Bundle Trust Board Public 4 September 2025

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
July SOX of the month – Rainier Baluyot, Spire Ward
July Patient Centred SOX – John Prado, Imber Ward
August SOX of the month –
August Patient Centred SOX –

1.2 10:10 - Patient Story
Introduced by Helen Rynne

1.3 Welcome and Apologies
Apologies received from Duncan Murray

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting held on 3 July 2025
For approval
1.5 Draft Public Board mins 3 July 2025

1.6 10:35 - Matters Arising and Action Log

1.7 10:40 - Chair's Business
Presented by Eiri Jones

1.7.a 10:45 - Letter from Region re development of Acute Group
Presented by Eiri Jones
For information
1.7a Letter to BSW Chairs

1.8 10:50 - Chief Executive Report/Managing Director Report
Presented by Cara Charles Barks
For information
1.8a Chief Executive Report Sept 2025

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 11:00 - Integrated Performance Report to include exception reports
Presented by Judy Dyos
For assurance
2.1a IPR Cover Sheet - Trust board
2.1b Integrated Performance Report - September 2025 TB

2.2 11:25 - Finance and Performance 29th July
Presented by Richard Holmes
For assurance
2.2 Finance and Performance Committee Escalation Report

2.3 11:30 - Clinical Governance Committee 29th July
Presented by Anne Stebbing
For assurance
2.3 Clinical Governance Committee escalation report 29th July 2025

2.4 11:35 - Trust Management Committee 23rd July
Presented by Nick Johnson
For assurance
2.4a TMC escalation report July meeting
2.4b TMC escalation report Aug meeting

2.5 11:40 - People and Culture Committee 31st July
Presented by Rakhee Aggarwal
For assurance

3 GOVERNANCE

3.1 Annual Report and Accounts - deferred to November

3.2 11:45 - Well Led - Group Perspective
Verbal update by Fiona McNeight

3.3 Annual Review of Board and Committee Effectiveness - deferred to November

3.4 11:50 - BSW Hospitals Group – Resolution to Update Partnership Agreement
Presented by Cara Charles Barks
For approval

- 3.4a Cover BSW Joint Committee_Update to Joint Functions and Joint Cee TORs_Aug-SeptV0.1docx
- 3.4b Appendix A BSW Hospitals Group Joint Functions - July 2025 V1.2 (1)
- 3.4c Appendix B BSW Hospitals Group Joint Cee TORs July 2025 - V1.2

4 STRATEGY AND DEVELOPMENT

4.1 12:00 - Triannual Strategy Deployment Update
Presented by Alex Talbott/Tony Mears
For assurance

- 4.1a Triannual-Strategy-Deployment-Update_CoverSheet

4.2 12:10 - Improving Together Update Report
Presented by Alex Talbott
For assurance

- 4.2a Cover sheet Improving Together Trust Board Report September 2025
- 4.2b Improving Together Triannual Report – September 2025

4.3 12:20 - BREAK

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 SIRO Annual Data Security and Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) – deferred to November

5.2 12:50 - Winter Plan 2025/26
Presented by Niall Prosser
For approval

- 5.2a Cover Sheet Public Trust Board Winter Plan 2025.26
- 5.2b Winter Plan July 2025 - V2 (3)
- 5.2c WINTER PLAN 2526
- 5.2d QIA Winter Plan 2025.26
- 5.2e Board Assurance Statement - NHS Trust

6 PEOPLE AND CULTURE

6.1 13:00 - Freedom to Speak Up Guardian Annual Report
Presented by Elizabeth Swift
For assurance

- 6.1 FTSU 2024-25 Annual Report Final

6.2 13:10 - Organisational Development and People Directorate Annual Report 24/25
Presented by Ian Crowley
For approval

- 6.2a ODP Annual Report-Cover Sheet
- 6.2b ODP Annual Report FY2425-Final

6.3 WRES and WDES - deferred to November

6.4 13:20 - Modern Slavery and Human Trafficking Statement 2025
Presented by Ian Crowley
For approval

- 6.4a Cover Sheet - Modern Slavery_Human Trafficking Statement - SFT Board 04.09.2025
- 6.4b Modern Slavery and Human Trafficking Statement 2025 - Final

6.5 13:25 - Medical Revalidation and Appraisal Annual Report including Statement of Compliance – deferred from July
Presented by Zoe Cole
For assurance

- 6.5a Appraisal and revalidation cover Sep 25
- 6.5b ANNUAL APPRAISAL AND REVALID REPORT 2425

7 QUALITY AND RISK

7.1 13:35 - Research Annual Report

Presented by Zoe Cole
For assurance

7.1 Research Annual report 2024_25_TK 16072025

7.2 13:45 - Perinatal Quality Surveillance Report July (June Data)
Presented by Judy Dyos / Vicki Marston
For assurance

7.2a Front sheet Perinatal Quality Surveillance Report - July (June data)
7.2b Perinatal Quality Surveillance July 2025 Slides (June data)

8 CLOSING BUSINESS

8.1 13:55 - Any Other Business

8.2 14:00 - Agreement of Principal Actions and Items for Escalation

8.3 14:05 - Public Questions

8.4 Date next meeting

9 Resolution
Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 3rd July 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Eiri Jones (EJ)	Chair
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Mark Ellis (ME)	Interim Chief Finance Officer
Lisa Thomas (LT)	Interim Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Jonathan Hinchcliffe (JH)	Interim Chief Technology
Judy Dyos (JD)	Chief Nursing Officer
Duncan Murray (DM)	Chief Medical Officer

In Attendance:

Tony Mears (TM)	Associate Director of Strategy
Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Tapiwa Songore (TS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (items 5.1, 5.2, 5.3)
Jonathan Hinchcliffe (JH)	Chief Transformation and Innovation Officer (interim)
Helen Rynne (HR)	Patient Engagement Lead (item 1.2)
Sophie Rolfe (SR0	PALS (item 1.2)

Apologies

Kirsty Matthews (KM)	Non-Executive Director
Cara Charles Barks (CCB)	Chief Executive

Observers

Jane Podkolinski	Governor
Nick Johnson	MD Designate
Mark Wareham	Unison
Holly Osper	Coach house

ACTION

TB1 3/7/1 **OPENING BUSINESS**

EJ welcomed everyone and informed those present that this was a meeting held in public but not a public meeting.

EJ reminded the Board to approach the meeting using the Improving Together Program methodology, the quality improvement tool used by the Trust in the delivery of change and transformation.

TB1 3/7/1.2 **Presentation of SOX Certificates**

EJ informed everyone that the SOX Nominations recognised staff in the organisation for their contribution to the development of the Trust strategy and patient care, and announced the following the SOX nominations:

- April SOX of the month – Fredrick Kajombo, Temporary Staff, Hospice.
- April Patient Centred SOX – Katherine Backhouse, Gynaecology Consultant.
- May SOX of the month – UHS Finance and Payroll Team (Zoe Cavill, Lauren Masson, Alfie Ingram, Harry Muland, Oliver Stanley Jones and Rose Bront
- May SOX of the month - Holly Storey, Fit Testing and Anja Richardson, EPRR
- May Patient Centred SOX – Doctor Daisy Christian Edwards ED Staff
- May Patient Centred SOX - Sabrina Arnold, Nicola Waters and Emma Burnett – ED Staff
- May Patient Centred SOX - Yuri Jackson, ED
- June SOX of the month – Financial Accounts (Liz Hills. Simon Bruce, Jo Kearney Steve Riddington and Lynee Abbott
- June Patient Centred SOX – Louise Morris, Laverstock Ward

EJ explained that the nominations were publicly acknowledged at the Board and the Certificates would be presented to the recipients by the members of the Executive Team. FMc informed the Board that Tapiwa Songore had worked diligently with the Finance colleagues in producing the Annual Report and Accounts, despite this being his first year with the Trust.

TB1 3/7/1.2 **Patient Story**

EJ introduced the Patient Story, and the Board welcomed HR and SR who presented a video from a patient's daughter narrating the service they received when her mum was being treated in hospital. Her mother had a strangulated hernia and was admitted to Emergency Department. After admission she had an operation, developed an infection and sadly passed on.

During her stay in hospital, she was moved wards against the family consent and when her condition deteriorated, there was no communication until after she died and this deeply upset the family.

Discussion

The Board discussed the story and noted the challenge of managing beds against other conflicting priorities, and acknowledged the importance of kindness and compassion, whilst under pressure. It was noted that a SOP had been reviewed to guide staff, and the story was now being used for training. The Board discussed and acknowledged the importance of such stories for Board awareness and emphasised the importance of making sure the family had closure.

The Board thanked the family and the team for sharing the story.

TB1 3/7/1.3 **Welcome and Apologies**

EJ welcomed everyone to the meeting and reported that apologies had been received from Cara Charles Barks and Kirsty Matthews.

EJ reported that Kirsty Matthews had stepped down from the role of Non-Executive Director for personal reasons and on behalf of the Board wished her well.

TB1 3/7/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of interest pertaining to the items on the agenda.

TB1 3/7/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 1st May 2025**

EJ presented the minutes from the Public Board meeting held on 1st May 2025.

Decision:

The Board **APPROVED** the minutes of the meetings held on 1st May 2025 as a true and correct record, subject to minor amendments suggested at the meeting

TB1 3/7/1.6 **Matters Arising and Action Log**

FMc presented the action log, and it was noted that one action had been completed and the other was due in September 2025

RH reported that the Audit Committee had pre warned the Board that the Auditors could include the EPR implementation in their value for money statement, however the did not do so.

EJ pointed out that the national report on stroke care was still not using the current stroke metric.

TB1 3/7/1.7 **Register of Attendance**

The Board noted the Register of Attendance

TB1 3/7/1.8 **Chair's Business**

EJ reported on the following.

- Started her induction as Chair and was looking forward to working with Board and management.
- The NHS ten-year plan which was being announced.
- Progress with the BSW Group development and the importance of ensuring clarity in working together for the trust and for the population served, but that also working through the group development, in maximizing any potential benefits for population and workforce
- The NHS changing landscape, the challenging environment and the importance of supporting to staff and adhering with the Trust values.

The Board noted the Chair's report.

TB1 3/7/1.9 **Chief Executive/Managing Director Report**

LT presented the Chief Executive's and Managing Director's Report and highlighted the following key points:

- The Oversight framework segmentation (SOF)which was expected imminently and the impact on the Trust and the BSW system
- The 10-year plan and other planning documents being developed by NHSE to guide its delivery

Discussion

The Board noted the opportunity of linking the Trust strategy to the NHS 10-year plan.

The Board sought clarity on the realistic expected impact of the Urgent and Emergency Care Plan 2025/26 and it was noted that while some of the improvements could be realised in year if the projects when expedited quickly, the national narrative of 'in year improvement' was aspirational. The challenge for the Trust was to develop a plan to support the aspiration and to focus on issues that made the most impact and added value to patient care.

The Board sought clarity on the elements of demand and NCTR that the system partners were supporting the trust strategy with and it was noted the Urgent Care Governance Group would be discussing the delivery of the transformation plans and the governance was being working out.

The Board asked for more information on the SOF measuring /segmentation, and it was noted that SOF was based on an algorithm which balanced performance with money. Segmentation was representative of the individual Trust performance. However, all Trust making a loss (or in receipt of 'deficit support') would be put in segment three or below. ICBs were not given a formal segmentation in this financial year.

The Board noted the report.

TB1 3/7/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 3/7/2.1 Integrated Performance Report (IPR) (M12 March)

ME presented the Integrated Performance Report for Month 2 and highlighted the following key points:

- The IPR was a summary of performance against strategic and operational objectives which balanced the trends in operational performance against KPI for strategic objectives
- May saw generally improved performance across key metrics.
- CHPPD at 7.5 (6.9 when excluding ICU, maternity and NICU) has remained relatively static over the last few months – this was due to the occupied bed days remaining higher than they were in 2024 when CHPPD was above 8.

Discussion:
The Board asked for an update on progress with implementing Martha's rule, and it was noted that minimal referrals were coming through, however this

was still be rolled out. The Board requested an update on its effectiveness at a later meeting.

The Board noted the deterioration in 62-day performance in M1 with submitted position below trajectory and sought assurance on the accuracy of the modelling, and the ability to predict performance and productivity based on past behaviours and external environment. It was noted that the trajectory was built on the best-known information at the time and could be affected by issues such as change in demand, activity or patient demography and staff changes. The changes could create peaks and troughs in demands and referrals. The Board requested that they be informed of any future errors in mapping out trajectories and acknowledged the importance of tracking performance against the strategic objectives.

The Board noted the report

TB1 3/7/2.2 **Audit Committee – 19th June**

RH presented the report from the Audit Committee meeting on 19 June and highlighted the following

- The Annual Report and Accounts had been signed by the Board and submitted to NHSE on time.
- The Head of Audit Opinion for the period 1 April 2024 to 31 March 2025 was that 'Significant assurance with minor improvement opportunities' on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- The Committee had received the Local Counter Fraud Annual Report
- The Trust was required to undertake a self-assessment for each of twelve components of the NHS Counter Fraud Authority requirements; 11 out of the 12 were assessed as Green with the remaining component rated as Amber. This was an improvement from last year. The regulatory submission had been signed off and was submitted in advance of the regulatory submission date.
- The Committee received a report on the audit of the EPR Programme. The Internal Auditors had provided a rating of 'significant assurance with minor improvement opportunities. Given the significant deterioration in the EPR Programme's after the Audit, and the separate Programme Assurance work undertaken in April/May by Berkley Assurance which highlighted a number of substantive issues to be resolved, the Audit Committee was concerned with the rating of the Internal Audit report.

Discussion

The Board discussed the audit of the EPR program, and it was noted that the purpose of internal audit process was to provide assurance on the effectiveness of the governance and the processes for now and the future and expressed concern at the EPR rating from the Internal Audit. The Board acknowledged the complexity of the EPR program involving three Trust and noted that this was probably outside of internal auditors' normal business.

The Board noted the report.

TB1 3/7/2.3 **Finance and Performance Committee – 3rd June and 24th June**

DB presented the report from the Finance and Performance (F&P) Committee meetings held on 3rd and 24th June and highlighted the following.

- The resources required to meet the various demands of the trust and the importance of prioritisation to allow these demands to be met and to avoid significant levels of stress, burnout and attrition.
- SFT's financial position deteriorated again, with the main driver being the withdrawal of deficit support funding.
- The following contracts had been approved
    - Clinical Insourcing Managed Service Gastroenterology – A contract to run to 31/3/26 was approved for this essential service.
    - 25/26 Diagnostic Capital – approval was given for 3 small projects – Audiology, Neurophysiology equipment and Physiological science equipment. A recommendation to Board to approve the CDC expansion was also given

Discussion

The Board discussed the importance of getting assurance both at SFT and at system level system regarding the delivery of the business plan and sought clarity on the combined effort going towards achieving the desired results and the work streams in place to remove the barriers to patient flow, and in response the Board noted some of the initiatives underway internally to improve NCTR.

The Board noted the report.

TB1 3/7/2.3a **Finance Update**

ME updated the Board on the risk of non-delivery assessment which was being used to decide whether or not trusts received funding. The assessment was based on combination of things, but in particular variance, the amount of savings made and the run rate. The BSW system was in level three which meant funding could not be accessed unless the regional office intervened.

The cash support regime had also been developed and was likely to be implemented together with a stringent performance management regime.

The Board noted the report.

TB1 3/7/2.4 **Clinical Governance Committee – 24th June**

AS presented the report from the Clinical Governance Committee meetings held on 24th June and highlighted the following.

- A failure in electronic discharge summary transmission due to an IT issue which has now been resolved
- An incident in histopathology which had resulted in a number of specimens being inappropriately processed

- The continuing concerns around the accuracy of key training data compliance.
- CGC questioned whether BAF 7 should increase given the current restrictions on recruitment, and the likely impact on staff morale and well-being.
- Concerns regarding the motor minutes metric in stroke care, which had not sustained the improvement expected from the information provided to CGC in a deep dive last meeting. The CMO had agreed to report further at the next CGC meeting.
- The Quality Account 2024/2025 which had been approved by Trust Board and the amount of work that had gone into putting the report together.
- CGC received the six-monthly Quality Impact Assessment Assurance report and noted the importance of this during this time-of-service change and recruitment restrictions.

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The Board noted the report.

TB1 3/7/2.5 **Trust Management Committee – 25th June and 28th May**

LT reported on the meeting TMC and reported on the following

- NCTR remained significantly off plan at 20% of beds rather than the planned 9% leading to higher staffing costs through escalation beds.
- Finance position was discussed noting the significant challenges and risks to the plan, agreed escalation meetings were outlined and the clear implications for cash were outlined to the Committee
- Digital steering group escalated continued challenges with LIMS implementation. Theatreman upgrade was also delayed from July to August due to supplier challenges.
- CDC expansion business case was approved, subject to understanding of the resourcing plan to accommodate additional reporting in the context of hard to recruit consultant radiologists.

The Board noted the report.

TB1 3/7/2.6 **People and Culture Committee – 26th June**

EJ presented the report and reported that RA had agreed to take over as Chair of the People and Culture Committee. EJ highlighted the following.

- The Impact of the CPO leaving.
- Focus on MLE with a training performance report coming to July Committee.
- The improving situation in gastro services with a further consultant appointment and improved tracking of demand for ERCP

The Board noted the report.

TB1 3/7/3 **PEOPLE AND CULTURE**

TB1 3/7/3.1 **Medical Revalidation and Appraisal Annual Report including Statement of Compliance**

The Board noted this report had been deferred to September.

TB1 3/7/3.2 **Health and Safety Report**

The Board received the Health and Safety Annual report 2025 looking at injury trends, actions taken to manage risks, and ongoing opportunities to improve the management of Health and Safety.

The Board noted the following.

- the number of lost time injuries fell, however, there was an increase in the number of days lost.
- reports of violence and aggression rose from 133 in FY24 to 208 in FY25. As in previous years antisocial behaviour, mental health and behavioural disorders and cognitive impairment in elderly patients remained relatively equally reported.
- near miss reports increased significantly, and sharps injuries saw a significant increase that would be explored in FY26 with the infection prevention group and occupational health.

Discussion

The Board noted continued improvements in H&S performance year on year and requested assurance, in a future report that all reported RIDDOR's actions to the health and Safety Executive had been closed off.

The Board noted the report.

TB1 3/7/4 GOVERNANCE

TB1 3/7/4.1 **Register of Seals**

FMc presented the report entries in the Trust's Register of Seals since the last report to Board in January 2025. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

The Board noted the report.

TB1 3/7/5 QUALITY AND RISK

TB1 3/7/5.1 **Maternity and Neonatal Quality and Safety Report Q4**

VM attended to present the Maternity and Neonatal Quality and Safety Report Q4. The Board noted the following.

- 1 Stillbirth
- 0 reportable Neonatal Deaths

The Board noted the report.

TB1 3/7/5.2 **Perinatal Quality Surveillance Report May (April data)**

VM presented the Perinatal Quality Surveillance Report May. The Board noted the following.

Staffing:

- Midwife to birth ratio 1:28– SFT recommended ratio 1:24.
- Increase in band six Midwifery vacancies to 6.93 WTE

PMRT

- Two stillbirths in April.
- SFT were now above the national ambition rates (2.5 per 1000) for stillbirth at 3.13 per 1000, but remained under the national stillbirth rate (3.9 per 1000)
- Seven Incidents reported as moderate or above

The Board noted the report.

TB1 3/7/5.3 **Perinatal Quality Surveillance Report June (May data)**

VM presented the Perinatal Quality Surveillance Report June (May data) and highlighted the following.

- seven Incidents reported as moderate or above.

PMRT:

- 0 stillbirths in May.
- 0 Neonatal death in May.
- One PMRT review in May, Grading of C and B – actions in progress to learn and improve.

Discussion

The Board discussed the feedback received from varying sources including MNVP. The Board also noted that Maternity Services moved to BadgerNet in February, and this has had an impact on maternity reporting during March/April/ May 25. It was agreed that JH/EJ would visit community midwives to discuss the challenges they were experiencing with the BadgerNet system.

The Board noted the report.

TB1 3/7/5.4 **Award presentation**

Alison Talbot - Deputy Chief Midwifery Officer presented an award to VM for Services to Maternity

TB1 3/7/5.5 **Board Assurance Framework and Corporate Risk Register**

FMc presented the Board Assurance Framework and Corporate Risk Register. There had been an increase in score for BAF risks 2 and 10 reflecting the system capacity to offer mutual aid to support fragility in services and the National NHS landscape changes and uncertainty this has generated.11 BAF risks were out of tolerance, and these were under regular Board scrutiny and the risk appetite would be revied at Board Seminar in September.

The Trust Internal Auditors, KPMG had undertaken a review of the top strategic and emerging risks across their internal and external audit client base. The Trust had received the report for Board and Audit Committee consideration

The Board noted the report.

TB1 3/7/5.6 **Patient Experience Report Q4**

The Board received a report on the feedback and insights drawn from the various methods by which our patients feedback on the Trust Services. The total number of complaints and concerns had increased marginally. A total of 111 were logged for Q4, compared with 110 in Q3. A total of 142 compliments were recorded on Datix this quarter across the Trust (115 less than last quarter).

The Board noted the report.

TB1 3/7/5.7 **Learning from Deaths Report Q4**

DM presented the report on Learning from Deaths Report Q4 which had been discussed at the Clinical Governance Committee.

The latest SHMI figure for the Trust was 0.94 (12-month period ending in December 2024). In the previous quarter this was reported as 0.96, and this continued to be the lowest figure that the Trust had observed in recent times. According to NHSE this figure remains statistically within the expected range for the Trust

The Board noted the report and approved for it to be uploaded

TB1 3/7/5.8 **Director of Infection, Prevention and Control Annual Report**

JD presented the Infection, Prevention and Control Annual Report to provide an overview of the work undertaken and provide assurance to the Trust Board that prevention and control of infection risks were being managed effectively

It was noted that the Trust had experienced a challenging twelve months for infection prevention and control, which included national UKHSA alerts and NHSE guidance released relating to Measles, Monkey Pox (Mpox) and the appropriate management of a suspected Middle East respiratory syndrome (MERS) case

The Board noted the report.

TB1 3/7/5.9 **Incident Reporting and Risk Report Q4**

JD presented the report aims to provide an overview of risk management activity in Quarter 4.

The Board noted the report.

TB1 3/7/6 **CLOSING BUSINESS**

TB1 3/7/6.1 **Any Other Business**

EJ informed the Board that this would be LT and MW last board meeting and on behalf of the Board, wished them well in their new roles

TB1 3/7/6.2 **Agreement of Principle Actions and Meeting Reflection**

- The financial position and the risk to the delivery of the 2025/26 Business Plan
- The delivery of the year end account which had been completed in time
- The Maternity Champion award presented to Vicky Marston

Meeting Reflection

The Board acknowledged that the meeting had been affected by the Patient Story and the mood had been strangely subdued. The Board agreed that it was important to reflect on the story and how things could have been done differently.

The Board also commended the Executive for managing the development of the BSW Group and SFT's transition into a group model, despite the various challenges and the impact on wellbeing.

TB1 3/7/6.3 **Public Questions**

There were no public questions.

TB1 3/7/6.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 4th September 2025.

TB1 3/7/7 **RESOLUTION**

TB1 3/7/7.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

NHS England
South West

To:
Liam Coleman
Chair, Great Weston Hospital
Ian Green
Chair, Salisbury Hospital
Alison Ryan
Chair, Royal United Hospital

NHS England
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

9 June 2025

Sent via email

Dear Liam, Ian and Alison

Thank you for meeting with us recently, it was a very useful opportunity to better understand the work in BSW and the development of the Acute Group. We shared our concerns with you, reflecting feedback from stakeholder groups, about the lack of sufficient consensus on the proposed direction for unifying the three Acute Trusts. We were reassured that as Chairs, you were committed to the plan to move beyond collaboration and to realise the benefits of a group as soon as possible.

The publication of the 10 year plan and structural changes across the NHS present both opportunity for the system to build on its vision of networked care and accountable care organisations but also potential risks given the current challenges in year and the focus on reorganisation rather than delivery. We agreed that maintaining the momentum in relation to the Acute Group was critical and that by April 2026 there should be a Group Board in place together with the permanent appointment of the Group Chair and Board members.

This will mean that in very short order, the Trusts need to move from a Special Purpose Joint Committee to a General Purpose Joint Committee (ie: full board in common with shared executives and non-executives as appropriate) by no later than April 2026. To support this, you are to prioritise the development of a group strategy and operating model led by the Interim Chairs and the Group CEO. The single joint chair is required to be in place from April 2026 to lead the single board as you move forward.

We discussed the need for clear and open communications and engagement across all 3 organisations to counter the myths and unhelpful narrative and to develop commitment to the group from Board to ward level, this will be a significant programme for the group and needs to be resourced and sit as a key action in its development.

The group operating model will be key to support both horizontal leadership as well as vertical leadership whilst realising the benefits of scale to support delivery of the strategy .Rachel will holding a review with the Group as part of our assurance process in the latter part of July where we would like to invite the interim Chairs as well as executive colleagues and discuss the operating model and associated timelines. We agreed that it was now imperative that the Group formation now moves forward and welcomed your commitment to moving at pace but also working with Governors and key

stakeholders to reaffirm the vision for change. We offered our support to you all both in being part of conversations but also in connecting you to other systems going through the same journey and to national colleagues who might bring expertise and advice.

You will need to work closely together with one voice now and build on the recent development session with all the Executives whilst ensuring a unified response to the challenges that the system faces in 25/26. I think it would be helpful to meet again together in August to reflect on progress following the review and your first joint committee on 16th July.

Yours sincerely

Sue Doheny
Regional Director (South West)
NHS England

Copy to:
Rachel Pearce
Stephanie Elsy

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of meeting:	4th September 2025		

Report title:	Chief Executive and Managing Director Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Cara Charles-Barks, Chief Executive Officer Lisa Thomas, Managing Director			
Executive Sponsor: (presenting)	Cara Charles-Barks, Chief Executive Officer			
Appendices	N/A			

Recommendation:

The Board is asked to receive and note this paper as progress against the local, regional and national agenda.

Executive Summary:

The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

National

Approach to Assessing Provider Capability

NHS England wrote to Provider Chief Executive's on 13th August 2025 providing an update on the approach to assessing Provider capability.

As set out in the recently published NHS Oversight Framework (NOF), NHS England will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help NHS England inform their response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as Trusts being considered for new FT status.

The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

The capability rating will be based on:

- an annual self-assessment by provider Boards and submission to NHS England, with supporting evidence. The assessment will be based on themes from last year's publication of 'The Insightful Board' (https://www.england.nhs.uk/publication/the-insightful-provider-board/)
- a review of the self-assessment, triangulated with the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. Whilst ICBs remain jointly responsible and involved in provider oversight we would also seek their views on the provider capability self-assessments for the providers in their systems.
- across the year, NHS England will use the capability rating and self-assessment to inform the relationship with the provider, revising the capability rating should events merit it e.g. if an issue emerges that was not foreseen in the self-assessment.

It is intended that the capability rating will be published alongside the NOF segmentation.

