Salisbury NHS
NHS Foundation Trust

Annual Report and Accounts 2010/2011

2010-2011

Sa NHS F a T

A a R a A
2010/2011

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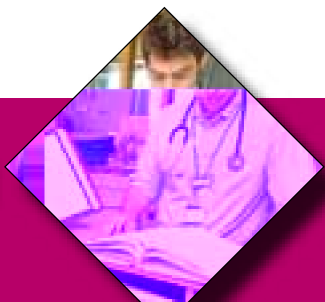
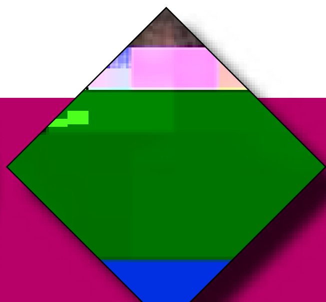
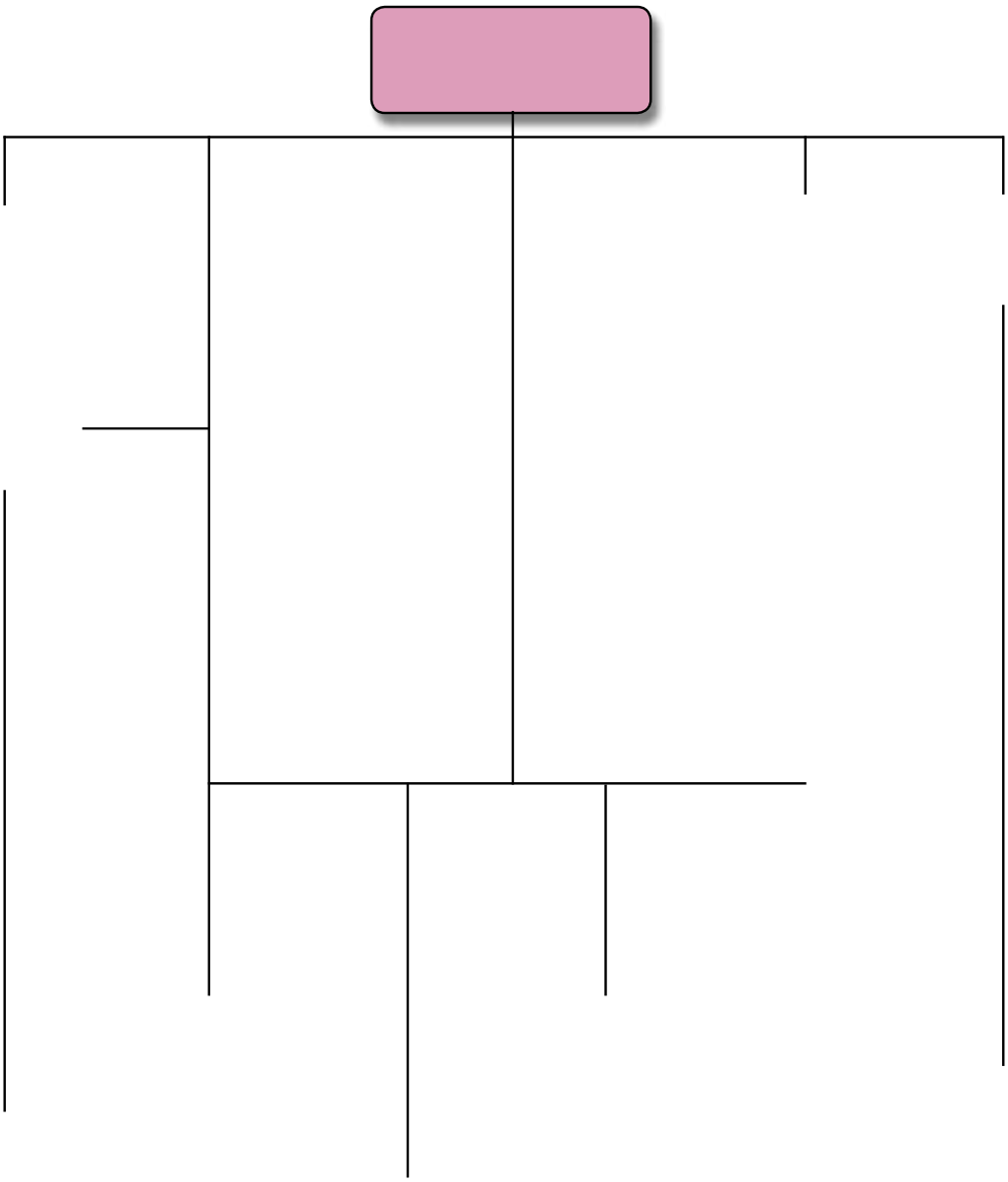
Na a H a S A 2006

It is essential that we maintain our focus on these areas and, for this year





D B ' R

L Ma	Chairman
P H	Interim Chief Executive (Director of Operations until 8 November 2010)
N A	Vice Chairman and Senior Independent Director
L Ma	Chief Executive Tu




