Managing Director	8/9
Richard Holmes	Non-Executive Director	9/9
Paul Cain	Non-Executive Director	7/8
Niall Prosser	Chief Operating Officer	9/9
Eiri Jones	Non-Executive Director	3/3
Mark Ellis	Chief Finance Officer	9/9

People and Culture Committee

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

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

Attendance at the People and Culture Committee was as follows;

Committee Member	Title	attendance rate
Eiri Jones	Non-Executive Director - Committee Chair	9/9
Melanie Whitfield	Chief People Officer (Lead Executive)	8/9
Judy Dyos	Chief Nurse	7/9
Rakhee Aggarwal	Non-Executive Director	7/9
Peter Collins	Chef Medical Officer	2/4
Duncan Murray	Chief Medical Officer	4/5
Michael von Bertele	Non-Executive Director	4/5
Tania Baker	Non-Executive Director	1/1
Kirsty Matthews	Non-Executive Director	5/7

Charitable Funds Committee

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

The Committee supports the Board in

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

Attendance at the Charitable Funds Committee was as follows;

Committee Members	Title	attendance rate
Ian Green	Trust Chair - Committee Chair	4/4
Debbie Beaven	Non-Executive Director	2/4

David Buckle	Non-Executive Director	2/2
Anne Stebbing	Non-Executive Director	3/3
Judy Dyos	Chief Nurse	3/4
Mark Ellis	Chief Finance Officer (Lead Executive)	4/4

Revaluation of Property and Land
The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. The five-yearly revaluations are carried out by a professional qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. The last full revaluation occurred at 31 December 2023. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – modern equivalent depreciated replacement cost

Annual desktop valuations and annual impairment reviews are carried out in all other years where a full revaluation has not taken place.

Recognition of Income
Of the Trust's income, 88% is received from other NHS organisations, with the majority being receivable from NHS Bath and North-East Somerset, Swindon, and Wiltshire ICB. The Trust participates in the Department of Health and Social Care's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivable balances that arise from Whole Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA payable and receivable balances are appropriately recorded. The Trust's external auditors will review the outcome of the exercise and report their findings to the Audit Committee.

Directors' Responsibilities for Preparing the Annual Report and Accounts
The Directors are aware of their responsibilities for preparing the annual report and accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executive's Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This can be found in the Annual Accounts for Salisbury NHS Foundation Trust. In Summary, the Annual Report and Accounts taken as a whole are fair, balanced, and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model and strategy.

Code of Governance Provisions to be included in the Annual Report and their location.

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency, and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Performance Report (page 9) / Annual Governance Statement (page 111)
Disclose	A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Staff Report (page 58)
Disclose	A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Performance Report (page 9) / Code of Governance (page 71)
Disclose	B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder,	Code of Governance (page 73)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
		director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. • Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
Disclose	B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Code of Governance (page 78)
Disclose	B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Code of Governance (pages 67,70,78)
Disclose	C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors (in relation to Executive or Non-Executive recruitment).	na
Disclose	C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Code of Governance (page 72)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise, and experience.	Code of Governance (page 73)
Disclose	C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Code of Governance (page 72) (AGS page 109)
Disclose	C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Remuneration Report (page 35)
Disclose	C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Code of Governance (page 71)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
Disclose	D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit. • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Code of Governance (page 80)
Disclose	D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Code of Governance (page 84)
Disclose	D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	AGS (Page 95)
Disclose	D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Performance Report (page 28) AGS (Page 95)
Disclose	D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As	Performance Report (page 16)

Part of Schedule A	*Code* section	Summary of requirement	Annual Report Location
Required disclosures			
		a result, material uncertainties over going concern are expected to be rare.	
Disclose	E 2.3	Where a trust releases an executive director, e.g., to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	na
Disclose	Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Code of Governance (page 68)
Disclose	Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Code of Governance (page 71)
Disclose	Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g., through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Code of Governance (page 79)
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Code of Governance (page 79)

NHS OVERSIGHT FRAMEWORK

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access, and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

Segmentation

The Trust is currently segmented at 3.

As part of this process the Trust is required to have Enhanced Oversight Meetings chaired by the Integrated Care Board. Significant progress has been made during 2024/25 across each of the areas under review, with regular reports of assurance received at the Finance and Performance Committee. The Trust's ability to achieve financial sustainability is highlighted as a major risk going into 2025/26. Further detail on mitigations and controls in relation to this can be found in the Annual Governance Statement (AGS)

This segmentation information is the Trust's position as of 31 March 2025
Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website:
https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

STATEMENT OF THE ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities, as the accounting officer of Salisbury NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Salisbury NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Salisbury NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS

foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

This confirmation is given and should be interpreted in accordance with the provisions of s418 of the Companies Act 2006.

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

Cara Charles-Barkes
Group Chief Executive
Date: 27 June 2025

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Salisbury NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Salisbury NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Salisbury Hospitals NHS Foundation Trust is committed to a Risk Management Strategy which minimises risk to all of its stakeholders through a comprehensive system of internal controls. The understanding of risk involves the interplay of risk processes affecting staff, patients and the environment.

Trust Board

The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors. The Board recognise that risk management is an integral part of good management practice and to be most effective should be embedded within the Trust's culture. This is embodied within the Strategy and Policy as this documents the Board's risk appetite and the processes applied across the Trust which see the oversight of the Trust's corporate and strategic risks assigned to a Board Committee and each risk has a named Executive Lead. The Board is committed to ensuring that risk management is embedded across all functions and is not seen or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

The Board brings together the corporate, financial, workforce, clinical and operational risk agendas. The Board Assurance Framework (BAF) ensures that there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

Board Committees

The Audit Committee has overall responsibility for ensuring there is effective risk management process employed across the Trust. The Audit Committee receive information annually from the Trust's internal auditors through their work which supports the Board Assurance Framework and through this work the Committee supports the Board to be assured over the robustness of the Trust's application of sound internal control processes.

The other key Board Committees of Clinical Governance, Finance and Performance and People and Culture receive and consider the strength of assurance of actions being taken to manage key corporate and strategic risks outside of the Board's stated risk appetite and request further assurance in the form of deep dives or specific reports where necessary.

Non-Executive Directors

All Committees are chaired by a nominated Non-Executive Director. The Audit Committee which plays a pivotal role in providing assurance on the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Directors, together with the Non-Executive Audit Committee chair, they all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit Committee and Board supports the effectiveness of the Trust's systems of internal control.

Executive Directors

The Chief Executive has overall responsibility for risk management within the Trust, supported by the Managing Director.

The day-to-day oversight has been delegated to the Chief Nursing Officer and Chief Medical Officer who are responsible for the strategic development and implementation of organisational risk management systems and processes and for ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) registration and legal requirements. The Chief Nursing Officer is specifically responsible for patient safety, patient experience and medical legal matters and the Chief Medical Officer for Clinical Effectiveness.

The Chief Finance Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud. The Chief Finance Officer attends the Trust's Audit Committee and liaises with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk-based approach.

The Trust's Senior Leadership Team Committee, Trust Management Committee, chaired by the Managing Director, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified.

There is a process of escalation to Executive Directors through Divisional Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

Divisional Governance Committees introduced to further strengthen the governance arrangements are now embedded in the risk management structure and have responsibility for the oversight of divisional governance and risk processes.

The Head of Risk Management supports the Executive Lead and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments and teams directly.

The Risk and Control Framework

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises, and managing finances will always involve an inherent degree of risk. Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve. The Trust considers risk management to be an intrinsic part of our governance and quality frameworks; it is an essential element of the entire management process and not a separate entity.

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality-of-care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives. The strategy is updated every three years to ensure that it continues to reflect best practice in risk management methodologies and sets out the key responsibilities and accountabilities and includes a review of the Trust's risk appetite. The Risk Management Strategy sets out the strategic goals towards which the Trust is working with regard to risk management and provides a framework that sets out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. These risks are documented on risk registers throughout the organisation.

Risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found, whilst higher scoring risks are managed at progressively higher levels within the organisation.

Risk control measures are identified and implemented to reduce the potential for harm. The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation.

Each Division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments, or the division, are recorded within the

Divisional risk register whilst individual departments/specialties maintain departmental risk registers containing risks to the achievement of individual department's objectives. The escalation process between these risk registers is monitored via the divisional management team with oversight through the Divisional Governance Committees. Escalation of Divisional risks to the Corporate Risk Register is via the Divisional Performance Reviews (DPRs). The escalations through the DPRs connect our continuous improvement management system with the Executives. It is via this route a team or department's unmitigated risks and root causes to problems are escalated and can be unblocked by the wider multi-disciplinary team.

Risks are identified through third-party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, improvement huddles, A3 thinking sessions, audits (including clinical and internal), information from the Patient Advice and Liaison Service (PALS), benchmarking and claims and national survey results. External stakeholders include the Care Quality Commission, NHS England, the Health and Safety Executive, NHS Resolution, the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

The Audit Committee oversees and monitors the performance of the risk management system, with internal and external auditors working closely with this committee. The internal auditors use a risk-based model to undertake reviews and provide assurances on the systems of internal control operating within the Trust. The results of internal audit reviews are reported to the Audit Committee which oversees that weaknesses in the system are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal Audit recommendations are tracked via reports to the Audit Committee.

The Trust's counter fraud work plan and Local Counter Fraud Specialist also play a key role in assisting the Trust to anticipate and manage risk, and regular reporting to each Audit Committee meeting ensures the Board is frequently appraised of counter fraud prevention and detection activity, and any necessary improvements required to the Trust's controls. Together with the internal audit plan the recommendations and learning identified from such reviews are taken forward in an action plan, to support improvements and the embedding of risk management in the Trust. Internal Audit reports relating to quality processes, also get reported to the Clinical Governance Committee to seek assurance on delivery of actions.

The Clinical Effectiveness Steering Group, reporting to the Clinical Management Board consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives. The Clinical effectiveness agenda is overseen by the Chief Medical Officer.

The Trust's Board Assurance Framework (BAF) details the principal strategic risks to the achievement of the Trust's corporate objectives. This is received by the Board on a quarterly basis together with the Corporate Risk Register. The Finance and Performance Committee, People and Culture Committee and Clinical Governance Committee have oversight of the BAF and Corporate Risk Register on a quarterly basis where the risk profile is reviewed and discussed in detail. Risk appetite is applied to both the strategic and corporate risks and risks out of tolerance are considered by the Board Committees. The work plan of the Board Committees is linked so that the Board is assured that there is an aligned independent and executive focus on strategic risk and assurance. Referral of issues between committees ensures a respective understanding of risk and assurance concerns.

The Trust risk appetite approach was first proposed at a Board Development Day in February 2024. It was agreed that there would be a phased approach to support development of risk definitions and risk appetite level descriptors for approval by Trust Board. A Risk Appetite Framework was developed as a result of several months of consultation with the Board and subject matter experts to develop risk definitions, risk categories and risk appetite level descriptors. The risk definitions and risk appetite were approved by Trust Board in October 2024. With the recent changes to the system model and appointment of a Group Chief Executive Officer, the Trust risk management approach and risk appetite framework is subject to ongoing review and adaptation. Applying a risk appetite framework involves translating the Trust's risk tolerance into actionable policies, controls and decision-making processes. This ensures that risks taken align with strategic goals, stakeholder expectations and regulatory requirements. The Trust has been evolving its approach to risk appetite with it predominantly being applied to the Board Assurance Framework (strategic risks) and the Corporate Risk Register. It is intended that the approach will become more sophisticated over time with risk appetite being implemented and embedded at Divisional level and then specialty level in the longer term. The application of the revised risk appetite resulted in a significant shift of risks from within tolerance to out of tolerance and is subject to on-going Board scrutiny.

The BAF records that the Trust has been managing 11 significant risks during the year. Ten risks are currently outside of the Board-agreed risk appetite since the application of the revised appetite in October 2024, compared to four prior to this. These relate to

- Delivery of the Electronic Patient Record (EPR) programme.
- Sustainability of some services.
- Delivery of the Digital Plan.
- Cyber attack or IT system failure.
- Capacity of the Board to effectively oversee the organisation and the delivery of key strategic priorities.
- Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.
- Financial sustainability.
- Workforce sustainability.
- Critical plant and building infrastructure within limited capital funding.
- Sustainability of key performance metrics.

The one risk within tolerance relates to partnership working across the Integrated Care System.

For each of the BAF risks, there is a detailed series of mitigations which will continue to be implemented throughout 2025/26. The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committee of the Board.

The Trust established controls or implemented actions to manage these risks as summarised below:

- BSW Hospitals Group EPR Joint Committee established and there is a programme structure to support delivery overseen by the Chief Executive Officer. The work is supported by an internal Digital Steering Group. Digital maturity informs the Strategic Planning Framework as a Strategic Initiative for 2025/26. Penetration tests continue to inform our cyber security work. Implementation of the digital strategy continues with focus on further development of the infrastructure and controls.

- Delivery of the Annual Plan 2025/26 supported by the Trust Strategic Planning Framework (SPF). There is an ICS programme structure of delivery groups to oversee BSW transformation initiatives. Internally at SFT the transformation boards for urgent and planned care drive forward the work to deliver the plan, implement and sustain the necessary improvements.
- Continued focus on succession planning and implementation of the governance structure of the newly formed Group.
- As part of BSW Hospitals Group, there are opportunities to improve sustainability.
- Continued focus on the urgent care transformation programme including SDEC (Same Day Emergency Care), the Emergency Department and Elderly Care.
- A comprehensive improvement programme against all 7 elements of the People Promise.
- Increased focus on financial controls, emphasising best value decisions.
- Robust capital prioritisation processes to ensure resources are deployed effectively. New Estates Strategy approved by Trust Board in March 2025.

Major risks 2025/26

As we enter 2025/2026, the Trust remains focussed on delivery of the operational and financial plans whilst dealing with significant operational challenges coupled with financial and workforce controls. The focus will be on the delivery of NHS England Operational Planning Priorities 2025/26.

- Reduce the time people wait for elective care;
- Improve Emergency Department waiting times and support ambulance response times through timely handover;
- Maintain focus on the quality and safety of services;
- Operate within agreed allocated budget, reduce waste and improve productivity.