NHS England confirmed on 26th August 2025 that the first stage of this assessment involves Trust Boards assessing their organisation's capability against a range of criteria derived from last year's Insightful Provider Board document and submitting these self-assessments to regions. Oversight teams in each region will then review these, triangulating with their own views of the provider, its track record of delivery and any relevant information from third parties before assigning a capability rating.

Provider self-assessments are to be completed by 22nd October 2025.

Lead Appointed for National Maternity Investigation

It has been announced that Baroness Amos has been selected to lead the independent investigation into NHS Maternity and Neonatal Care.
The investigation was announced by the Secretary of State in June 2025 and will look at up to ten services in the country. It will also review the maternity and neonatal system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care.

It will begin its work this Summer and produce an initial set of national recommendations by December 2025.

NHS Publishes Strike Impact Data
NHS England published data earlier in the month which outlined the impact of last month's industrial action by Resident Doctors, which showed the results of a more robust approach by NHS leaders with staff working around the clock to keep services open for patients.

The data showed that more care was delivered during the July 2025 Resident Doctors' strike than in the 5-day June 2024 walkout, with NHS analysis estimating that an additional 11,071 appointments and procedures went ahead. Staff absence due to industrial action was lower during this latest round, with around 1,243 fewer staff absent each day on average compared to last June – a 7.5% drop – helping Trusts to maintain more services and protect patient care.

An overview of the industrial action by Resident Doctors across SFT is outlined below:

Following an announcement from the British Medical Association on 9th July 2025, the Trust had approximately two weeks to plan and prepare a response for the strike period, adopting a similar approach to planning and response from previous episodes of strike action, and needing to address known risks including high annual leave, impact upon planned activity, and difficulty covering critical services.

The response was well coordinated throughout the entire period using a "command and control" approach, although no critical incident was declared.

Impact of strike action:

- No cancer activity was cancelled
- No patient safety issues directly resulting from industrial action were reported
- Cancellation of planned activity:

Appt Type	2024	2025	Difference (abs)	Difference (%)
Inpatient/Daycase	14	12	-2	-14%
Outpatient New	24	86	62	258%
Outpatient Fup	120	147	27	23%
Grand Total	**158**	**245**	**87**	**55%**

The increase in cancelled activity compared to previous episodes of IA is counter to the national position. However, it should be noted that booking processes locally have evolved since previous strike periods such that proportionally more activity would have already been booked at the time the IA was announced compared to previous episodes, and therefore there would have been more needing to be to cancelled to maintain safety critical services.

The financial impact due to additional payments to clinical staff covering resident doctor absence and loss of income from cancelled activity was ~ £300k

It should also be noted that it is difficult to measure patient harm resulting from IA as the impact may be indirect, delayed, and multifactorial, and therefore not immediately visible. Importantly, there is a significant impact upon staff, both for clinical teams, with an impression formed of growing fatigue

and frustration amongst senior staff who absorb the impact of resident doctor absence, as well as for operational teams for whom the preparation and planning for IA consumes a considerable amount of time. Beyond the senior operational teams, the central booking team undertake very significant additional activity around cancellations and rebooking of appointments and procedures.

A post IA debrief was undertaken to provide an opportunity for reflection and learning which identified several areas and opportunities for improvement in our planning and preparation for any further episodes of strike action.

Tiering Approach for Salisbury NHS Foundation Trust
NHS England confirmed on 11th August 2025 that following a review of Salisbury NHS Foundation Trust Elective, Cancer and Diagnostic performance, that the Trust will move out of Tiering for quarter two of 2025/26.

Group Update

Joint Committee & Partnership Agreement

Our second BSW Hospitals Group Joint Committee meeting was held on 16th July in Swindon with focus being on discussion and approval of the proposed Group Operating Model and Leadership Model. Initial corporate services plans were introduced for priority services – Finance, People, Digital, Estates & Facilities and Capital Planning. Proposed clarifications to the Group Partnership Agreement Joint Functions and Joint Committee Terms of Reference were approved pending ratification by Boards. The establishment of a Group Strategy and Planning working Group was approved. A report from the July Group Joint Committee has been included with September Trust Board papers.

Leadership Team

September and October will see developments in the Group leadership team. Our three Managing Directors (Lisa Thomas – GWH, John Palmer – RUH, Nick Johnson – SFT), will start in-post on 1st September. Following approval of proposed leadership model by the Remuneration Committees in Common at the end of July a consultation exercise is now underway. The post-consultation report will be considered by the Joint Committee on 29th September. In the short-term we have progressed recruitment to:

- Strategic Clinical Transformation Director. Advertised. Interviews 27th August. Target in-post September.

Group Strategy & 26-27 Planning

The development of our Group Strategy has begun, led by SRO Joss Foster and coordinated by Trust strategy leads. Our Transitional support partner Teneo is supporting this work. The strategy will be developed in close coordination with the 26-27 planning round.

Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the programme team is focused on developing a detailed governance and assurance roadmap in readiness for consideration by the 29th September Joint Committee. The development of our group risk approach and assurance arrangements will form an important part of this roadmap.

Councils of Governors Workshop

On 5th August the three Councils of Governors came together in Devizes, to start the conversation about opportunities for BSW Hospitals and the 10-Year Plan, to discuss the emerging Operating Model and Council of Governors role. It was agreed that a follow-up meeting would be arranged, so Governors can continue the conversation on Group Development and our response to the 10-Year Plan; this next session will be held on 1st October.

Board to Board Development
We have begun planning for our next Board-to-Board sessions planned on 2nd October and 12th February. Further details will be circulated in early September.

Managing Directors – Local update

The Trust continues to focus on delivery of our business plan for 2025/26 and have shown some significant progress in our quality and performance metrics. The Trust continues to make improvements in planned care, and formally exited NHS England Tiering process for diagnostics, referral to treatment (RTT) and Cancer waiting times. This was fantastic news and reflects the significant improvements made by teams across the Trust focusing on patient experience. There is more information in the Integrated Performance Report on our key metrics.

Our financial position remains a significant challenge. Another clear and consistent Government message is that they want to end what they see as an NHS culture where deficits are normalised. The Trust has produced a recovery plan this month focusing on opportunities to manage pay expenditure more effectively, whilst agency spend has reduced, we still have areas where bank expenditure is exceeding planned levels. Progress will continue to be a focus for the executive team.

The Improving Together approach remains a cornerstone of the Trust improvement work, we have been approached by several Trusts wanting to visit to understand how we use our operational management system to effective change. It is a great opportunity to gain feedback from visiting NHS Trusts on what they see and hear when visiting departments as well as our staff showcasing the improvements they have made in their areas.

Looking ahead the Trust is celebrating Thank you week, with the annual staff awards from the 11th of September which is a fantastic opportunity to celebrate and thank the staff for the difference they make to patients every day. The week also has a family fun day which staff can bring family to participate in lots of fun activities.

Car parking changes for staff are starting from the 1st September, this has been a focus of communication for some months, the frequency of the staff Hopper Bus will be increased supporting staff to use different modes of transport to get to site which is a great improvement.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	4th September 2025		

Report title:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nurse Officer			
Appendices				

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 4 (July 2025).

Executive Summary:

Breakthrough Objectives

- *Time to First Outpatient Appointment* remained fairly static at 125 days against the target of 90 although continued an improved trend compared to 2024 and baseline of 139 days in April 2023.
- *Managing Patient Deterioration* saw an improvement to new highest point at 52.5% against the 60% target and baseline of 45.7% in April 2024.
- *Staff Retention* reduced again to new lowest point at 16.4% against the 15% target and baseline of 20.4% in April 2024.
- *Productivity* remained static at -13.3% against the target of -5.33% and baseline of -14.97% in April 2024.

Alert

- *Income* reported an in-month position was a deficit of £2.4m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

Advise

- *Attendances* into the Emergency Department (ED) remain high at 7,205 although performance improved across all metrics:
  - *4-hour Performance* increased from 68.8% to 73.9%.
  - *Ambulance Handover* time reduced from 26 to 21 minutes average.
  - *Ambulance Handovers >60 minutes* reduced from 90 to 50.

  - *ED 12-hour Breaches (arrival to departure)* reduced from 333 to 246.
- Diagnostics *DM01 Standard* also continued improvement by increasing from 83.4% to 85.1% against the plan of 86% with Urodynamics and MRI challenged, Cardiology and Endoscopy continuing to improve.
- *No Criteria to Reside (NCTR)* remains above the plan position of 54 but reduced from 91 to 77.
- Stroke Care measure of *Motor Minutes per Patient per Day* minutes increased from 30 to 42 minutes as stabilisation in staff absence and recruitment supported
- Incidents resulting in High Harm increased again from 3.3% to 4%.
- Falls per 1,000 bed days increased again from 6.81 to 7.45 and above improvement target of 7.

Assure

- *Referral to Treatment (RTT)* waiting list metrics were impacted by the five days Industrial Action (IA), but remain above both plan and national target:
  - *RTT Performance* reduced from 67.1% to 66.4% against the March 2026 target of 65%.
  - *RTT Waiting List* increased from 29,128 to 30,230.
  - Patients waiting *>52 weeks* increased from 224 to 253 and accounts for 0.84% of the total waiting list against the March 2026 target of 1%.
  - Patients waiting *>65 weeks* increased from 4 to 8 with Plastic Surgery challenged by limited capacity due to ongoing consultant sickness.
- Cancer performance continued improvement in June:
  - *28-day Faster Diagnosis Standard (FDS)* increased from 76% to 77.5% and close to the plan of 78% with Colorectal and Urology challenged, Breast and Skin leading.
  - *62-day Standard* increased from 65.2% to 72.9% however still below the plan of 78% with Colorectal and Urology challenged.
- Flow into the hospital eased as *Bed Occupancy* reduced from 95.1% to 94.7% average and below the improvement target of 96%.
- Staff Vacancies reduced again from -2% to -2.4% continuing net Trust position of over-establishment.
- *Pressure Ulcers* - Hospital Acquired Cat 2 - reduced from 2.7 to 1.25 and lowest point in over a year.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe):	☐

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

September 2025

(July 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

July saw continued good performance across the Trust generally, with most metrics further improving their positions in comparison to June, despite a period of Industrial Action (IA) staged by resident Doctors for five days.

The access-related breakthrough objective of *Wait Time to 1st Appointment* remained fairly static at 125 days average. The *Referral to Treatment (RTT)* level - percentage of patients waiting less than 18 weeks from referral for elective treatment - reduced slightly to 66.4% although, remains ahead of plan and the March 2026 target of 65%. Patients waiting *Longer than 52 weeks* increased to 253 which represents 0.84% of the total waiting list - also increased to 30,230 - against the March 2026 target of 1%. And patients waiting *Longer than 65 weeks* rose slightly to 8 against the plan of 0.

Cancer performance - reporting June data - improved for the second month in succession, as the *28-day Faster Diagnosis Standard (FDS)* increased to 77.5% and the *62-day Standard* also increased to 72.9% and despite challenges in Urology and Colorectal.

Diagnostics continued to improve, as the *DM01 Standard* - the percentage of patients waiting less than 6 weeks - performance increased again to 85.1% with Cardiology and Endoscopy improvements contributing most to the overall performance.

The Stroke care measure of *Motor Minutes per Patient per Day* increased for the first time in 3 months to 42 minutes average because of stabilisation in absence with recruitment supported.

The Emergency Department (ED) benefitted from an ease in flow around the Trust, as the *4-hour Standard* and *Ambulance Handover* time both improved by increasing to 73.9% and reducing to 21 minutes average, respectively. Wider metrics reinforced performance improvement overall as *ED 12-hour breaches* and *Ambulance Handovers longer than 60 minutes* both dropped to 246 and 50 instances of each. As noted, the number of patients with *No Criteria to Reside (NCTR)* and *Bed Occupancy* levels both contributed to this performance through reduction to 77 and 94.7% respectively.

The quality breakthrough objective of *Managing Patient Deterioration* saw further improvement to 52.2% of NEWS2 observation compliance against the target of 60%. Wider quality metrics were variable, with increases were seen in the number of patient *Falls* per 1,000 bed days to 7.45 and above target, the Infection Control metric of *E. Coli Infections* to 4 and *Incidents* resulting in High Harm to 4% of total. However, the number of *Pressure Ulcers* reduced to its lowest point in over a year at 1.25 and the number of *Mixed Sex Accommodation* breaches continued its reduction to 11.

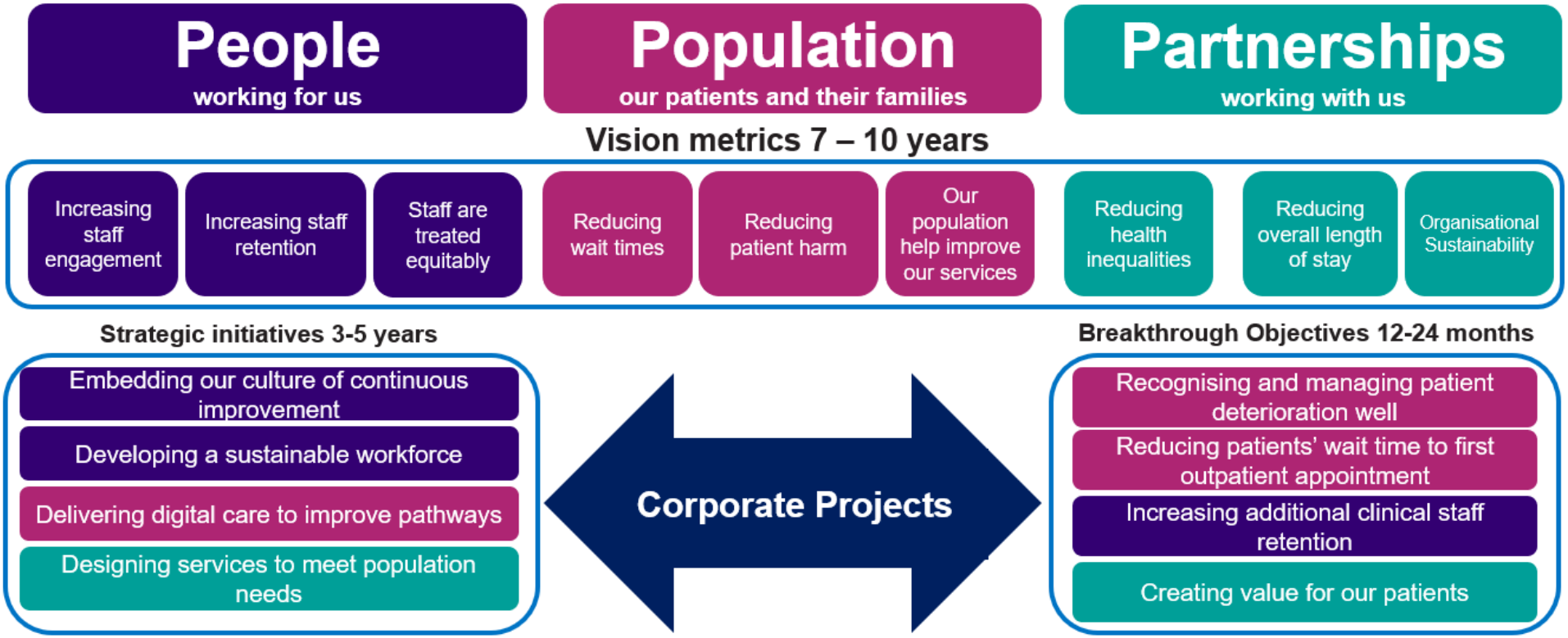
The workforce breakthrough objective of *Staff Retention* reduced to the lowest point on record at 16.4% against the 15% target. Other workforce metrics were contrasting, as *Staff Vacancies* continued reduction further to -2.4% and *Staff Sickness Absence* increased for the second month in succession to 3.8% overall, but remains below the regional average of 4.5%.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* remained static at -13.3% against the revised target of -5.33%. The Trust reported an in-month deficit of £2.4m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan year-to-date (YTD), the Trust cannot access the national element of the deficit support funding.

Strategic Priorities

NHS Salisbury NHS Foundation Trust

Our Vision is to provide an outstanding experience for our patients, their families and the people who work for and with us.



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections: Quality of Care, Access and Outcomes, People and Finance and Use of Resources which contain the following within them:

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

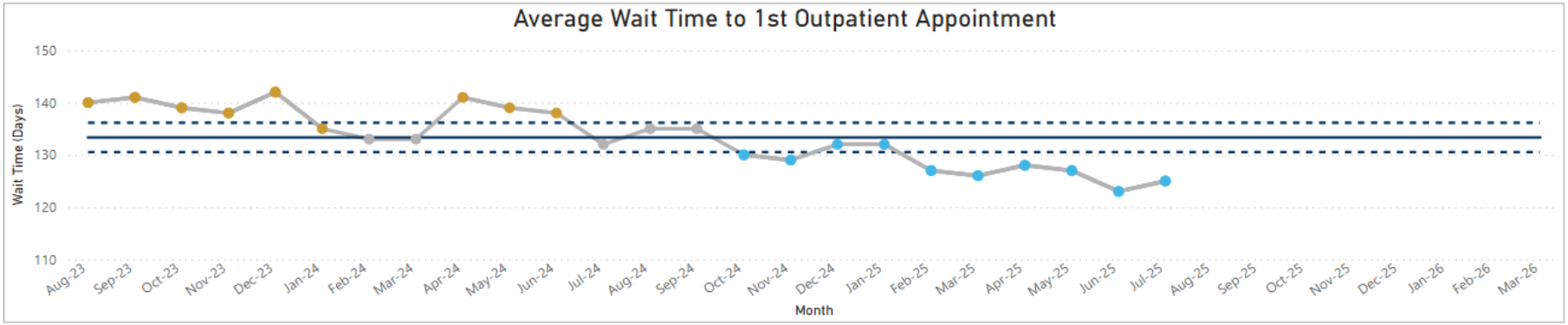
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 139 days (April 2023)**	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% Referral to Treatment (RTT) 18-week elective treatment target since October 21. A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18-week RTT target at risk. It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Target: ≤90 days Performance: 125 days Position: Special Cause Improvement



Understanding the Performance

Time to First Outpatient Appointment (TT1OPA) shows an increase from 123 to 125 days in July.

High waiting list specialties (>500 patients) with longest average wait times (in days) are:

- Rheumatology (157)
- Plastic Surgery (144)
- Cardiology (141)

Plastics and Cardiology are not within the current Phase 2 Outpatient Operational Group (OOG) support but will be considered for Phase 3 if continuing their current trajectory.

Respiratory and Trauma and Orthopaedics (T&O) are both reducing their TT1OPA and number of patients waiting over 52 weeks for the last 2 months.

Countermeasure Actions	Due Date
• Both Respiratory and T&O are part of the focused specialties within OOG for their Phase 2 (Oct 25 to Dec 25). Both specialties have had further A3 sessions and have updated actions and countermeasures.	Dec 25
• First Outpatient Explore, Review and Action (OPERA) session for Phase 2 specialties beginning Oct 25. Phase 3 specialties planned for Jan 26.	Oct 25
• Exploring waiting list validation options to support reduction in PTL	Oct 25
• Outpatient clinic utilisation & efficiency: Linking in with Space Utilisation and Administration Transformation and Optimisation Programme (ATOP) workstreams to gather data on current rooms space utilisation.	Oct 25

Risks and Mitigations

- Continued risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties. Mitigation: The programme strategy includes monitoring and specific focus on top contributing areas.
- Exploring use of Dr Doctor system for waiting list validation.
- Any further Resident Doctor's strikes - impact currently not assessable.
- FDP / CCS room management software demo 12/08/2025 - questionnaire to be completed to understand suitability for us to pilot.

Recognising and Managing Patient Deterioration

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 45.7% (April 2024)**	Improving the early recognition of patient deterioration is a multidisciplinary team activity and comprises of three recognised steps – **Record, Recognise and Respond.** The first step is regular measurement and recording of clinical observations and in line with recommendations from the *Royal College of Physicians* and *Academy of Medical Royal Colleges*, frequency of these physiological measures is determined by the NEWS2 score. Monitoring trends in both the patient's physiology and NEWS2 score will provide information to the clinical teams to triage workload and to identify potential patients at risk of deterioration. Our aim is to improve upon the current compliance for the recording of these measures with reductions in both mortality, morbidity and late escalations of care.

Target: ≥60% Performance: 52.2% Position: Special Cause Improvement

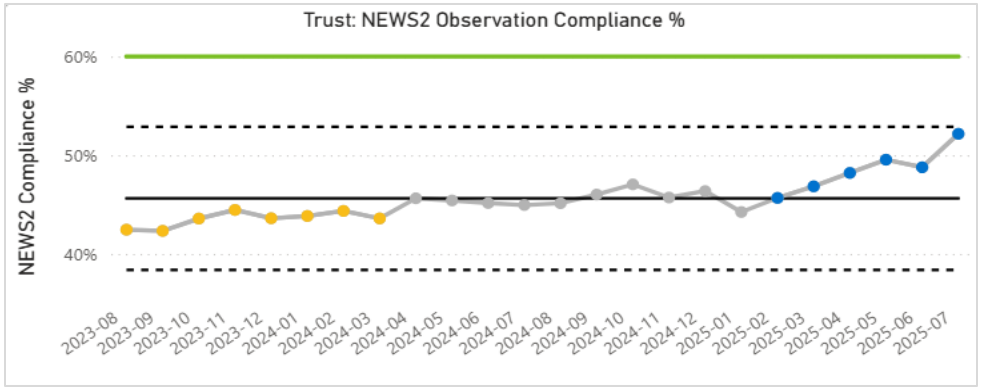


Chart A: NEWS2 scores of 3-6

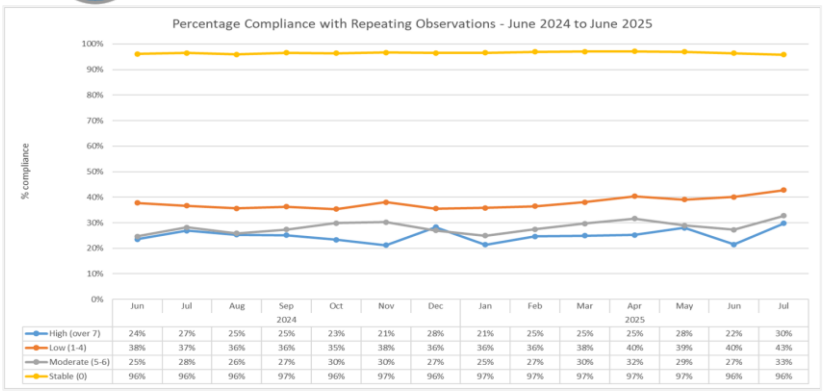


Chart B: NEWS2 scores by risk categories

Understanding the Performance

Performance of 52.2% in July continuing improvement.
Chart A includes selected departments and wards across the Trust with NEWS2 scores of 3-6. Chart B is measuring inpatient wards only across all NEWS2 scores making the sample size larger. This accounts for the difference in compliance.
The Escalation Workstream has been working collaboratively with the surgical divisions to improve compliance with NEWS2 scores in the 1-4 range low risk of deterioration (orange line on chart B).
Following several PDSA cycles, frequency of clinical observations in the low-risk category has improved which is reflected in chart A. Focus wards are: Odstock, Downton, Chilmark, Amesbury and Britford. Wards in the medical division of: AMU, Durrington and Tisbury are continuing to improve.

Countermeasure Actions	Due Date
RECORD:	
• Ward individual A3s monitored through the divisional performance meetings with quarterly review.	Oct 2025
RECOGNISE:	
• Continue to evaluate outcomes for those patients identified at the daily huddle and review process quarterly.	Oct 2025
RESPOND:	
• Complete A3 following baseline audit.	Oct 2025

Risks and Mitigations

- Risk of unrecognised deterioration which may lead to patient harm. However, whilst we continue to learn and improve, other measures allow us to monitor the risk including:

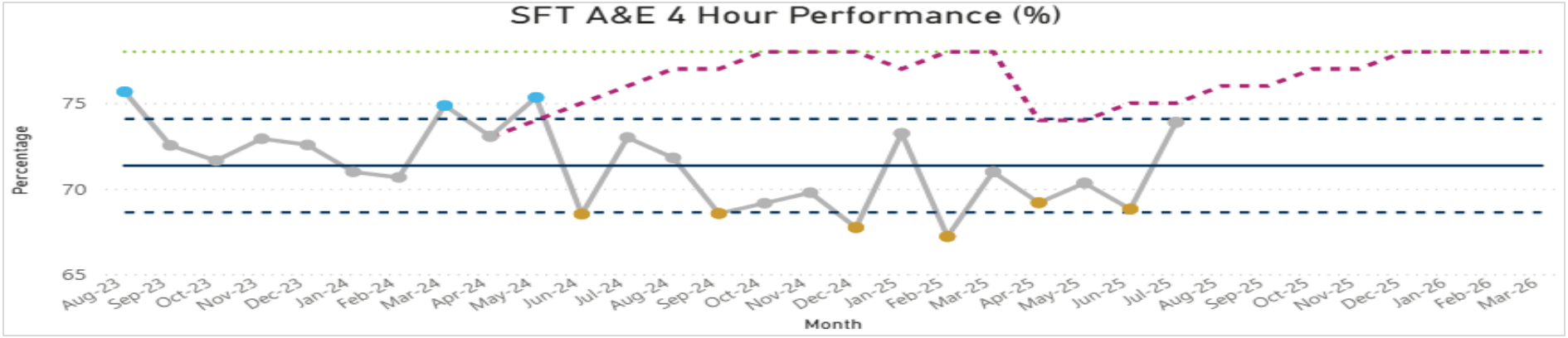
Positive

- Overall mortality rates decreasing.
- Cardiac arrest rates remain low at 2-4 per month.
- Medical emergency team call are increasing prompting earlier treatment.
- Unplanned admissions to Radnor Ward from the wards has decreased this month.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 73.9% Position: Common Cause



Month	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Proportion of patients spending more than 12 hours in an emergency department	4.3	6.4	5.6	8.0	7.1	7.8	10.5	8.7	8.9	9.0	6.6	4.8

Understanding the Performance

Our national target for this financial year is 78% by Mar 26, with M4 plan of 75%. Performance improved in M4 to 73.8% up from 68.81% in June.

Attendances into the Emergency Department (ED) remained high in July at 5,097 and bed occupancy across the Trust also continues to be high, although improved, at 94.7%. Reduced occupancy and a reduction in the number of patients no longer meeting the criteria to reside (NCTR) contributed to improved flow out of the ED.

Industrial Action for resident doctors took place between the 25th - 30th July, and performance achieved between 70.7% - 80.9% during this time. The increased senior decision makers in ED had a noticeable impact, given that the number of attendances remained unchanged.