R a B a D

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

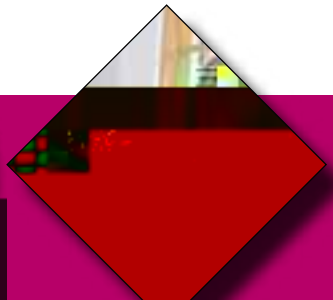
P B P a a E
S a D a

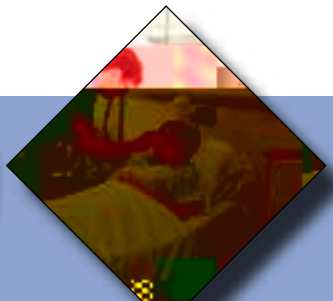
The Trust has the 'Positive About Disabled' people 'two ticks standard' and has in place policies that apply to the recruitment, retention, training and development of staff with disabilities. This includes provisions to ensure that disabled people who apply to work for the Trust are treated fairly with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

P I a a
I E

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

P a a T a
a a C a
AB a a

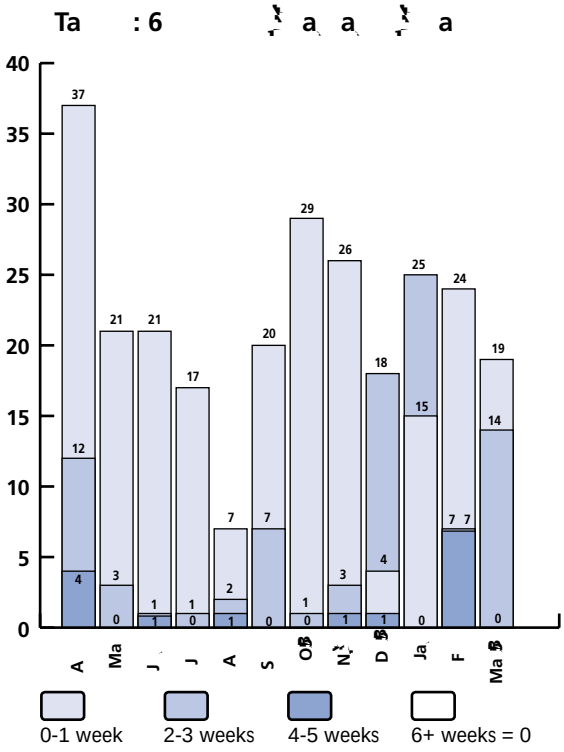


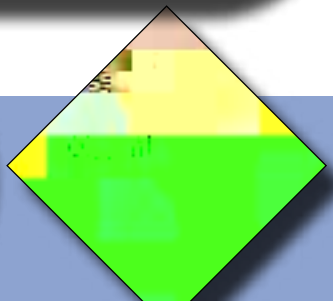
Cleanliness and good infection, prevention and control policies and procedures are essential to the safety of patients and the Trust again received an excellent rating for cleanliness, as part of the Hospital Environment category of the Patient Environment Action Team (PEAT) Inspection. The PEAT assessment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

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

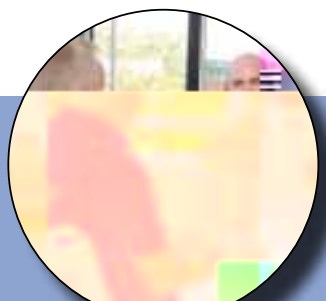
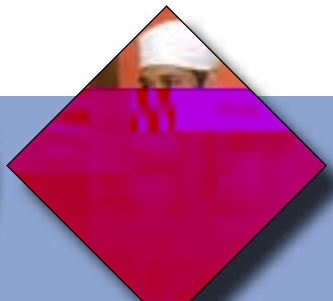
The Trust already had low MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia rates and these were reduced further to zero during the year. In hospital Clostridium Difficile (C.Diff) rates were also reduced and were better than those in other Trusts across the country.

KEY PERFORMANCE INDICATOR
APRIL 2010 MARCH 2011

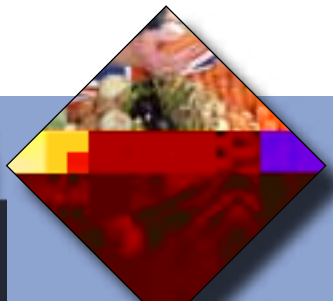




Patients who need emergency treatment can now benefit from better facilities and an improved service thanks to a complete redesign of the Accident and Emergency

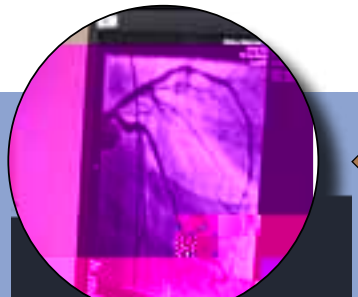



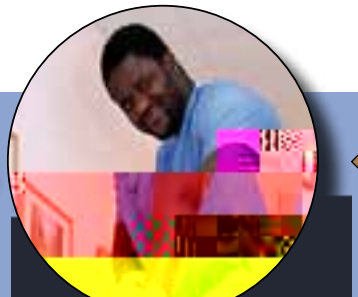


Respect & dignity and whether patients felt that they had confidence and Trust in staff treating them were also positive themes. The survey highlights specific areas for action which includes the prompt answering of call bells. This, along with other themes such as copying letters to patients, will provide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