Key risks include:

- Sustainability of some key services for our local population due to workforce issues; that is, unable to recruit, affordability and economies of scale.
- Transformation of services through place-based care, working at both BSW System level and BSW Hospital Group level.
- Collective response to new operational models and navigation of the overall strategic landscape and complexity with the right leadership and skills to address all the competing priorities.
- Responding to the changes in NHS Policy and publication of the NHS ten year plan.
- Managing demand and capacity and delivery of operational performance targets.
- Responding effectively through partnership models to financial and workforce instability.
- Investment in and development of digital and technological infrastructure and skills to support the business.
- Have sufficient workforce (both clinical and non-clinical) with the correct skills and competence.

Within this context, we acknowledge the great opportunity in our closer integration with local partners and will continue to prioritise this and the benefits it provides in the delivery of our wider strategic objectives alongside our BSW Hospital Group members. We will review these to ensure the Trust is best placed to deliver the NHS and Bath, Swindon, and Wiltshire

Integrated Care System (BSW ICS) Long Term Plans and we will embrace the priorities of the NHS People Plan with the vision to make the Trust 'the Best Place to Work.'

Our underlying financial position remains a significant challenge, with an initial planned deficit of £17m in 24/25 and an efficiency requirement of £21m. This included a liquidity challenge leading to a reliance on both the NHS revenue and capital support Public Dividend Capital (PDC), subject to approval by DHSC. NHS England confirmed in year, cash backed, non-recurrent deficit support funding of £17m to bring the plan to break even. Additional cash backed system revenue funding of £10m was confirmed in February to support the in-year costs related to urgent and emergency care pathways where activity volumes have been significantly above planned levels.

The financial context for the NHS as a whole in 2025-26 is as challenging as has been seen in recent years. We will continue to operate under a national tariff (i.e. payment by number of patients treated) for a significant proportion of planned activity but fixed income for other care, we must therefore manage internally the expenditure risk associated with growth in demand for emergency pathways. As a healthcare system, financial sustainability is a priority; For our own part, SFT will be seeking to reduce our underlying deficit through a significant £21m savings plan, delivery of which is underpinned by the 'Creating value for the patient' breakthrough objective, which aligns with the national operational planning priority to reduce waste and improve productivity. Concurrently, BSW ICS is developing plans to address the system deficit where Salisbury will play a significant role.

The future sustainability of the Trust will also be dependent on our ability to progress the delivery of our Estates masterplan. The operational resilience of areas such as Day Surgery and the Maternity Unit remain regular concerns, alongside managing the risk of high capital expenditure on reactive maintenance in the ageing parts of our estate.

Our focus for 2025/26 will be improving services for patients through focussing on our breakthrough objectives:

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

Quality Governance

The Trust is committed to and expects to provide excellent healthcare services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Management Team have a critical role in leading a culture which promotes the delivery of high-quality services. All efforts are focussed on creating an environment that nurtures and supports transformation and continuous improvement.

The Trust has a robust Quality Governance reporting structure in place through an established Clinical Governance Committee. The Quality Governance arrangements are described in the Integrated Governance and Accountability Framework which is reviewed on an annual basis. The framework was presented for approval at the Trust Board in May 2025. This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Governance and Accountability Framework makes it

clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Quality Account published alongside this Annual Report and Accounts describes quality improvements and quality governance in more detail.

The Chief Executive is the Accountable Officer for quality governance, supported by the Managing Director. Each Director is a lead for several Board objectives. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.

Improving Together is the operational excellence management system we share across BSW. It aligns with the five components of NHS Impact and links improvement tools and routines with the behaviours needed for a culture of continuous improvement. It is founded on the development of a coaching approach, which enables every member of staff to improve the services they work in and contribute to achieving our strategy.

Evidence supports that Trusts that have a continuous improvement approach like this provide better patient care, and colleagues working in these Trusts have greater job satisfaction. The Trust staff survey results are reflective of this.

Ultimately Improving Together is about improving the quality-of-care provision. By focusing our efforts where they will have the most positive impact on our services, we will improve the way we work and our quality of care. It covers the following main areas:

- Alignment of priorities – using the strategic planning framework from board to ward we focus on linked priorities, helping us achieve our goals more effectively.
- Empowerment – colleagues will know they are empowered to make changes in their team. Every member of SFT will be supported to develop and improve their skills to be able to identify and adopt improved ways of working.
- Developing our culture – by empowering each and every member of staff to have a voice and supporting our leaders to adopt compassionate and enabling leadership approaches.
- Improving quality – by adopting a data and evidenced based continuous improvement approach to better understand and continually improve the services we offer.
- Stopping doing things that do not add value to our people, population and partners.

With the simple goal of delivering an outstanding experience for patients, their families and the people who work with us - and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work.

Over the last year we have been successful in deepening the use of this approach in the Trust. We now have over 100 teams trained (of c.180 teams) and the development of our speciality and team level performance review meetings (PRMs) is ensuring we can show the ‘golden thread’ from ward to board in alignment with our strategy. The PRMs are also strengthening our governance by ensuring clear lines of escalation through the operational management system: team to speciality, speciality to divisional management team (DMT), and DMT to the Executives.

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

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The quality impact assessment (QIA) process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes or workforce controls responding to headcount controls will not have an adverse impact on quality. This process was reviewed and refreshed in 2023-24 and again in February 2025 in response to increasing workforce controls. The Clinical Management Board and Workforce Control Panel, jointly chaired by the Chief Nursing Officer and Chief Medical Officer, now has oversight of and responsibility for approving all QIA's.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2024-25 and the quality priorities selected for 2025-26. Progress of the priorities is monitored via the Clinical Management Board and Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators.

The Integrated Performance Report (IPR) is aligned to our key areas of focus within the strategic planning framework. It comprises of detailed reports on quality, operational performance, finance and workforce, has been received by the Board monthly and is considered in detail. Our divisions follow the same approach via the Divisional Performance Reviews, which feed into the IPR.

Dedicated data quality teams pro-actively manage elements of data quality within key Trust systems and provide appropriate training and guidance to service colleagues across the Trust. The Trust has an internally developed data quality dashboard held in Power BI where key performance indicators are monitored each month at Divisional and Specialty/Ward level. Independent assurance regarding data quality is provided using published NHS England dashboards, ad hoc internal audits which review internal processes and the annual Data Security and Protection Toolkit self-assessment audit review. The Trust's Data Quality Manager attends regional Data Quality network forums across the Southwest where key challenges are discussed and ideas for improvement are shared amongst acute providers.

Risks to data quality and data security are continually assessed and added to the Trust's risk register and scored appropriately. These are all managed through internal governance processes, overseen at the Information Standards Group and assured through the Digital Steering Group. Escalation of issues goes to the Trust Management Committee and the Trust's Finance and Performance Committee where appropriate.

Data Security and Cyber Security risks are invariably treated as Trustwide risks, overseen by the Informatics Directorate and assured through Digital Steering Group up to Finance and Performance Committee. A range of data protection and security risks are identified on the risk register and progress to reduce the risks are reviewed monthly through the Informatics

Divisional Management Committee. A range of technologies are in place to protect the Trust from threats which are maintained by the Informatics technical teams. The Trust's compliance with the Data Security and Protection Toolkit (DSPT) and the underpinning external audit provides assurance that the Trust has the expected minimum level of controls and protections in place, recognising that that there is always an element of risk tolerance required. The Trust's risk appetite for data security has been agreed at Trust Board. A rolling awareness programme on key areas such as phishing is also in place to help educate staff on data protection and security, with the annual Information Governance training a mandatory training requirement.

The Trust has a Freedom to Speak Up Guardian (FTSUG) to act in an independent and impartial capacity to support staff who raise concerns and whom has access to the Chief Executive, Managing Director and the Trust's nominated Non-Executive Director for 'Freedom to Speak Up'.

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies underpins the Risk Management Strategy and are available to staff on the intranet. Training and awareness sessions are available to staff across the Trust and via mandatory training. Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and divisions also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken. The ICB quality leads are an integral part of the Trust quality governance arrangements and attend key quality committees. The Trust works in partnership with our commissioners to share learning and improvement actions.

The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) on the 8th January 2024.

The four aims of the PSIRF are:

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

As part of the transition, the Trust (SFT) developed and implemented the SFT Patient Safety Incident Response Plan and Policy which support the requirements of the PSIRF. They set out the Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents and concerns for the purpose of learning. The policy and plan enable the Trust to use a systems-based approach to explore patient safety incidents and where there is identified new learning to support an improvement workstream to enable effective and sustainable change in the most important areas. As a Trust we are still learning and adapting our processes, as such the plan and policy remain active documents and can

be reviewed depending on the situation and or within 12-18 months after transition and at regular intervals going forward.

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

PSIRF continues to evolve in SFT with enhancing our patient safety reviews by developing a systems-based and multi-disciplinary approach. Education and the practical application of this is supported to the divisions by the Patient Safety Team. A daily patient safety huddle has been established to provide immediate actions, support, and review of any patient safety incident form (Datix) that is submitted. All cases that are classified as moderate and above or a significant near miss are presented to the weekly Patient Safety Summit which is supported by the Chief Nursing and Chief Medical Officer. All patient safety responses are presented to the bi-monthly Patient Safety Oversight Group for completion and oversight of the response, any concerns are escalated to the Patient Safety Steering Group (PSSG).

PSSG supports any improvement workstreams that may be required following a patient safety response. To ensure the learning is shared widely from these reviews, over the past year the divisions have developed monthly Learning from Incident Forums with a quarterly Trust-wide Learning from Incidents Summit led by the Heads of Nursing and supported by the Patient Safety Team. These are multi-disciplinary, with all members of staff encouraged to attend.

In January 2024, the Trust recruited two Patient Safety Partners who work in partnership with staff to influence and improve the governance and leadership of safety within SFT. Their involvement in various committees, steering groups and activities both within SFT and regionally and nationally continue to evolve. In early 2025 we are undertaking active recruitment for a further two PSP to continue developing their role and support with Trust workstreams ensuring the patients voice is contributed to in all that we do with patient safety.

A daily safety huddle occurs to review all incidents from the previous 24 hours and reviews all patients' News 2 scores to support good practice identification of cases for PSIRF review .

This year patient safety, risk management, patient experience, Freedom to Speak up, and legal services are working together to triangulate the data and information from each service. Any areas of concern, or assurance are escalated to the Clinical Management Board.

SFT has signed up with NHSE to be a pilot site for early implementation of Martha's Rule, in advance of a national launch.

Local adoption of *Martha's Rule* will further strengthen our range of patient safety measures. Early recognition and response to patient deterioration are key factors in enhancing patient safety and improving outcomes in acute illness, and it is well understood that patients themselves and those who are close to them and know them well are often best placed to detect subtle signs that indicate a patient is becoming more unwell. Our local processes will allow a patient, family member or staff member to invoke *Martha's Rule*, by calling the dedicated Call for Concern phone line, (available 24/7), if they feel their concerns about the patient are not being heard and addressed by the attending team. If the Critical Care

Outreach Team determines a prompt review is required, they will make an appropriate referral for another clinician to attend and review the patient. Call for Concern was launched at the Trust on 20th February 2025.

The third phase of Martha's rule is for every patient to be asked key wellness questions on a daily basis; this has been piloted in 2 wards and is rolling out Trust wide from May 2025. Early National data indicates these questions identify soft signs of patient deterioration up to 24 hours before vital signs change. Salisbury hospital is one of the only Trusts regionally that are recording this digitally and this is seen to be best in field practice.

Fundamentals of Care is the essential care that every patient needs to optimise their physical and psychosocial wellbeing. In September 2024, the Trust initiated an 8 month focus programme with each month having a different focus; oral hygiene, bladder and bowel care, communication, personal care, skin care, nutrition and hydration, pain management and movement and mobility. These have been led by subject matter experts and supported by the Patient Safety Team and Tendable audit tools.

The Trust continues to demonstrate a clear commitment to person centred care and acknowledges that this correlates with good patient engagement. The Trust has focused through Improving Together methodology, measures to demonstrate an overall engagement score and problem solve barriers to achieving this. The Patient Engagement Score covers an array of elements including patient stories, patient focus groups and panels, complaints and concerns, real-time feedback and Friends and Family Tests. The Trust completes an annual engagement report, outlining this progress, which is reported to Trust Board.

Patient Stories continue to be a highly valued part of our commitment to ensuring the voices of our patients and services users are heard. These have been poignant and powerful, with a mixture of positive and negative experiences covering a range of journeys. So far, we have had 2 in-person patient stories, covering the following themes:

- Harry's Story – Shared by his daughter, themes included, poor communication, the impacts of not feeling listened to and the additional distress caused by the clinical review process. Harry's story was also shared at Medicine's Divisional Learning from Incidents Forum to ensure their maximum impact and reflection.

- Ken's Story – Ken shared his story from symptoms onset to diagnosis and through to treatment for myeloma. The story was largely positive noting the impact of staff (both clinical and non-clinical) on his experience. He talked candidly about the importance of good communication and empathy, ensuring the patient understands what is being said to them and that they have the right support around them.

Story from Sarum – shared by a member of staff, learning that came from managing a child with complex needs. Working in collaboration with their parents to adjust processes to better suit the needs of the patient. This work involved various departments including theatres and pre-assessment and exampled the successful use of the Patient Passport in sharing these needs. This story outlined the impact on patient experience that reasonable adjustments have, and how important it is to collaborate with those who know the patient best.

Our two fully patient-led service improvement panels within our spinal and cancer services, continue to grow, both in maturity and in membership. We continue to develop the governance of both of these forums, by facilitated formal reporting into the Patient Experience Steering Group, this aims to simultaneously grow the presence of the patient voice in this forum. The

effectiveness of these collaborations is actively being showcased across the Trust, and this is driving appetites amongst other specialities to replicate similar engagement opportunities. We aim to have other panels established for Stoma, Parkinsons and Learning Disabilities over the next 6 months as a result.

The Trust's readership group remains highly active reviewing patient facing material on a weekly basis. All material reviewed by the readership group now carry an identifiable "patient reviewed" stamp.