Countermeasure Actions	Due Date
• Same Day Emergency Care (SDEC) continues to not be used for escalation space which has enabled the pull of patients from ED, with continued review of the impact of SDEC ability to pull patients in the morning.	Sep 2025
• ED have a clinical project lead allocated to review the use of SSEU and plan to implement a Clinical Decisions Unit (CDU) model which will both improve performance and enhance patient experience and care.	Oct 2025
• Further expansion of SDEC services and streaming pathways	Oct 2025

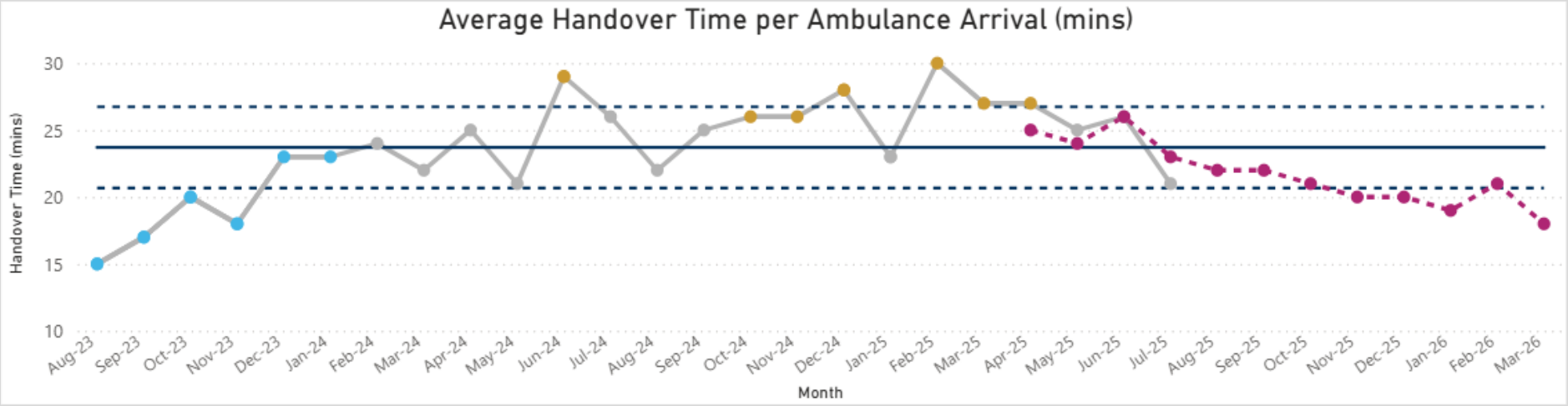
Risks and Mitigations

- SSEU conversion to a CDU may lead to an increase of inpatients awaiting an inpatient bed, however this will be offset by the expansion of AMU / SDEC and appropriate patients for CDU will be cared for in a more appropriate environment.
- The implementation of agency Emergency Nurse Practitioners (ENP's) within the Minors service appears to be having a positive impact on performance, however this is in its infancy and will require further analysis and time to allow for data collection.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

Target: <24 mins Performance: 21 mins Position: Common Cause

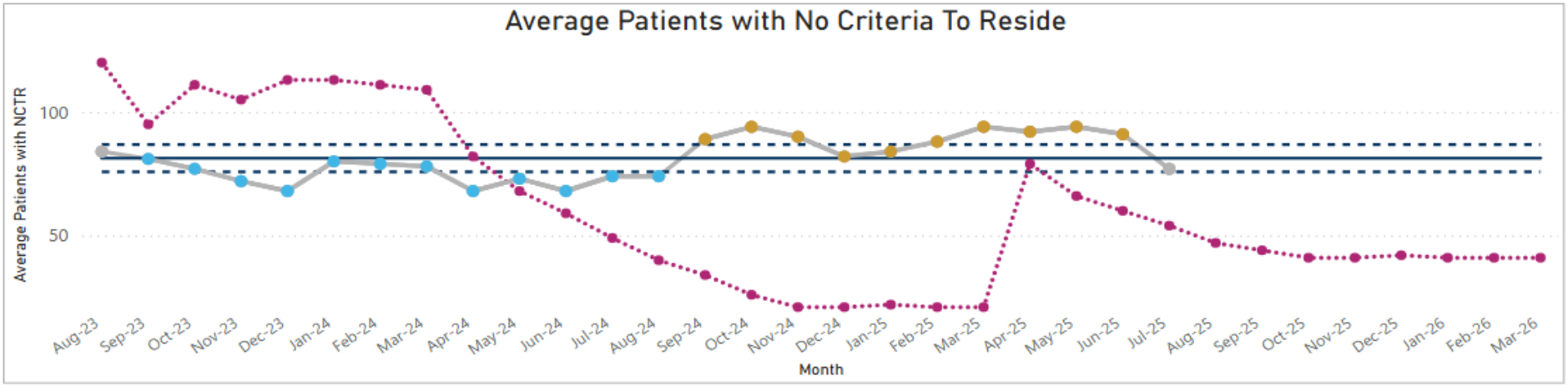


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Performance for Ambulance Handovers this month has seen an improvement, in line with 4h performance, at 21minutes average from 26minutes in June. This is the first month where performance has achieved below the trajectory target (by 2minutes). The <60 minutes performance has seen an average of 96.3 % up from 95.6% in June and 94.1% in May. Time to first clinician has improved marginally to an average of 104m which has contributed to the triage of patients in RATT, increasing offload space and therefore ambulance handover performance. The days in which performance declined, is directly associated with the higher numbers of attendances, staffing gaps or multiple ambulance arrivals within an hour.	• ED and SWAST continue to work closely to review data which supports analysis of ambulance handover performance • ED and SWAST are working collaboratively to review the role of the HALO regarding its current perceived limited positive impact on increasing performance	Sep 2025 Sep 2025	• Gaps in the Hospital Ambulance Liasion Officer (HALO) rota expected towards the end of August, are expected to have limited impact on service and performance now that a Band 6 RATT co-ordinator is present within this area • Levels of non-elective activity, ED attendances and the proportion of beds occupied by patients no longer meeting the criteria to reside resulting in high occupancy levels which slows flow into the hospital. Ongoing work with System and local authority partners to transform pathways and reduce demand and discharge delays.

Optimising Beds

NHS Salisbury NHS Foundation Trust

Target: ≤25 (5%) Performance: 77 Position: Common Cause



Understanding the Performance

The number of patients with No Criteria to Reside (NCTR) in July 2025 was at the lowest it has been since July 2024, with 77 patients average and 18.82% of beds, a reduction from 90 in June.

The data has shown a steady week on week increase in the number of NCTR within the month. There has been a focus on data recording to understand the delay reasons for higher numbers of NCTR and has seen a shift away from the interface delays to capacity in Pathway 3 being the top reason. The data is being reviewed further for root causes and will be worked through with system partners to identify solutions.

July saw a higher proportion of discharges across the month compared to the rest of the year in Pathway 0. There has been no significant difference in the discharges seen in other pathways 1-3 from other months across the year.

Countermeasure Actions	Due Date
• NCTR trajectories and daily tolerance numbers in place for SFT NCTR to allow for bed closures. BSW linking with Trusts BI Leads to finalise.	Sept 2025
• Digitalisation of Decision to Admit Form approved at CMB and due to go live August.	Aug 25
• Discharge Assessment and Action (DANA) team went live the end of July but awaiting data to review effectiveness.	Sep 25
• ESD additional resource to support Wiltshire Council with P1 discharges. Data review August.	Aug 25
• Medicine Divisional chosen reduction in deconditioning and NCTR as Divisional Driver to support reductions in Length of Stay. Focus Imber.	March 26
• Care Diaries (dependency form) rolled out across inpatient wards. Awaiting data for improvement.	Sep 25
• Discharge Roadshow planned for July rescheduled to Dec.	Dec 25
• Deep Dive for NCTR undertaken with system partners to review actions to support discharge and address interface delays. Home is best programme set up.	Mar 26

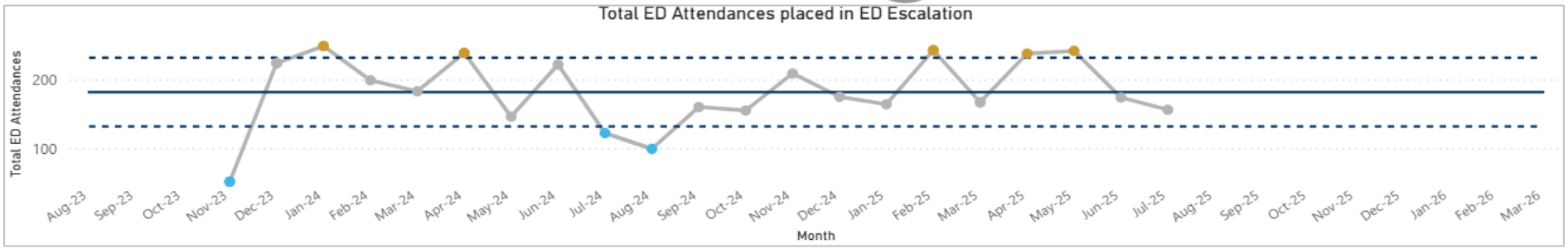
Risks and Mitigations

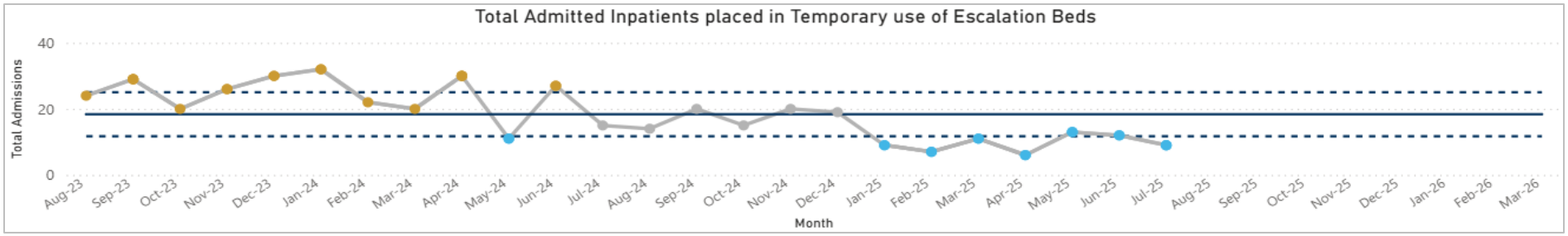
- Inability of the system to meet the NCTR trajectories for discharge.
- HCRG (Community Services provider) changes have meant a pause in roll out of Hospital at Home (H@H).
- External conflicts such as reduction in capacity in local authority social care teams and financial constraints.
- Changes to the community model.
- Clinical Capacity and demand conflicts.
- Clinical Engagement.
- Operational Pressures.

Use of Temporary Escalation Beds & ED Escalation

NHS Salisbury NHS Foundation Trust

Target: 0 Performance: 156 Position: Common Cause





Understanding the Performance

There has been a reduction in the number of patients placed into escalation spaces in the Emergency Department, and a reduction in the use of Temporary Escalation spaces in inpatient ward areas.

The reduction in bed occupancy 94.7% has improved flow out of the ED slightly with improvement in the number of patients spending longer than 12 hours in the department (246 patients in July compared to 333 in June and 462 in May). This has reduced the need to use escalation space.

The protection of Same Day Emergency Care beds overnight from escalation use has improved the flow out of ED first thing in the morning, reducing the need to use temporary escalation space on inpatient wards.

Countermeasure Actions	Due Date
• Plans to reduce the number of spaces used in the Short Stay Unit in ED for patients awaiting ward beds which will enable faster flow and treatment times for patients in the Emergency Department. Proposal to go to Urgent & Emergency Care board in August	Aug 2025
• Further expansion of Same Day Emergency Care and streaming pathways to enable patients requiring specialty review to move more quickly to those areas.	Oct 25

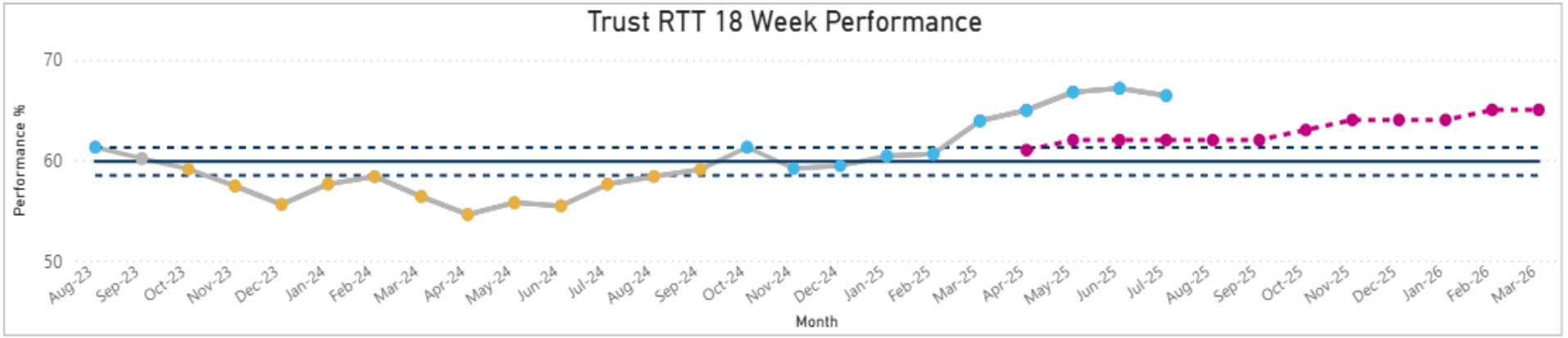
Risks and Mitigations

- The protection of SDEC areas from being used as escalation areas overnight may result in more patients waiting in the Emergency Department
- The stopping of SDEC bedding overnight and as use of escalation, has been felt to have had an impact on the number of Medical patients being placed in escalation in ED. This is being regularly monitored through the UEC board.

Elective Referral to Treatment

NHS Salisbury NHS Foundation Trust

Target: ≥61% Performance: 66.4% Position: Special Cause Improvement



Balancing Metric	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Longest waiting patient	74	78	83	73	74	78	71	74	78	64	64	68	71	76

Understanding the Performance

RTT performance in July of 66.4% is a decrease from 67.1% in June although remains ahead of both target and plan.

Notable specialties in month and performance against the 62% plan:

- Urology - 76.8%
- ENT - 70.6%
- Plastic Surgery - 68.7%

Work to reduce long waits was impacted by the five days of Industrial Action (IA), as the number of patients waiting more than 65 weeks increased from 4 to 8 and the number of patients waiting more than 52 weeks also increased from 224 to 253.

Total RTT Waiting List increased from 29,128 to 30,230 and aligns with referrals as both at highest points.

Countermeasure Actions	Due Date
• Validation of waiting list to ensure patients mislabelled as Non-RTT status are corrected to ensure active monitoring and reporting - Analysis and education plan being made to improve this.	Oct 2025
• Waiting list validation to ensure accuracy of RTT waiting list and to ensure patients are waiting well, i.e. no change in their health that would alter course of the referral pathway.	Oct 2025
• Existing digital software for waiting list management is being enhanced and expanded to improve the process overall.	Sep 2025
• Digital solutions are being explored to automate the validation process.	Sep 2025

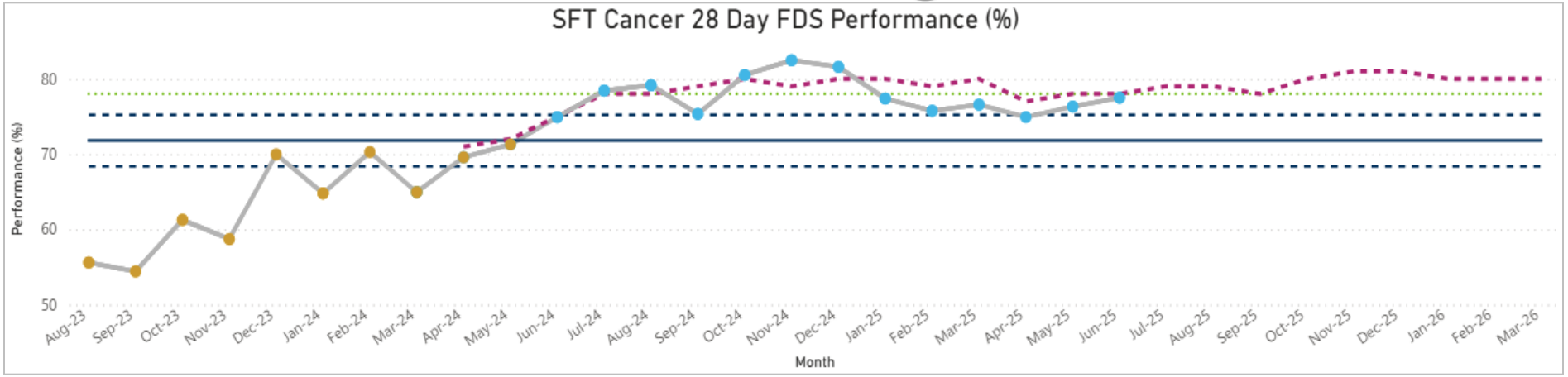
Risks and Mitigations

- Patients incorrectly categorised as Non-RTT status in the Electronic Patient Record (EPR) system can be a risk if not correctly labelled, with mitigating processes to correct in place.
- Capacity of clinical services to treat patients within 18 weeks is a risk and being mitigated through additional capacity where necessary.
- Weekly Access Meeting ongoing with the aim of reducing risk around long wait times whilst also driving performance to meet national targets.
- Any further IA will present a challenge and risk to all elements of the RTT waiting list.

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: ≥78% Performance: 77.5% Position: Special Cause Improvement



Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

28-day performance standard not achieved in M3 with month-end position of 77.5%.

Specialties which remain most challenged in delivering the standard include:

- Lower GI: 55.1% (from 50.8%)
- Gynaecology: 71.6% (from 65.1%)
- Haematology: 0% (from 14.3%)
- Lung: 58.8% (from 79.5%)
- NSS: 58.1% (from 59%)
- Urology 40.7% (from 48.7%)

Breaches are driven by high referrals with reasons associated: the impact of Bowel screening capacity, insufficient diagnostic capacity (both locally and at tertiary centres), patient choice / engagement, letter typing backlogs and pathway complexity. Services continue to be impacted by poor referral quality and completeness from primary care.

Countermeasure Actions	Due Date
• Review Breast and Skin capacity for first appointments to support overall delivery of FDS.	Sep 2025
• Audit of patient choice delays underway to identify themes and opportunities to reduce impact on pathways.	Q2 2025/26
• Involvement in SWAG "Days Matter" Improvement programme for Urology, Lower GI and Gynaecology pathways. 5% improvement in standard expected within 90 days, with 10% expected by year end. Project group established to manage improvement plans; positive feedback received in relation to progress against actions.	Q3 2025/26
• GI GP education event planned for October '25 with the aim of improving referral quality, to better facilitate straight to test pathways.	Oct 2025

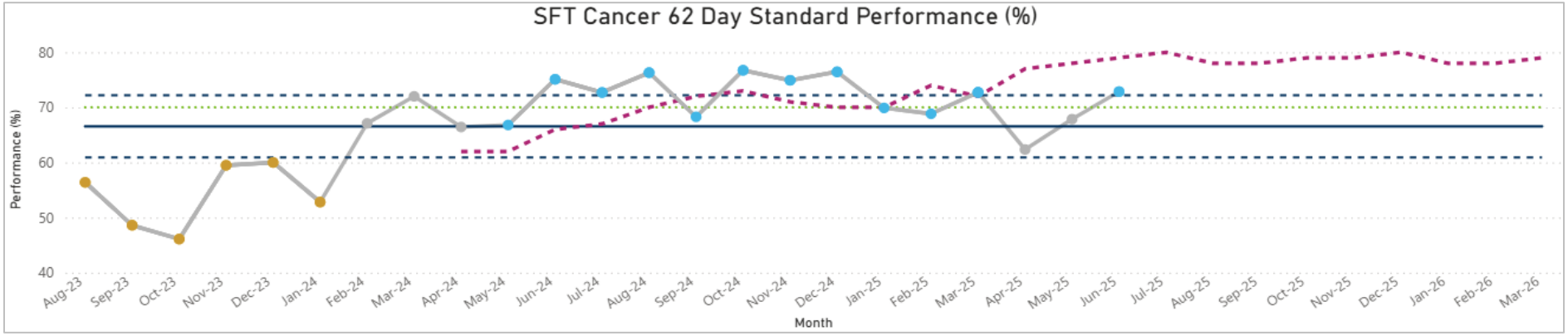
Risks and Mitigations

- High referral volume across all pathways is significantly impacting capacity, particularly within Skin, where average wait is increasing and insourcing has been delayed due to lack of availability / resource across BSW. Super clinic model under review and Teledermatology roll out across BSW will support, with service also scoping AI triage opportunities.
- Resource within MDT cancer services remains challenged in terms of capacity and a risk, impacting Breast and Skin pathways. Assistant MDT coordinators recruited fixed-term to mitigate.
- Automation of processes via Blueprism software, alongside procurement of SCR modules to support efficiency. Cancer 360 PTL management tool being rolled out by September '25.
- Letter typing backlogs in multiple tumour sites. Navigators identifying priority letters to support discharge. Additional resource in place for Respiratory and Urology will be a pilot site for digital dictation from September '25.

Cancer 62 Day Standard

Salisbury NHS Foundation Trust

Target: ≥70% Performance: 72.9% Position: Special Cause Improvement



Patients waiting over 62 days for treatment	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	76	65	61	69	78	68	55	84	84	69	66	70	85	82

Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

Improvement in 62-day performance in M3 with submitted position of 72.86%.

A total of 159 patients were treated against the standard in M3, with 41 patients breaching 62 days. Specialties not meeting the standard include:

- Breast: 67.2% (11 breaches of 33.5 patients)
- Gynaecology: 57.1% (3 of 7)
- Lower GI: 43.5% (6.5 of 11.5)
- Head & Neck: 0% (0.5 of 0.5)
- Urology: 66.7% (13.5 of 40.5)

Breach reasons include complex diagnostic pathways, clinical delays, insufficient diagnostic capacity, oncology and theatres (locally and tertiary centre), patient choice and engagement.

Countermeasure Actions	Due Date
• Review Patient Tracking List (PTL) meetings to improve resilience and standardisation across all tumour sites.	Sep 2025
• Facilitate roll out of 'Cancer 360' FDP PTL management tool within SFT in conjunction with BSW.	M6 2025/26
• Involvement in SWAG "Days Matter" Improvement programme for Urology, Lower GI and Gynaecology pathways. 5% improvement in standard expected within 90 days, with 10% expected by year end. Project group established to align with management of improvement plans.	Q3 2025/26
• Evidence of increase in patient choice breaches throughout pathways; audit underway to identify opportunities.	Q2 2025/26

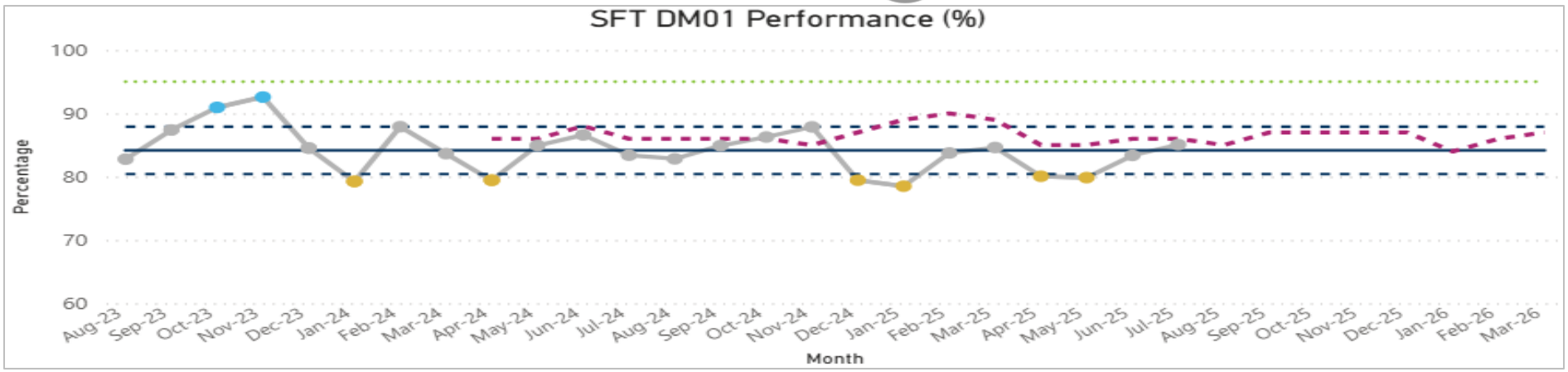
Risks and Mitigations

- Whilst there remain focus on reducing 62-day backlog, 62-day compliance will be detrimentally impacted. Increase in backlog noted over M3, with anticipated impact over M4/5.
- Noted resource within MDT Cancer services remains challenging in terms of long-term capacity. A3 in development to review training and development of workforce.
- Increase in Breast service breaches associated with screening demand and insufficient onco-plastic capacity for immediate reconstruction has impacted overall denominator. Locum now in post to support oncoplastic capacity. Screening demand expected to reduce from the end of August 2025.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 85.1% Position: Common Cause



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	76.0%	208	Dexa	100%	0	Colonoscopy	68.1%	90	Urodynamics	51.0%	24
CT	94.0%	63	Neurophysiology	100%	0	Gastroscopy	80.7%	57	Cystoscopy	93.8%	3
Ultrasound	86.5%	331	Echo	89.5%	32	Flexi Sigmoid	56.6%	53	Audiology	83.5%	94

Understanding the Performance

Performance against the 6-week standard increased to 85.1% (83.4% last month) just 1% off plan position of 86.2% for July.

Modalities below plan are:
- MRI - 78% against a plan of 82%
- Ultrasound - 86.5% against plan of 94%
- Cystoscopy - 93.8 against a plan of 98.3%
- Urodynamics - 51% against a plan of 57.8%

Ultrasound (USS) recovery plans via insourcing are in place and continue to improve in month. Cardiac Echo insourcing has commenced in M4. MRI backlog continues to challenge, continued support from Nuffield.

Endoscopy has improved from 46% in M1 to 70% in 4 and continues to be ahead of the recovery trajectory.

Countermeasure Actions	Due Date
• Review of WTAG weekly meeting, A3 in draft from Radiology to review USS and MRI challenges.	05/09/2025
• Discussion with Sulis reference potential MRI capacity.	30/08/2025
• USS capacity and demand describes a gap in USS workforce - consider business case.	05/09/2025

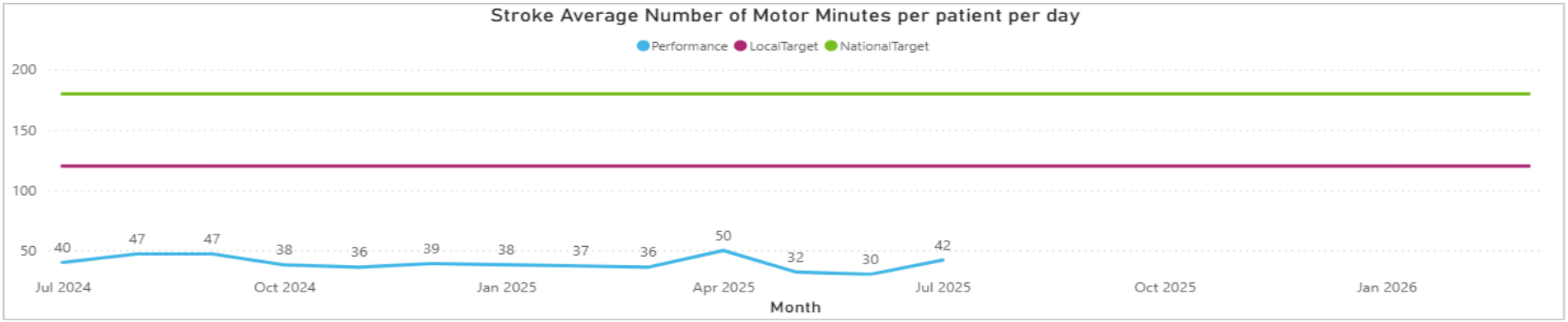
Risks and Mitigations

- Ongoing work to improve demand and capacity planning and ensure capacity is opened as far out as possible.
- Capacity remains reliant on either insourcing or in house overtime to meet demand.
- Weekly WTAG meeting to discuss performance.