In a national survey of maternity sl3eonall[illegible]ao[illegible]e






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

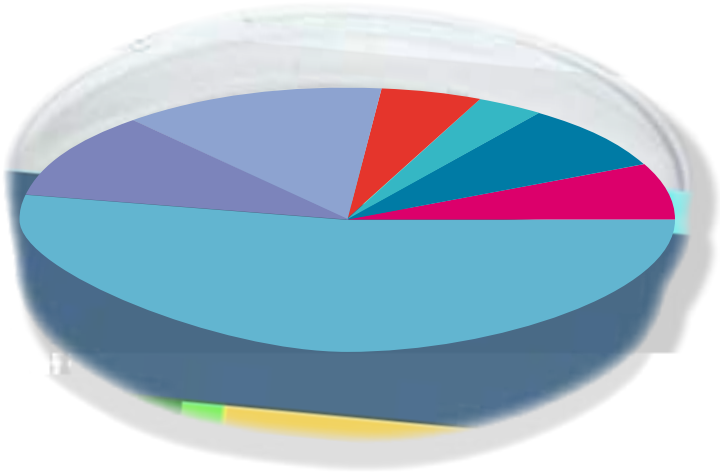
In this challenging climate, the Trust needs to have an effective Assurance Framework – a set of risks that it acknowledges and monitors in order to ensure the viability of the organisation. These are linked closely to the Trust's financial and operational objectives and includes: an assessment of income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

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

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

Communication with staff is an essential task and staff



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

Income generated by Odstock Medical Ltd (OML), is being used to further research and create new developments that help patients. The Trust owns 68% of OML. The Trust can report that OML made a profit and this is reflected in the consolidated accounts. The Trust also treats private patients through a partnership with Odstock Private Care Limited (OPCL), working within guidance published by Monitor, the independent Regulator for Foundation Trusts. To support this, the Trust opened the Clarendon Suite during the year, which is a designated unit where private patients can be treated on the Salisbury District Hospital site. xsdkjf[trnership jf[with Odstockpos)stp6k2[jf[2vhe(the 8ate0talae0i



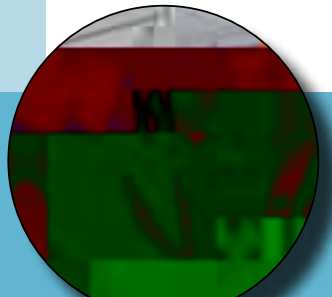

C aB A B a Sa D B H a

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

Pa I a a Sa D B H a

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

IMPROVING SERVICES AND FACILITIES FOR OUR PATIENTS




B A a a T a S (B.A.T.S.)

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

Fa Ra R T a T

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

E a O - -H Pa Ta S

Following requests to provide a full round-the-clock service to release beds sooner, the Patient Transport Team has expanded services making them more responsive to ward staff's needs and ensuring that patients get the




T Ma F, E a P a & C , C B , C a a C D

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

LISTENING AND LEARNING FROM OUR PATIENTS

W Ra Ma S B

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

Ca B Pa ' S

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

Na a l a ' S

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

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

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

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

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




K ' F P Ca P a

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

A a F V T (VTE) W

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

N R a G a Sa S

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

Sa S I G L T B D

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

CELEBRATING ACHIEVEMENTS

Pa C R U I S a U Ga

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

Sa M R I a a Ba F A a




Y V Y a

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

E a T a W T a A a

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

WORKING WITH OUR STAKEHOLDERS, PARTNERS AND LOCAL COMMUNITY

Na a Pa W

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

K F V

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

S G a V

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

E A a

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

Sa C a A a Ra (SCAR) a

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

C a A a

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

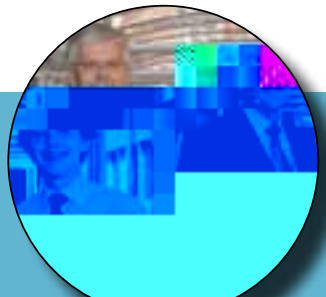
L a G C I a D C ' U

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

C S S a E A H a V

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




Na	R	A a B
L Ma B	Chairman	4
N A	Member	4
L a B	Member	4
Ba B	Member	3
Ia D	Member	3
S L	Member	4
M B R a	Member	2
J S	Member	2

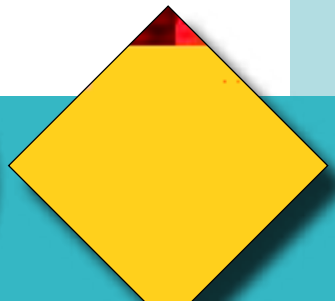






This reflects the increase on CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



TRUST BOARD EMPLOYMENT TERMS

T C a a a N -E D T a a C G a a B a .T a a B a a a a .

The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a contract with no time limit attached and the contract can be terminated by either party with three-month's notice. The contract is subject to normal employment legislation.