The Trust has invested in the digitisation and extraction of data insights from our Friends and Family Test (FFT) surveys, to help shape service improvements. Response rates and overall experience ratings are nationally reported currently, but it is recognised the additional value this data provides with its additional ability to theme and analyse feedback received through this mechanism. Implementation of the new digital solution was launched In June 2024, and since implementation the Trust has been able to consistently exceed its 15% response rate target and has demonstrated additional benefits or more robust analysis of data, aiding triangulation with other patient experience measures.

Real time Feedback (RTF) is a face-to-face opportunistic survey undertaken at the patient's bedside whilst they are in hospital. Used alongside other methods of gathering feedback it can help teams improve quality of care and also provide transparency about how well the ward and Hospital are doing in areas of inpatient care. This measure continues to go from strength to strength with a total of 334 surveys undertaken between July 2023 and July 2024. The survey mirrors the focuses of the National Inpatient survey and includes questions to measure the patient's perspective, this is then summarised with an overall experience rating. This feedback continues to develop and is being used to triangulate themes being seen though complaints, FFT and the National Inpatient Survey.

The Trust's Council of Governors engage with the quality agenda through its relevant working groups and a nominated Governor attends the Clinical Governance Committee. There is nominated Governor representation on all Board and Board Committees.

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

There is no requirement for 2024/25 to submit a Corporate Governance Statement as per previous years.

<u>Workforce</u>
As a Trust, the following approaches and mechanisms are used to ensure that short, medium and long-term workforce strategies support staffing systems to ensure that staff processes are safe sustainable and effective.

- The Trust has been developing a strategic workforce plan which looks at the requirement for the next 5 years as a Trust. The plan takes into account analysis of population demographics for our service catchment areas, any adjustment to NHS operational direction and priorities, system plans and Trust strategy. The Strategic Workforce Plan enables a long-term view of workforce requirements,

which supports the generation of retention and recruitment plans across the Trust.

- The Organisation Development and People (OD&P) Business Partners and workforce planning team work collaboratively with Divisional Management Teams to provide guidance and support in recruitment and replacement or redesign of roles as vacancies and opportunities become available. Further emphasis is required in both organisational design and organisational development to ensure effective establishments are designed, with both well designed roles and skill and staffing levels which meet safe staffing guidance.
- The annual review of the operational plan is informed by the strategic workforce plan and developed at Divisional Level to ensure clinical outcomes can be met, within the agreed financial envelope and that safe staffing levels are met in accordance with Developing Workforce Safeguards and local Trust guidance. Resourcing the plan is a collaborative venture between service leads and the OD&P team who support attraction campaigns with a focus on hard to recruit posts for both clinical and non-clinical roles. Positions currently subject to high turnover, such as Health Care Assistants remain as active campaigns with a regular timeframe to ensure that these pipelines are maintained with trained staff. For example, this year improving retention of our Additional Clinical Services staff has been one of four Trust breakthrough objectives in line with our Strategic Planning Framework.
- In year, where there is an identified review and or requirement to modify the workforce plan, a system is in place which provides scrutiny at Divisional Management Team level, and then at Trust level through the Workforce Control Panel to ensure changes are within the financial envelope, provide no risk to patient or staff safety and are necessary to deliver Trust outcomes safely and effectively. In the current financial year an additional level of scrutiny has been added through a weekly ICB Vacancy Control panel.
- An established process for proposed changes to clinical staffing profiles to undergo Quality Impact Assessment in accordance with national guidance by the Chief Medical and Nursing Officers.
- The nursing establishment and skills mix on wards is assessed bi-annually and reported to the Trust Board through the Clinical Governance Committee, in accordance with National Quality Board guidance.
- Workforce risks are identified and monitored in the Board Assurance Framework and divisional risk registers.
- Staff wellbeing is monitored in two ways. For Junior Doctors, our Guardian for Safe Working ensures that the health, wellbeing, and safety of junior doctors is maintained through routine engagement with clinical and educational leads and monthly forums with the Junior Doctors, which drives a monthly reporting process. An escalation and assurance report is then provided at the end of each academic term to the People and Culture Committee. More widely, health and wellbeing issues for staff are monitored by wellbeing conversations between line managers and staff and issues raised through the Wellbeing Committee, which monitors the effectiveness of a number of wellbeing initiatives through wellbeing ambassadors, staff side representation and management input. The Trust also routinely monitors both the frequency and cause of sickness absence through the monthly integrated performance report and proactive interventions discussed at the Safe and Health operational working group.

Our Board is provided with assurance of these mechanisms and processes in the following ways.

- E-Roster is used to capture and collate staffing numbers and skills mix for nursing staff. The system also enables routine capture of staff absence through illness, providing a trigger for line managers to monitor their staff and offer the correct support. The project to roll out E-Roster to all medical staff and remaining Agenda for Change areas continues. Routine reports from the E-Roster system are raised through the Strategic Workforce Systems Steering Group into OD&P Management Board for action and assurance.
- A suite of Power BI dashboards are now available to support data management and assurance of safe staffing and workforce requirements. Staff Availability metrics are routinely shared with Executives and Divisional leads each month.
- Integrated performance reports articulate safe staffing levels and bank/agency usage on a monthly basis.
- Divisional Performance Review meetings consider staffing issues with escalation of any concerns to Executives monthly.
- The OD&P Management Board provides oversight of all workforce plans concerns and takes an escalation report from the safe staffing group to enable triangulation of workforce capacity and safety concerns. The OD&P Management Board raises issues for escalation to the Trust Management Committee, and to the People Committee for assurance, thus providing assurance for the Trust Board. In the year ahead both OD and P Management Board and People and Culture Committee have accepted the recommendation for additional workforce data to be shared in line with the revised annual planning guidance, paying particular attention to the impact of any changes. The Trust board also receives regular updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes, which includes skills mix and care hours per patient day.
- Safe staffing reviews using evidence-based assessment tools for nursing and midwifery are provided to Board through the Clinical Governance Committee bi-annually. Routine Safe Staffing concerns are escalated to OD&P Management Board for resolution.
- The Trust's BAF reflects increased risk to sustainable staffing against our strategic vison of a sustainable workforce in the 5-year period.

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

Maternity Service assessment

The Maternity Service was assessed on 24th September 2024 under the new single assessment framework. This assessment was unannounced and was undertaken due to a concern CQC had received about culture, poor care, low staffing and poor performance. In the report published on 14th February 2025, CQC found these concerns to be unsubstantiated. The rating of maternity services was upgraded from requires improvement to good, having achieved a good rating across all key questions.
Inspectors found:

- Staff reported incidents promptly and received feedback from leaders which was also shared to others. This demonstrated a strong safety culture.

- Staff understood duty of candour and were open and honest when things went wrong or could be a risk.
- The team met regularly to discuss and learn from service performance. Leaders took direct action to address identified risks.
- The team collaborated closely with the mental health team to support women who had experienced birth trauma. They offered dedicated support through a birth reflections service.
- Leaders took proactive steps to address staff challenges. This included implementing a twilight midwife role to ensure there was consistent care from 4pm until midnight.
- People were supported to raise concerns without fear of being treated negatively if they did so.

However:

- The Trust needs to make sure people's privacy and confidentiality is maintained on the day assessment unit as conversations and telephone calls could be easily overheard at the midwife station.
- Some women fed back that they had experienced delays and long wait times when waiting for an obstetric review, medical consultation or scan result.

The maternity team will give consideration as to how these two points can be addressed through their on-going improvement work.

The full report is available as a link here: Salisbury District Hospital HTML report for assessment AP5984 - Care Quality Commission

With regards to the Maternity Safety Support Programme the team submitted a formal exit plan to NHSE in July 2024, having met the predefined exit criteria that was agreed at the start of the programme. Following a meeting with key stakeholders, the team received a formal letter dated 2nd December 2024 from NHSE confirming exit from the programme.

CQC Ionising Radiation (Medical Exposure) Regulations 2017 inspection

The Trust had an announced CQC Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) inspection of the radiology service on 12th February 2025, that took place as part of their proactive inspection programme focused on diagnostic radiology. A further follow up call was held with the department virtually on 6th March 2025. A rating is not awarded following IR(ME)R inspections and findings do not change a provider's existing rating.

The CQC inspectors found the service did display many areas of good practice, and inspectors noted clear escalation of IR(ME)R relevant risks within radiology and that there was learning from topics highlighted in the enforcing authority's annual report. The department was managing its risk from a lack of medical physics expert provision, and was able to explain how it was prioritising service critical work. Staff of all grades were engaged and spoke of a good working culture.

The CQC issues the Trust with two Improvement Notices under the Health and Safety at Work Act 1974 on 13th March 2025. These notices outlined breaches under IR(ME)R regulations 6(1)(a), 6(2) and 10(5). These breaches related to missing procedures or gaps in detail and the use of non-registered staff in making referrals.

The report outlined areas for improvement where a breach was identified which did not justify regulatory action. The recommended action related to Regulation 6(5), referral guidelines:

The employer must establish recommendations concerning referral guidelines for medical exposures and ensure that these are made available to the referrer. The Trust submitted the required action plan within the 6-week deadline which has been acknowledged by the inspector.

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

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

Engagement with the core services commenced in year which involves a self-assessment process. This process involves a self-assessment against themed, common must dos and 'should dos' gathered from a variety of CQC reports with different ratings by the Head of Compliance and, developing an improvement plan if required. Part of this process includes a 'check and challenge' of their findings by the Head of Compliance and Director of Integrated Governance (Divisional Management Team have assumed responsibility for this from January 2025) prior to presentation at the Trust Management Committee (TMC). At TMC the core service leads present key findings, challenges and their learning from having undertaken the process. On-going oversight of the process requires improvement plan actions to be monitored through divisional management team and senior leadership team meetings and sharing at divisional governance meetings for wider learning and, escalation to Executives via divisional performance reviews if required. This process has received positive feedback from the services who have engaged in it to date and members of the TMC.

External Well-led Developmental Review

In Quarter 4, 2022/23 a successful system wide procurement process was undertaken across the 3 BSW Acute Trusts to secure an external company to undertake a well-led developmental review. The Trust review commenced in April 2023 for a three-month period, concluding in June. The report was received in July 2023. The Executive Directors reviewed the outcome of the review prior to a Board workshop in October 2023 which focussed on agreement of the key areas for improvement.

The review reflected "an organisation with clear strategic ambition and commitment to lead for the benefit of the wider system. Operational and governance arrangements are in place and a key development challenge relates to the leadership attention needed to sustain and strengthen those foundations. Throughout the review it was clear that Improving Together is a pivotal focus in defining the organisational approach to improvement and development. Whilst recognising that this is still at a formative stage, aligned to more recent changes to board leadership there is now a platform for resetting some of the core foundations of good governance. Regulatory peer reviews continue to have a strong bias in their focus upon these features".

There have been bi-annual reports to Board on progress against the key improvement themes. There has been significant progress made against all identified areas for improvement. The Trust has aligned the key areas for improvement to existing programmes

of work to ensure this has oversight through existing governance arrangements. Some of this work now forms part of a wider BSW corporate governance workstream supporting the move to a Group Model.
The on-going focus into 2025/26 include:

- Continue to embed governance arrangements at Divisional and specialty level, in particular, the performance review process.
- Continued focus on risk registers and risk management.
- Further development of the talent management and succession planning approach.
- Health inequalities awareness and reporting.
- Policy compliance.
- Cyber security and digital awareness.
- Review of the Board adopted risk appetite framework.
- Structured approach to co-production and development of patient panels.

There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS England and the corporate governance statement.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust has identified a strategic risk in respect of financial sustainability. The Trust's external auditor has reported a 'significant weakness' in the Trust's arrangements to secure financial sustainability. This related to the unplanned deficit in 2023/24 and the deficit for 2024/25, underpinned by a significant cost improvement programme. The Trust has taken a series of actions to mitigate the risks to the delivery of the plan, including developing a £21m savings and efficiency programme. The Trust has sought further support through the NHS revenue support Public Dividend Capital process, which received approval from the Department of Health and Social Care. Whilst we recognise the underlying deficit we face

due to structural factors such as the profile of patients we treat and the cost of maintaining our estate, we do not believe this finding represents a significant weakness in our internal control.

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

The Audit Committee gives specific consideration to matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's local counter fraud specialist and internal audit service.

The Trust continues to actively pursue the opportunities as identified through the model hospital, Getting It Right First Time (GIRFT) and the population health data, increasingly the Trust is working with system partners to identify how working collaboratively can reduce the cost base. This is reviewed via the Hospital group and BSW Directors of Finance meetings.

Arrangements to operate efficiently, economically, and effectively are formally reviewed by external audit. Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and facilitated by the deployment of the 'Improving Together' operating management system. In addition, for the duration of 2024/25 the Trust have been holding a monthly Financial Recovery Group meeting, acting as escalation from the Divisional Performance Reviews and reporting into Finance and Performance Committee. This will continue to be taken forward as a key part of financial governance and controls.

The Trust's finances are reviewed by the Finance and Performance Committee at its monthly meetings. Monthly performance, workforce and quality information is scrutinised each month by the Board through the Integrated Performance Report.

Information Governance

The Trust recognises the importance, value and risk that comes with processing large volumes of personal, sensitive and corporate data. The Trust is committed to proactively managing the confidentiality, integrity, availability and resilience of this data through clear leadership and accountability, which is underpinned by the Trust's values and behaviours through awareness and education.

The Chief Medical Officer (Caldicott Guardian) and Chief Digital Officer (Senior Information Risk Owner (SIRO)), oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively balances a data protection by design and default approach while ensuring that the right data is available at the right time to ensure excellent care can be provided.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) is an annual assessment which demonstrates that organisations can meet the required standards in relation to confidentiality, security and resilience of personal information. The Trust met the standards

of this assessment in 2023/24 and is on course to meet the standards again in 2024/25. The Trust's assessment is subject to an independent audit and the results are published, to provide transparency and increase public confidence. The DSPT reporting year runs from the 1st July to the 30th June. In line with the NHS England guidance, the Trust confirms it will submit the 2024/2025 DSPT assessment on or before the 30th June 2025.

Since July 2024, the Trust reported one data security incident to the Information Commissioner's Office. The incident related to the inappropriate access of Trust information by an employee, which was not needed in the course of their duties. The ICO has not yet provided an outcome for this incident.