Stroke Care

Salisbury NHS Foundation Trust

Target: ≥180 mins Performance: 42 mins Position: Special Cause Concern - Lower



	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
SSNAP score	B	A	B	C	C	C	C	D

Understanding the Performance

M4 demonstrates an increased position of an average of 42 motor minutes up from an average of 30 minutes in June. This is attributed to the stabilisation of absence and additional recruitment in the team. It should also be noted that the ward was not in escalation for much of the month, meaning a higher staff to patient ratio, leading to more time spent per patient.

Key themes:

- No of minutes of motor therapy is averaged across all patients requiring **any** duration or level of motor input. This means that at any point up to 30% of patients will be too unstable or have no therapy goals so will lower the average minutes for all patients.
- A key area of development is psychology therapy minutes. A lack of staffing to provide this impacts on other areas of therapy, increasing length of stay and lowering SNAPP scores and a business case is being developed.

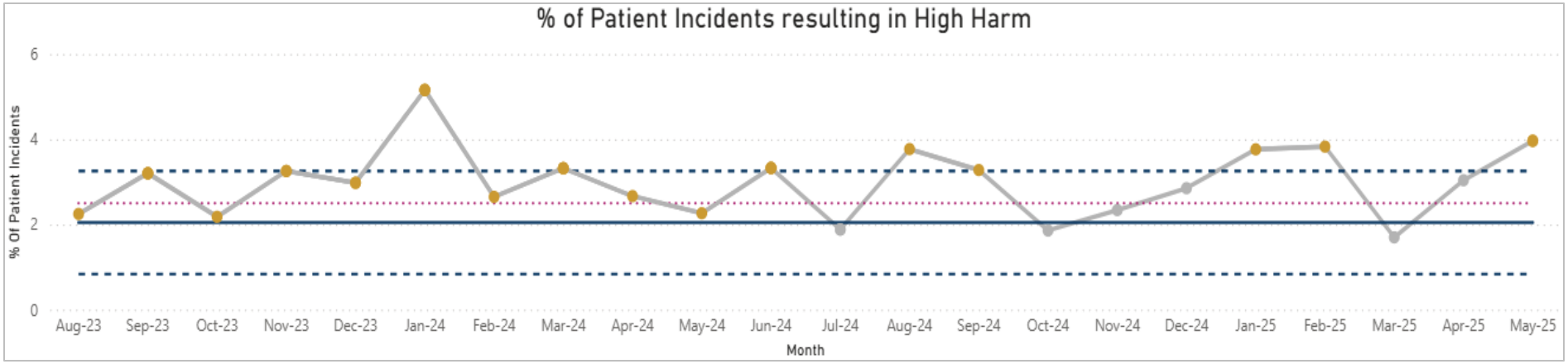
Countermeasure Actions	Due Date
• Further work to optimise uncaptured activity from outlying patients and ward nurses.	Sep 25
• Time in motion and job planning for current team to ensure all available capacity is utilised effectively.	Sep 25
• Gap analysis between current registered workforce (8.55 WTE) and new recommendation workforce (13.29 WTE) in increased productivity.	Sep 25
• If optimisation of capacity is achieved, then work up business case for additional staffing.	Sep 25

Risks and Mitigations

- The number of therapy motor minutes provided to patients requiring and able to participate is higher than performance suggest (reduced by averaging across all patients requiring any motor input during stay).
- The mitigation is a redesign of A3 which will include benchmarking and sharing of good practice across Wessex network. Initial meetings have found SFT to be leading in average motor minutes across BSW.
- Team working with original workforce on 10.55 WTE therapists and 15.29 WTE recommended.
- Psychology Business Case in progress to contribute to motor minutes.

Incidents

Target: ≤2.5% Performance: 3.97% Position: Special Cause Concern

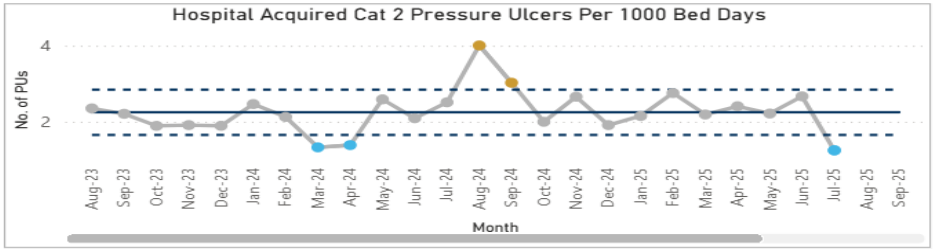


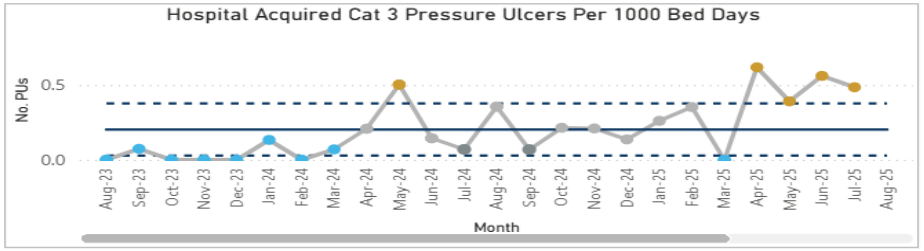
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
There were 966 total incidents reported in May compared to 989 in April. Of those 966 incidents, 828 were relating to patient safety. Of those 828, 33 were classified as moderate harm (an increase of 7 from April), 2 reported major harms and 0 reported catastrophic harm. **<u>Patient Safety Incident Investigation (PSIIs) commenced in July:</u>** • PSII 14 - Audiology Cluster review (national priority) • PSII 15 - Never Event Insulin administration in a non-insulin syringe (national priority) *There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively.*	• Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients. Quarterly review of this process and themes arising. • Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue / trend and a patient safety incident investigation (PSII) is indicated. Quarterly review of this process. • Quarterly learning from incidents forum.	Oct 2025 Oct 2025 Oct 2025	• Use of Naloxone requires prescription. • Any patient who has developed hepatic encephalopathy needs to have neuro observations. • Non standardised approach to patient handovers within nursing and medical teams a risk and development area. • Scope to enhance Sepsis 6 pathway within ED. • Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required mitigating risks. • Weekly Patient Safety Summit (PSS) where all incidents are discussed to mitigate risks

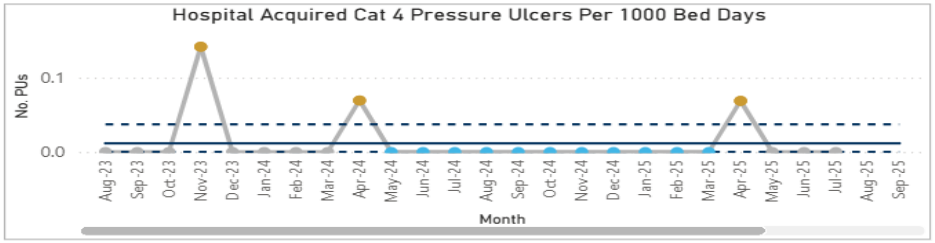
Pressure Ulcers

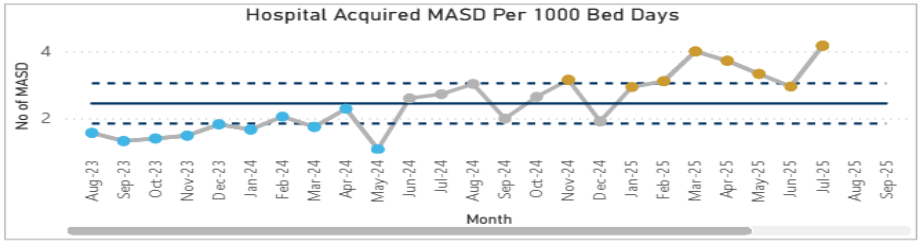
NHS Salisbury NHS Foundation Trust

Target: 0 Performance: 1.25 Position: Common Cause









Understanding the Performance

Number of Hospital acquired reported pressure ulcers Cat 2 – 4 for July was 25 decreased from 46 reported in June.
Category 2 pressure ulcer incidence numbers have decreased (18).
The number of reported category 3 pressure ulcers decreased from 8 to 7 and for the 3rd consecutive month there have been 0 Category 4s reported.
The number of medical device related pressure ulcers has decreased to 0 from 9 in June.
The number of pressure ulcers (Cat 2-4) identified on admission was 55 increased from 47 in June.
Hospital acquired MASD (moisture associated skin damage) incidence has increased (60) and remains high. This could be due to the increase in environmental temperature. 42 incidences were reported in June.
The number of MASD incidence reported on patient admission was 51.

Countermeasure Actions	Due Date
• MASD Pathway now agreed.	Sept 2025
• MASD Pathway launch – ward visits TBA	Jan 2026
• Ward temperatures being monitored and bed number now added to MASD DATIX form to observe for trends.	Oct 2025
• A new skin tear pathway is being developed within the team.	Dec 2025
• New Topical Negative Pressure Wound Care Therapy Guide being produced.	Dec 2025

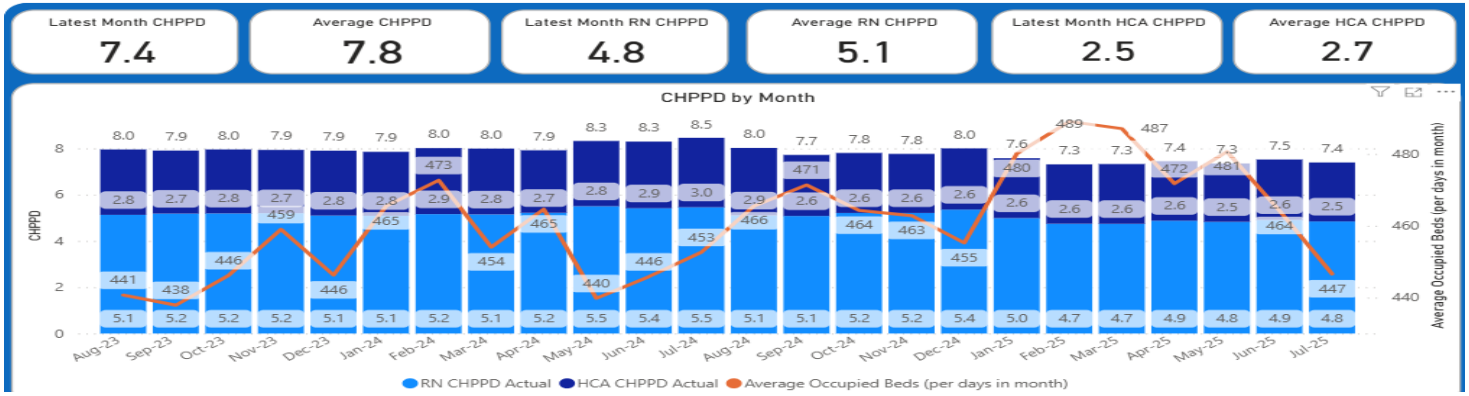
Risks and Mitigations

- MASD and PU numbers are being monitored due to a spike in the weather temperature on the wards.
- Wards to utilise Link workers to support with wound care management and prevention of skin tissue injury.
- The new MASD pathway to be discussed at July's Drugs and Therapeutic meeting for approval.
- The Tissue Viability Service is currently under review and focusing on systems and pathways relating to prevention and management of wounds.

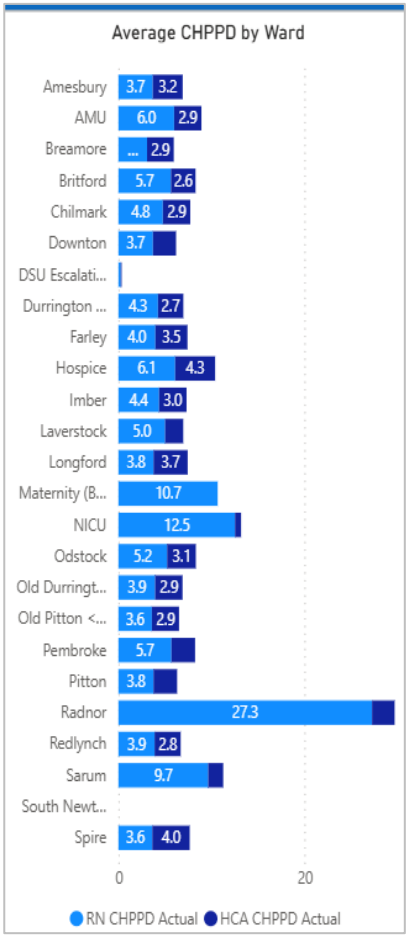
Care Hours per Patient per Day (CHPPD)

NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.4 hours Position: N/A



Definition: CHPPD measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight and is nationally reported. Note: There is no national target as is a benchmark to review individual ward trends.



Understanding the Performance

CHPPD for July is 7.4. This reflects less boarding beds and static fill rate with HCA day shifts being the hardest to fill. Pitton ward closed this month and several wards have moved to accommodate a refurb in Tisbury, resulting in some fluctuation of bed numbers on each ward and a decrease in overall beds - this will impact on the data at ward level as CHPPD should only be benchmarked against that same ward. As DSU is currently a 12 bedded surgical facility this is now extracted for CHPPD purposes.
The shifts filled above capped rates were Angio Cath lab with 16 shifts.

There were a total of 1,344 hours provided by registered staff overall for ETOC (*enhanced therapeutic observations and care)*,1,223 hours filled by agency. Additionally, 179 hours of HCA fill for ETOC along with security which we do not report on currently. Work is being undertaken to scrutinise the appropriate use of RMNs through daily staffing meetings alongside a divisional drive to reduce spend and manage within templated numbers when possible.

Countermeasure Actions	Due Date
• Trust-wide workstreams for agency reduction in specialist areas and sickness reporting via Administration Transformation and Optimisation Programme (ATOP) with quarterly review.	Oct 2025
• Regional work on aligning bank rates of pay.	Sept 25
• Tighter controls around additional duties being created and shifts going out to bank, especially short notice gaps with quarterly review.	Oct 2025
• Annual Safe Staffing reviews are underway with 4 inpatient wards remaining – last one booked 3/9/25	Sep 25

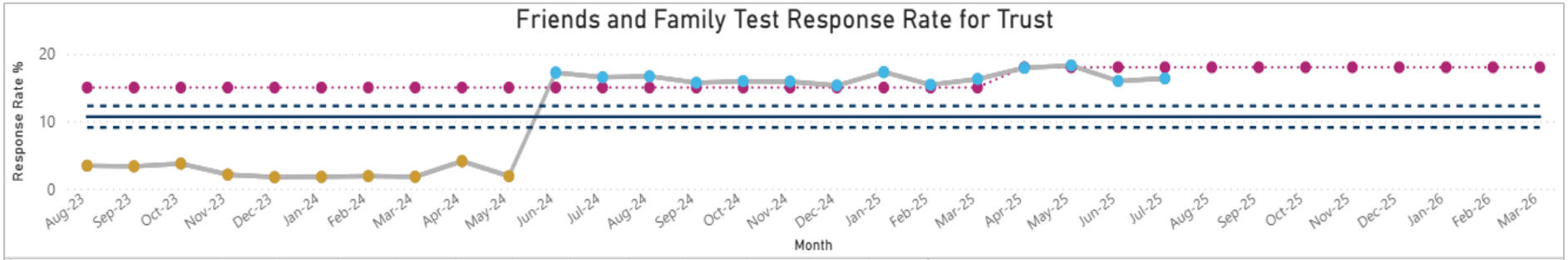
Risks and Mitigations

- Requirement to reduce headcount / temp staffing (risk).
- Ongoing demand driven by Mental health team for RMN usage to support patients at risk (risk).
- Short term sickness and absences driving temporary staffing spend above headroom allowance (risk).
- Use of boarding spaces resulting in occasional temp staffing use and / or redeploying ward staff so some wards run short (risk/mitigation).
- HCA vacancy and turnover (risk).
- South-West collaborative holding agency at capped rates (mitigation).

Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥18% Performance: 16.36% Position: Special Cause Improvement



Response Rate by Area	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
FFT Response Rate - A&E	22.0%	20.7%	21.6%	20.6%	21.7%	21.8%	20.0%	19.5%	21.1%	21.1%	20.2%	21.2%
FFT Response Rate - Day Case	11.2%	6.3%	10.3%	8.7%	10.1%	12.3%	9.6%	23.0%	17.0%	20.5%	14.3%	15.9%
FFT Response Rate - Inpatient	31.8%	21.4%	26.0%	24.8%	27.2%	30.2%	19.9%	34.6%	46.2%	39.3%	23.7%	30.2%
FFT Response Rate - Maternity	10.1%	10.3%	9.5%	10.2%	10.4%	10.3%	8.9%	3.5%	100.0%	100.0%	100.0%	100.0%
FFT Response Rate - Outpatient	16.0%	15.8%	15.6%	15.8%	14.5%	16.8%	15.4%	14.5%	15.5%	16.4%	15.3%	15.2%

Understanding the Performance

Our response rate in July reported was still maintaining an increasing response rate since the new digital dashboard and SMS message service went live in June 2024. Our response rate was 17% with a satisfaction rate of 93% therefore we fell short of our newly increased response rate target of 18% and satisfaction rate target of 95%.

The top three themes for dissatisfaction are:
- Staff attitude
- Environment
- Waiting times

This data is reported to individual wards with an expectation that areas take these themes forward as part of their Improving Together work.

It is to be noted that due to the BadgerNet system upgrade we are currently unable to survey Maternity patients via text message until data transferred correctly – maternity response rate reflects very small cohort.

Countermeasure Actions	Due Date
• The installation of the new FFT boards currently in the inpatient areas is currently taking place, with a second phase rollout planned for outpatient areas. There is a delay in completion of phase 1 and 2 due to Estates capacity.	Oct 2025
• Resolve issues relating to data in BadgerNet system to ensure Maternity patients can provide feedback and increase overall response rate.	Oct 2025

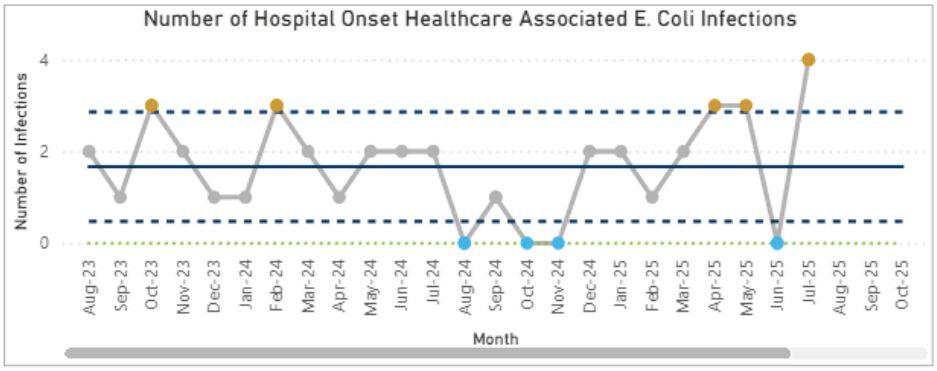
Risks and Mitigations

- The Envoy dashboard provides improved insight analysis of responses, enabling better and clear understanding of feedback, reducing risk of missing themes.
- Going forward we are offering more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 18% improving together response rate target set for 2025/26.
- Risk around missing Maternity feedback to be resolved.

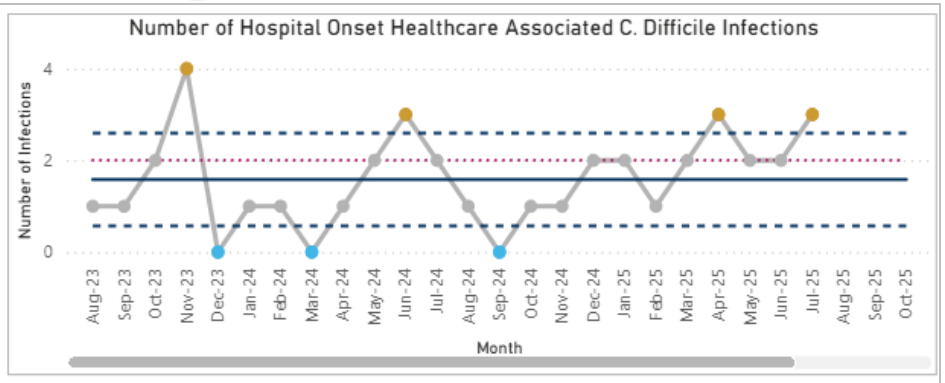
Infection Control

NHS Salisbury NHS Foundation Trust

Position: Special Cause Concern



Position: Special Cause Concern



Year	2023-2024	2024-2025
MSSA Bacteraemia Infections: Hospital Onset	10	10
MRSA Bacteraemia Infections: Hospital Onset	0	0

Understanding the Performance

There have been four hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, compared with none for last month.

For HOHA reportable *C.difficile* cases, there have been three cases, compared with two cases last month. For COHA reportable *C.difficile* cases, there have been three cases, compared with one case last month - overall increase in healthcare associated cases.

The previously reported PIIs of C.difficile for Spire Ward continues due to ongoing review of practice.

An outbreak of COVID-19 previously declared for Breamore Ward has now closed.

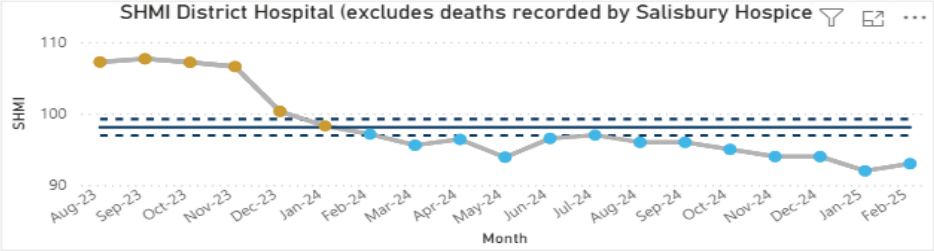
Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas/teams to identify good practice and any new learning continues with identified timeframes.	31/08/25
• From reviews completed for *C.difficile,* lapses in care have been identified with ongoing themes. The divisions continue to monitor those areas that have produced action plans and provide updates to the IP&CWG.	31/08/25
• Completion of Tendable inspections and specific audit work (including increased hand hygiene audits on the instruction of the DIPC) by the divisions.	31/08/25
• The IPC nursing team continue to undertake targeted ward visits and use educational opportunities with different staff groups.	31/08/25

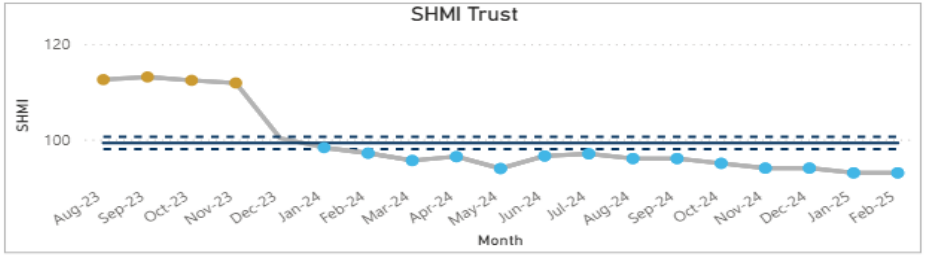
Risks and Mitigations

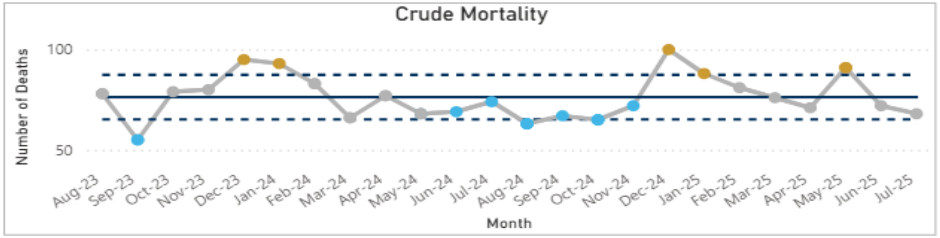
- Demanding and intense clinical workload for IPC nursing team members has resulted in very limited progress with other preventative HCAI work.
- Continued periods of absence of the Lead Nurse has greatly reduced the ability of the service to complete any additional educational activities and policy practice reviews. Recruitment plan for Band 6 vacancy position in progress.
- Underlying risk continues to be potential increase in reportable HCAI with poor patient outcomes.
- Continued delays in completion of investigations by the divisions to identify learning has impacted any improvements in patient care outcomes.
- Exceeding the NHS Standard Contract 2025/26 threshold levels set for SFT – currently for reportable *C.difficile*, the threshold is set at 21 healthcare associated cases. So far, from 1st April to 31st July, there have been 18 cases (10 HOHA and 8 COHA).

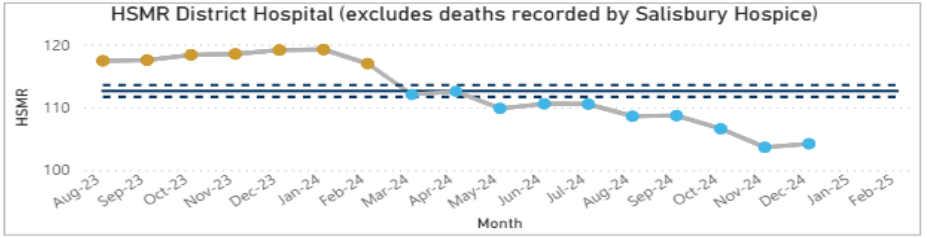
Mortality

Target: N/A Performance: N/A Position: N/A









Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in March 2025 is 0.93 and remains statistically within the expected range. The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in January 2025 for Salisbury District Hospital is 102.7. This figure has continued to reduce and remains statistically within the expected range. A national revision to the methodology for calculating the SHMI came into effect from Dec '23 onwards. The HSMR was also remodelled (now HSMR+).	• The online mortality system to support learning from deaths was launched in March last year, and activity has been focused on improving reporting input/ outputs from mortality reviews. The Trust are currently working closely with mortality leads at RUH and GWH to improve how mortality data is being viewed and reported. Development work recently commenced to align our Power-Bi reporting across the 3-acutes. By using the same methodology, this will enable us to further improve our learning and understanding of the data.	31st October	• The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups. • Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken. • Benchmarked mortality data are shared via the regional System Mortality Group which included Bath, Salisbury and Swindon Acute Trusts.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	77	90	50		0		Special Cause Improving - Run Below Mean	X	60
Cancer 31 Day Performance Overall	93.1%	97.4%	94.8%		96%		Common Cause Variation	X	1
Complaints Closed within agreed timescale %	41.0%	45.0%	45.0%	85.0%			Special Cause Improving - Two Out of Three High	X	60
Diagnostics Activity	9135	9421	9640	9956			Special Cause Improving - Above Upper Control Limit	X	1
ED 12 Hour Breaches (Arrival to Departure)	462	333	246		0		Special Cause Concerning - Run Above Mean	X	60
ED Attendances	7392	7317	7205				Special Cause Concerning - Above Upper Control Limit		
Inpatients Undergoing VTE Risk Assessment within 14hrs %	13.2%	15.5%	14.8%		95%		Common Cause Variation	X	60
Mixed Sex Accommodation Breaches	21	13	11	0	0		Special Cause Improving - Two Out of Three Low	X	60
Number of High Harm Falls in Hospital	3	5	4	0	0		Special Cause Concerning - Run Above Mean	X	14
RTT Incomplete Pathways: Total 65 week waits	3	4	8	0	0		Special Cause Improving - Below Lower Control Limit	X	3
Total Incidents (All Grading) per 1000 Bed Days	65	73	71				Special Cause Concerning - Above Upper Control Limit		
Total Number of Complaints Received	26	23	24				Special Cause Concerning - Above Upper Control Limit		
Total Patient Falls per 1000 Bed Days	6.52	6.81	7.45	7			Special Cause Concerning - Above Upper Control Limit	X	1
Trust 30 day Emergency Readmission Rate	11.3%	10.9%	11.9%				Special Cause Concerning - Run Above Mean		

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Improvements in watch metrics relating to flow can be seen across a range of measures including ambulance handover delays over 60 minutes (reducing to 50 from 90 in June) and although still alerting as it remains above the mean the number of patients in the Emergency Department for longer than 12 hours has improved for the last 2 consecutive months from 462 in May to 246 in June linked to the improvement in occupancy levels (94.7% this month compared to 95.1% last month and 96.7% two months ago). Additionally, the number of instances were patients were cared for in mixed sex accommodation decreased to 11.