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

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

No significant awards have been made to past senior managers.

Peter Hill
Interim Chief Executive
6 June 2011




E B G P BC B

Na	C B	Da E B	T O B	A a B 4
J Ca (L a G)	Salisbury City	May 2009	Three years	3
C C	Salisbury City	May 2008	Three years	4
C Wa	Salisbury City	May 2009	Three years	4
Ka B a	South Wiltshire Rural	May 2009	Three years	4
R C a	South Wiltshire Rural	May 2009	Three years	4
C H	South Wiltshire Rural	May 2008	Three years	4
B R	South Wiltshire Rural	May 2009	Three years	3
Sa a W a	South Wiltshire Rural	May 2009	Three years	3
Pa G a	North Dorset	May 2008	Three years	4
Ma H B	North Dorset	May 2009	Three years	4
Wa A	New Forest	May 2009	Three years	2
J Ma	Kennet	May 2009	Three years	4
Ca N a	West Wiltshire	May 2009	Three Years	4
E a C B	East Dorset	May 2009	Three years	4

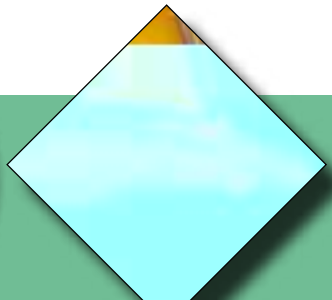
E B G - Pa /Ca C B

Na	C B	Da E B	T O B	A a B 4
A Fa	Patient/ Carer	May 2009	Three years	3

E B G - S a C B

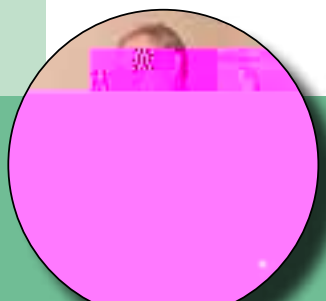
S a F a	Medical & Dental	May 2009	Three years	3
C Ma a	Nurses & Midwives	Nov 2009	Three years	4
L a W	Hotel & Property Services	May 2009	Three years	3
L A	Clerical, Administrative and Managerial	May 2009	Three years	2
*N B C	Scientific & Therapeutic	May 2009	Three Years	2
E BG	Volunteers	May 2009	Three Years	2

VolunteTf (May 2009 Thr e Y ars HeamokcRu VolunteTf May 2009 hr e N ars ar

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

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




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

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

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

- Safeguard assets
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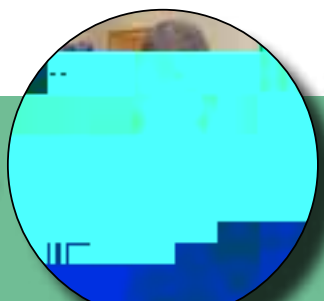



The Trust has continued to make real progress over the last year with the key quality measures that impact on patients', their families' and visitors' experiences. This is reflected in a number of positive improvements over the year. These include greater support and access to acute medical care, expansion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

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

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

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

PRIORITY ONE

CONTINUE TO IMPROVE THE END OF LIFE CARE FOR PATIENTS

D [illegible] a [illegible] a [illegible]

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

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

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

W a [illegible] a a [illegible] ?

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

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

- Our work on Venous Thrombo-Embolism (VTE) continued. The Trust is a national exemplar site for VTE and has continued to work hard on all aspects of VTE prevention. The number of patients undergoing a full assessment for their risk of VTE increased to




PRIORITY THREE

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

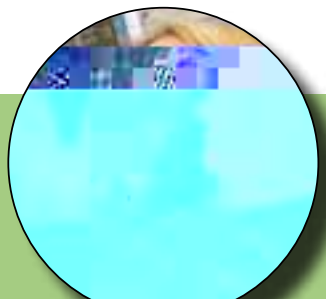
D

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

W ?

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

- In the Emergency Department (ED) patients E[n fm2Br1pV (emerY 1 o a(saTV Y(Mly andBatv(n




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

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

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

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- We will continue our work on the Productive Ward – Releasing Time to Care Programme to ensure that all wards have completed all modules. We have already seen a number of improvements across the Trust
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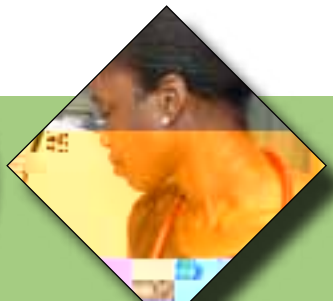


PRIORITY FIVE

CONTINUE TO KEEP PATIENTS SAFE DURING THEIR STAY IN HOSPITAL

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

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

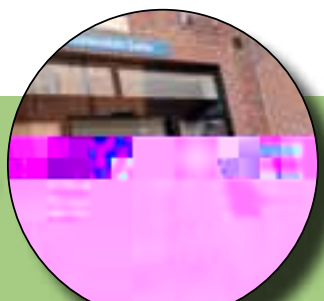
Patients continue to tell us that they want a clean hospital and that they do not want to get any infections during their stay with us. Our infection rates are below the national average - there have been no hospital apportioned MRSA bacteraemia in 2010/11 and a continued downward trend with C Difficile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

W a a ?