During the year, work has continued to align processes with ICS partners, and in particular, Great Western Hospitals NHS Foundation Trust, as there is joint digital leadership across the two Trusts. This has included sharing knowledge and resources, aligning best practice and collaborating on programmes of work to improve consistency for patients and service users, such as implementing shared policies and achieving a successful DSPT assessment.

Data Quality and Governance

There is corporate leadership for data quality with the Chief Digital Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees.

The Trust has an up-to-date Data Quality Policy that was last refreshed in February 2025. The policy outlines a comprehensive approach to data quality, focussing on the following key areas:

- Raising awareness of the importance of high-quality data.
- Assisting all staff in understanding their role and responsibility in maintaining high quality data.
- Assisting staff in getting data quality 'Right First Time' through supporting staff to implement and maintain working practices and processes that enable high data quality at the first time of input.
- Minimising risks arising from poor data quality.
- Monitoring the quality of data used by the Trust via various dashboards and reports, and where needed, to highlight where data is inaccurate and needs to be checked and improved.
- Establishing a framework within which data quality issues can be raised and actioned.

The Trust's Information Standards Group (ISG), chaired by the Chief Digital Officer oversees implementation of the Data Quality Policy. This includes the routine assessment of data quality maturity (DQMI) for all metrics used in core external returns and internal monitoring by Trust committees. Monitoring of all DQMI data helps the Trust identify Key Performance Indicators (KPIs) which are monitored via ISG. Where potential improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process.

The Trust is an active participant in system wide Business Intelligence analytical Forums (one focusing on Elective Care and one on Urgent Care) which seek to standardise the approach to regular reporting, ensuring best practice methodologies are followed and building a shared pool of expert resource across the system in the use of tools such as Power BI and demand and capacity. The system wide Business Intelligence strategy developed in 2021-22 sets a clear direction towards convergence on cloud-based technology for our underpinning business intelligence infrastructure in the coming years. This will enable improved collaborative working, reduced duplication of reporting and increased ability to support detailed interpretation and predictive analysis on areas such as population health management.

All data used for quality reporting is derived from operational clinical systems which are well known and reviewed by the staff using them. The weekly division-led Delivery Performance Group regularly reviews performance data, including patient level information, especially on elective waiting times.

Waiting list data is updated daily and this feeds into a suite of reports that allow various operational teams to monitor the size and performance of the waiting list. There is a dedicated team that review and validate the waiting list, ensuring that records are accurate and up to date as far as possible. There is close review of the longest waiting patients by the divisional teams via a weekly Access Meeting, providing the Trust with the greatest possible opportunity to meet waiting list targets and be assured of data accuracy. All external performance reporting returns are reviewed and signed off at Executive level before being submitted. Waiting list size data is included as part of the integrated performance report which is reviewed monthly at Trust Board. This is supported by the use of Statistical Process Control (SPC) charts to allow close monitoring of specialty level performance over time, highlighting any deteriorating or improving trends or outliers.

One of the Data Quality Policy's activities is to increase awareness of Data Quality in the Trust. The Trust's own Data Quality Dashboard was published in 2024 and now allows all users to easily monitor their ward/departments' compliance with KPIs, ADT (Admissions, Discharges and Transfers) and raised DATIX incidents relating to DQ.

A Data Quality Improvement Group reviews key data quality issues and oversees data quality improvement across the following areas:

- Training – design and delivery of targeted training to support high quality data.
- Awareness – reviewing any data quality issues and feeding this back to departments to ensure they are aware of the issues.
- Process change – use of structured Standard Operating Procedures to meet operational and reporting requirements.
- Information systems – regular checks to ensure data being used is compliant and accurate.
- Data quality monitoring – reviewing nationally and locally developed data quality reports, use of spot checks (e.g., monthly review of waiting list data) and software such as coding software to check data quality.
- Data Quality Standards - agree and approve different DQ standards within the Trust e.g., Identifying an Admitting Consultant. This is created as a document (which is reviewed annually) and published to the Intranet.

The Improvement Group also feeds up any persistent DQ issues to the Information Standards Group with further escalation to the Digital Steering Group which meets monthly. This is an opportunity to reflect current performance to senior Executive staff.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly which covers the key national priority and regulatory indicators, and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supported by a number of more granular reports reviewed by Board committees and regular Divisional Performance Review meetings with the Executive Directors.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection and these are underpinned by the Improving Together methodology.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. There is a full programme of clinical audit in place now supported by a new digital system, AMaT.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for the period 1 April 2024 to 31 March 2025 is that 'Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

During 2024-25, Internal Audit conducted core reviews of governance (Electronic Patient Record (EPR) implementation), risk (risk management), financial control (procurement and workforce controls) and data quality (data quality: outpatients). It was deemed that there are robust controls over governance and risk management. No high priority areas for improvement were found. Partial assurance was provided in relation to the following elements of data quality and finance:

- Data Quality: one high priority finding over the need to improve the recording of outcomes from outpatient appointments. An action was agreed to determine a

reasonable timeliness target for recording outcomes and implement a method to monitor compliance with this. This action is completed.

- Procurement: one high priority finding was raised over the completion of conflict of interest declarations within procurement exercises, where the process could not be consistently evidenced. Two actions were agreed to clarify policy and to require declarations of interest to be embedded within recommendation reports prior to approval. Both actions have been completed.

The above two areas did not affect the overall opinion.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made, and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, with the results of audit work reported to the Audit Committee. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. Where Internal Audit issued a report rated high risk, the relevant audit Executive Sponsor attended the Audit Committee to discuss the report and actions taken. There is an established process in place that any extension to action deadlines requires collective Executive approval and is presented by the Executive Sponsor for the audit.

The Trust is focused on action plans to address the identified risks reported in 2024-25 which have been approved by the Trust Audit Committee. The Trust utilises an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. The success of this has been sustained and is demonstrated by quarterly reports to Audit Committee.

Conclusion

The Trust Board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. Any serious incidents or incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action. This is to ensure that patients, service users, staff and stakeholders can be confident in the quality of the services delivered, and the effective, economic, and efficient use of resources.

Overall, there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. The risks the Trust has faced, together with the actions taken to address each of these areas are detailed within this annual governance statement. My review confirms that Salisbury NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts and no significant internal control issues have been identified.

Cara Charles-Barkes
Chief Executive (Accounting Officer)
27 June 2025 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2025

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2025 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:

Cara Charles-Barks - Group Chief Executive

Date: 27th June 2025

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

Report on the Audit of the Financial Statements

Opinion

In our opinion the financial statements of Salisbury NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2025 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and trust statements of comprehensive income;
- the group and trust statements of financial position;
- the group and trust statements of changes in equity;
- the group and trust statements of cash flows; and
- the related notes 1 to 38.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at:
www.frc.org.uk/auditorsresponsibilities
This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the group and its control environment and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

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

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team, including relevant internal specialists such as valuations and IT specialists, regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature, is subjective and therefore vulnerable to manipulation: we tested a sample of expenditure to assess whether they met the relevant accounting requirements to be recognised as capital in nature.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and [in-house / external] legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance,and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

- the trust build on the measures already taken to accelerate its efforts to identify and realise specific opportunities from those areas of potential efficiency savings identified to deliver its plan,
- to continue to focus on its governance arrangements over the cost improvements programme and related implementation plans,
- on a longer term basis the trust should work with the Integrated Care System to develop a more sustainable financial settlement

This weakness has not yet been addressed. On 19 June 2025 we additionally recommended that the trust should also work with the BSW Hospitals Group to identify efficiencies that are possible within this structure.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate of completion of the audit

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

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Salisbury NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Salisbury NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Chris Randall (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Appointed Auditor
Reading, United Kingdom
27th June 2025

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2025

		Group		Trust	
		2024/25	2023/24	**2024/25**	2023/24
	Note	**£000**	£000	**£000**	£000
Operating income from patient care activities	3	**373,347**	332,928	**373,347**	332,928
Other operating revenue	4	**43,530**	51,908	**29,396**	38,999
Operating expenses	6	**(422,613)**	(373,779)	**(408,283)**	(360,604)
OPERATING SURPLUS / (DEFICIT) FROM CONTINUING OPERATIONS		**(5,736)**	11,057	**(5,540)**	11,323
FINANCE COSTS					
Finance income	11	**1,635**	1,565	**1,418**	1,417
Finance expense	12	**(3,586)**	(5,425)	**(3,514)**	(5,359)
PDC Dividends payable		**(5,242)**	(4,928)	**(5,242)**	(4,928)
NET FINANCE COSTS		**(7,193)**	(8,788)	**(7,338)**	(8,870)
Other gains / (losses)	7.2	**51**	(198)	**(174)**	(192)
Share of profit / (losses) of associates/ joint ventures	33	**(168)**	31	**(168)**	31
Movement in fair value of other investments	17	**75**	1,093	**-**	-
Corporation tax expense		**(81)**	(80)	**-**	-
(DEFICIT) / SURPLUS FOR THE YEAR FROM CONTINUING OPERATIONS		**(13,052)**	3,115	**(13,220)**	2,292
(Deficit) / surplus from discontinued operations and the (loss) on disposal of discontinued operations		**(163)**	-	**(163)**	-
(DEFICIT) / SURPLUS FOR THE YEAR		**(13,215)**	**3,115**	**(13,383)**	**2,292**
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations	15	**(951)**	(4,278)	**(951)**	(4,278)
Items that may be reclassified to income and expenditure					
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(14,166)**	**(1,163)**	**(14,334)**	**(1,986)**
NOTE: ALLOCATION OF SURPLUS / DEFICIT FOR THE YEAR					
(a) (Deficit) / surplus for the period attributable to:					
(i) Non-controlling interest, and		**59**	46	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(13,274)**	3,069	**(13,383)**	2,292
TOTAL		**(13,215)**	**3,115**	**(13,383)**	**2,292**
(b) Total comprehensive (expense)/ income for the year attributable to:					
(i) Non-controlling interest, and		**59**	46	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(14,225)**	(1,209)	**(14,334)**	(1,986)
TOTAL		**(14,166)**	(1,163)	**(14,334)**	(1,986)

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

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

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2025

		Group		Trust	
		31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	Note	**£000**	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	14	**11,557**	7,762	**11,557**	7,762
Property, plant and equipment	15	**204,154**	205,630	**203,414**	204,873
Right of use assets	16	**7,015**	6,382	**4,664**	4,375
Investments in joint ventures	33	**-**	331	**-**	331
Other investments	17	**9,428**	9,143	**500**	500
Other financial assets	18	**3,177**	2,907	**3,830**	3,577
Receivables	21	**344**	324	**344**	324
Total non-current assets		**235,675**	232,479	**224,309**	221,742
CURRENT ASSETS					
Inventories	20	**7,520**	8,628	**5,664**	6,477
Receivables	21	**19,063**	33,179	**20,820**	32,872
Investments	17	**396**	460	**-**	-
Other financial assets	18	**-**	-	**420**	537
Non-current assets held for sale	19	**-**	1,415	**-**	
Cash and cash equivalents	22	**28,951**	16,963	**19,591**	10,638
Total current assets		**55,930**	60,645	**46,495**	50,524
Total assets		**291,605**	293,124	**270,804**	272,266
CURRENT LIABILITIES					
Trade and other payables	23	**(47,219)**	(51,796)	**(45,414)**	(49,338)
Borrowings	24	**(3,261)**	(8,168)	**(2,994)**	(7,486)
Provisions	25	**(590)**	(444)	**(590)**	(444)
Total current liabilities		**(51,070)**	(60,408)	**(48,998)**	(57,268)
Total assets less current liabilities		**240,535**	232,716	**221,806**	214,998
NON-CURRENT LIABILITIES					
Borrowings	24	**(30,479)**	(30,102)	**(28,604)**	(29,064)
Provisions	25	**(492)**	(490)	**(492)**	(490)
Total non-current liabilities		**(30,971)**	(30,592)	**(29,096)**	(29,554)
TOTAL ASSETS EMPLOYED		**209,564**	202,124	**192,710**	185,444
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	34	**141,988**	120,382	**141,988**	120,382
Revaluation reserve	38	**79,494**	80,451	**79,494**	80,451
Income and expenditure reserve	38	**(28,079)**	(14,174)	**(28,772)**	(15,389)
Charitable fund reserves	35	**15,966**	15,329	**-**	-
OTHERS' EQUITY					
Minority Interest	38	**195**	136	**-**	-
TOTAL TAXPAYERS' AND OTHERS' EQUITY		**209,564**	202,124	**192,710**	185,444

The notes on pages 5 to 58 form an integral part of these financial statements.
The financial statements on pages 1 to 58 were approved by the Board on 27th June 2025 and signed on its behalf by:

Signed:

Cara Charles-Barks - Group Chief Executive

STATEMENT OF CHANGES IN EQUITY

		Trust				Subsidiary		Charitable Fund	Group
	Note	Public dividend capital (PDC) £000	Income and expenditure reserve £000	Revaluation reserve £000	Trust Reserves £000	Income & expenditure Reserves £000	Minority interest £000	Charitable Funds reserve £000	Total taxpayers' equity £000
Taxpayers' and Others' Equity at 1 April 2023		99,600	(7,778)	84,729	176,551	1,605	90	14,162	192,408
Changes in equity for 2023/24									
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023		-	(9,903)	-	**(9,903)**	-	-	-	**(9,903)**
Retained surplus/(deficit) for the year		-	2,292	-	**2,292**	(390)	46	1,167	**3,115**
Impairment of property plant and equipment		-	-	(4,441)	**(4,441)**	-	-	-	**(4,441)**
Net gain/(loss) on revaluation of property plant and equipment	15.2	-	-	163	**163**	-	-	-	**163**
Public dividend capital received in year	34	20,782	-	-	**20,782**	-	-	-	**20,782**
Balance at 31 March 2024		**120,382**	**(15,389)**	**80,451**	**185,444**	**1,215**	**136**	**15,329**	**202,124**
Changes in equity for 2024/25									
Retained surplus/(deficit) for the year		-	(13,383)	-	**(13,383)**	(528)	59	637	**(13,215)**
Impairment of property plant and equipment	7.1	-	-	(951)	**(951)**	-	-	-	**(951)**
Other reserve movements		-		(6)	**(6)**	6	-	**-**	**-**
Public dividend capital received in year	34	21,606	-	-	**21,606**	-	-	**-**	**21,606**
Balance at 31 March 2025		**141,988**	**(28,772)**	**79,494**	**192,710**	**693**	**195**	**15,966**	**209,564**