Progress continues to show in elective programmes with diagnostic activity levels and the number of patients waiting over 65 weeks for elective treatment (Referral to Treatment) both alerting positively.

Areas of challenge in the watch metrics are reflected in the number of ED attendances which remains above plan (5% above plan levels year to date). The number of falls per 1000 bed days has increased above the target of 7 to 7.45 following a third consecutive month of increase.

Countermeasure Actions

- Falls audit data has revealed that there are improvements that could be made with compliance to the risk assessment and completion of lying and standing blood pressure assessments. The falls team are offering additional support to ward areas, in particular higher risk areas, and continue to visit all patients that have fallen to ensure that all interventions have been completed. A caffeine-free project is due to start on Spire ward in the coming months. Research suggests reduced caffeine intake can reduce the number of inpatient falls. The falls champion / falls link nurse role group has been revived, with plans of getting members more involved with ward-based training.

- Ongoing conversations with the ICB to identify cause of increase in ED attendances and whether there are any alternative options for patients. The increase of Same Day Emergency Care (SDEC) services will enable more patients to be streamed from the front door to specialty areas reducing the time spent in the Emergency Department.

Risk and Mitigations

- Lying and standing blood pressure compliance is poor and improvement is still required; it is anticipated this will reduce the number of falls as this rises with the falls reduction training currently being delivered throughout wards.

- Development of streaming pathways from the Emergency Department to SDEC areas will reduce the volume of activity in ED, ensuring SDEC areas remain protected to preserve this capacity is essential.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Beds Occupied %	96.7%	95.1%	94.7%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	68.1%	77.0%	67.0%				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	6	7	0	0			Special Cause Improving - Below Lower Control Limit	✓	0
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	2	2	0	0			Common Cause Variation	✓	0
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0				✓	0
RTT % of patients waiting less than 18 weeks for 1st Appointment	64.5%	64.2%	62.5%				Special Cause Improving - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	524	224	253	450	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	68.0%	65.0%	77.0%		50%		Special Cause Improving - Above Upper Control Limit	✓	0
Total Number of Compliments Received	24	92	44				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

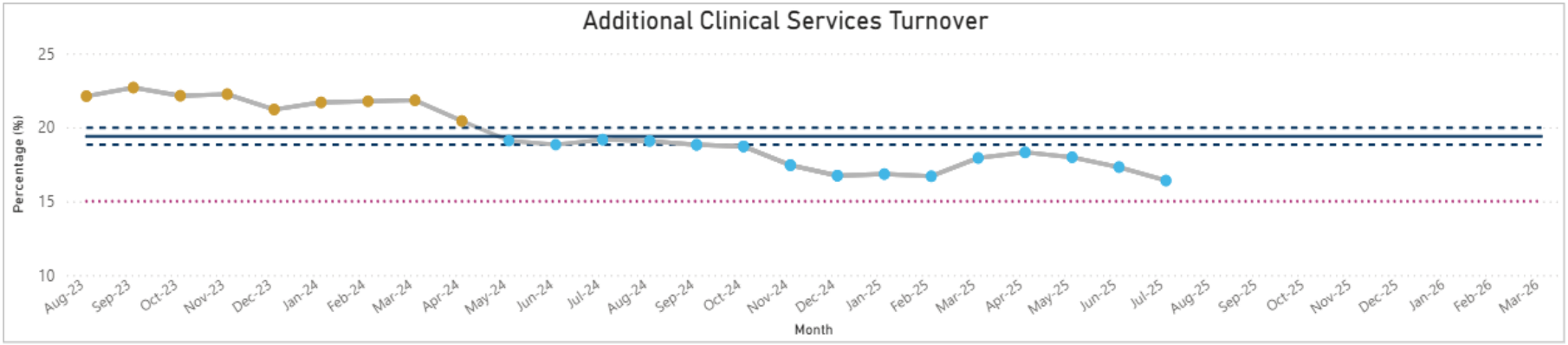
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest turnover areas by staff group (HCA), length of service and Age of Leavers.
Baseline: 20.4% (April 2024)	We have developed an A3 approach to focus on improving retention in this staff group due to the significant impact this turnover has on direct patient care. This will enable more direct patient care hours due to more available HCAs working each shift.

Target: ≤15% Performance: 16.4% Position: Special Cause Improvement



Understanding the Performance

Additional Clinical Staff (ACS) Turnover reduced to 16.4% in M4, from 17.31% in M3, lowest level in over 2 years (above the 15% target).

This equates to 6 WTE leavers in month:
- 4.5 WTE had 2 or less years' service
- 1.0 WTE were under 30
- 1.7 WTE 31-40
- 0.6 WTE 41-50
- 2.7 WTE 51-60

Leavers reasons given:
- 2 WTE Relocation
- 0.8 WTE further education or training
- 0.6 WTE Work life Balance & Unknown

SFT overall turnover increased to 12.31% M4 (12.26% M3) Target is 12%.
South-West NHS turnover in Q1 is 13.6%.

Countermeasure Actions

Countermeasure Actions	Due Date
• Focus on highest / lowest turnover teams to triangulate data and develop lessons learned.	31st Dec 2025

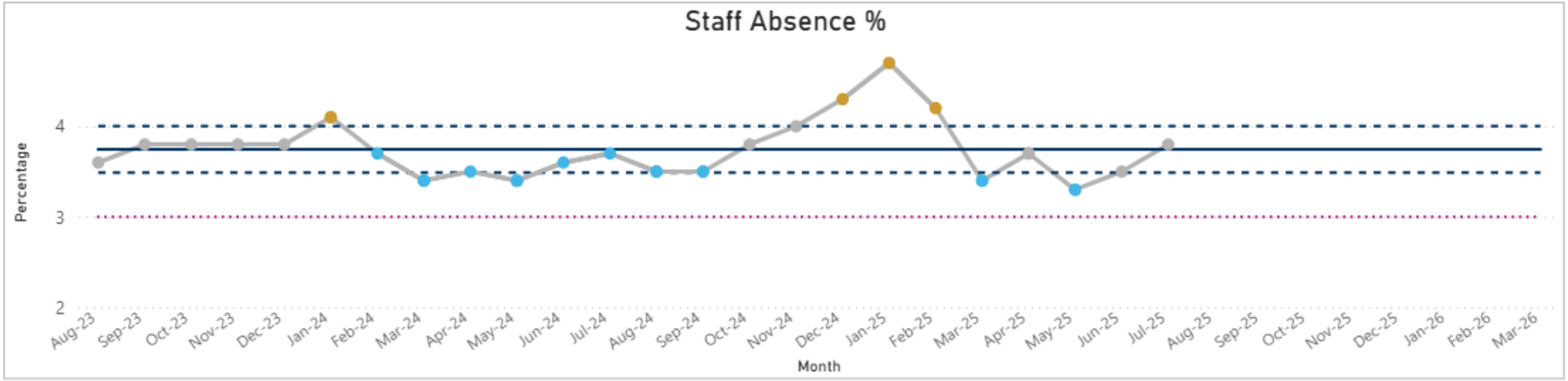
Risks and Mitigations

- The target of 15% is generally on track – a continued decrease in turnover in this staff group is demonstrable over the last 2 years.
- The relatively low number of monthly leavers (on average 4-6 WTE per month) mean the monthly graphic can be subject to significant fluctuation.
- Potential for an increase in leavers in September /October as current staff members leave to undertake university courses.
- Risks around high turnover in HCA staff group mitigated by R&R team focus.

Sickness Absence

NHS Salisbury NHS Foundation Trust

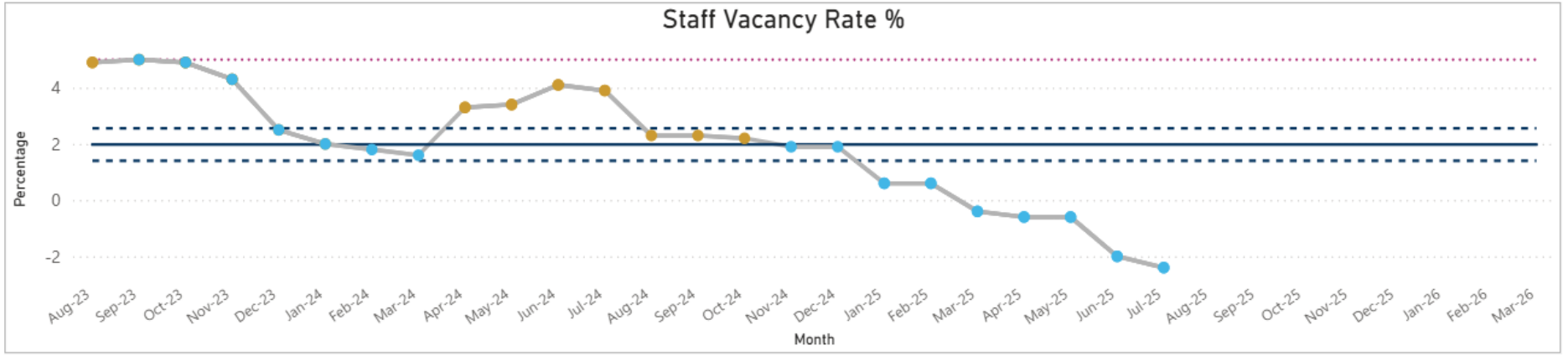
Target: ≤3% Performance: 3.8% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Absence has risen to 3.75% (M4) from 3.54% previous month. It is 3.84% rolling 12 months. Surgery has highest divisional absence of 4.59%. Corporate is the lowest at 2.32% (the only one below the 3% target). ACS highest staff group 5.45% AHP (2.88%) and Medical / Dental (1.93%) <3% There are 8 staff with 20+ absence occurrences in rolling 12 months period to July 2025 4,773 WTE days taken in M4 with 1,491 WTE days due to anxiety / stress / depression. Regional absence average in Q1 is 4.5%.	• Licence to manage training programme rolled out and includes training on attendance management practice and policy, review end of Q2. • Review of all highest absence staff led by ER Advisor with Ops managers to ensure all appropriate actions are being followed to enable higher attendance, review end of Q2. • Focus on ward teams sickness absence, particularly to reduce short term sickness and review quarterly.	Oct 2025 Oct 2025 Oct 2025	• Consistency of application of policy and attendance management processes is variable due to range of management experience and training is not mandatory to attend. • Availability of managers to attend training is an ongoing issue. • Limited number of HR advisors to support high demands of high-volume attendance cases. • Targeted approach to highest absence (individuals and teams) should provide most benefits to reducing overall absence levels. • Restorative approach to attendance management is hoped to enable higher attendance due to tailored support and reasonable adjustments.

Vacancies

Target: ≤5% Performance: -2.4% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Vacancy rate down again, -2.35% in M4 (another lowest recorded figure). This is NET figure and so there are teams under establishment and teams above establishment, but the net position is that the trust is over establishment. *The Power BI dashboard is still be updated / checked at the time of publishing, so no further information is available to be published.* M4 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 240 WTE M4 (215 WTE M3), a vacancy rate of 5.3%. Vacancy rate for South-West region is 5.5% in Q1	• Continued scrutiny on all recruitment at Divisional, Executive and MD / CEO levels. Quarterly review. • Targeted campaigns and regular (monthly) review of all hard to recruit roles, helping to reduce reliance on Locums and agency workers. Quarterly review.	Oct 2025 Oct 2025	• Resourcing leads, DMT and HRBPs working to design and develop attraction packages for hard to recruit roles with aim to reduce high-cost locum/agency usage. • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through poor publicity around NHS (dissolution of NHS E, reduction in staffing levels due to restriction on budgets etc.). • Corporate Recruitment freeze (May 2025).

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	75.8%	80.2%	79.9%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	60
Non-Medical Appraisal Rate %	74.0%	74.4%	75.1%		90%		Special Cause Improving - Increasing Run	X	60

Watch Metrics: Alerting Narrative

People

Understanding the Performance

Mandatory training for M4 is showing below target at 79.9% (from 80.2% M3) completion rate across the Trust. The best performing area was Facilities with 93% completion. The lowest contributors are Corporate at 73% and Medicine at 80%. The 90% target has not been met for since January 2023.
The application of significant oversight from management teams remains the most effective action to increase compliance. Fire Safety, EDI & Prevent are the only courses above 90% compliance. Conversely Safeguarding Level 3 for both children and adults are under 40%.

Medical appraisals improved "in month" and is 92.1%. However, note the number of "out of date" appraisals has increased from 93 to 100, with the number out of date by more than 3 months increasing from 27 to 30.

Non-medical appraisals rates have improved to 75.1% (74.4% M3). This is 3.3% lower than the previous July. This equates to 813 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 61.9% (216/ 567 out of date) and Estates at 64.7% (12/34 out of date).

Countermeasure Actions

- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. A working group is established to review and improve the process to enable higher completion rates.
- The review/project to overhaul non-medical appraisals is also looking to link to talent management, and CPD required for colleagues across SFT. This is part of the OD&L steering group for monthly review and update.
- A Pilot approach of targeted focus on appraisal compliance within OD&P has seen an improvement from 64% in January 2025 to 994.4%, highest Directorate in SFT.

Risk and Mitigations

- Work is ongoing to improve accuracy and design course content which is easy to understand and use.
- Inability to release staff to enable MLE completion is frequently cited as the main blocker to success.
- Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.
- Management time to enable appraisal completion is frequently cited as the main blocker to success.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	91.5%	92.8%	92.1%	90.0%			Special Cause Improving - Above Upper Control Limit	✓	0
Staff Turnover (Trust overall)	12.3%	12.3%	12.3%	13.0%			Special Cause Improving - Below Lower Control Limit	✓	0
Staffing Availability	3.5%	3.5%	3.4%	3.7%			Common Cause Variation	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

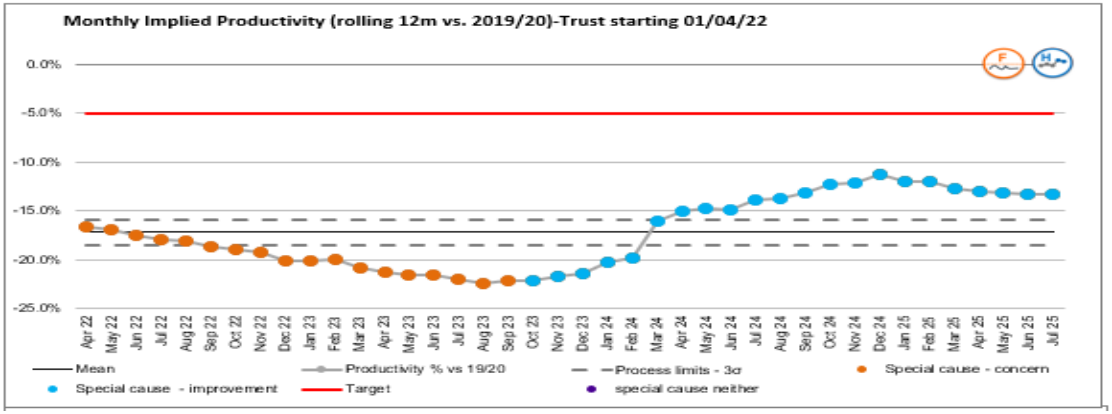
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -14.97% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: ≤-5.33% Performance: -13.31% Position: Special Cause Improvement



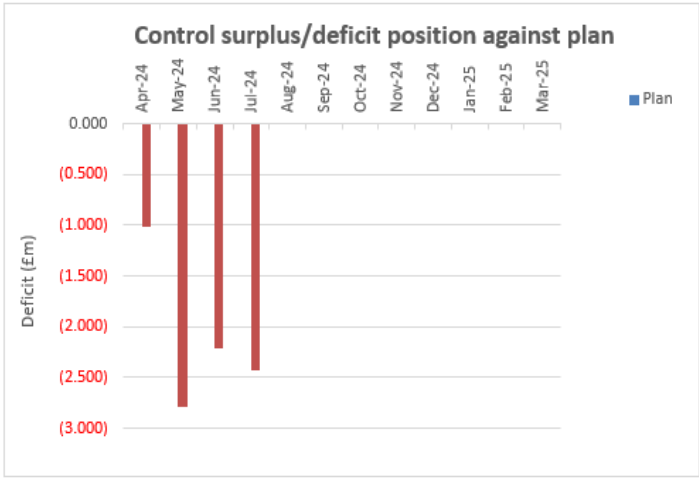
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Performance static at -13.3% in Month 4. Higher pay costs from medical agency requirements and backfill for unavailable staff as well as tariff drugs have been partially mitigated by maintaining high levels of non-elective activity. Below plan elective and outpatient activity due to availability constraints lead to a 0.08% deterioration in the rolling 12-month delivery from Month 3, and 0.55% deterioration from March 2025. There is an improvement of 1.66% from April 2024 due to cost increases being mitigated by activity improvements with the main increase in Non-Elective +1-day delivery. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• Detailed actions on the response to Division's productivity drivers are detailed within the A3 Productivity countermeasures and discussed at Divisional Performance Reviews.	August 25	• The Finance Recovery Group and Delivery group supports the savings programme and Elective points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	July '25 In Month			July '25 YTD			25-26 Plan
Operating Income							
NHS Clinical income	28,354	27,455	(899)	113,651	112,161	(1,490)	331,367
Other Clinical Income	1,566	1,373	(193)	5,201	4,785	(416)	21,069
Other Income (excl Donations)	3,768	2,931	(837)	14,544	13,747	(797)	42,987
Total income	**33,688**	**31,759**	**(1,929)**	**133,396**	**130,693**	**(2,703)**	**395,423**
Operating Expenditure							
Pay	(22,752)	(23,039)	(287)	(88,826)	(90,460)	(1,634)	(263,725)
Non Pay	(10,720)	(9,840)	880	(43,706)	(43,781)	(75)	(129,119)
Total Expenditure	**(33,472)**	**(32,878)**	**594**	**(132,532)**	**(134,240)**	**(1,708)**	**(392,844)**
EBITDA	**216**	**(1,120)**	**(1,336)**	**864**	**(3,547)**	**(4,411)**	**2,579**
Financing Costs (incl Depreciation)	(1,882)	(1,818)	64	(7,530)	(6,962)	568	(22,579)
NHSI Control Total	**(1,666)**	**(2,938)**	**(1,272)**	**(6,666)**	**(10,509)**	**(3,843)**	**(20,000)**
Deficit Support Funding - local	515	515		2,060	2,060		6,182
Deficit Support Funding - national	1,151		(1,151)	4,606		(4,606)	13,818
Reported Position		**(2,423)**	**(2,423)**		**(8,449)**	**(8,449)**	



Understanding the Performance

The financial plan submitted to NHS England on 7 May 2025 showed a breakeven position for the year and included an efficiency requirement of £20.9m. The plan assumes deficit support funding of £20m phased equally throughout the year.

The in-month position was a deficit of £2.4m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

The YTD adverse variance against plan is £8.4m, of which £4.6m is due to the loss of deficit support funding and £0.3m from Industrial Action impact. The adverse month 4 position has been driven by pay and income pressures, specifically elective activity volume reducing due to clinician unavailability. The pay costs are driven by servicing a higher than planned bed base, additional backfill requirements for high sickness levels, and medical agency costs, in addition to higher drugs costs.

Countermeasure Actions	Due Date
• Trust financial recovery plan resubmitted August 25 with actions for Trust-wide departments and efficiency programmes.	March 26

Risks and Mitigations

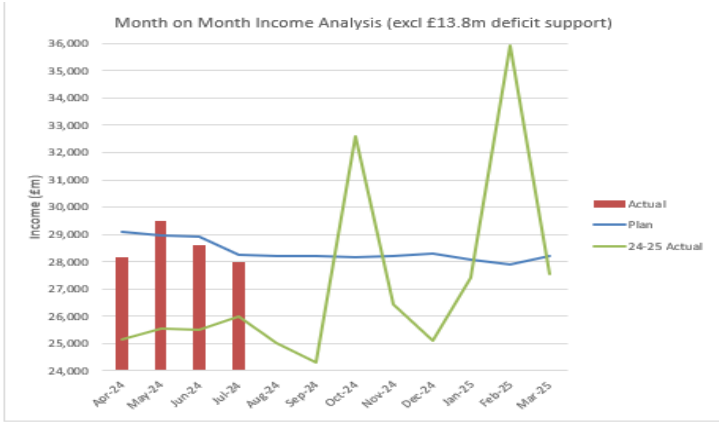
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and system working.
- The Trust's £20.9m efficiency savings plan includes 20% non-recurrent delivery and underperformance on recurrent schemes signals a risk into 26/27.

Income and Activity Delivered by Point of Delivery

Target: N/A Performance: N/A Position: N/A

Income by Point of Delivery (PoD) for all commissioners	July Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	5,340	5,463	123
Day Case	9,540	9,277	(263)
Elective inpatients	6,363	5,734	(629)
Excluded Drugs & Devices (inc Lucentis)	10,155	10,818	663
Non Elective inpatients	31,156	31,216	60
Other	34,038	33,348	(690)
Outpatients	17,059	16,305	(754)
TOTAL	113,651	112,161	(1,490)

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	69,565	67,575	(1,990)
Dorset ICB	10,573	10,228	(345)
Hampshire, Southampton & IOW ICB	9,539	9,196	(343)
Specialist Services	15,818	16,954	1,136
Other	8,156	8,208	52
TOTAL	113,651	112,161	(1,490)



	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	26,707	27,809	1,102	27,076	733
Day case	9,429	9,353	(76)	9,433	(80)
Elective	1,300	1,208	92	1,186	22
Non Elective	10,306	10,744	438	10,332	412
Outpatients	109,561	105,245	(4,316)	98,819	6,426

Understanding the Performance

The Trust level performance is driven by lower Elective Inpatients, Day cases and Outpatient First and Procedures attendances impacting on the ERF income and underperformance.

There is underperformance across all the main commissioners apart from Specialised commissioning due to overperformance on high-cost drugs and chemotherapy delivery. BSW depreciation pass through funding and CDC are underperforming but this is offset by overperformance on Provider-to-Provider contracts and Local authorities.

Activity across the main points of delivery was higher in July than June for all main points of delivery except for High-cost drugs and devices.

Countermeasure Actions	Due Date
• 2025/26 contracts are progressing to signature following dispute resolution with HIOW and Dorset ICBs.	August 25
• Mitigations for the under-performance year to date to be confirmed as part of the Trust Recovery plan.	August 25

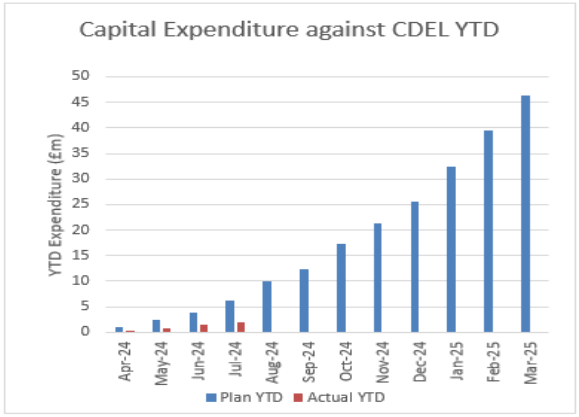
Risks and Mitigations

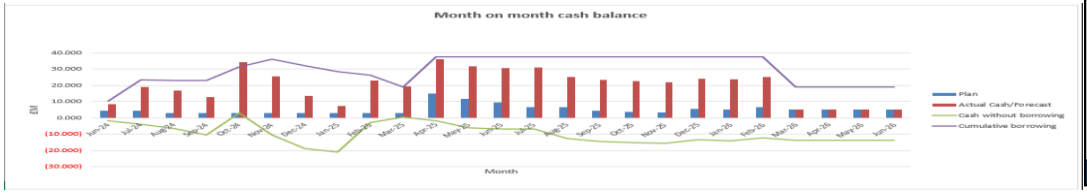
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

Target: N/A Performance: N/A Position: N/A

	Closing Balance March 2025 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,520	7,542	22
Debtors	19,291	28,987	9,696
Cash	22,530	30,913	8,383
TOTAL CURRENT ASSETS	**49,341**	**67,442**	**18,101**
Creditors	(49,082)	(57,750)	(8,668)
Borrowings	(1,391)	(19,829)	(18,438)
Provisions	(590)	(579)	11
TOTAL CURRENT LIABILITIES	**(51,063)**	**(78,158)**	**(27,095)**
TOTAL WORKING CAPITAL	**(1,722)**	**(10,716)**	**(8,994)**





Schemes	Annual Plan £000s	July '25 YTD Plan £000s	July '25 YTD Actual £000s	July '25 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,915	388	518	130
Building projects	1,392	184	379	195
Fire schemes	608	80	41	(39)
IM&T	5,370	400	625	225
Medical Equipment	3,000	400		(400)
Leases	750	100	480	380
Total CDEL schemes	**14,035**	**1,552**	**2,043**	**491**
National Funding				
Shared EPR - Nationally funded element	3,199	2,199	1,332	(867)
Estates Safety Funding	5,254	816	88	(728)
25/26 Community Diagnostic Centre	12,160			
25/26 Seed Funding for Elective Care Centre	5,400	1,300	320	(980)
25/26 Procedure room	300		3	3
25/26 Urgent Treatment Centre	7,000	300	1,026	726
Total National Funding	**33,313**	**4,615**	**2,769**	**(1,846)**
GRAND TOTAL	**47,348**	**6,167**	**4,812**	**(1,355)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £4.8m in Month 4. This is mainly driven by EPR and building projects. Nationally funded schemes are dependent on the successful submission of business cases, except for Shared EPR which has already been approved, and the Estates Safety Funding which has already received NHSE approval.