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

C D Ra



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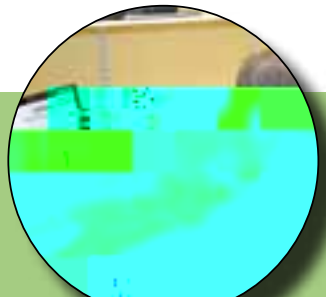
We will work with staff, patients and visitors to continue our safety work.

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




Participation in clinical audits

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

During that period, Salisbury NHS Foundation Trust participated in




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

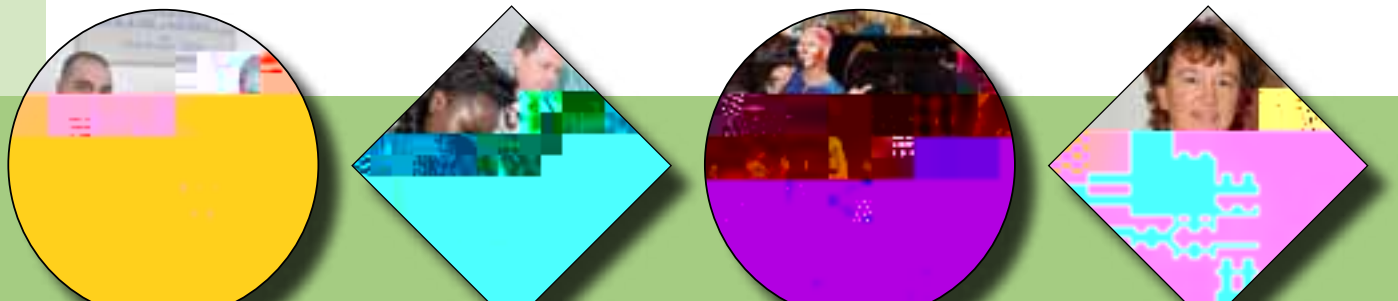



CQUIN		Data	Target 10/11	Performance
1	Venous-thromboembolism (VTE) prevention - Reduce avoidable death, disability and chronic ill health from VTE	Safety	90%	Fully Achieved
2	Improve responsiveness to personal needs of patients	Patient Experience	Mean score improvement of 8 (73.4 and above)	Partially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

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

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

Spending time working with clinicians and administrative



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




	2008/09	2009/10	2010/11	Na a A a	W a a ?	S B B
10. Compliance with NICE Technology Appraisal Guidance (TAG) published in year	83%	92%	80%	Not Measured	Higher number better	Local indicator
Pa E B I a						
11. Number of patients reported with pressure ulcers (grade 3 &4)	45	58	19	Not available	Lower is better	National definition with data taken from hospital reporting systems
12. % of patients	80%	75%	81%	Not		




Na a Ta a R a R

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

* I 2008/2009 a 2009/2010 T a a a a a a a a T a , GP a a T - a . T a 2008 2010. F 2010/2011 a a T - a a T a (72 a a) a - T a (a 72 a).

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

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

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

D C C H a S C

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

S a W I N (WIN)

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

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

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

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

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

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

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




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

S [illegible] a [illegible] a

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

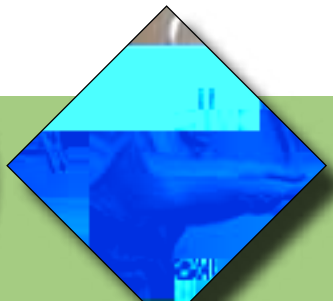
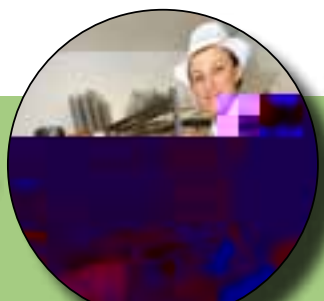
R [illegible] D [illegible] a [illegible]

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

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

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

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


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

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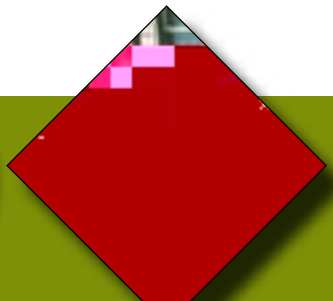
It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

C B

Based on the results of my procedures, nothing has come to my attention that causes me to believe that,



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

P Ba D

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

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

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	S H T Q	H T Q	H T Q	H T Q			

P a a a a

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

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

In addition we will also:

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

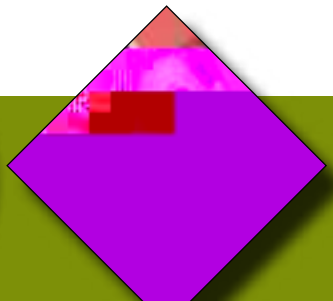
These priorities are regularly reviewed and performance monitored and measured through the Equality and Diversity Steering Group, which is chaired by a non-executive director of the Trust.