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

STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2025

	Note	Group 2025 £000	Group 2024 £000	Trust 2025 £000	Trust 2024 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating (deficit) / surplus		**(5,899)**	11,057	**(5,540)**	11,323
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	6	**15,683**	14,955	**14,905**	14,274
Impairments	6	**8,097**	669	**8,097**	669
Expense / income recognised in respect of capital donations - NHS Charity		**608**	(828)	**(1,032)**	(828)
Income recognised in respect of capital donations - Other		**(489)**	(10,326)	**(489)**	(10,326)
Decrease / (increase) in trade and other receivables	21	**14,788**	(9,315)	**12,435**	(11,080)
Decrease / (increase) in inventories	20	**1,108**	(673)	**813**	(379)
Increase / (decrease) in trade and other payables	23	**565**	(12,802)	**1,350**	(12,818)
Increase / (decrease) in provisions	25	**143**	(139)	**143**	(139)
Movements in charitable fund working capital		**107**	8	**-**	-
Net cash inflow / (outflow)from operating activities		**34,711**	**(7,394)**	**30,682**	**(9,304)**
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**1,080**	1,058	**1,080**	1,130
Payments to acquire property, plant and equipment	15	**(25,246)**	(32,539)	**(25,008)**	(32,502)
Receipts from sale of property, plant and equipment		**-**	-		-
Receipt of cash donations to purchase capital assets		**489**	10,326	**489**	10,326
Payments to acquire intangible assets	14	**(4,849)**	(3,673)	**(4,849)**	(3,673)
NHS charitable funds - net cash flows from investing activities		**27**	111	**-**	-
Net cash (outflow) from investing activities		**(28,499)**	(24,717)	**(28,288)**	(24,719)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	**21,606**	20,782	**21,606**	20,782
Loans repaid	24	**(5,011)**	5,011	**(5,011)**	5,011
Loan repayment received	24	**-**	-	**134**	689
Movement in loans from the Department of Health and Social Care	24	**(631)**	(631)	**(631)**	(631)
Capital element of lease liability repayments		**(1,059)**	(805)	**(482)**	(249)
Capital element of Private Finance Initiative obligations	29	**(1,492)**	(1,296)	**(1,492)**	(1,296)
Interest paid		**(13)**	(24)	**(13)**	(24)
Interest element of lease liability repayments		**(251)**	(87)	**(179)**	(21)
Interest element of Private Finance Initiative obligations	29	**(1,898)**	(1,892)	**(1,898)**	(1,892)
PDC dividend paid		**(5,475)**	(5,163)	**(5,475)**	(5,163)
Net cash inflow from financing		**5,776**	15,895	**6,559**	17,206
Increase / (decrease) in cash and cash equivalents		**11,988**	(16,216)	**8,953**	(16,817)
Cash and cash equivalents at the beginning of the financial year		**16,963**	33,179	**10,638**	27,455
Cash and cash equivalents at the end of the financial year	22	**28,951**	16,963	**19,591**	10,638

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

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

1.3 Critical accounting estimates and judgements

International accounting standard IAS1 requires management to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

Further detail is outlined in notes 36 and 37.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Basis of Consolidation

1.4.1 NHS Charitable Fund

The Trust is the Corporate Trustee to Salisbury District Hospital Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The consolidation is for reporting purposes only and does not affect the charity's legal and regulatory independence and day to day operations.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.4.2 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the previous year together with draft figures for the current year.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Unless otherwise stated the notes to the accounts refer to the Group and not the Trust. Where the Trust's balances are materially different, these are stated separately.

1.4.3 Associates

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

1.4.4 Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

Joint ventures are accounted for using the equity method.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised.

Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

Fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services.

The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding is provided to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.5.2 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Income received by the Charity
Charitable incoming resources are recognised once: the charity has entitlement to the resources, it is certain that the resources will be received, and the monetary value of the incoming resources can be measured with sufficient reliability.

Legacy income is accounted for within the charity as incoming resources, either upon receipt, or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made, or property transferred, and once all conditions attached to the legacy have been fulfilled.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Expenditure on employee benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

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

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

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

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

These schemes comply with legislative requirements.

1.7 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost (DRC) and the value in use where the asset is income generating. The Trust uses historic cost less depreciation as an approximation of DRC. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

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

Useful lives of intangible assets

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

Software 1 - 7 Years

1.9 Property, plant and equipment

1.9.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9.2 Measurement

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential, but are surplus with no plan to bring them back into use, are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Useful lives of property, plant and equipment
Items of property, plant and equipment are depreciated in a straight line over their remaining useful lives, as follows:

Buildings (excluding dwellings)	4 - 78 years
Dwellings	5 - 56 years
Plant and Machinery	1 - 15 years
Transport equipment	3 - 10 years
Information Technology	1 - 10 years
Furniture and Fittings	5 - 15 years

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

1.9.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds, less costs associated with the sale, and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

1.9.4 Donated, government grant and other grant funded assets

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

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

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.9.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

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

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Initial application of IFRS16 liability measurement principles to PFI liabilities
IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

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

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

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

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

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

1.10 Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

Investments in quoted stocks, shares, gilts and alternative investments are included in the Statement of Financial Position at mid-market price, ex-dividend.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or value at purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or value at purchase date if later).

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life (except for Towels and Scrub Suits which have a two year life), in determining an approximation of net realisable value.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

1.13 Cash and cash equivalents

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

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

1.14 Financial assets and financial liabilities

1.14.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.14.2 Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities are classified as subsequently measured at amortised cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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

1.14.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.14.5 De-recognition

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.15.1 The Trust as lessee

Initial recognition and measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust’s incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.721% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement
As required by HM Treasury's interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases (continued)

1.15.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal Rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years and up to 10 years	4.07%	4.03%
Long-term	After 10 years and up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

		Inflation rate	Prior year rate
Year 1		2.60%	3.60%
Year 2		2.30%	1.80%
Into perpetuity		2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

A Contingent liability is not recognised but is disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

The Trust does not have a corporation tax liability for the year 2024/25 (2023/24 £nil). Tax may be payable by the Trust on activities described below:

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

The Trust's subsidiary companies have made a modest profit leading to a corporation tax liability of £81k (2023/24: £80k).

1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.22 Foreign exchange (continued)

- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.23 Third party assets

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

1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Transfers of functions to other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

NOTES TO THE ACCOUNTS

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

IFRS 14 Regulatory Deferral Accounts is not UK-endorsed. It applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts: application required for accounting periods beginning on or after 1 January 2023. Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.

IFRS 18 Presentation and Disclosure in Financial Statements: Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures: Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise six key operating areas where costs are closely monitored during the year. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board reviews and makes decisions on activity and performance of the Trust as a whole entity, not for its separate business activities. The activities of the subsidiary companies, Odstock Medical Limited and Salisbury Trading Limited, and of the charity, Salisbury District Hospital Charitable Fund, are not considered sufficiently material to require separate disclosure.

NOTES TO THE ACCOUNTS

3 Income From Patient Care Activities

3.1 Income by Nature

	Group and Trust	
	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts - fixed and variable elements*	**285,616**	253,981
High cost drugs income from commissioners	**29,450**	24,397
Other NHS clinical income	**27,655**	29,895
Total income at full tariff	**342,721**	308,273
Private patient income	**2,731**	2,607
Agenda for change pay award central funding**	**746**	174
Additional pension contribution central funding***	**15,229**	9,148
Other clinical income	**11,920**	12,726
Total income from patient care activities	**373,347**	332,928

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

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

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

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

3.2 Income by Source

	Group and Trust	
	2024/25	2023/24
	£000	£000
NHS England	**76,103**	66,833
Integrated Care Boards	**279,941**	250,384
Department of Health and Social Care	**5**	51
Other NHS providers	**9,048**	6,395
NHS other	**531**	585
Local authorities	**1,564**	1,630
Non NHS:		
- Private patients	**2,731**	2,607
- Overseas patients (chargeable to patient)	**208**	349
- NHS Injury cost recovery scheme	**327**	751
- Other	**2,889**	3,343
	373,347	332,928

NHS Injury Scheme income is subject to a provision for doubtful debts of 24.45% (2024: 23.07%) to reflect expected rates of collection. The doubtful debt provision is included in the allowance for impaired contract receivables included in note 21.3.

NOTES TO THE ACCOUNTS

3 Income From Patient Care Activities (continued)

3.3 Commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group and Trust	
	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	**349,661**	316,248
Income from services not designated as commissioner requested services	**23,686**	16,680
	373,347	332,928

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

	Group and Trust	
	2024/25	2023/24
	£000	£000
Income recognised this year	**208**	349
Cash payments received in-year	**65**	162
Amounts written off in-year	**13**	97

3.5 Additional information on contract income (IFRS 15) recognised in the period

	Group and Trust	
	2024/25	2023/24
	£000	£000
Income recognised from performance obligations satisfied (or partially satisfied) in previous periods	**-**	240

3.6 Transaction price allocated to remaining performance obligations

	Group and Trust	
	2024/25	2023/24
	£000	£000
Income from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	**1,366**	1,334
after one year, not later than five years	**1,366**	2,668
after five years	**-**	-
Total income allocated to remaining performance obligations	**2,732**	4,002

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

NOTES TO THE ACCOUNTS

4. Other operating income

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Reimbursement and top up funding	**-**	-	**-**	-
Research and development	**1,450**	870	**1,450**	870
Education and training	**12,816**	11,320	**12,816**	11,320
Non-patient care services to other bodies	**3,161**	4,226	**3,161**	4,226
Received from other bodies- donated assets	**746**	10,326	**746**	10,326
Received from NHS charities - donated assets	**-**	-	**1,032**	828
Contributions to expenditure - from other bodies	**-**	152	**-**	152
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**-**	169	**-**	169
Income from laundry services	**10,493**	10,493	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**2,519**	1,581	**-**	-
Odstock Medical Limited	**3,185**	3,185	**-**	-
Accommodation	**1,785**	1,559	**1,785**	1,559
Administrative services provided to Sterile Supplies Limited	**253**	313	**253**	313
Car Parking	**2,114**	1,682	**2,114**	1,682
Catering	**903**	868	**903**	868
Payroll services provided to other organisations	**3,024**	2,443	**3,024**	2,443
Other	**1,081**	2,721	**2,112**	4,243
	43,530	51,908	**29,396**	38,999

Included within 'Other' income above are: Covid mass vaccination centre income £nil (2023/24: £223k), Royalty Income £360k (2023/24: £106k), Leisure Centre income £216k (2023/24: £172k), income from the rent and hire of rooms £169k (2023/24: £144k), cancer transformation £39k (2023/24: £26k) and overseas recruitment £nil (2023/24: £526k).

5. Operating lease income

5.1 As lessor

The Trust has entered into short term commercial leases on buildings, which primarily relate to the rental of an area within the hospital main entrance to a high street retailer and properties rented to subsidiary companies.

5.2 Receipts recognised as income

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Rental income from operating leases - minimum lease receipts	**144**	119	**283**	283

NOTES TO THE ACCOUNTS

5. Operating lease income (continued)

5.3 Total future lease income

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
Future minimum lease receipts due at 31 March:	**£000**	£000	**£000**	£000
- not later than one year	**164**	136	**169**	170
- later than one year and not later than two years	**145**	145	**145**	187
- later than two years and not later than three years	**145**	145	**145**	145
- later than three years and not later than four years	**145**	145	**145**	145
- later than four years and not later than five years	**145**	145	**145**	145
- later than five years	**85**	230	**85**	222
Total	**829**	946	**834**	1,014

6. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**3,980**	4,457	**3,980**	4,457
Purchase of healthcare from non-NHS and non-DHSC bodies	**4,949**	5,080	**4,949**	5,080
Staff and executive directors costs	**269,428**	242,038	**261,746**	234,506
Non-executive directors	**182**	168	**182**	168
Supplies and services – clinical (excluding drugs costs)	**34,609**	26,998	**33,138**	25,632
Supplies and services - general	**4,685**	4,441	**3,010**	2,907
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**35,633**	32,087	**35,633**	32,087
Inventories written down	**484**	66	**484**	66
Consultancy costs	**209**	126	**209**	126
Establishment	**3,905**	5,482	**3,905**	5,482
Premises	**22,591**	21,191	**21,539**	20,502
Transport	**1,909**	2,119	**1,249**	1,627
Depreciation on property, plant and equipment and right of use assets	**14,062**	12,077	**13,284**	11,396
Amortisation on intangible assets	**1,621**	2,878	**1,621**	2,878
Impairments net of (reversals)	**8,097**	669	**8,097**	669
Movement in credit loss allowance: contract receivables / contract assets	**23**	17	**23**	17
Provisions arising /(released) in year	**189**	17	**189**	17
Change in provisions discount rate(s)	**-**	(5)	**-**	(5)
Audit fees payable to the external auditor			**-**	
audit services- statutory audit	**277**	223	**277**	223
Internal audit costs	**97**	188	**97**	188
Clinical negligence	**7,979**	7,038	**7,979**	7,038
Legal fees	**118**	200	**118**	200
Insurance	**464**	413	**464**	413
Research and development	**26**	36	**26**	36
Education and training	**1,827**	2,685	**1,827**	2,685
Charges to operating expenditure for on-SoFP PFI scheme	**1,342**	1,290	**1,342**	1,290
Other NHS charitable fund resources expended	**963**	593	**-**	-
Other	**2,964**	1,207	**2,914**	919
	422,613	373,779	**408,283**	360,604

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

There were no Redundancy payments in either 2025 or 2024.

The impairment of £9,009k is made up of £8,846k relating to property, plant and equipment in year (see note 15) and £163k write down of investment in Wiltshire Health and Care which ceases to exist after 31st March 2025 (see note 33).

There is a limitation on the Auditor's liability of £1.0m (2023/24: £1.0m). The fees payable to auditors for the statutory audit and additional services above are quoted gross of VAT at 20%, reflecting the Trust's inability to reclaim VAT on this type of expenditure.