The cash balance at the end of Month 4 was £30.9m. The position excludes non recurrent deficit support and an additional month's contractual payment by BSW of £18.7m.

BSW ICB has paid two month's contract payments in April to mitigate any requirements for PDC support in 25/26.

Countermeasure Actions

- Due to the challenged BSW revenue position, and the subsequent loss of deficit support funding, CDEL capital schemes which are not yet in progress, or have a high-risk rating and are required to proceed, are being paused to preserve cash to support the revenue position. The same constraint does not apply to nationally funded schemes, which are cash backed. Review this position quarterly.

Due Date

Oct 2025

Risks and Mitigations

- The ageing estate, medical equipment and digital modernisation means that the Trust's capital requirements are more than resources. The Trust seeks to mitigate the constraint of available system capital by proactively bidding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.
- Deficit support funding in 25/26 is contingent on the system financial plan delivery which was not achieved at Month 4. The funding will be achieved if the system can recover the position by the end of the financial year. Financial recovery is of paramount importance.

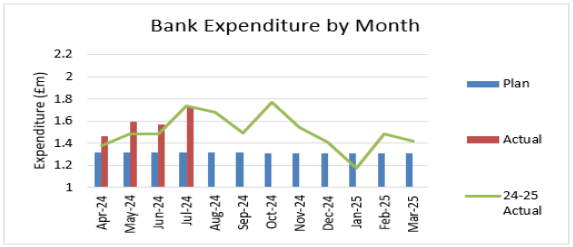
Workforce and Agency Spend

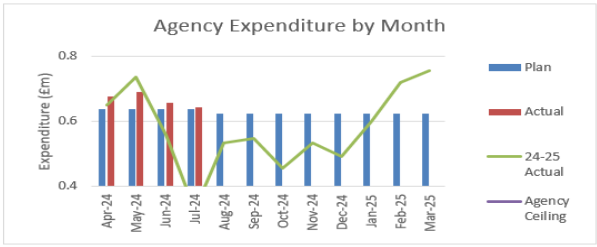
Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	July '25 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	82,061	81,366	695
Pay - Bank	5,284	6,354	(1,070)
Pay - Agency	1,197	2,665	(1,468)
Other (eg apprenticeship levy)	284	75	209
TOTAL	**88,826**	**90,460**	**(1,634)**
Medical Staff	22,930	25,696	(2,766)
Nursing	24,423	23,993	430
Support to Nursing	6,844	7,099	(255)
Other Clinical Staff	12,948	11,942	1,006
Infrastructure staff	21,397	21,396	1
Other (eg apprenticeship levy)	284	335	(51)
TOTAL	**88,826**	**90,460**	**(1,634)**

	July '25 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	569.3	566.6	(2.7)
Nursing	1,249.0	1,320.8	71.8
Support to Nursing	556.0	575.2	19.2
Other Clinical Staff	660.1	667.2	7.0
Infrastructure staff	1,376.8	1,451.7	74.9
TOTAL	**4,411.2**	**4,581.5**	**170.3**





Understanding the Performance

In month 4 pay costs were £23.0m against a plan of £22.7m: an adverse variance of £0.3m. All relevant pay awards have been accrued into the position based on national assumptions.

The pay expenditure run rate increased by £0.5m since month 3, driven entirely by medical staff pay, across all contract types. £0.2m of this increase in medical pay run rate was due to the costs of industrial action. Unavailability of staff in month 4 was the second highest in 4 years, with sickness, annual leave and parental leave above plan in month. A ward was closed in July, in line with efficiency plans, and escalation beds open remained low.

The WTE trajectory is a reduction from the funded establishment of 4,509 in month 1 to 4,349 in month 12: a reduction of 160 WTE. At month 4 there is an over establishment of 170 WTE.

Countermeasure Actions

- Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients), and oversight groups for workforce focused transformation programmes are producing countermeasures by workstream. These range from non-clinical vacancy controls, weekly temporary staffing expenditure scrutiny and bed escalation policy review to enable the planned reduction in bed numbers. Quarterly review.

Due Date

Oct 2025

Risks and Mitigations

Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although it is likely that the Trust will require both due to operational pressures.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

Change	Date	Metric	Description of Change
1	01/04/2025	Elective Referral to Treatment	Revised from measuring Total Elective Waiting List in 2024/25 to Referral to Treatment (RTT) Performance % in line with national target for 2025/26
2	01/04/2025	Productivity	Revised target from -8% to -5.33%
3	01/04/2025	Elective Referral to Treatment	Watch metric of '78+ week waits' removed and '% of patients waiting less than 18 weeks for first appointment' added as a Watch metric
4	01/04/2025	Urgent and Emergency Care	Metric added for '% of ED attendances over 12 hours'
5	01/04/2025	Cancer	Cancer 31-day performance slide removed and now reported as a Watch metric
6	01/04/2025	Friends and Family Response Test Rate	Target increased from 15% to 18%

Appendix

Business Rules – Driver Metrics

NHS Salisbury NHS Foundation Trust

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target for a single month	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 or more months in a row	Performing above target for multiple months in a row	Share success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 4 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric/increase target of Driver	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric, or increasing target of Driver metric
6	Driver is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	Driver is blue	Performance outside of expected range in a positive /improving direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – orange	Concerning performance	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
10	Watch has 2 out of 3 points low – orange	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 4 points below mean or 4 points deteriorating - orange	Worsening performance	Consider: - Upgrading to a Driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - blue	Improving performance, not yet sustained	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is grey (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

Appendix

NHS Salisbury NHS Foundation Trust

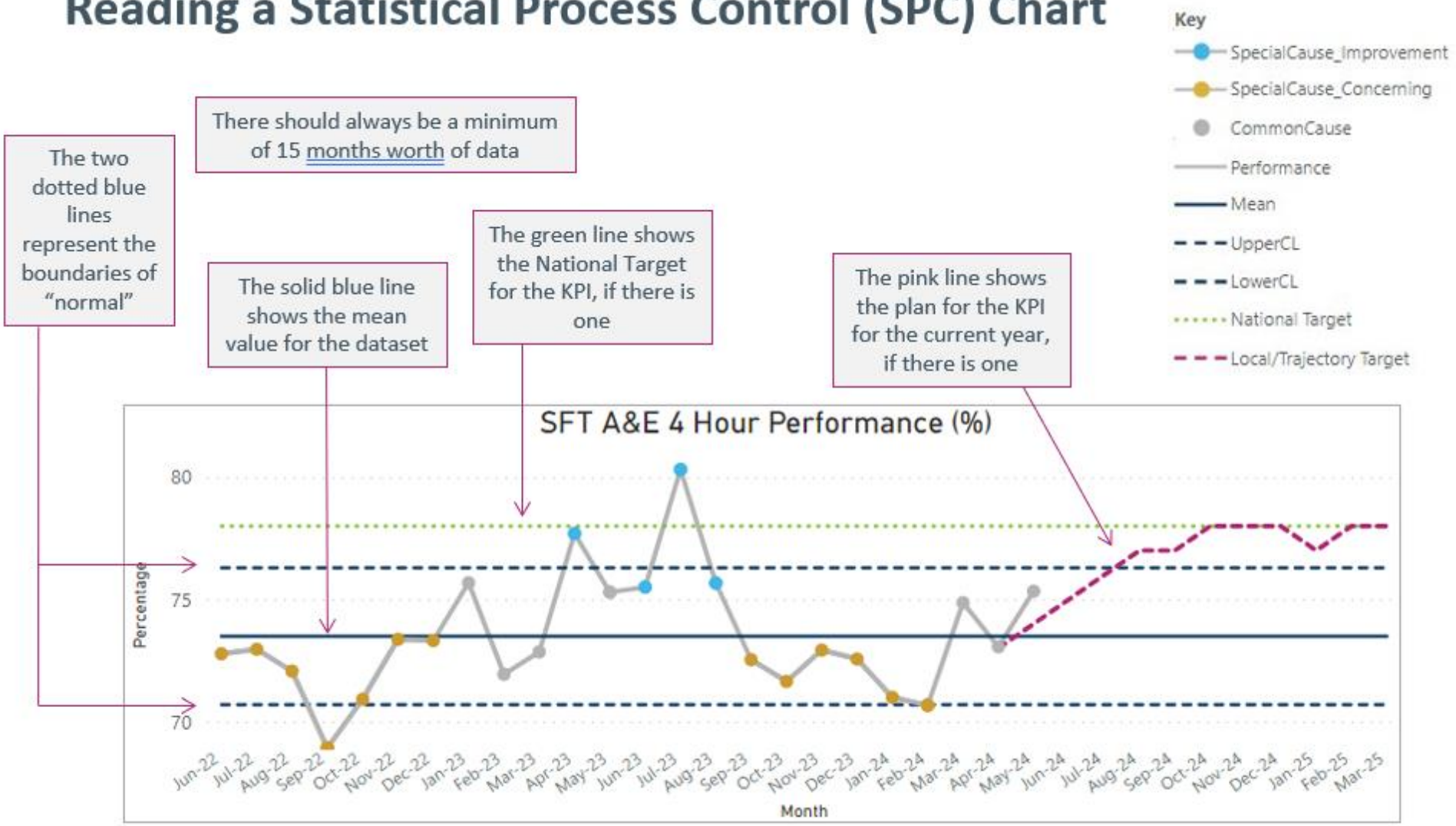
Business Rules – Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.
Whether or not a metric has met its target each month will be indicated by a tick or a cross icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has NOT met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Actions are suggested depending on how many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

Rule No	Rule	What it means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance Give structured verbal update by exception	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if counter measure summary required	Showing signs of continued difficulty meeting the target and need understanding of root cause.
18	Mandatory does not meet target for 4 or more months in a row	Performing below improvement target for a sustained length of time	Consider applying improvement target	Showing signs of continued difficulty meeting the target despite understanding of root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of Mandatory	Assess Mandatory metrics and ensure performance culture is maintained.
20	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly	Mandatory metrics are being deliberately monitored and therefore SPC rules are not strict enough for monthly performance assurance purposes

Appendix

Reading a Statistical Process Control (SPC) Chart



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	4 September 2025		

Report from (Committee Name):	Finance and Performance Committee		Committee Meeting Date:	29 July 2025
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Richard Holmes (Acting Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- At the regular check-in, Executives without exception reported being extraordinarily busy, trying to balance their time between day-job management, business improvement, group development and responding system/regional/national commitments. The Committee acknowledged that every hour spent on one of the above meant an hour not spent on any of the other three, and balancing these conflicting priorities is a huge current challenge. These issues will only be exacerbated with the imminent changes to SFT Executive Management Team. The Committee acknowledged the personal toll this is taking on the Exec.

- Financial performance remains a significant concern. M3 out-turn was £2.6m behind plan, a deterioration over the M2 position, with a further £3.4m adverse variance as a result of the current withholding of Deficit Funding.
- Significant contributors to this adverse variance include under-delivery of CIP savings, expenditure over plan on temporary staffing and WTE, and income under-plan due to disappointing elective output.
    - The Committee requested a Temporary Staffing deep dive from a financial lens, rather than a workforce lens, to be brought to the next meeting which provides sufficient assurance that the plans to reduce this ongoing adverse cost variance are appropriate.
- Substantial controls have been introduced National level on cash, particularly on access to cash for capital programmes, with a 'pause' on capital expenditure not actually committed. Disappointingly, this includes work on the new ECC, which has been paused, with no formal indication as to when or whether this pause will be lifted.
- The MD advised the Committee that the System has required a Financial Recovery Plan at Trust and Group level be prepared, completed and submitted by 31 July (two days after this meeting). This is nearing completion and given the timescales will be submitted as a first draft without further Board oversight. Board will be sighted on the submitted plan and it will be presented at the next Board meeting for discussion. The Group Plan, comprising three Trust plans, will include actions aimed at addressing amongst other things the matters above, and aimed at meeting the System aspiration of a FY break-even position for the Group. It is anticipated that the initial plan will be refined over time.

- Of major significance, the Committee was recommended to:

  'Note the approach to the Trust's forecast of a NHSE Control Total of breakeven'.

  Given that financial performance to date has been in deficit for each of the first three months, that cash is restricted, and that the recovery plan has not yet been completed, the Committee instead:

  'Supported the production of a Financial Recovery Plan to deliver a NHSE Control Total of breakeven',

  as the Committee was not assured that a breakeven position is achievable without further intervention yet to be set out in the financial recovery plan.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The Committee was advised that the planned ward closure had taken place, reducing beds by 27, and refurbishment works are due to continue for the rest of this calendar year. Full time staff are being deployed elsewhere, and plans are in place to reduce temporary staffing as a consequence, given appropriate re-rostering which in itself is complex. This will (should) drive a step change reduction in temporary staffing costs in following months.

  The closure brings separate operational challenges to occupancy levels and escalation from ED. A key driver to the financial operating costs is the number of beds in the hospital, so the Committee noted that consideration will need subsequently to be given as to whether to re-open these beds, or to maintain the reduced bed level.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The Committee received a deep dive from Caroline Holmes from BSW about the new system-led initiative to address the continuing unsatisfactory NCTR position. It is clear that the system as a whole, including primary, acute and community care sectors, is now working together with one ambition, which is encouraging, and builds on the relationships developed in the 'NCTR Sprint' earlier this year.

  A five-stream programme has been kicked off to address all elements of all of the discharge pathways across the System as a whole - "Wiltshire Home is Best". The design of these five streams has been heavily influenced by the SFT COO. Initial analysis has been completed of appropriate targets ('Tolerances') which demonstrate that SFT can 'tolerate' 41 NCTR patients on an ongoing basis, of which 31 are Wiltshire and 10 are other localities. Additional analysis was presented that showed that as at 3 July, SFT had 81 NCTR patients against the 'tolerance' of 41, of which 15 were considered to be NCTR as a result of SFT's processes, 39 are for Wiltshire Community Partners, 21 are for other ICBs (eg Dorset and Hampshire), with 6 either GP or No Pathway.

  Notwithstanding that SFT only has direct control of 15 of those NCTR patients, the Committee acknowledged that by working together as a whole, SFT can support system partners to improve their outcomes, in turn reducing the overall SFT NCTR position.

The Committee noted the aspiration of the programme, but in order to gain assurance the Committee requested that further information as to programme governance, and workstream activities and timescales be brought back to the Committee by the Programme Lead.

- Operational performance as presented in the IPR is encouraging, with a number of measures 'Improving', 'Recovering' and 'Easing', which is a credit to the hard work of staff in such challenging times, particularly with continuing high ED attendances. The impact of the recent industrial action appears minimal to date, largely because of the work done to prepare for the event, but there is no expectation that any tolerance of underperformance as a result of any industrial action will be considered either by the System, Region or Nationally. SFT is not in 'Tiering' for any measure.

- The Committee received the Annual Data Security and Protection Assurance Report. The report confirms that the Trust has successfully submitted the 2024/25 DSPT assessment which included an internal audit on a subset of evidence. This audit reported a 'Significant assurance with minor improvement opportunities', with seven medium findings. Cyber controls remain in place and programmes to improve the Trust's cyber posture around areas such as unsupported technology continue. The report also confirms that the Trust's Data Protection Officer continues to fulfil their statutory duties.

- The Committee received the results of its own committee effectiveness self-assessment which showed an encouragingly positive view of committee effectiveness. The Committee acknowledged that the outcome of Group Governance considerations may well impact the future look and feel of the Committee into the future.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- The Committee received a proposal to award a contract to manage royalty income as a result of a license granted to Dokimazo Ltd for the Provision of Post Deal Management post of an Exclusive Licence. Previously this work has been handled in-house on an ad-hoc basis, but as more royalties are due this work will be contracted to Dokimazo Ltd at a commission of 10%. With the current the level of royalty income the commission payable at the moment is below the threshold for F&P approval, but the Committee noted that an increase in royalty income will be accompanied by an associated increase in costs, potentially above threshold. For clarity, if there are no royalties received, no commission will be payable. The Committee approved this proposal.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	4th September 2025		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	29th July 2025
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing Chair of CGC			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

-

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- CGC received an update from paediatric audiology regarding the national review of services which had previously identified concerns about the quality (accuracy) of neonatal hearing tests. NHSE subject matter experts have conducted a lookback exercise over the last 5 years, identifying 78 patients to be recalled, out of those assessed in the five-year period. Two possible harms have been identified so far, with a third of the cohort not yet traced. NHS England is content with current practice with baby hearing tests and happy with current practice for older children. NHSE will want oversight of every recall completed. CGC noted that Group partners had fewer patients identified for recall (none at GWH, who are providing mutual support). Depending on the outcomes of the recalls, NHSE may decide to extend the look back exercise. CGC noted that the department is managing this process in addition to the usual workload. CGC will receive a further update in January 2026
- CGC received the divisional governance report from Surgery. Significant assurance was noted for the division's engagement with governance processes and in particular considering risk and risk appetite. Challenges from reduced staffing in admin teams were noted, but also that the risks were being mitigated by staff working flexibly across teams. It was noted outpatient letters are being dispatched on average 4 weeks after appointment (with a range of 1 day to 12 weeks). No harms have been identified from this to date. Action is being taken to address safety, quality and performance concerns regarding theatre sets from SSL, Laser service, and plastic surgery.
- CGC received a deep dive on Pressure Injuries, noting Tissue Viability is delivered by a small team, supported by ward link nurses, and in the last year there has been a focus on education and helping the wards to better understand what they can do, and when to seek advice. CGC noted the ambition for a new breakthrough objective on pressure injury is to, using Improving Together methodology, ask the teams what would make a difference to them. Work is also underway to align practice across BSW group, including reporting.
- The **Annual Research Report** – noted research activity had returned to pre-covid levels, but there are frustrations from changes to research networks, and some concerns regarding governance and oversight of the SFT research function, noting that attendance at the Research and Innovation Board

had been less than expected. The CMO explained that future changes are likely as a result of the developing group structure.

- CGC received the monthly Perinatal Surveillance report and noted compliance with 1:1 care in labour and supernumerary labour ward leader, but continued non-compliance with BAPM standards. The increased compliance in Saving Babies lives was welcomed, (now 87%). Trust Board is asked to note concerns from the board of the Maternity and Neonatal Voices Partnership (MNVP), concerning lack of ICB funding which is impacting the work of the MNVP. CGC also noted the Maternity dashboard was not available and therefore some data was not included. Work is underway with BI/IT and the team to resolve this.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- CGC noted the committee effectiveness review suggested the committee is functioning well, but had highlighted the lengthy agenda and papers at times. CGC was pleased to hear that as part of the development of BSW group functions an active discussion on how best the Trusts and Group might obtain assurance.
- CGC noted assurance regarding the delivery of HIV services, the first of several specialist services papers requested to provide greater assurance to CGC. It was noted that these services are reviewed as part of the quality contract, and also some by operational delivery groups as well. It was agreed that papers to CGC should draw on the work already done, rather than create extra work for teams.
- CGC received a brief paper on the quality aspects of the Single Oversight Framework, and requested a quarterly update on SFT scoring.
- The **Annual Health Inequalities report** provided significant assurance regarding the activity within SFT to address health inequalities, noting that there is still much that can be done. It was noted that SFT is proposing to change a vision metric to the difference in RTT performance between the top and lower quintiles in terms of deprivation, which would align with RUH.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

-

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	4th September 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	23rd July 2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	N/A			
Appendices (if necessary)	N/A			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Performance for 4 hour emergency standard remains challenged, UEC Transformation Board is reviewing the improvement plans.
- The Financial performance continues to be a challenge with a focus on improving elective activity and managing staffing levels to budgeted levels. The recovery plan is in development.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- LIMS progress continues to be high risk and monitored closely, the programme is very tight, but on plan to date. Ongoing monitoring is key in delivery.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- Facilities presented a report highlighting positive achievements in ERIC return being submitted, audit completed of all bleeps and pagers and catering launching an on line meal ordering tool.
- The Trust considered a number of benefits realisation cases including Stem Cell Transplantation service, cancer pathway navigator and pharmacy aseptic unit. The documentation progress needs further refinement but understanding the benefits against plan was key.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- The Trust Green plan for 2025/26 was approved

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	4th September 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	27th August 2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	N/A			
Appendices (if necessary)	N/A			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The Financial position remains a significant focus for all of TMC membership, the leadership session in August was used to discuss in more detail the specific actions required with a focus on high cost locum spend and bank usage.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- A business case for radiology governance lead (Radiology protection) was not approved due to not having an identified funding stream (c£60k), the Division is reviewing any further funding opportunities. This would lead to a risk and an EQIA process will be followed if funding not identified.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- A revised process for bank authorisation (excluding nursing/medical) was approved and will be adopted by 1st October.
- Improving Together quarterly report was considered which outlined progress and risks to ongoing sustainability.
- The Trust is now out of Tiering for RTT and Cancer performance due to sustained improvement.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- The Winter plan was considered and approved at TMC, there was further ongoing work to ensure the bed escalation plan was clear across surgery and medicine.
- Space allocation policy was approved

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

BSW Hospitals Group

Report to:	Salisbury NHS Foundation Trust Board	Agenda item:	3.4
Date of meeting:	4 September 2025		

Report title:	BSW Hospitals Group – Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Ben Irvine, Programme Director, BSW Hospitals Group			
Executive Sponsor:	Cara Charles-Barks, CEO, BSW Hospitals Group			
Appendices	• Appendix A: Schedule 3: Group Joint Functions. • Appendix B: Schedule 5: Joint Committee Terms of Reference			
BAF Risk Link	N/A			

Recommendation:

Following Trust Board agreement in principle (July 2025) to changes intended to provide further clarity regarding delegated functions and Joint Committee Terms of Reference, the Trust Board is asked to **approve** the proposed variations to the May 2025 Partnership Agreement, Schedule 3 - Group Joint Functions, and Schedule 5 - Joint Committee Terms of Reference, of the BSW Hospitals Partnership Agreement.

Executive Summary:

In July 2025, Private Boards of Great Western Hospitals NHSFT (GWH), Royal United Hospitals Bath NHSFT (RUH), and Salisbury NHSFT (SFT) received and approved a proposal to move to a Joint Chair and a General-Purpose Joint Committee (Group Board) by 01 April 2026.

The Boards approved an immediate first step to strengthen the formal delegations of the existing Special Purpose Joint Committee giving it the specific and delegated remit to:

- Develop and approve the roadmap from now to 01 April 26 implementation of the Group Board and Joint Chair
- Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)
- Develop and approve the Target Operating Model for the Group
- Develop and approve the Group's governance and assurance framework
- Develop and approve the Group's OD and engagement plan, including the approach to engagement with the Councils of Governors
- Develop and approve a single financial plan for the Group
- Oversee the development of the Group Strategy (for approval by the Group Board in April 2026)

Two Schedules in the BSW Hospitals Group Partnership Agreement have been updated in response, incorporating these strengthened delegations. **Appendix A** comprises an update to Schedule 3: Group Joint Functions. **Appendix B** comprises a revision to Schedule 5, the Joint Committee Terms of Reference. Revisions in Schedules 3 and 5 are highlighted in red text.

On 16th July the BSW Hospitals Group Joint Committee approved these changes in principle, noting that Clause 18 of the BSW Hospitals Group Partnership Agreement requires:

- *18.1 Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.*

Accordingly, the Trust Board is asked to confirm approval of the proposed variations to Schedule 3 and Schedule 5.

Group Vision Metrics	Select as applicable:
Developing an engaged workforce	x
Making our teams diverse and inclusive	x
Making our services safer	x
Improving timely access to our services	x
Improving the experience of those who use our services	x
Improving our financial sustainability	x
Improving health equity	x

Browne Jacobson

Date **[INSERT DATE WHEN APPROVED]** **2025**

Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Partnership Agreement
for the purpose of establishing Hospital Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions

Version control

[Once approved , Version 2.0]

Schedule 3– Joint Functions

1 Subject to paragraph 2:

1.1 Joint Functions are any Functions relating to any of the matters set out in paragraph 3 below.

1.2 Joint Functions may additionally include any or all Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 4 below (excluding references to legislation that is applicable to or in force in Wales only) which the Trusts agree by Variation should be Joint Functions.

2 Joint Functions may not at any time include Mandatory Reserved Functions.

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy (by April 2026) and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

3.2 Transforming our Model of Care for the BSW Population we Serve - Clinical Services Organisation/ Pathways/ Design

- Development and approval of Group **clinical services framework for the collective population we serve** with associated decision-making processes.
- **Approval** of service/pathway/treatment configuration changes across the Group.

3.3 Financial Sustainability - Use of Resources

- Development and approval of a single financial plan for the Group.
- Setting and delivery of Group Financial Recovery and long-term Group financial sustainability plans.
- Capital Programme. Development and approval of capital investment programme for the Group ensuring we attract capital into BSW to address priorities.
- Capital Programme. Development and approval of capital limits for each Trust within the group to be delegated.

3.4 Group Mobilisation & Development

- Oversight of Group Mobilisation & Development. Development and approval of Group Roadmap [June 2025-April 2026] to implementation of a Group Board [by April 2026] and Joint Chair [by April 2026].
- Development and approval of Group Target Operating Model,
- Development and approval of the Group Governance, assurance and accountability framework (including development and approval of Group Board - General Purpose Joint Committee Terms of Reference), and associated Integrated Performance Reporting.
- Development and approval of Group Board membership.
- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.
- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.
- Group Development - Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.
- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows: [Note: Not changed. Refer to original Partnership Agreement]

Browne Jacobson

Date: 22nd May [INSERT NEW DATE WHEN APPROVED] 2025

Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Partnership Agreement

for the purpose of establishing Hospital Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions

Schedule 5. BSW Hospitals Group Joint Committee ToR

Terms of Reference for a special purpose joint committee (the BSW Hospitals Group Joint Committee) between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP
12 June 2025	004	Ben Irvine, BSW Hospitals Programme Director [added Partnership Agreement execution date]
26th June	July 001	Ben Irvine.

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated 22nd May 2025 (the Partnership Agreement).

1.2 As set out in the Partnership Agreement, the BSW Hospitals Group Joint Committee will oversee the plan for closer collaboration, the subsequent delivery programme, and development of the proposed Group model. The shared narrative for the Group is as follows:

1.2.1 Together we will make the best use of collective resources available to us. Our decisions will be judged by their ability to make best use of resources for the population in BSW.

1.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

1.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts, including with our Place-based, network and tertiary partners.

1.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers real opportunity to remain as stand-alone local organisation focused on needs of population within the support structure of a group.

1.2.5 Risk: We will develop collective approach to risk and address differences between local and group risk appetite when they emerge.

1.3 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trust Boards have agreed are Joint Functions in accordance with the Partnership Agreement.

2 Authority & Accountabilities

2.1 The BSW Hospitals Group Joint Committee is authorised by the Boards to exercise the Joint Functions.

2.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust Board for the exercise of the Joint Functions and shall at all times comply with the Partnership Agreement and NHS England guidance when exercising Joint Functions.

2.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or each Trust jointly and severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.4 The BSW Hospitals Group Joint Committee is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The BSW Hospitals Group Joint Committee shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Joint Committee meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The BSW Hospitals Group Joint Committee shall provide regular update reports to each Trust's Board on the activities of the BSW Hospitals Group Joint Committee in accordance with a single reporting schedule agreed by the Trust Boards.