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

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

Sales, Publicity and Charitable Gifts

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

Patient and Public Involvement

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

Public Sector Equality Duty

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

Staff Absence Information

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

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

Compliance with HM Treasury and Office of Public Sector Information Guidance

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

Serious Untoward Incidents

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

Review of Effectiveness of Internal Control

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

Taken as read by the Trust Board on 6 July 2011.

PHILIP CHEEK
6 July 2011

Sa NHS F a T C a F a Ba S a F T Y a T 31 Ma B 2011




FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2011 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 Ä

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

The National Health Service Act 2006 states that the Chief Executive is the J ru

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Signed:

Date: 6 June 2011

Annual Governance Statement

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Salisbury NHS Foundation Trust's policies, aims and objectives, whilst safeguarding

The Trust has established a quality framework for the review of individual services which includes

Aligned to the headings in

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

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

7. REVIEW OF EFFECTIVENESS

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

The Head of Internal Audit has provided me with an opinion of significant assurance on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the annual internal audit plan; there is a generally sound system of internal control, designed to meet the organisation"s objectives, and that controls are generally being applied consistently. However, some weaknesses in the design of controls and/or inconsistent application have been identified in the Internal Audit Annual Report. These include an area which was identified last year - workforce performance management, in particular the application of the

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

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

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

This report is made solely to the Council of Governors of Salisbury NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an

	Note	2010/11 Ã000	2009/10 £000	2010/11 Ã000	2009/10 £000
Revenue from patient care activities	3	**161,794**	160,436	**161,794**	160,436
Other operating revenue	5	**16,528**	17,147	**15,045**	15,663
Operating expenses	7	**(172,987)**	(170,787)	**(171,540)**	(169,410)
OPERATING SURPLUS		**5,335**	6,796	**5,299**	6,689
FINANCE COSTS					
Finance income	12	**105**	112	**105**	112
Finance costs - financial liabilities	13	**(1,819)**	(1,711)	**(1,819)**	(1,711)
Finance costs - unwinding of discount on provisions	13	**(13)**	(9)	**(13)**	(9)
PDC Dividends payable		**(3,566)**		15, fsco	(aya0

	Note	**31 March 2011 Ã000**	31 March 2010 £000	**31 March 2011 Ã000**	31 March 2010 £000
NON-CURRENT ASSETS					
Intangible assets	16	**86**	-	**86**	-
Property, plant and equipment	17	**137,665**	126,442	**137,627**	126,394
Investments in subsidiaries	32	**-**	-	**-**	-
Total non-current assets		**137,751**	126,442	**137,713**	126,394
CURRENT ASSETS					
Inventories	18	**2,263**	1,698	**2,179**	1,643
Trade and other receivables	19	**13,313**	11,041	**13,274**	11,016
Cash and cash equivalents	20	**10,040**	10,193	**9,915**	10,039
Total current assets		**25,616**	22,932	**25,368**	22,698
CURRENT LIABILITIES					
Trade and other payables	21	**(16,404)**	(12,004)	**(16,303)**	(11,897)
Borrowings	22	**(2,165)**	(1,262)	**(2,165)**	(1,262)
Provisions	23	**(331)**	(325)	**(331)**	(325)
Tax payable	21	**(7)**	(26)	**-**	-
TOTAL CURRENT LIABILITIES		**(18,907)**	(13,617)	**(18,799)**	(13,484)
TOTAL ASSETS LESS CURRENT LIABILITIES		**144,460**	135,757	**144,282**	135,608
NON-CURRENT LIABILITIES					
Trade and other payables	21	**-**	-	**-**	-
Borrowings	22	**(25,618)**	(26,971)	**(25,618)**	(26,971)
Provisions	23	**(334)**	(362)	**(334)**	(362)
TOTAL NON CURRENT LIABILITIES		**(25,952)**	(27,333)	**(25,952)**	(27,333)
TOTAL ASSETS EMPLOYED		**118,508**	108,424	**118,330**	108,275
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		**57**	48	**-**	-
Public dividend capital		**51,229**	51,181	**51,229**	51,181
Revaluation reserve		**58,628**	51,302	**58,628**	51,302
Donated asset reserve		**3,013**	1,144	**3,013**	1,144
Income and expenditure reserve		**5,581**	4,749	**5,460**	4,648
TOTAL TAXPAYERS EQUITY		**118,508**	108,424	**118,330**	108,275

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

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

Signed:

Peter Hill - Interim Chief Executive

	Public	Income and	Revaluation	Donated	Minority	Total

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Intangible assets

Intangible assets are non-monetary assets without physical substance, which are capable