Other operating expenses include professional fees £1.5m (£0.63m 2023/24),

NOTES TO THE ACCOUNTS

7.1 Impairment of assets

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Net impairments charged to operating surplus / deficit resulting from:				
Loss or damage from normal operations	**163**	-	**163**	-
Other	**7,934**	669	**7,934**	669
Total net impairments charged to operating surplus / deficit	**8,097**	669	**8,097**	669
Impairments charged to the revaluation reserve	**951**	4,441	**951**	4,441
Total net impairments	**9,048**	5,110	**9,048**	5,110

Other impairments relates to the write down to depreciated replacement cost of a refurbished building brought into use following its first professional valuation after completion of the work.

7.2 Other gains and losses:

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Gain on disposal of asset held for sale	**225**	-	**-**	-
Loss on disposal of property, plant and equipment.	**(174)**	(192)	**(174)**	(192)
Losses on disposal of right of use assets (lease termination - lessee)	**-**	(6)	**-**	-
Total	**51**	(198)	**(174)**	(192)

8. Employee benefits

8.1 Staff costs

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Salaries and wages	**202,631**	182,910	**195,385**	176,036
Social security costs	**21,703**	18,250	**21,267**	18,250
Apprenticeship levy	**1,006**	922	**1,006**	922
Employer's contributions to NHS pensions	**38,615**	30,277	**38,615**	30,277
Pension cost - other	**-**	28	**-**	28
Temporary staff (including agency)	**8,094**	12,014	**8,094**	11,356
Total gross staff costs	**272,049**	244,401	**264,367**	236,869
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**272,049**	244,401	**264,367**	236,869
Of which				
Costs capitalised as part of assets	**2,621**	2,563	**2,621**	2,563

NOTES TO THE ACCOUNTS

8. Employee benefits (continued)

8.2 Directors' remuneration

	Group and Trust	
	2024/25	2023/24
	£000	£000
Salaries and wages	**1,238**	1,063
Social Security Costs	**138**	130
Employer contributions to Pension Schemes	**170**	173
	1,546	1,366

The total number of Directors accruing benefits under pension schemes is 7 (2023/24: 6). The Directors Remuneration only relates to the Group.

9. Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution schemes for Odstock Medical Limited and Salisbury Trading Limited was £23.6m (2023/24: £21.1m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf at 9.4% (2023/24: 6.3%), as at 31 March 2025 (and 2024), contributions of £3.32m (2023/24: £3.05m) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

9.1 NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

NOTES TO THE ACCOUNTS

9. Pension costs (continued)

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

10. Retirements due to ill-health

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

During the year to 31 March 2025 there were no (2023/24: 1) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be nil (2023/24: £42k).

NOTES TO THE ACCOUNTS

11. Finance income

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Interest on bank accounts	**1,080**	1,064	**1,080**	1,064
Interest on other investments / financial assets	**270**	248	**338**	353
NHS charitable fund investment income	**285**	253	**-**	-
	1,635	1,565	**1,418**	1,417

12. Finance expenditure

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	**9**	20	**9**	20
Interest on lease obligations	**251**	87	**179**	21
Finance costs on PFI obligations:				
Main finance costs on PFI obligations	**1,897**	1,892	**1,897**	1,892
Remeasurement of the liability resulting from change in index or rate*	**1,424**	3,422	**1,424**	3,422
Total interest expense	**3,581**	5,421	**3,509**	5,355
Unwinding of discounts on provisions	**5**	4	**5**	4
Total finance costs	**3,586**	5,425	**3,514**	5,359

13. Losses and special payments

	Group and Trust			
	2024/25		2023/24	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Bad debts and claims abandoned	**46**	**45**	94	133
Stores losses	**3**	**567**	-	-
	49	**612**	94	133
Special payments				
Ex-gratia payments	**21**	**5**	18	7
Special severance payments	**1**	**14**	-	-
	22	**19**	18	7
Total losses and special payments	**71**	**631**	112	140

There were no special payments that exceeded £0.1m in year (23/24 zero). There was one stock loss at £0.4m that exceeded £0.1m in year (23/24 zero).

NOTES TO THE ACCOUNTS

14. Intangible Assets

14.1 Intangible assets at the balance sheet date comprise the following elements:

Group and Trust

	Assets under Construction £000	Software Licences £000	Total £000
Cost or valuation			
At 1 April 2024	5,692	18,939	24,631
Additions - purchased	4,849	-	4,849
Additions - donated	148	-	148
Reclassifications	(2,876)	3,483	607
Disposals	-	(13,364)	(13,364)
At 31 March 2025	**7,813**	**9,058**	**16,871**
Amortisation			
At 1 April 2024	-	16,869	16,869
Provided during the period	-	1,621	1,621
Reclassifications	-	120	120
Disposals	-	(13,296)	(13,296)
Amortisation at 31 March 2025	**-**	**5,314**	**5,314**
Net book value at 31 March 2025			
- Purchased at 31 March 2025	7,813	3,735	11,548
- Donated at 31 March 2025	-	9	9
Total at 31 March 2025	**7,813**	**3,744**	**11,557**

Cost or valuation			
At 1 April 2023	2,254	18,704	20,958
Additions - purchased	3,673	-	3,673
Reclassifications	(235)	235	-
At 31 March 2024	**5,692**	**18,939**	**24,631**
Amortisation			
At 1 April 2023	-	13,991	13,991
Provided during the period	-	2,878	2,878
Amortisation at 31 March 2024	**-**	**16,869**	**16,869**
Net book value at 31 March 2024			
- Purchased at 31 March 2024	5,692	2,070	7,762
Total at 31 March 2024	**5,692**	**2,070**	**7,762**

NOTES TO THE ACCOUNTS

15. Property, plant and equipment

Group

15.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2024	2,071	124,711	7,004	40,296	52,826	110	16,391	3,618	247,027
Additions - purchased	-	-	-	19,080	-	-	-	-	19,080
Additions - donated	-	-	-	1,373	-	-	-	-	1,373
Impairments	-	(8,379)	-	-	-	-	-	-	(8,379)
Reclassifications	-	31,755	2	(42,908)	7,120	-	3,699	(275)	(607)
Revaluation	30	(5,737)	(205)	-	-	-	-	-	(5,912)
Disposals	-	-	-	-	(2,902)	-	(5,814)	(241)	(8,957)
At 31 March 2025	**2,101**	**142,350**	**6,801**	**17,841**	**57,044**	**110**	**14,276**	**3,102**	**243,625**
Accumulated depreciation									
At 1 April 2024	-	-	-	-	28,474	61	10,049	2,813	41,397
Provided during the period	-	5,168	226	-	4,718	10	2,105	224	12,451
Impairments	-	(445)	-	-	-	-	-	-	(445)
Reclassifications	-	15	-	-	162	-	11	(308)	(120)
Revaluation	-	(4,735)	(226)	-	-	-	-	-	(4,961)
Disposals	-	-	-	-	(2,830)	-	(5,785)	(236)	(8,851)
Accumulated depreciation at 31 March 2025	**-**	**3**	**-**	**-**	**30,524**	**71**	**6,380**	**2,493**	**39,471**
Net book value at 31 March 2024									
Owned	2,071	101,577	7,004	29,970	23,749	49	6,342	805	171,567
On balance sheet PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	-	-	10,326	603	-	-	-	10,929
Total at 31 March 2024	**2,071**	**124,711**	**7,004**	**40,296**	**24,352**	**49**	**6,342**	**805**	**205,630**
Net book value at 31 March 2025									
Owned	2,101	106,550	6,801	16,788	22,266	39	7,877	380	162,802
On-SoFP PFI	-	22,817	-	-	-	-	-	-	22,817
Donated	-	12,980	-	1,053	4,254	-	19	229	18,535
Total at 31 March 2025	**2,101**	**142,347**	**6,801**	**17,841**	**26,520**	**39**	**7,896**	**609**	**204,154**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Newmark, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a full revaluation at 31 December 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024 and 2025. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £8,846k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £39k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

The disposals in year were made up of a CT Scanner, IT Servers, network and hubs, Medical Equipment and replaced Refrigeration and Ventilation. All items were at the end of their useful lives and therefore had been depreciated to near zero.

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Group

15.2 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2023	2,420	124,245	7,864	16,660	49,062	110	14,692	3,453	218,506
Additions - purchased	-	-	-	30,111	-	-	-	-	30,111
Additions - donated	-	-	-	11,154	-	-	-	-	11,154
Impairments	-	(669)	-	-	-	-	-	-	(669)
Reclassifications	-	10,269	279	(17,629)	5,156	-	1,735	190	-
Revaluation	210	(9,134)	(266)	-	-	-	-	-	(9,190)
Transfer to assets held for sale	(559)	-	(873)	-	-	-	-	-	(1,432)
Disposals	-	-	-	-	(1,392)	-	(36)	(25)	(1,453)
At 31 March 2024	**2,071**	**124,711**	**7,004**	**40,296**	**52,826**	**110**	**16,391**	**3,618**	**247,027**
Accumulated depreciation									
At 1 April 2023	-	-	-	-	26,038	50	8,259	2,587	36,934
Provided during the period	-	4,693	236	-	3,640	11	1,826	248	10,654
Revaluation	-	(4,693)	(219)	-	-	-	-	-	(4,912)
Transfer to assets held for sale	-	-	(17)	-	-	-	-	-	(17)
Disposals	-	-	-	-	(1,204)	-	(36)	(22)	(1,262)
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**28,474**	**61**	**10,049**	**2,813**	**41,397**
Net book value at 31 March 2023									
Owned	2,420	101,080	7,864	16,660	22,347	60	6,433	866	157,730
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	-	-	-	677	-	-	-	677
Total at 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**23,024**	**60**	**6,433**	**866**	**181,572**
Net book value at 31 March 2024									
Owned	2,071	101,577	7,004	29,970	23,749	49	6,342	805	171,567
On-SoFP PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	-	-	10,326	603	-	-	-	10,929
Total at 31 March 2024	**2,071**	**124,711**	**7,004**	**40,296**	**24,352**	**49**	**6,342**	**805**	**205,630**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Newmark, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a desktop valuation using indices of the Trust's land and buildings as at 31 March 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024 . The valuation was carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £669k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £4,278k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

15.3 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2024	1,670	124,711	7,004	40,197	50,490	110	16,391	3,618	244,191
Additions - purchased	-	-	-	18,984	-	-	-	-	18,984
Additions - donated	-	-	-	1,373	-	-	-	-	1,373
Impairments	-	(8,379)	-	-	-	-	-	-	(8,379)
Reclassifications	-	31,755	2	(42,812)	7,024	-	3,699	(275)	(607)
Revaluation	30	(5,737)	(205)	-	-	-	-	-	(5,912)
Disposals	-	-	-	-	(2,912)	-	(5,814)	(241)	(8,967)
At 31 March 2025	**1,700**	**142,350**	**6,801**	**17,742**	**54,602**	**110**	**14,276**	**3,102**	**240,683**
Accumulated depreciation									
At 1 April 2024	-	-	-	-	26,395	61	10,049	2,813	39,318
Provided during the period	-	5,168	226	-	4,595	10	2,105	224	12,328
Impairments	-	(445)	-	-	-	-	-	-	(445)
Reclassifications	-	15	-	-	162	-	11	(308)	(120)
Revaluation	-	(4,735)	(226)	-	-	-	-	-	(4,961)
Disposals	-	-	-	-	(2,830)	-	(5,785)	(236)	(8,851)
Accumulated depreciation at 31 March 2025	**-**	**3**	**-**	**-**	**28,322**	**71**	**6,380**	**2,493**	**37,269**
Net book value at 31 March 2024									
Owned	1,670	95,952	7,004	29,871	23,482	49	6,342	805	165,175
On balance sheet PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	5,625	-	10,326	603	-	-	-	16,554
Total at 31 March 2024	**1,670**	**124,711**	**7,004**	**40,197**	**24,085**	**49**	**6,342**	**805**	**204,863**
Net book value at 31 March 2025									
Owned	1,700	106,550	6,801	16,689	22,026	39	7,877	380	162,062
On-SoFP PFI	-	22,817	-	-	-	-	-	-	22,817
Donated	-	12,980	-	1,053	4,254	-	19	229	18,535
Total at 31 March 2025	**1,700**	**142,347**	**6,801**	**17,742**	**26,280**	**39**	**7,896**	**609**	**203,414**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Newmark, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a full revaluation at 31 December 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024 and 2025. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £8,846k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £39k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

15.4 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2023	1,460	124,245	6,991	16,561	46,753	110	14,692	3,453	214,265
Additions - purchased	-	-	-	30,074	-	-	-	-	30,074
Additions - donated	-	-	-	11,154	-	-	-	-	11,154
Impairments	-	(669)	-	-	-	-	-	-	(669)
Reclassifications	-	10,269	279	(17,592)	5,119	-	1,735	190	-
Revaluation	210	(9,134)	(266)	-	-	-	-	-	(9,190)
Disposals	-	-	-	-	(1,382)	-	(36)	(25)	(1,443)
At 31 March 2024	**1,670**	**124,711**	**7,004**	**40,197**	**50,490**	**110**	**16,391**	**3,618**	**244,191**
Accumulated depreciation									
At 1 April 2023	-	-	-	-	24,046	50	8,259	2,587	34,942
Provided during the period	-	4,693	219	-	3,553	11	1,826	248	10,550
Revaluation	-	(4,693)	(219)	-	-	-	-	-	(4,912)
Disposals	-	-	-	-	(1,204)	-	(36)	(22)	(1,262)
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**26,395**	**61**	**10,049**	**2,813**	**39,318**
Net book value at 31 March 2023									
Owned	1,460	95,360	6,991	16,561	22,717	60	6,433	866	150,448
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	5,720	-	-	-	-	-	-	5,720
Total at 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**22,717**	**60**	**6,433**	**866**	**179,333**
Net book value at 31 March 2024									
Owned	1,670	95,952	7,004	29,871	23,492	49	6,342	805	165,185
On-SoFP PFI	-	23,134	-	-	-	-	-	-	23,134
Donated	-	5,625	-	10,326	603	-	-	-	16,554
Total at 31 March 2024	**1,670**	**124,711**	**7,004**	**40,197**	**24,095**	**49**	**6,342**	**805**	**204,873**

The Trust's policy is to complete a full revaluation at least every five years relating to Land and Buildings, with a desktop review in all other years. Newmark, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a destop valuation using indices of the Trust's land and buildings as at 31 March 2023 and a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024. The valuation was carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The impairment of £669k has been charged to operating expenses in the year (see note 6) and the net revaluation movement of £4,278k has been charged to the revaluation reserve (see Page 3 - Consolidated Statements of Changes in Taxpayers Equity)

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases rooms in medical centres/ practices to provide outreach clinics closer to the population it serves, vehicles for staff visiting these sites as well as patients in their own homes, commercial vehicles for site management, a computer server environment and medical equipment provided as part of managed service agreements. The subsidiary company, Salisbury Trading Limited, is purchasing through a leasing arrangement new laundry equipment as well as the hire of commercial premises for production and storage of laundered items and vehicles for delivery.