4 Membership

4.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members (Members) of the BSW Hospitals Group Joint Committee during their terms of office.

4.2 Each Trust shall appoint the following Members, who may be Voting Director or Non-Voting Directors:

4.2.1 Chair, Vice Chair and three other Voting NEDs nominated in writing by the Trust's Chair

4.2.2 Chief Executive Officer, Managing Director and two other EDs nominated in writing by the Trust's Chair and Chief Executive Officer.

4.2.3 All joint Executive Director roles created by the Trusts.

4.3 The Trusts shall ensure that in appointing the EDs in accordance with paragraph 4.2.2 the membership of the BSW Hospitals Group Joint Committee shall include a Chief Nursing Officer, a Chief Medical Officer, a Chief Finance Officer, a Chief People Officer, a Chief Operating Officer, and a Director of Estates and Facilities. The role of these EDs shall be to bring their portfolio expertise to the decisions of the BSW Hospitals Group Joint Committee in the interests of the Group.

4.4 It is acknowledged that the role of the Members shall be to make decisions in the interests of the Group rather than to represent the views of their individual Trusts.

Commented [RH1]: Browne Jacobson comment: I have suggested separating this provision out so that it is a standalone provision that applies to all members of the Joint Committee rather than just the EDs.

4.5 The Trusts may agree in writing to vary these Terms of Reference to amend the number of Members of the BSW Hospitals Group Joint Committee provided that:

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

4.5.3 The Chair and other Voting NED Members outnumber the ED Members.

4.6 Additionally, the Trusts may agree in writing to vary these Terms of Reference to permit them to appoint Non-Voting Directors of the Trusts to be Members of the BSW Hospitals Group Joint Committee.

4.7 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a Member.

4.8 A Member's initial term of appointment to the BSW Hospitals Group Joint Committee shall be up to three years, or the end of their term of appointment as a Director of a Trust, whichever is the earlier. A Member's may be reappointed by their Trust in accordance with paragraph 4.2 for further terms.

5 Attendance

5.1 The Trust Secretary of one of the Trusts will attend as required to ensure that the BSW Hospitals Group Joint Committee business is transacted as per this Terms of Reference, the Partnership Agreement, the Trusts' Standing Orders and documents referred to in them.

5.2 With the consent of the BSW Hospitals Group Joint Committee Chair, other persons may be invited to attend and contribute to meetings of the BSW Hospitals Group Joint Committee but not take part in making decisions.

5.3 In line with the Trusts' Standing Orders, Members must attend at least half the BSW Hospitals Group Joint Committee's meetings annually. Any failure of a Member to meet this attendance requirement shall be considered as part of that individual's Annual Review and Appraisal process.

5.4 Subject to paragraph 5.3 and the prior agreement of the Chair, each Trust may nominate a deputy to attend a meeting of the BSW Hospitals Group Joint Committee in the event of a Member's absence. For Members appointed under paragraph 4.2.1 the deputy shall be a Voting NED nominated by the Chair of the relevant Trust. For Members appointed under paragraph 4.2.2 the deputy shall be an ED or senior director nominated by the Chair and Chief Executive of the relevant Trust. For Members appointed under paragraph 4.2.3 the deputy shall be an ED or senior director nominated by the Chief Executive. A deputy shall be formally nominated with the same rights and privileges as the Member for whom they are deputising.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the BSW Hospitals Group Joint Committee or, if the Joint Chair is absent, the Deputy Chair of the BSW Hospitals Group Joint Committee shall preside. If the Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

6.2 Pending the appointment of a Joint Chair of the Trusts, the current Chairs of the Trusts shall agree between them who shall chair meetings of the BSW Hospitals Group Joint Committee (where possible rotating between them) and any reference in these terms of reference to 'Joint Chair' shall (where the context requires) be construed as the Trust Chair who presides at a meeting.

7 Quorum

7.1 No business shall be transacted at a meeting of the BSW Hospitals Group Joint Committee unless:

7.1.1 At least half the Members of the BSW Hospitals Group Joint Committee are present

7.1.2 At least half of the Members present are Voting NEDs

7.1.3 The Members present include (in addition to the Joint Chair) at least two EDs of each of the Trusts (who in the case of a joint director may be the same person) and at least two Voting NEDs of each of the Trusts (who in the case of a joint director may be the same person).

8 Decision making

8.1 The BSW Hospitals Group Joint Committee will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all Members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst Members.

8.2 If the BSW Hospitals Group Joint Committee is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A special majority of not less than two thirds of the Members present and voting are in favour, and

8.2.2 The Members in favour include more than half of the Members from each Trust.

8.3 Each Member of the BSW Hospitals Group Joint Committee shall have one vote except in the event that prior to the appointment of the Joint Chair an individual is appointed as the Chair of two of the Trusts but not the other, in which case they shall be treated as if they were separate individuals and entitled to cast a vote on behalf of each Trust to which they are appointed.

8.4 The decisions of the BSW Hospitals Group Joint Committee (which for the avoidance of doubt extend only to decisions in respect of the Joint Functions) are binding on each of the Trusts.

9 Admission of the public to meetings

9.1 Meetings of the BSW Hospitals Group Joint Committee shall be held in in private.

9.2 But the BSW Hospitals Group Joint Committee may, by resolution, permit the public to attend a meeting to observe (whether during the whole or part of the proceedings).

10 Managing Conflicts of Interest

10.1 Each Member of the BSW Hospitals Group Joint Committee must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

10.2 At the first meeting of the BSW Hospitals Group Joint Committee, the BSW Hospitals Group Joint Committee will select a chair ("Joint Committee Chair") from amongst the members who are Trust Chairs. A Deputy-Chair will also be selected. Once a joint chair for the Trusts is appointed, he or she shall become the BSW Hospitals Group Joint Committee Chair and the incumbent Joint Committee Chair (if not the joint chair) shall immediately hand over.

10.3 The Trusts acknowledge that sections 63A and 223L to 223N of the NHSA (as introduced by the Health and Care Act 2022) impose duties on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. In the light of these duties, there should be few occasions where the interests of the Trusts are not aligned and directors of each Trust must have regard to the wider impact of their decisions on the other Trusts and seek to cooperate with the other Trusts in exercising their functions.

11 Administrative Support

The Chief Executive Officer shall nominate a Trust Secretary to arrange provision of administrative support to the BSW Hospitals Group Joint Committee.

12 Annual Workplan

The BSW Hospitals Group Joint Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Ordinary meetings of the BSW Hospitals Group Joint Committee shall be held not less than six times a year and shall be coordinated with the cycle of Board meeting of the Trusts.

13.2 Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

13.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

All papers will be published using the available electronic Board paper system. Publication of papers will be seven working days before meetings. A progress report of outstanding/pending Joint Committee actions will be presented to each meeting of the BSW Hospitals Group Joint Committee.

15 Routines, Behaviours and Standards

15.1 The BSW Hospitals Group Joint Committee will implement the following routines and behaviours, in order to enable a safe, inclusive and trusting environment, where teams build and maintain effective relationships:

15.1.1 Develop a shared purpose and vision for the population we serve

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

15.1.6 An open book approach to information to build understanding and trust.

15.1.7 Be facilitative, enabling and pace setting in their role as System leaders.

15.2 The BSW Hospitals Group Joint Committee shall comply with the following standards:

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

15.2.6 King's Fund: The Practice of Collaborative Leadership: across health and care services

15.3 The BSW Hospitals Group Joint Committee shall work to the following principles:

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

16.1 Agendas will be built around the BSW Hospitals Group Joint Committee annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

16.1.7 Self-assessment of the BSW Hospitals Group Joint Committee's effectiveness

16.1.8 Review of the BSW Joint Hospitals Group Committee's terms of reference

16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

17.1 The BSW Hospitals Group Joint Committee shall have the following committees (sub-committees to the Joint Committee):

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

17.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more additional committees.

17.3 The voting members of a committee of the BSW Hospitals Group Joint Committee may may comprise or include individuals who are or are not voting Members of the BSW Hospitals Group Joint Committee.

17.4 The BSW Hospitals Group Joint Committee may authorise a committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the committee in its ToR.

18 Amendment

These terms of reference may only be amended by variation agreed by resolution of each of the Trust Boards save that the Chair and Chief Executive of each of the Trusts may agree a non-material variation that they may reasonably consider to be necessary for the purpose of remedying any obvious error or omission in the terms of reference.

Date approved:

Date of review:

Annex to BSW Hospitals Group Joint Committee Terms of Reference

Functions Delegated by each of the Boards of GWH, RUH and SFT – Roles & responsibilities

Role of the Joint Committee		Role of the Trust Boards
1. Group Strategy & Planning		
Strategy		
1	Development of BSW Hospitals Group Strategy (for approval by the Group Board in April 2026). The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
2. Transforming Models of Care for the Population we Serve		

1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.
2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Development and approval of a single financial plan for the Group.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
2	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
3	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
4	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Develop and approve the roadmap from June/July 2025 to 01-April-26 implementation of the Group Board and Joint Chair. *Develop and approve the Target Operating Model for the Group, including the Accountability Framework* and associated *Integrated Performance Reporting*. Develop and approve the Group and Trust leadership structures in line with the Target Operating Model (subject to relevant approvals from the Remuneration committees in common). Develop and approve the Group governance and assurance framework (including development and approval of Group Board (General Purpose Joint Committee TORs) and Board committee structure and ToR. Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)	Works within the Group governance structure, assurance and accountability framework to deliver services ensuring that local governance aligns with group governance.

2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors	
5	Develop and approve the Group's communications strategy, including key communication tools/ artifacts.	Engagement in and contribution to the development of the Group narrative.
6	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	4th September 2025		

Report title:	Triannual Strategy Deployment Update			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Executive Directors (1:1s for relevant SPF elements)			
Prepared by:	Tony Mears - Deputy Director, Strategy & Operational Planning			
Executive Sponsor: (presenting)	Nick Johnson, Managing Director			

Recommendation:

1) The Board is asked to note the report and progress against our Vision Metrics and Strategic Initiatives.
2) The Board is asked to take assurance in the process standard work surrounding our strategy deployment.

Executive Summary:

The Trust continues to make positive progress against its 2022-2026 strategy and long-term vision, with demonstrable improvements observed across most Vision Metrics and Strategic Initiatives.

The Triannual Strategy Deployment Update demonstrates that we are making significant progress against the Trust's Strategic Planning Framework (SPF). The SPF is structured across time horizons, with Vision Metrics (7-10 year timeframe), Strategic Initiatives (3-5 years), and Breakthrough Objectives (18-24 months). Each element has assigned executive sponsorship, responsible leads, and contributing forums ensuring clear accountability and governance.

People
The Trust is making substantial progress against its people-focused metrics. Staff engagement has increased to 7.09 in 2024, continuing to outperform the falling national average. Staff retention has significantly improved with overall Trust turnover declining, with the contributing Breakthrough Objective for Additional Clinical Services staff turnover successfully reduced from 21% to 15%, exceeding the target. The Trust has developed comprehensive equitable treatment strategies, with an EDI Steering Group scheduled to launch in September 2025.

The Strategic Initiative to embed a continuous improvement culture has shown strong results, with 115 teams now trained in our Improving Together methodology, demonstrating improved performance against key staff survey questions, and benchmark us favourably against national comparators. The sustainable workforce initiative is addressing critical gaps through strategic workforce planning, talent management, and focused retention efforts, with 5 clinical services assessed as frail receiving targeted support.

Population
The Trust is actively tackling wait times through UEC and Planned Care Board actions, including successful expansion of Same Day Emergency Care (SDEC) to 7-day service with specialty expansions. Patient harm reduction is being addressed through multiple workstreams, including the managing patient deterioration

Breakthrough Objective, falls reduction initiatives, and pressure ulcer prevention programmes. Patient engagement has improved significantly with Friends and Family Test response rates consistently above 17% target and 95% rating good or very good.

Digital care transformation is progressing well, with preparations for Electronic Patient Record implementation in October 2026, alongside complementary systems like BadgerNet Neonates and GP ICE Order Communications to improve clinical pathways.

Partnerships

The partnerships pillar demonstrates progress in reducing health inequalities, with specific projects showing measurable impact such as the 30% reduction in time LDAN patients wait for care. The Trust has live projects on paediatric 'not brought' rates and cancer screening improvements.

Length of stay reductions are being achieved through multiple interventions including the Acute Frailty Unit, which has dramatically cut stays from 17 days to under 5 days.

Organisational sustainability efforts include systematic addressing of backlog maintenance (with a 20% improvement target by 2027/28) and development of the 10-year campus masterplan. A new Strategic Initiative on *Designing services to meet population needs* has been established to address demographic shifts, particularly Wiltshire's nationally significant ageing population, with workshops completed across the system to define the problem statement.

Governance and Oversight

Strategy deployment is overseen through a robust governance structure with monthly Executive Engine Room meetings chaired by the Managing Director. Each Vision Metric and Strategic Initiative has clear executive sponsorship, responsible leads, and contributing forums. Regular A3 iteration clinics provide peer support and strategic alignment across all workstreams.

Significance for Board

This update is important for the Board for several reasons:

- It demonstrates how all levels of the organisation are **aligned** to deliver the Trust's vision of providing an outstanding experience for patients, families, and staff.
- The clear **ownership structure** with executive sponsors, responsible leads, and contributing forums ensures proper oversight of strategy implementation.
- Metrics show tangible **improvements across multiple domains**, from staff engagement outperforming national trends to measurable patient outcome improvements.
- The **timeframes** provide clear expectations of when benefits will be realised, helping the Board understand the maturity and trajectory of different initiatives.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	X
Partnerships: Working through partnerships to transform and integrate our services	X
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	X
Other (please describe):	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	4 September 2025		

Report title:	Improving Together Triannual Roadmap Progress Report			
Status:	Information	Discussion	Assurance	Approval
			✓	
Prepared by:	Emma Cox, Head of Continuous Improvement and Coach House Alex Talbott, Director of Improvement			
Executive Presenting:	Alex Talbott, Director of Improvement			
Appendices (if necessary)				

Executive Summary:

The embedding of a culture of continuous improvement at SFT continues to progress positively. Since May's report training has remained on trajectory, while an increase in hours of coaching for improvement at the frontline is focusing on the issue of sustainability of improvement huddle routines. The growth of performance review meetings across the speciality and team layers in both clinical and non-clinical departments is cementing Improving Together as the way we work, and A3 thinking as our structured way of solving problems. As we head into a period of change in corporate services and development of our BSW Hospitals Group is it important we maintain these fundamentals at SFT and across the Group to ensure we build on the successes to date of our continuous improvement management system.

A review of the next steps listed in May 2025's report shows:

1. Establish a robust benefits realisation approach to capture further benefits as a result of embedding Improving Together methodology. Both the Transformation and Coach House teams have been trained in the approach and are now actively using it in their work. Wider implementation plan to be considered at September's Improving Together Board.

2. Further analysis of the staff survey results to aid in the strategic alignment of which teams we train, coach and support over 25/26. This has been completed and informs the teams we have scheduled for training through to January.

3. Review our training material for Improver Standard with OD&L and Group colleagues to improve the training experience. Completed, with more time being given to post-training coaching and greater emphasis on partnership working between the teams to enhance delivery.

4. Share regular good news stories of clinical lead and wider consultant involvement in Improving Together to encourage further engagement across teams. Continues and a booklet describing the impact of Improving Together at SFT is being finalised.

5. Establish next steps for external partnership working with Chemring Countermeasures (CCM). SFT colleagues are now coaching CCM to test how impactful it can be, with plans in place for sites visits for both teams to go & see how each uses the OMS.

6. Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are introduced and sustained over time. Good progress across the corporate divisional rollout of PRMs. Further work to do to help teams sustain the routines post-training and coaching.

7. Review the approach to initiating Corporate scorecard agreements and performance review meetings, identifying areas of improvement as a result. Estates and Facilities PDSAs are informing this work well and with positive feedback. Further departments are due to test the approach in Q3.

8. Review and further align the maturity assessment scoring, with a focus on leadership behaviours, increasing the number of responses received and introducing peer-to-peer constructure challenge. In addition, review maturity assessments across RUH and GWH and consider shared assessment tool/approach. This work continues and may be impacted by the corporate services redesign as we pause work that is likely to be done once across the Group.

Below we have used the Alert, Assure, Advise approach to help inform the Board of our levels of assurance in the embedding of Improving Together at SFT.

The next steps for September to January are noted at the end of report.

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- None escalated from Improving Together Board.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- There are 46 active improvement huddles, a decline or 6 from May 2025. The Coach House team has this as one of their improvement drivers. Their work with frontline teams and their speciality and divisional leadership teams is showing early signs of positive impact as teams stabilise in their use of Improvement huddles and we expect this number to return to the mid-50s over the next quarter.

- Increasing and improving how we routinely include patients, families and carers continues to score low in the NHS Impact assessment. Examples of good practise exist at SFT and we will look to promote and expand these throughout the rest of the year.

- The impact of the corporate services redesign process and supporting the development of our BSW Hospitals Group will mean an initial reduction in the time we can focus on SFT. However, the development of a more harmonised model of deployment of Improving Together provides us all with a great opportunity to get even more from the operational excellence approach.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The training trajectory is on track to have 100% of teams trained by Q2 of 26/27.

- Our leadership behaviours are now routinely part of recruitment, appraisals, team development and succession planning.

- Appendix 2 shows the benefits delivered through our project delivery system, a key component of Improving Together.

- Externally SFT remains known as a good place to visit to see Improving Together in action and learn from our work to date. Visits to SFT from three further NHS trusts are in the pipeline for Q3/4.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	✓
Partnerships: Working through partnerships to transform and integrate our services	✓
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	✓
Other (please describe):	

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Improving Together Triannual Roadmap Progress Report – September 2025

This progress report reflects the outcomes in the nine workstreams overseen by the monthly Improving Together Board. It also includes updates on additional areas of work that align to embedding a culture of continuous improvement at SFT.

Reporting in May 2025, identified the following areas of focus:

1. **Training and Coaching Support**
   Achievement against the training trajectory of 100% of teams trained to Improver Standard remains on track (Q2 of 2026/2027). Revised processes for improvement coaching have been introduced, offering greater focus and collaboration between the Coach House and divisional colleagues, as a result in the first month, time spent providing improvement coaching has risen from 42 to 83 hours. This has resulted in improved use of improvement huddles by frontline teams.

   The Coach House continue to provide training via planned and bespoke masterclasses. As maximising engagement is critical to ensure effective use of resource, during Q3, the Coach House will shift capacity to increase the number of hours spent providing improvement coaching and delivery of bespoke sessions. A reduced and revised masterclass offer focusing on practical applied learning sessions will be made available to teams.

   Identify areas of aligning training content across RUH/GWH/SFT to ensure consistent messages are cascaded will prioritised by the Heads of the Coach Houses in Q3.

   Equipping our leaders with the right skills and capabilities to lead a culture of continuous improvement continues to be a key focus this year. The People team have launched successful initiatives across recruitment, the annual appraisal process, talent management and succession planning which strongly contribute to this work. Continuing to embed the Trust's Leadership Behaviours Framework remains a focus for the OD&L team, alongside supporting teams to translate and apply their learning to their daily practice.

2. **Celebrating and Maturity**

   The self-led maturity assessment helps the divisions, specialities and teams to identify where further support is required and to celebrate and share successes. Progress has been made in reviewing the assessment tool and introducing new elements to help teams demonstrate improvements in their ways of working.

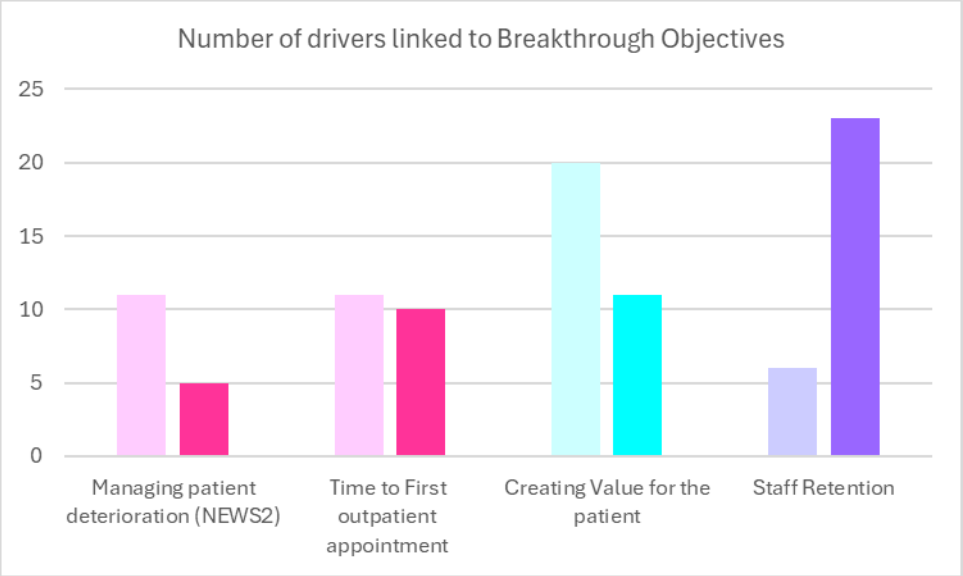
   Regular and routine sharing of successes continues despite the communication team staffing challenges. These stories and case studies offer insight into improved performance that can be shared to establish greater impact and sustained improvement. A review of the communications workstream roadmap has provided clarity on the targeted outcomes for achievement by 31 March 2026.

3. **Operational Management System (OMS)**
   Continuing to strengthen the OMS will help fully embed Improving Together as our way of working.

   The continued introduction of team and specialty level performance review meetings in

both clinical and non-clinical teams has helped further align all areas of the organisation. This is a significant milestone for the programme. Continuing to increase the number of performance review meetings undertaken across speciality and team level and the sharing of information via driver meetings will strengthen our way of working and providing greater strategic alignment across the range of our transformation and improvement efforts.

Alignment of drivers being chosen and focused on that align to the strategic planning framework continues to increase, with 113 drivers in total identified as shown below:



Number of drivers aligned to each breakthrough objective. Coloured by Vision Domain, with lighter columns relating to Team drivers and darker columns Specialty drivers.

Supporting programmes and projects continues to be overseen by the Corporate Projects Prioritisation Group (CPPG) and discussed at the monthly engine room. Since May, there has been a positive shift to supporting strategic initiatives (56%), which indicates that more improvement work linked to breakthrough objectives is being operationally led. Benefits being realised through corporate services is made available in **appendix 2**, with 25 organisational projects supporting our strategic initiatives, breakthrough objectives and mandated time sensitive/patient safety priorities.

4. Collaborative Working

An increasing amount of collaborative work in this period has been linked to the development and building of routines to support the Group Engine Room and moving forward the Group Strategy, ensuring continuation of the Improving Together methodology as our way of working.

SFT specific development of a Centre of Excellence, across Coach House, OD&L and Transformation teams has been paused due to the resource requirements for our corporate services redesign across the Group.

Building relationships with Chemring countermeasures continue to be developed with further progress available by the end of Q3.

5. Emerging Risks

- Corporate service redesign work risks diverting resources away from the workstream roadmaps and achievement of the overarching outcomes. The roadmaps and outcomes have been reviewed with each roadmap now having a top 3 outcomes to focus on for 25/26.
- The development of our BSW Hospitals Group and the associated changes in roles and people risks us not having enough time or focus to maintain our current level of leadership input to Improving Together. The Executive team at SFT continue to huddle and run the routines that underpin the OMS such as Divisional Performance Reviews and go and sees. Improving Together training is included in all new starters' induction, alongside improvement coaching for new Executives.

6. Identified Next Steps

The following have been identified as key areas of focus between September and January 2026, and have been identified based on balancing our Group development and the corporate services redesign work.

- To have defined and agreed an approach to roll out clinical and corporate Performance Review Meetings (PRMs) across the organisation, which can be sustained and embedded across all layers (divisions, specialities and teams).

- To have produced and presented an aligned approach to the Improving Together Board on the roll out of benefits realisation standardisation at SFT.

- Embed the routine of the maturity assessment process for divisions, speciality and teams resulting in identification and support offered in focus areas that require improvement moving forward.

- Review the maturity of driver meetings across clinical and non-clinical areas and provide further training and coaching to areas where this is not yet embedded in routine practice/BAU, resulting in a positive improvement and sustained use of this routine to focus our improvement efforts.

- Continuing to develop external partnership collaborations with Chemring Countermeasures.

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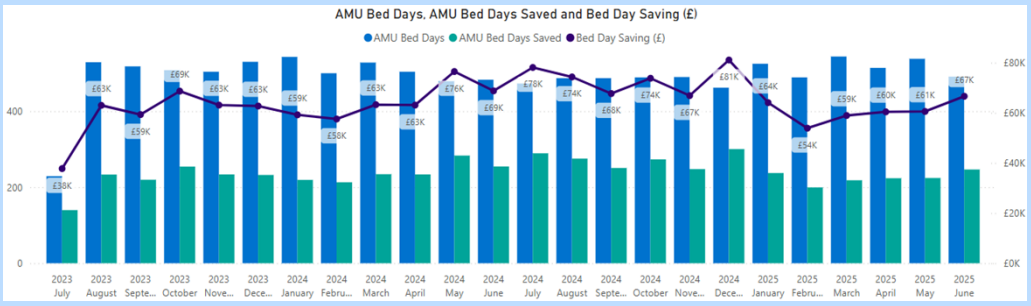
Appendix 2 - Some of the benefits delivered through the project delivery system - supported by the Trust wide Transformation Team.

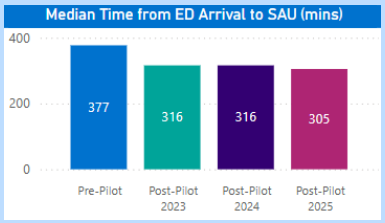
Urgent Emergency Care projects: Links to Creating value for the patient breakthrough objective

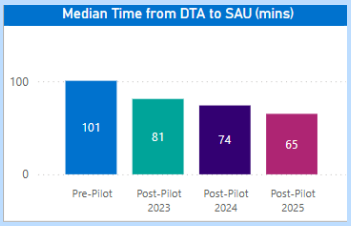
Medical SDEC Bed Days saved and bed day saving maintained



Total Bed Day Saving since commencement AFU £5,952,510 AMU SDEC £1,511,460

- Zero-day length of stay improvement maintained - **currently 49.2%**
- Expanded medical SDEC (2 in/out rooms introduced Feb 2025) demonstrating improvement in assessment space average **LoS from 10 hours to 5 hours**
- Introduced colour-coding for identifying patient cohorts in AMU and SDEC spaces, resulting in time saved identifying responsible nurse and doctor for each patient, and reducing likelihood of patient harm
- **AFU continued upward trend of % 0-day Length of Stay**
- **AFU Average length of stay further reduced from 4 days to 3 days**
- Frailty 'In-reach into ED' pilot – 74 patients seen through this initiative since March 2025. Of those, **57% went home the same day, 10% LoS between 1-3 days.**
- Surgical SDEC launched March 2025. **Average Length of Stay gradually reducing** time from ED arrival to SAU reducing.