1.6 Property, plant and equipment (continued)

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

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

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

1. ACCOUNTING POLICIES (CONTINUED)

1.6

Donated

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Lifecycle replacement

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

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

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

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

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

Other assets contributed by the Trust to the operator

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

1.7 Investment

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

1.8 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.9 Government Grants

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

1. ACCOUNTING POLICIES (CONTINUED)

1.10 Inventories

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

1.11 Cash and cash equivalents

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

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

1.12 Provisions

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred

1. ACCOUNTING POLICIES (CONTINUED)

1.21 Contingencies

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

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

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

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

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

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

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

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

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

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

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

2. Segmental Analysis

Group and Trust

3 Revenue

Group and Trust

3.1 Revenue by Type

	2011 Ã000	2010 £000
Elective revenue	**36,195**	35,477
Non-elective revenue	**62,444**	63,037
Outpatient revenue	**28,161**	27,858
A & E revenue	**4,089**	3,852
Other types of activity revenue	**23,381**	24,604
Total revenue at full tariff	**154,270**	154,828
Revenue from activities		
Private patient revenue	**1,387**	384
Other non-protected clinical revenue	**6,137**	5,224
	161,794	160,436

3.2 Revenue by Source

	2011 Ã000	2010 £000
Foundation Trusts	**839**	699
NHS Trusts	**1,141**	1,326
Strategic Health Authorities	**129**	81
Primary Care Trusts	**155,424**	154,420
Local Authorities	**-**	138
Department of Health - grants	**-**	-
Department of Health - other	**-**	377
NHS Other	**41**	49
Non NHS:		
- Private patients	**1,387**	384
- Overseas patients (non-reciprocal)	**23**	60
- NHS Injury scheme (was Road Traffic Act)	**1,088**	1,187
- Other	**1,722**	1,715
	161,794	160,436

3.3 Mandatory Services

	2011 Ã000	2010 £000
Mandatory services	**155,617**	153,855
Non-mandatory services	**6,177**	6,5 6

4. Private Patient Revenue

Group and Trust	Base year 2002/03 Ã000	**2011 Ã000**	2010 Ã000
Private patient revenue	1 #		

7. Operating Expenses

Operating expenses comprise:

Group	**2011**	2010
	Ã000	Ã000
Services from other NHS Foundation Trusts	**232**	233
Services from NHS Trusts	**1,103**	1,114
Services from other NHS bodies	**597**	552
Purchase of healthcare from non-NHS bodies	**2,223**	780
Executive directors costs	**876**	948
Non-executive directors costs	**149**	147
Staff costs	**113,152**	114,420
Drug costs	**10,811**	10,146
Supplies and services - clinical (excluding drug costs)	**16,151**	16,230
Supplies and services - general	**2,742**	2,872
Establishment	**1,981**	2,179
Transport	**629**	635
Premises	**6,223**	6,074
Provision for impairment of receivables	**770**	19
Depreciation and amortisation	**7,744**	7,348
Impairments and x A f receivabl ³ e ª я s		

10.1 Pension costs (continued)

Annual Pensions

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as a

17. Property, plant and equipment

Group

17.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	Ã000	Ã000	Ã000	Ã000	Ã000	Ã000	Ã000	Ã000	Ã000
Cost or valuation at 1 April 2010									
At 1 April 2010	5,760	90,075	5,715	2,488	45,691	661	11,533	844	162,767
Additions - purchased	-	1,547	-	4,938	2,758	-	316	125	9,684
Additions - donated	-	224	-	827	952	-	49	-	2,052
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	1,123	-	(1,911)	160	-	557	71	-
Revaluation	(22)	4,132	-	-	-	-	-	-	4,110
Disposals	(800)	-	-	-	(294)	-	-	-	(1,094)
At 31 March 2011	**4,938**	**97,101**	**5,715**	**6,342**	**49,267**	**661**	**12,455**	**1,040**	**177,519**
Accumulated depreciation at 1 April 2010									
At 1 April 2010	-	-	-	-	27,374	626	7,831	494	36,325
Provided during the period	-	3,896	127	-	2,576	7	1,076	56	7,738
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation	-	(3,896)	(127)	-	-	-	-	-	(4,023)
Disposals	-	-	-	-	(186)	-	-	-	(186)
Accumulated depreciation at 31 March 2011	**-**	**-**	**-**	**-**	**29,764**	**633**	**8,907**	**550**	**39,854**
Net book value at 31 March 2010									
Owned	5,760	70,014	5,715	2,488	16,752	35	3,692	350	104,806
Finance leased					431				431
On balance sheet PFI		20,061							20,061
Donated	-	-	-	-	1,134	-	10	-	1,144
Total at 31 March 2010	**5,760**	**90,075**	**5,715**	**2,488**	**18,317**	**35**	**3,702**	**350**	**126,442**
Net book value at 31 March 2011									
Owned	4,938	74,940	5,715	5,515	17,230	28	3,490	490	112,346
Finance leased	-	-	-	-	369	-	-	-	369
On balance sheet PFI	-	21,937	-	-	-	-	-	-	21,937
Donated	-	224	-	827	1,904	-	58	-	3,013
Total at 31 March 2011	**4,938**	**97,101**	**5,715**	**6,342**	**19,503**	**28**	**3,548**	**490**	**137,665**

17.2 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2011	2,390	92,337	-	-	-	-	-	-	94,727
Unprotected assets at 31 March 2011	2,548	4,764	5,715	6,342	19,503	28	3,548	490	42,938
	4,938	**97,101**	**5,715**	**6,342**	**19,503**	**28**	**3,548**	**490**	**137,665**

Protected assets are those required to provide either mandatory goods or services under Salisbury NHS Foundation Trust's terms of authorisation

In accordance with the requirements of HM Treasury, the District Valuer revalued the Trust's estate on 31 March 2010 using the Modern Equivalent Asset (MEA) valuation method. On 31 March 2011 the District Valuer reviewed the Trust's land, buildings and dwellings on an MEA basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their fair value at 31 March 2011.