16.1 Right of use assets - 2024/25

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

NOTES TO THE ACCOUNTS

16.2 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Cost or valuation						
At 1 April 2023	1,067	3,897	992	1,943	7,899	-
Additions - leases	362	2,537	515	-	3,414	25
Disposals / derecognition / lease termination	-	-	(546)	-	(546)	-
At 31 March 2024	**1,429**	**6,434**	**961**	**1,943**	**10,767**	**25**
Accumulated depreciation						
At 1 April 2023	301	853	288	1,652	3,094	-
Provided during the year	260	631	241	291	1,423	2
Disposals / derecognition / lease termination	-	-	(132)	-	(132)	-
Accumulated depreciation at 31 March 2024	**561**	**1,484**	**397**	**1,943**	**4,385**	**2**
Net book value at 31 March 2024	**868**	**4,950**	**564**	**-**	**6,382**	**23**

NOTES TO THE ACCOUNTS

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

16.3 Right of use assets - 2024/25

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 1 April 2024	685	4,863	155	1,943	-	7,646	25
Additions - leases	-	1,245	-	-	-	1,245	-
Disposals / derecognition / lease termination	(46)	(294)	(15)	(1,943)	-	(2,298)	-
At 31 March 2025	**639**	**5,814**	**140**	**-**	**-**	**6,593**	**25**
Accumulated depreciation							
At 1 April 2024	193	1,037	98	1,943	-	3,271	2
Provided during the year	146	765	45	-	-	956	2
Disposals / derecognition / lease termination	(46)	(294)	(15)	(1,943)	-	(2,298)	-
Accumulated depreciation at 31 March 2025	**293**	**1,508**	**128**	**-**	**-**	**1,929**	**4**
Net book value at 31 March 2025	**346**	**4,306**	**12**	**-**	**-**	**4,664**	**21**

NOTES TO THE ACCOUNTS

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

16.4 Right of use assets - 2023/24

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 1 April 2023	595	2,335	138	1,943	-	5,011	-
Additions - leases	90	2,528	17	-	-	2,635	25
At 31 March 2024	**685**	**4,863**	**155**	**1,943**	**-**	**7,646**	**25**
Accumulated depreciation							
At 1 April 2023	88	630	54	1,652	-	2,424	-
Provided during the year	105	407	44	291	-	847	2
Accumulated depreciation at 31 March 2024	**193**	**1,037**	**98**	**1,943**	**-**	**3,271**	**2**
Net book value at 31 March 2024	**492**	**3,826**	**57**	**-**	**-**	**4,375**	**23**

NOTES TO THE ACCOUNTS

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

16.5 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£'000	£'000	**£'000**	£'000
Carrying value at 1 April	**4,714**	2,513	**2,994**	608
Lease additions	**2,125**	3,414	**1,245**	2,635
Lease liability remeasurements	**119**	-	**-**	-
Interest charge arising in year	**251**	87	**179**	21
Early terminations	**-**	(408)	**-**	-
Lease payments (cash outflows)	**(1,310)**	(892)	**(661)**	(270)
Carrying value at 31 March	**5,899**	**4,714**	**3,757**	**2,994**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

16.6 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Undiscounted future lease payments payable in:				
- not later than one year;	**1,339**	1,101	**678**	582
- later than one year and not later than five years;	**4,144**	3,296	**2,736**	1,918
- later than five years.	**1,355**	1,163	**1,072**	1,182
Total gross future lease payments	**6,838**	5,560	**4,486**	3,682
Finance charges allocated to future periods	**(939)**	(846)	**(729)**	(688)
Net lease liabilities at 31 March	**5,899**	4,714	**3,757**	2,994
Of which:				
- Leased from other NHS providers	**-**	-	**-**	-
- Leased from other DHSC group bodies	**21**	23	**21**	23

NOTES TO THE ACCOUNTS

17. Investments

Non-current	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Carrying value at 1 April	**9,143**	8,245	**500**	500
Additions	**4,740**	4,674	-	-
Fair value gains taken to I & E	**75**	1,093	-	-
Disposals	**(4,530)**	(4,869)	-	-
Carrying value at 31 March	**9,428**	9,143	**500**	500
Current				
Financial assets designated at amortised cost	**396**	460	**-**	-

Non-current investments represents an investment portfolio managed by HSBC Private Bank (UK) Limited on behalf of the charitable fund.

Current asset investments are the cash balances held by HSBC Private Bank (UK) Limited on behalf of the charitable fund and represents dividend income, interest income and the proceeds of fixed asset investment disposals which have not yet been reinvested.

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also note 18.

Fair value measurement of investments
Financial assets and financial liabilities measured at fair value in the Statement of Financial Position are grouped into three levels of a fair value hierarchy. The three levels are defined based on the observability of significant inputs to the measurement, as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets or liabilities
Level 2: inputs other than quoted prices included in level 1 that are observable for the asset or liability, either directly or indirectly
Level 3: unobservable inputs for the asset or liability

The investments in the group financial statements are all level 1 investments and are measured at quoted prices at the date of the Statement of Financial Position.

NOTES TO THE ACCOUNTS

18. Other financial assets

Non-current	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,907**	2,658	**3,577**	3,900
Transfer (to)/ from current assets	**-**	-	**117**	117
Amortisation at the effective interest rate	**270**	249	**270**	249
Repayments in year	**-**	-	**(134)**	(689)
Carrying value at 31 March	**3,177**	2,907	**3,830**	3,577
Current				
Carrying value at 1 April	**-**	-	**537**	654
Transfer (to) non-current assets	**-**	-	**(117)**	(117)
Carrying value at 31 March	**-**	-	**420**	537

Current other financial assets represent loans made to:

a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due in less than one year

b) Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.

Non-current other financial assets represent loans made to:

a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due after more than one year

b) Sterile Supplies Limited to re-develop a new production facility with a third party. £3.177m Group and Trust in 24/25 (£2.907m in 23/24).

NOTES TO THE ACCOUNTS

18. Other financial assets (continued)

Details of the loan to Sterile Supplies Limited is as follows:
In March 2016 the Trust made a loan to its then wholly owned subsidiary company, Sterile Supplies Limited. The intention was for this sum to be used to help finance a joint venture arrangement with a third party, which will deliver cost savings into the future. Until the joint venture agreement was finalised and formal agreement signed, the loan remained repayable on demand.

During 2016-17 Sterile Supplies Limited became the joint venture vehicle between the Trust and a third party, Steris PLC (Registered in Ireland (formerly Synergy Health PLC)). As part of the joint venture agreement the Trust ceded control of Sterile Supplies Limited and the loan agreement was formalised as long term.

The long term loan of £2.0m is to assist the development of a new production facility. Loan repayments will commence when the building becomes operational. Interest is payable at 4% above the Bank of England base rate and is capitalised and added to the principal sum.

Details of the loan to Odstock Medical Limited is as follows:
During 2021-22 the Trust made a loan to its wholly owned subsidiary company, Odstock Medical Limited, to assist with its working capital requirements. The loan repayments commenced in November 2021. Interest is payable at 3.5% above the Bank of England base rate and is capitalised and added to the principal sum.

During 2023-24 Odstock Medical Limited repaid the loan and interest in full.

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

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Net Book Value of non-current assets for sale				
Carrying value at 1 April	**1,415**	-	**-**	-
Assets classified as available for sale in the year	**-**	1,415	**-**	-
Less assets sold in year	**(1,415)**			
Carrying value at 31 March	**-**	**1,415**	**-**	**-**

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

NOTES TO THE ACCOUNTS

20. Inventories

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Drugs	**1,820**	2,598	**1,820**	2,598
Consumables	**3,711**	3,784	**3,711**	3,784
Laundry and other subsidiary stock	**1,856**	2,151	**-**	-
Other	**133**	95	**133**	95
	7,520	8,628	**5,664**	6,477
Inventories recognised as an expense in the period	**68,682**	62,663	**67,288**	59,778

21. Receivables

21.1 Non-current

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Clinician pension tax provision reimbursement funding from NHSE	**344**	324	**344**	324
	344	324	**344**	324
Of which receivables from NHS and DHSC group	**344**	324	**344**	324

21.2 Current

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Contract receivables	**13,133**	28,471	**15,118**	28,022
Capital receivables	**403**	-	**403**	-
Allowance for impaired contract receivables / assets	**(1,158)**	(1,151)	**(1,158)**	(1,151)
Prepayments (non-PFI)	**4,497**	3,731	**4,497**	3,738
PDC dividend receivable	**525**	292	**525**	292
VAT receivable	**1,297**	1,422	**1,297**	1,422
Clinician pension tax provision reimbursement funding from NHSE	**13**	10	**13**	10
Other receivables	**353**	404	**125**	539
	19,063	33,179	**20,820**	32,872
Of which receivables from NHS and DHSC group	**3,314**	19,633	**3,314**	19,633

NOTES TO THE ACCOUNTS

21. Receivables (continued)

The majority of transactions are with Integrated Care Boards (ICBs) or NHS England's Specialist Commissioners, as commissioners for NHS patient care services. As ICBs and Specialist Commissioners are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

The average credit period taken on sale of goods is 19 days (2023/24: 33 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2025		31 March 2024	
	Receivables and contract assets £000	**All other receivables £000**	Receivables and contract assets £000	All other receivables £000
Allowance for credit losses at 1 April - brought forward	**1,151**	**-**	1,270	-
New allowances arising	**-**	**-**	90	-
Changes in the calculation of existing allowances	**23**	**-**	(73)	-
Utilisation of allowances (write offs)	**(16)**	**-**	(136)	-
Balance at 31 March	**1,158**	**-**	1,151	-

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

22. Cash and cash equivalents

	Group		**Trust**	
	31 March 2025 £000	31 March 2024 £000	**31 March 2025 £000**	31 March 2024 £000
Balance at beginning of year	**16,963**	33,179	**10,638**	27,455
Net change in year	**11,988**	(16,216)	**8,953**	(16,817)
Balance at end of year	**28,951**	16,963	**19,591**	10,638
Made up of:				
Cash with Government Banking Service	**19,345**	10,374	**19,345**	10,374
Cash at commercial banks and in hand	**9,606**	6,589	**246**	264
Cash and cash equivalents as in balance sheet	**28,951**	16,963	**19,591**	10,638
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**28,951**	16,963	**19,591**	10,638

NOTES TO THE ACCOUNTS

23. Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Current:				
Trade payables	**23,234**	25,543	**21,834**	23,083
Capital payable	**8,079**	13,353	**8,079**	13,353
Accruals	**2,937**	1,310	**2,937**	1,310
Receipts in advance	**3,024**	2,023	**3,024**	2,023
Social security and other taxes payable	**5,288**	4,892	**5,288**	4,892
Pay and pensions related	**3,316**	4,169	**3,316**	4,169
Other	**1,341**	506	**936**	508
	47,219	51,796	**45,414**	49,338
Of which payables from NHS and DHSC group bodies:	**4,710**	9,795	**4,710**	9,795

All Trade and other payables are current liabilities.

24. Borrowings

Group	Current		Non-current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Lease liabilities	**1,339**	1,101	**4,560**	3,613
Amounts due under PFI (note 30.7) *	**1,601**	1,419	**25,919**	26,170
Loans from Department of Health and Social Care (DHSC)	**321**	637	**-**	319
Other loans	**-**	5,011	**-**	-
	3,261	8,168	**30,479**	30,102

Trust	Current		Non-current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Lease liabilities	**1,072**	419	**2,685**	2,575
Amounts due under PFI (note 30.7) *	**1,601**	1,419	**25,919**	26,170
Loans from Department of Health and Social Care (DHSC)	**321**	637	**-**	319
Other loans	**-**	5,011	**-**	-
	2,994	7,486	**28,604**	29,064

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

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

Other loans represents an interest free advance from NHS Bath and North East Somerset, Swindon and Wiltshire ICB that was repaid in the first quarter of 2024-25.