17.6

18.

NOTES TO THE ACCOUNTS

19.4 Impaired receivables past their due date

	Group		Trust	
	31 March 2011 Ã000	31 March 2010 £000	**31 March 2011 Ã000**	31 March 2010 £000
By up to three months	-	-	**-**	-
By three to six months	**644**	8	**644**	8
By more than six months	**380**	276	**380**	276
Total	**1,024**	284	**1,024**	284

19.5 Non-impaired receivables past their due date

	Group		Trust	
	31 March 2011 Ã000	31 March 2010 £000	**31 March 2011 Ã000**	31 March 2010 £000
By up to three months	**3,532**	824	**3,532**	824
By three to six months	**2,199**	78	**2,199**	78
By more than six months	**2,742**	2,816	**2,742**	2,816
Total	**8,473**	3,718	**8,473**	3,718

The sums included in receivables past due date by more than six months, but not impaired, relate to the amount due from the NHS Injury Scheme. The Department of Health issued guidance to provide for debts on the amount owed at 9.6%. These debts relate to insurance claims and hence the date of receipt of monies is not known and so the debts are disclosed as due after one year.

20. Cash and cash equivalents

	Group		Trust	
	31 March 2011 Ã000	31 March 2010 £000	**31 March 2011 Ã000**	31 March 2010 £000
Balance at beginning of year	**10,193**	13,329	**10,039**	13,189
Net change in year	**(153)**	(3,136)	**(124)**	(3,150)
Balance at end of year	**10,040**	10,193	**9,915**	10,039
Made up of:				
Cash with Office of HM Paymaster General	**9,469**	9,340	**9,469**	9,340
Cash at commercial banks and in hand	**571**	853	**446**	699
Current asset investments	**-**	-	**-**	-
Cash and cash equivalents as in balance sheet	**10,040**	10,193	**9,915**	10,039
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**10,040**	10,193	**9,915**	10,039

NOTES TO THE ACCOUNTS

23. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	Ã000	£000	**Ã000**	£000
Pensions relating to other staff	**26**	26	**132**	153
Legal claims	**140**	128	**-**	-
Other	**165**	171	**202**	209
	331	325	**334**	362

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**Ã000**
At 1 April 2010	179	128	380	687
Change in the disount rate	-	-	-	-
Arising during the year	-	74	-	74
Utilised during the year	(26)	(40)	(21)	(87)
Reversed unused	-	(22)	-	(22)
Unwinding of discount	5	-	8	13
At 31 March 2011	**158**	**140**	**367**	**665**
Expected timing of cash flows:				
Within 1 year	26	140	165	331
1 - 5 years	104	-	58	162
5-10 years	28	-	144	172
	158	**140**	**367**	**665**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury claims. These are based on valuation reports provided by the Trust's legal advisers.

Other provisions include the following:
a) £217,000 the Trust has provided for injury benefits payable to former employees as a result of an injury suffered whilst in the Trust's employment (2010: £223,000).
b) £48,000 for legal fees in respect of a claim against the Trust (2010: £50,000).
c) £102,000 in respect of a compromise agreement reached with a former employee (2010: £102,000).

£30,582,000 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (2010: £26,827,000).

27. Related Party Transactions (continued)

	Income Ã000	Expenditure Ã000	Receivables Ã000	Payables Ã000

NOTES TO THE ACCOUNTS

31. Intra-Government and Other Balances

	Receivables: current and non-current Ã000	**Payables: current and non-current Ã000**	Receivables: current and non-current Ã000	Payables: current and non-current Ã000
English NHS Foundation Trusts	**135**	**117**	169	43
English NHS Trusts	**371**	**481**	282	395
Department of Health	**2,777**	**-**	2	-
English Strategic Health Authorities	**48**	**6**	47	-
English Primary Care Trusts	**6,462**	**520**	4,358	300
RAB Special Health Authorities	**-**	**-**	-	242
NHS CGA bodies	**-**	**-**	-	-
NHS WGA bodies	**-**	**1,499**	85	1,390
Other WGA bodies	**246**	**2,366**	221	2,409
Public Corporations and Trading Funds	**-**	**-**	-	-
Bodies External to Government	**3,274**	**11,422**	5,877	7,251
	13,313	**16,411**	11,041	12,030

32. Investment in subsidiary

Salisbury NHS Foundation Trust has established, following Department of Health approval, a subsidiary company, Odstock Medical Limited, to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 68% of Odstock Medical Limited.

Shares	Trust Ã
At 31 March 2011 and 31 March 2010	**34**

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.