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.1 Reconciliation of liabilities arising from financing activities (Group)

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

Group - 2023/24	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	**1,591**	**-**	**2,513**	**15,564**	**19,668**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	5,011	(805)	(1,296)	**2,279**
Financing cash flows - payments of interest	(24)	-	(87)	(1,896)	**(2,007)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	-	9,903	**9,903**
Additions	-	-	3,414	-	**3,414**
Remeasurement of PFI liability resulting from change in index or rate	-	-	-	3,422	**3,422**
Application of effective interest rate	20	-	87	1,892	**1,999**
Early terminations	-	-	(408)	-	**(408)**
Carrying value at 31 March 2024	**956**	**5,011**	**4,714**	**27,589**	**38,270**

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

24.2 Reconciliation of liabilities arising from financing activities (Trust)

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

Trust - 2023/24	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	**1,591**	**-**	**608**	**15,564**	**17,763**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	5,011	(249)	(1,296)	**2,835**
Financing cash flows - payments of interest	(24)	-	(21)	(1,896)	**(1,941)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	-	9,903	**9,903**
Additions	-	-	2,635	-	**2,635**
Remeasurement of PFI liability resulting from change in index or rate	-	-	-	3,422	**3,422**
Application of effective interest rate	20	-	21	1,892	**1,933**
Carrying value at 31 March 2024	**956**	**5,011**	**2,994**	**27,589**	**36,550**

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Pensions - early departure costs	**12**	14	**9**	12
Pensions - injury benefits	**27**	27	**139**	154
Legal claims	**538**	348	**-**	-
Clinician pension tax reimbursement	**13**	10	**344**	324
Other	**-**	45	**-**	-
	590	444	**492**	490

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2024	26	181	348	334	45	**934**
Change in the discount rate	-	-	-	(3)	-	**(3)**
Arising during the year	7	10	438	15	-	**470**
Utilised during the year	(13)	(29)	(27)	(6)	-	**(75)**
Reversed unused	-	-	(221)	-	(45)	**(266)**
Unwinding of discount	1	4	-	17	-	**22**
At 31 March 2025	**21**	**166**	**538**	**357**	**-**	**1,082**
Expected timing of cash flows:						
Within 1 year	12	27	538	13	-	**590**
1 - 5 years	9	77	-	45	-	**131**
5+ years	-	62	-	299	-	**361**
	21	**166**	**538**	**357**	**-**	**1,082**

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2023	40	191	375	418	45	**1,069**
Change in the discount rate	-	(5)	-	(72)	-	**(77)**
Arising during the year	-	17	-	-	-	**17**
Utilised during the year	(15)	(25)	(27)	(12)	-	**(79)**
Reversed unused	-	-	-	(22)	-	**(22)**
Unwinding of discount	1	3	-	22	-	**26**
At 31 March 2024	**26**	**181**	**348**	**334**	**45**	**934**
Expected timing of cash flows:						
Within 1 year	14	27	348	10	45	**444**
1 - 5 years	12	87	-	17	-	**116**
5+ years	-	67	-	307	-	**374**
	26	**181**	**348**	**334**	**45**	**934**

Pension provisions arise from early retirements (£26k) and from ill health (£181k). These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to a pension provision of £479k and the Trust's provision for personal injury and employee claims of £59k. These are based on valuation reports provided by the Trust's legal advisers.

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges (continued)

Clinician pension tax reimbursement provision arises in respect of clinicians who are members of the NHS Pension Scheme, and who as a result of work undertaken, face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. Government policy is that the Trust will reimburse the NHS Pension Scheme on the retirement of the clinician in exchange for the Scheme paying the additional tax due.

Other provisions related to an additional tax liability following revised guidance by HMRC which has been reversed in year.

£0 m is included in the provisions of NHS Resolution at 31 March 2025 in respect of clinical negligence liabilities of the Trust (2023/24: £0 m).

26. Capital and other commitments

Capital commitments - Group and Trust

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	2,008	1,988
Intangible assets	1,025	23
Total	**3,033**	2,011

27. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £0.5m (2023: £0.5m).

28. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year ended 31 March 2025 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities include Clinical Commissioning Groups, NHS England, Health Education England, NHS Resolution and other Trusts and Foundation Trusts.

Salisbury NHS Foundation Trust also has the following transactions listed below with its subsidiary companies, joint ventures, charitable funds (for which it is the Corporate Trustee) and other organisations identified as related parties by DHSC:

	Income	**Expenditure**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**
Year ending 31 March 2025				
Salisbury Trading Limited	**1,123**	**1,053**	**3,061**	**26**
Odstock Medical Limited	**652**	**3**	**67**	**3**
Salisbury District Hospital Charitable Fund	**1,071**	**27**	**871**	**-**
Sterile Supplies Limited	**252**	**2,399**	**51**	**478**
Wiltshire Health and Care LLP	**501**	**942**	**9**	**8**
Locums Nest Limited	**-**	**60**	**-**	**-**
NHS Confederation	**-**	**13**	**-**	**-**
Vyaire UK 236 Limited	**-**	**62**	**-**	**-**
Year ending 31 March 2024				
Salisbury Trading Limited	200	1,027	2,127	90
Odstock Medical Limited	214	-	64	1
Salisbury District Hospital Charitable Fund	867	39	144	-
Sterile Supplies Limited	313	2,313	50	1
Wiltshire Health and Care LLP	615	987	139	815
Locums Nest Limited	-	72	-	-
NHS Confederation	-	14	-	3
Vyaire UK 236 Limited	-	6	-	-

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI)

29.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services covering a number of specialties including: Burns, Plastics, Orthopaedics, Elderly Medicine, Inpatient and Outpatient facilities. A replacement Laundry also forms part of the scheme, which brought the off-site service onto the District General Hospital premises.
At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration.
There were no changes to the terms and conditions of the PFI agreement during the year.

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

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

	Group and Trust	
	2025	2024
	£000	£000
Interest	**1,897**	1,892
Repayment of finance lease liability	**1,492**	1,296
Service element	**1,342**	1,290
Capital lifecycle maintenance	**433**	432
Unitary payment payable to service concession operator	**5,164**	4,910

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

The Trust is committed to make the following service payments on the PFI:	**2025**	2024
	£000	£000
Due within one year	**3,397**	3,223
Due within 2 to 5 years	**13,777**	13,021
Due after 5 years	**22,333**	24,548
Gross PFI liabilities	**39,507**	40,792
Finance charges allocated to future periods	**(11,987)**	(13,203)
Net PFI liabilities	**27,520**	27,589
- not later than one year;	**1,601**	1,419
- later than one year and not later than five years;	**7,757**	6,835
- later than five years.	**18,162**	19,335

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

29.4 Total future payments committed in respect of PFI

Total future commitments under these on-SoFP schemes are as follows:

	2025	2024
	£000	£000
Total	**65,515**	70,109
of which due:		
Within one year	**5,339**	5,164
Within 2 to 5 years	**22,726**	21,979
Due thereafter	**37,450**	42,966
Total	**65,515**	70,109

NOTES TO THE ACCOUNTS

30. Financial instruments

IFRS 7 and IFRS 9 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

30.1 Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations although the charity holds a small number of investments denominated in United States dollars and Euros, these are immaterial and, as a result, the Group has low exposure to currency fluctuations.

30.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

30.3 Interest-rate risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

30.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2025

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Fixed rate									
Finance lease obligations	**0.95 - 7.16**	**112**	**335**	**892**	**1,040**	**3,104**	**1,355**	**(939)**	**5,899**
PFI obligations	**6.5**	**283**	**566**	**2,548**	**3,444**	**10,333**	**22,333**	**(11,987)**	**27,520**
DHSC capital loan	**1.64**	**-**	**-**	**324**	**-**	**-**	**-**	**(3)**	**321**
Floating rate									
Trade and other payables	**-**	**34,250**	**-**	**-**	**-**	**-**	**-**	**-**	**34,250**

As at 31 March 2024

	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Fixed rate									
Finance lease obligations	0.95 - 7.16	91	181	816	1,092	2,183	1,177	(826)	4,714
PFI obligations	6.5	269	537	2,417	3,397	9,624	24,548	(13,203)	27,589
DHSC capital loan	1.64	-	323	321	322	-	-	(10)	956
Floating rate									
Trade and other payables	-	40,206	-	-	-	-	-	-	40,206
Other borrowings	-	5,011	-	-	-	-	-	-	5,011

NOTES TO THE ACCOUNTS

30. Financial instruments (continued)

30.5 Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2025 are in receivables from customers, as disclosed in note 21.

30.6 Carrying values of financial assets

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

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2025				
Trade and other receivables excluding non financial assets	**12,141**	**-**	-	**12,141**
Other investments / financial assets	**3,177**	**-**	-	**3,177**
Cash and cash equivalents (excluding NHS Charitable fund cash	**22,530**	**-**	-	**22,530**
Consolidated NHS Charitable fund financial assets	**7,008**	**9,428**	**-**	**16,436**
Total at 31 March 2025	**44,856**	**9,428**	**-**	**54,284**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2024				
Trade and other receivables excluding non financial assets	27,923	-	-	27,923
Other investments / financial assets	2,907	-	-	2,907
Cash and cash equivalents	13,044	-	-	13,044
Consolidated NHS Charitable fund financial assets	4,514	9,143	-	13,657
Total at 31 March 2024	48,388	9,143	-	57,531

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2025				
Trade and other receivables excluding non financial assets	**14,363**	-	-	**14,363**
Other investments / financial assets	**4,750**	-	-	**4,750**
Cash and cash equivalents	**19,591**	-	-	**19,591**
Total at 31 March 2025	**38,704**	**-**	**-**	**38,704**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2024				
Trade and other receivables excluding non financial assets	27,607	-	-	27,607
Other investments / financial assets	4,945	-	-	4,945
Cash and cash equivalents	10,638	-	-	10,638
Total at 31 March 2024	43,190	-	-	43,190

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

30.7 Carrying values of financial liabilities

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

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

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2024			
Loans from the Department of Health and Social Care	956	-	956
Other borrowings excluding lease and PFI liabilities	5,011	-	5,011
Obligations under finance leases	4,714	-	4,714
Obligations under PFI, LIFT and other service concession contracts	27,589	-	27,589
Trade and other payables excluding non financial liabilities	44,272	-	44,272
Provisions under contract	779	-	779
Total at 31 March 2024	83,321	-	83,321

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2025			
Loans from the Department of Health and Social Care	**321**	**-**	**321**
Obligations under finance leases	**3,757**	**-**	**3,757**
Obligations under PFI, LIFT and other service concession contracts	**27,520**	**-**	**27,520**
Trade and other payables excluding non financial liabilities	**29,913**	**-**	**29,913**
Provisions under contract	**51**	**-**	**51**
Total at 31 March 2025	**61,562**	**-**	**61,562**

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2024			
Loans from the Department of Health and Social Care	956	-	956
Other borrowings excluding lease and PFI liabilities	5,011	-	5,011
Obligations under finance leases	2,994	-	2,994
Obligations under PFI, LIFT and other service concession contracts	27,589	-	27,589
Trade and other payables excluding non financial liabilities	42,012	-	42,012
Provisions under contract	779	-	779
Total at 31 March 2024	79,341	-	79,341

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	**31 March 2025 £000**	31 March 2024 £000
In one year or less	**36,992**	54,574	**36,331**	51,210
In more than one year but not more than five years	**17,921**	16,754	**16,513**	16,754
In more than five years	**23,688**	26,085	**23,405**	26,085
Total	**78,601**	97,413	**76,249**	94,049

31. Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2025 (2023/24: £nil) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Investment in subsidiary

32.1 Odstock Medical Limited

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

	Trust 31 March 2025 £'000	Trust 31 March 2024 £'000
Shares at cost		
At 31 March	**-**	**-**

The Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

The Trust's charity, Salisbury District Hospital Charitable Fund, owns a further 18% of Odstock Medical Limited.

NOTES TO THE ACCOUNTS

32. Investment in subsidiary (continued)

32.2 Salisbury Trading Limited

Salisbury NHS Foundation Trust established a subsidiary company, Salisbury Trading Limited (registered in England), to market and deliver laundry and linen services. The company commenced trading on 1 October 2013. Salisbury NHS Foundation Trust owns 100% of Salisbury Trading Limited. The company has experienced steady growth since commencing to trade by winning new linen contracts. It has increased operational capacity through arrangements involving the management of another NHS laundry facility, which will provide an additional base for future expansion.

	2025	2024
Shares at cost	**£000**	£000
At 31 March 2025 and 31 March 2024	**500**	500

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also notes 17. and 18.

33. Investment in Joint Ventures

33.1 Sterile Supplies Limited

Salisbury NHS Foundation Trust owns 50% of the issued share capital of Sterile Supplies Limited, a company registered in England. The remaining 50% is owned by Synergy Health (UK) Limited, a company registered in England. The Board structure and voting rights are such that the Trust is not able to exert overall control of Sterile Supplies Limited, the Trust therefore recognises the company as a joint venture. The joint venture is re-developing a new production facility, from which it will market and deliver sterilisation services. The joint venture currently trades from the Trust's existing sterilisation and disinfection unit. Sterile Supplies Limited reported a loss in year and so the carrying value of the investment has fallen to zero.

Group and Trust	**2025**	2024
	£000	£000
Carrying value of investment at 1 April	**168**	137
Share of (loss) / profit in the period	**(168)**	31
Carrying value of investment at 31 March	**0**	**168**

33.2 Wiltshire Health and Care

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

Group and Trust	**2025**	2024
	£000	£000
Carrying value of investment at 1 April	**163**	163
Share of surplus in the period	**-**	-
Impairments	**(163)**	-
Carrying value of investment at 31 March	**-**	**163**

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	2025 £000	2024 £000
Public Dividend Capital at 1 April	**120,382**	99,600
New public dividend capital received	**21,606**	20,782
Public Dividend Capital at 31 March	**141,988**	120,382

The new public dividend capital received in the year relates to additional funding to purchase capital items of £16,406k (2023/24: £16,485k) and £5,200k revenue support (2023/24 :£4,297k).

35. Charitable fund balances

Group only	2025 £000	2024 £000
Restricted funds	**4,199**	4,162
Unrestricted funds	**11,767**	11,167
Endowment funds	**-**	-
	15,966	15,329

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

36. Critical accounting judgements

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements

Valuation basis

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The current site forms the basis in determining the MEA, but the Trust has to make assumptions that are practically achievable, but is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the catchment area for patients using the services, and transport infrastructure has been taken into account when deciding on an appropriate alternative site.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for the administrative buildings occupied by Salisbury District Hospital would be a multi storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

NOTES TO THE ACCOUNTS

37. Critical accounting estimates

In the application of the Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

Property Valuations

Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health. Property valuation techniques include an inherent element of estimation; in particular specialised assets that have no active market require valuation based on assessing the likely replacement cost of an asset. Future property values will be influenced by factors such as construction costs and developments in healthcare technology and any recognised impairments. Future asset values will inevitably fluctuate but the Trust mitigates against material correcting adjustments by commissioning regular professional asset valuation reviews.

The Trust's estate of land and buildings was valued using an index on 31 March 2025 by Newmark, Chartered Surveyors. Newmark valued the land and buildings (including dwellings) at £150.9m, of which £144.1m relates to specialised assets valued on a depreciated replacement cost basis. It is the rebuilding cost values determined by the valuer using industry standard rates that gives rise to the uncertainty in the valuation.

A 10% change in the valuation would have £15.1m impact on the statement of financial position with a £483k impact on the PDC dividend due to be paid next year and accrued in these financial statements.

38. Reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time the establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Group and the Trust.

Minority interest
Minority interest relates to the ownership stake in the subsidiary companies which is under 50% of the total shares in terms of voting rights and hence doesn't exercise control of the company.