Stour Infusion Unit A newly renovated infusion unit to combine two existing infusion spaces opened 31st March 2025, delivering:

- A unit that is fit for purpose, with clean utility and compliant flooring and wall materials to support infection prevention and control and reduced likelihood of patient harm.
- Change of product preparation to pre-made, **releasing approximately 5 hours per week** of Registered Nurse time for alternative tasks
- The teams are now working **extended opening hours** and have increased to 6pm 3 days per week adopting improving together methodology and using PDSA cycles to make improvements to the lay out of the department
- Alignment of booking processes resulting in removal of single point of failure, **greater space utilisation, reduced use of paper** supporting sustainability goals, reduction of data errors, visibility of changes in real-time
- Alignment of co-morbidity coding leading to **increase in revenue** to the Trust
- Merged workforce bringing together staff with different skillsets, who have undertaken cross-training and upskilling to **reduce patient harm** and provide **greater resilience** and cover for periods of leave, sickness absence, mandatory training
- Real-estate freed up to accommodate addition of Urgent Treatment Centre and **optimise use of SDEC**
- **Patient** satisfaction collection has now started they are receiving FFT feedback which shows **100% satisfaction rate**. There first week of data collection showed a 14.3% response rate

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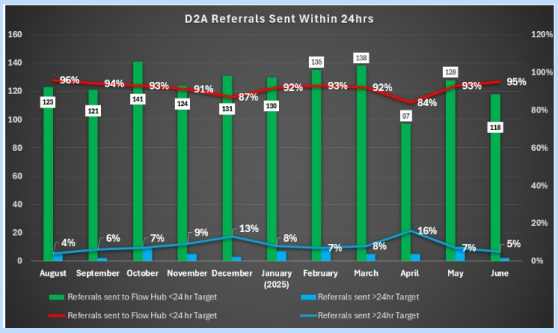
Non Criteria to Reside (NCTR): Links to Creating value for the patient breakthrough objective - Sustained delivery of 90% of D2A referrals being completed and sent to the flow hub within 24hours of NCTR declaration, for timely and efficient pathway decisions to be made (with the exception of operation pressures during December 2024 and April 2025):



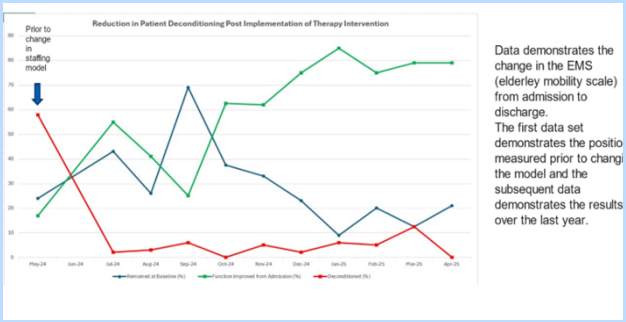
The quality of D2A referrals has significantly improved. The data below Identifies the low % of referrals, where Improvement actions sit locally within SFT (forming next steps):

1. Inclusion of clinical care plans (31 incidences /300 refs = 10.3%)
2. Care Diaries/Night Needs information (24 incidences/300 refs = 8%)
3. Incomplete forms - including Diagnosis, PMH, LPA details, empty boxes (23 incidences/300 refs = 7.6%)

- Dedicated Early Therapy Input has seen a sustained Increase in patient functionality from point of admission and decrease in % of patients deconditioning prior to discharge. Contributing to reduction in LoS :

This has delivered the following quantifiable benefits to date:

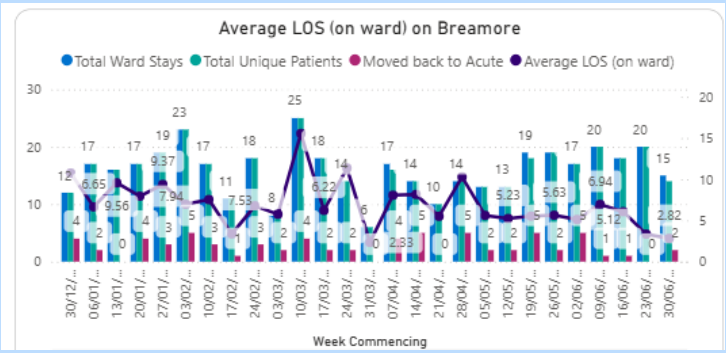
- 19 packages of care reduced.
- 12 discharge home assessments completed by ward OT saving approx. 6 bed days per patient.
- 64% of patients' function and mobility improved from admission, with 30% remaining at baseline since re-design and staffing change.
- 50% of Pathway 2 bed-based rehabilitation referrals changed to Pathway 1 from Jan – April 2025.
- 391 patients seen and maintained by therapy.



Data demonstrates the change in the EMS (elderley mobility scale) from admission to discharge.
The first data set demonstrates the positio measured prior to changi the model and the subsequent data demonstrates the results over the last year.

Breamore (BAU since February 2025)

- Sustained reduction in LoS vs high number of patient discharges:



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NHS App Phase 2 – Notifications & Messaging - Creating value for the patient breakthrough objective

- Reduced spend on SMS messages for appointment confirmation, reminder and appointment cancellation texts.
  - Over the first 3 months of go live (April, May and June 2025), a total of 134,250 NHS App notifications, informing patients of changes to their OP appointment information, have been sent.
  - Of this amount, 104,212 NHS App notifications have been successfully read by patients within the 8-hour fallback window, and therefore have avoided the full SMS cost from being incurred. This has resulted in a cost avoidance of £1200 over the first 3 months of go live.
  - Uptake of the NHS app, and numbers of patients reading the app notifications, is showing a steady month by month increase, showcasing opportunity for further cost avoidance:

NHS App volumes & spend

Month	NHS app notification sent	£ Rate (per unit)	£ amount	% of total messages sent via the NHS app per month	Cost Avoidance per month
Apr-25	31,666	0.0115	364.15	14.8%	£364.16
May-25	35,424	0.0115	407.38	15.2% ↑	£407.37
Jun-25	37,122	0.0115	426.91	16.2% ↑	£426.89

Original target of 16% SMS avoidance rate has been met at M3 post go live

- Contributing to local and national ambitions to utilise a digital by default approach
- Taking a proactive approach to involving patients more successfully in their healthcare – increasing accessibility for patients to easily view their information via the NHS App

Digital ReSPECT – Strategic Initiative Digital Care

Over 1200 Digital ReSPECT plans have been created in the Integrated Care Record System enabling the removal of a paper process which promotes a single source of truth with a robust audit trail so that any changes are documented.

A recent audit of the process by the BSW ICR Project team has shown that 88.9% of the Digital ReSPECT plans are being created by the Trust on admission leading to;

- Improved patient experience – stops multiple conversations occurring at a distressing time. The digital plan is shared across Wiltshire so that GPs, SWASH, community partners as well at RUH and Great Western can see.
- Improved patient care – no longer reliant on paper copies as the information on the ICR system.

Badgernet Maternity EPR – Strategic Initiative Digital Care

- Achieved digital record: all service users records are now held digitally in BadgerNet
- Achieved Badger Notes usage: all service users can view their record in their BadgerNotes App
- Achieved shared care records with neighbouring Trusts: Neighbouring Trusts are now able to access service user records by utilising the "break glass" functionality in BadgerNet.
- Paper storage has been reduced: This will have a long-term cost saving implication in the longer term.
- Clinicians are able to access records at any place at any time, this is also achieved using Offline mode if internet is not available: This means that MDT working is now possible remotely. This saves clinician time and travel costs are reduced.
- Referrals happen in real time: Reducing delays in patient care.

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Shared EPR – Strategic Initiative Digital Care

- 500 workshops have taken place with Oracle across 12 workstreams to review and sign off the Oracle workflows.
- Gap analysis completed to identify "Gap" between Lorenzo and Oracle so programme team can mitigate.
- 232 out of 308 workflows have been approved 75% - Remaining workflows to be approved by 29/08/25
- Data Workbook Collection – DCW's - 95% completed to set up the Oracle system
- Future State Review – FSR took place at SFT on 30/06, 01/07 and 02/07 - Attended by 562 SFT colleagues to see first look at the new Oracle EPR System.
- Future State Validation Gateway 16/07/25 - SFT signed off with 14 conditions.
- EPR Go live Planned for Nov 26 at SFT – System build to be completed by Feb 2026 for RUH Go live in March 26.

Digital upgrades to support enhanced service delivery / cyber security – Digital Care Strategic Initiative

- Lilie system (Sexual Health) and Auditbase (Audiology) upgraded
- Server refresh - the number of fully decommissioned out of support servers is at 448, with a further 20 currently moving through the decommissioning process. Each server decommissioned increases our cyber-security and hence patient safety, whilst enhancing the user experience through increased performance and resilience.

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Report to:	Public Trust Board	Agenda item:	5.2
Date of meeting:	4th September 2025		

Report title:	Winter Plan 2025/26			
Status:	Information	Discussion	Assurance	Approval
				Y
Approval Process: (where has this paper been reviewed and approved):	Provide details on where the paper has been previously discussed/ approved. TMC approval 27th August 2025			
Prepared by:	Sarah Needle, Deputy Chief Operating Officer			
Executive Sponsor: (presenting)	Niall Prosser, Chief Operating Officer			
Appendices	SFT UEC & Winter Plan Action Log, Winter Plan 2025/26 presentation			
BAF Risk link				

Recommendation:

This paper is coming to the Trust Board for approval and sign off of the Board Assurance Statement prior to submission to the ICB in September.

Executive Summary:

The has been approved by TMC on the 28th August 2025. The Winter Plan Board Assurance report and Winter Plan Action Log will be submitted to the ICB where it will be taken to ICB Executive Board in September for approval.

September will see the plan exercised with system partners at the Winter Planning Session scheduled for the 2nd of September (ICB led meeting). A de-brief will be submitted to the Quality and Outcomes Committee following the exercise on the 2nd Sept. Surveillance and implementation of the Winter Plan will take place within the ICB from October to April 2026. .

The plan will form part of the agenda on the SFT Urgent and Emergency Care Board for monthly review.

Alert – Inability to progress POCT testing this year and will need to go into next years planning. Medicine Division working with FASS to progress

The assumes that we will achieve the SFT annual plan and therefore reductions in growth and NCTR. There is a contingency plan being prepared should these not be achieved.

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Assure – Monthly review of the plan will take place at UEC Board. The plan will be reviewed and updated weekly by the Deputy COO and report into the COO and ICB on progress.

Escalate – Nothing to escalate.

The plan has been compiled in conjunction with Divisional leads and corporate team members. The joint organisation leads for the winter are Sarah Needle and Stuart Henderson and will be responsible for ensuring that we deliver against the plan and reportable to the Niall Prosser, Chief Operating Officer.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

SFT UEC & WINTER PLAN 2025/26

Requirement	Division	Plan	Owner	Due Date	On track/Off track/Complete	Comments
SFT Capacity Escalation plan reflect the NHSE UEC Plan	Corporate	Update SFT Capacity Escalation Plan and SFT Time Handover Process to reflect current NHSE requirements	Sarah Needle	Jul-25	Complete	To be reviewed in line with changes as and when capacity changes
Demonstrate plans to improve vaccination rates in health and care workers	Corporate	Vaccination programme set up to run from October 25 - March 26	Angie Ansell/Jo Rowntree	Sep-25	Complete	Plan commenced.
Infection prevention and Control	Corporate	Testing Protocols For Respiratory viruses (admission and symptomatic	Lee Phillips Fiona McCarthy/Angie Ansell	Sep-25	Complete	For the Testing Protocols for respiratory viruses (admission and symptomatic) – protocol in place . The document is still on SALi in the EPRR section
	Corporate & Divisions	Flu & IPC Outbreak management plan	Fiona McCarthy	Sep-25	Complete	
		Fit testing programme	Holly Storey	Sep-25	Complete	Not recorded on ESR but all recorded on MLE. Scheduled appointments on MLE.
Have an accessible OH vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk in appointment	Corporate	Vaccination programme set up to run from October 25 - March 26	Angie Ansell/Jo Rowntree	Sep-25	Complete	
Acute Trusts to establish a defined improvement trajectory towards achieving 15 mins hospital handover target	Corporate	Trajectory in place to meet 18 mins average by March 26	Sarah Needle/Niall Prosser	Mar-26	On track	
Update OPEL Cards for the Trust	Corporate & Divisions	1 set of cards to be produced across the Trust and align with RUH & GWH	Sarah Needle/Stuart Henderson	Sep-25	Off track	BAU in OPEL 1 to move into ward processes group. SN & SH reviewing ward processes group along with A3 for LOS 8th Sept.
Workforce Resilience	Corporate	Staff wellbeing measures Rest areas, phychological support, hot food, fatigue monitoring	Ian Crowley	Oct-25	On track	Refurbed 14 rest areas and money to do 5 more. Secured funding for counselling support and explore option for extended hours including clinical pyschology.
		Sickness absense contingency Bank/Agency coverage, redeployment protocols	Ian Crowley	Sep-25	On track	Covered by sickness absense work. Review tolerances for cover arrangements. Temporary staffing supporting this work based on risk tolerance.
		Review annual leave against pinch point staffing (Christmas/Bank Holidays)	Ian Crowley	Nov-25	On track	Divisional reporting measure for winter. OD&P Board in Sept for discussion and next steps
		Staff communications Regular briefings, winter bulletons, escalation alerts	Yvonne Boateng	Oct-25	On track	Comms plan to be provided
Communicatons and Public messaging	Corporate	Internal comms Realtime status updates via intranet/sms/email	Yvonne Boateng	Oct-25	On track	Comms plan to be provided
		External Comms Website updates, collatboration with NHS 111, Local media campaigns	Yvonne Boateng	Oct-25	On track	Comms plan to be provided
Monitoring, Review and Continuous Improvement	Corporate	Key performance indicators (KPIs) ED 4 Hour Standard, ambulance handovers, delayed discharges	Louise Drayton Emily Carter	Jul-25	Complete	Content these are in place and will go to 7 day reporting from November to March
		Daily Operational Reporting SitRep submission processes	Emily Carter	Jul-25	Complete	Content these are in place and will go to 7 day reporting from November to March
		Post Winter Review Lessons learned session and improvement planning for next year.	Sarah Needle/Stuart Henderson	Apr-26	Not started	Will be put in place after Winter but monthly review of the plan will take place in UEC Board.
Acute Trust and local authorities to set local performance targets for pathway 1,2 and 3 patients	System partners	System work in place to deliver the bed reduction plan based on steady state NCTR numbers. Discharge trajectories is still a work in progress	Jo Williamson/Emma Cavill	Mar-26	On track	Slight reduction seen in July. Trajectories are on hold as further data is required to support this. ICB picking up with Acutes BI teams. Home is Best Programme in place for system partners to review progress against actions for Pahtway 3. DRD data being reviewed for accuracy in collaboration with other Acutes. BI team leading on this
Admission avoidance and Early Discharge	All Divisions	Dischare planning Daily Board rounds EDD setting Discharge to assess model	Sarah Needle/Stuart Henderson Danielle Bagg/Olly Sohan/Pedro Serra		Not started	SH and SN reviewing A3 for LOS 9th Sept. Work to be reviewed against current Ward Processes Group. Will report monthly through UEC Board.
Surgery Winter Plan	Surgery	Review use of DSU to support ward closures in July	Surgery DMT	Jul-25	Complete	
		Review use of DSU following opening of Tisbury to 23 hour elective unit alongisde theatre activity plan	Surgery DMT	Dec-25	On track	Reviewing current environment on DSU and staffing model
		SDEC pathways to bypass ED	Damien Mayo/Ardy Nasawanji	Sep-25	On track	Streaming from ED to SDEC start 4/9/25
		Review Preoperative assessment pathways to resolve/reinstate: 1. Swabbing issues that lead to extended lengths of stay 2. Patient expectation and information to prevent extended LOS 3. Weekly report from Preop assessment for elective activity	Katie Ramsby Champi Dona & Gary Dawson	Sep-25	On track	Reported via Planned Care Board
		Review Outlying bed suitability on Longford for plastics complex patients	Collette Byelong	Sep-25	On track	Initial meeting held. Proposal to be worked up between Surgery & FASS
		Changes to medical rota to support additional cover for review.	Vikki Insull	Sep-25	On track	In place from Sept.
		Golden Patients	Katie Ramsby	Sep-25	On track	Good progress working with wards to identify and appropriately prioritise patients in theatres and for discharge.
		ICU Escalation Plan	Collette Byelong	Jul-25	Complete	For review in November 2025
FASS Winter Plan	FASS	Vaccination programme for children - system action	Lou Pitton/ Andrea Robson	Sep-25	Complete	Group stay well campaign for the flu vaccination starting in September that targets: all children aged 2 or 3 years on 31 August2025 primary school aged children (from Reception to Year 6) secondary school aged children (from Year 7 to Year 11) all children in clinical risk groups aged from 6 months to less than 18 years.
To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young peoples specific services and standards		Relaunch of TOWARD Project in Q1to ensure that paediatrics patients arrive in Sarum within 1 hour.	Andrea Robson/Liam Gondelle	Aug-25	On track	2 Paeds SHOs recruited to support them being seen quicker and improve 4 hour performance. Monthly paediatric meeting looking at tends monthly. IPC Sarum respiratory pathway – This is to be added as an appendices to our escalation policy . Review current escalation policy – still meets our needs - ? no amendments needed . Communication Sarum / Children's ED ,2 recent examples to be discussed where communication could be improved CED Band 7's looking at checking of O2 cylinders at the end of the day shift CED core nursing staff group within paediatric area.
Medicine Winter Plan	Medicine	Roles and responsibilities of Silver,Site and MOD	Helen Benfield Laura Osman	Sep-25	On track	First meeting held. Second meeting planned for to review actions
		SDEC expansion (Medicine and Frailty)	Helen Benfield Laura Osman	Oct-25	Off track	Working through model. Planned expansion of AMU consultants Nov. Potential plans for seperate GIM rota. Second on call consultant cover on Sundays from Nov.
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	Actions	%
Complete	11	30%
On track	21	57%
In progress	0	0%
Not started	2	5%
Awaiting Update	0	0%
Off track	3	8%
Total	**37**	**100%**

NHS
Salisbury
NHS Foundation Trust

Winter Plan 2025/26
Draft v2

August 2025.

Sarah Needle, DCOO

Content

Salisbury NHS Foundation Trust

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- Section 7: Achievements so far 23-25
- Section 8: UEC Breakthrough Objectives 25/26
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Overview

Salisbury NHS Foundation Trust

This document outlines SFT's plan for winter 2025/26. As with previous winters, urgent care services are under increasing demand. This, along with continued high numbers of patients with no criteria to reside put significant pressure on services to deliver improved access performance and bed closures to support delivery of a financial plan.

After a year of negotiations and end to BMA industrial action in the early part of 2025, we saw the first of further industrial action in July 2025. This saw further pressure on the financial challenge and elective care performance although SFT continues to be ahead of trajectory for RTT and remains out of tiering for UEC performance.

The summer of 2025 has felt the impact of climate change with amber heat wave warnings and the continuing to impact of climate change is likely to impact services going into winter. (for both health and care services). Considering climate change the plan will recognize the seasonal recommendations set out in the NHSE operational planning guidance 2025/26, the SFT position in relation to the guidance and provide mitigation plans where there are gaps.

The plan includes all the areas outlined in the Operational Guidance and references work already underway in Urgent and Emergency Care Board and Planned Care Board to deliver the Trusts vision to deliver an outstanding experience for all our people, population and partners, with improving together quality improvement methodology.

This year will also see the changes as a result of maximizing value and delivering against the priorities and see the abolishment of NHSE. The plan has been developed in conjunction with divisional and corporate teams and will be reviewed monthly through the Urgent and Emergency Care Board.

1. National UEC Plan 25/26

NHS Salisbury NHS Foundation Trust

Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter

- reduce ambulance wait times for Category 2 patients – such as those with a stroke, heart attack, sepsis or major trauma – by over 14% (from 35 to 30 minutes)
- eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard, helping get 550,000 more ambulances back on the road for patients
- ensure a minimum of 78% of patients who attend A&E (up from the current 75%) are admitted, transferred or discharged within 4 hours, meaning over 800,000 people a year will receive more timely care
- reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time. This will improve patient safety for the 1.7 million attendances a year that currently exceed this timeframe
- reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month
- tackle the delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually
- increase the number of children seen within 4 hours, resulting in thousands of children every month receiving more timely care than in 2024/25

2. National UEC Plan 25/26

Salisbury NHS Foundation Trust

Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter

- improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points
- Increase the number of patients receiving urgent care in primary, community and mental health settings, including the number of people seen by Urgent Community Response teams and cared for in virtual wards
- meet the maximum 45-minute ambulance handover time standard
- improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours, and making progress on eliminating corridor care
- set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings
- reduce length of stay for patients who need an overnight emergency admission. This is currently nearly a day longer than in 2019 (0.9 days) and needs to be reduced by at least 0.4 days

National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference

Allocating over £370 million of capital investment to support:

- around 40 new same day emergency care centres and urgent treatment centres
- mental health crisis assessment centres and additional mental health inpatient capacity to reduce the number of mental health patients having to seek treatment in emergency departments
- expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions

3. National Operating Plan 25/26

Salisbury NHS Foundation Trust

The national expectations of the National Operating Planning Guidance for 25/26 sets out:

- **Reduce the time people wait for elective care**, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026
- **Improve A&E waiting times and ambulance response times** compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- **Improve patients' access to general practice,** improving patient experience, **and improve access to urgent dental care,** providing 700,000 additional urgent dental appointments
- **Improve patient flow through mental health crisis and acute pathways,** reducing average length of stay in adult acute beds, **and improve access to children and young people's (CYP) mental health services**, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

4. SFT Bed Closure Plan

NHS Salisbury NHS Foundation Trust

The table below sets out the requirements to achieve the bed closure plan based.

	scenario description	Core demand with growth excluding NC2R	NC2R pts	total bed requirement	core beds	variance
2	1.4% growth (97% bed occupancy) - no change in NC2R (17%)	358	80	438	437	-1
4	8% growth (95% bed occupancy) - no change in NC2R (17%)	392	80	472	437	-35
5	**1.4% growth (95% bed occupancy) - NC2R reduces to 9%**	**361**	**45**	**406**	**437**	**31**
6	1.4% growth (97% bed occupancy) - NC2R reduces to 9%	353	45	398	437	39
8	8% growth (95% bed occupancy) - NC2R reduces to 9%	387	45	432	437	5

The table below shows both higher than planned activity for ED attends (up 5% on plan) and NEL spells (3% up on plan, well babies)

ED attends	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
25/26 plan	4755	4914	4755	4914	4914	4755	4914	4755	4914	4914	4438	4914	19338
Actual	4894	5129	5097	5096									20216
Variance on plan	102.9%	104.4%	107.2%	103.7%									105%
NEL spells	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
25/26 plan NEL spells	2303	2380	2303	2380	2380	2303	2380	2303	2380	2380	2149	2380	9365
Actual spells	2352	2357	2337	2555									9601
Variance on plan	102.1%	99.1%	101.5%	107.4%									103%

5. SFT Bed Closure Plan

So far…..

Plan was to:

- System approach to reducing the numbers of patients with NCTR to steady state (45 patients) - ongoing
- Reduce the use of escalation (excluding DSU) by July - complete
- Closure of Tisbury beds in July. - complete
- Capital works to take place until Dec - ongoing

Demand and NCTR remained above plan and have limited the ability to reduce all escalation spaces, most notably DSU upstairs which has been used to support Medicine Division closure of Tisbury ward.

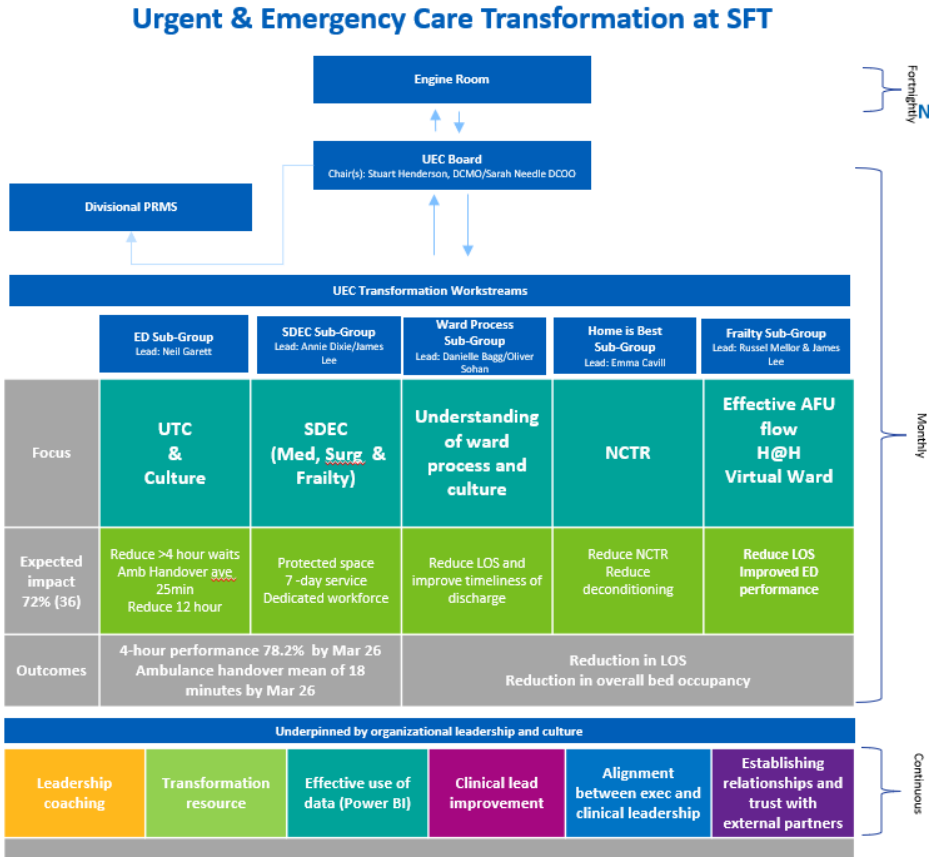
If NCTR does not reduce to 9%, consider opening of a ward in Medicine as NCTR ward with reduced operating costs.

Further proposed changes through to Mar 26.

- Reduce ICU by 2 bed – being worked through by CMB
- Eradicate Temporary Escalation Space (TES)
- Close DSU escalation space

6. SFT UEC Transformation

Salisbury NHS Foundation Trust



Transformation work continues across the Trust and is central to many of the areas of work that support the Trust's Winter and operating plan. These exist within Urgent and Emergency Care Board and Planned Care Board.

7. Achievements so far
SFT UEC A3 23-25

Salisbury NHS Foundation Trust

Problem Statement:

SFT is not achieving the ED 4 hour access standard resulting in delayed care, prolonged ambulance handover times and harm to patients and staff.

Current Situation:

The current urgent and emergency care performance is highlighted below.

In addition to the clinical root causes identified on the right it was also recognised that there was a lack of organisational focus with no structure to support understanding and improvement within the UEC space.

Root Cause Analysis:

Inefficient real time bed management process

- Existing whiteboards not used effectively
- Minimal clinical engagement
- Multiple versions of the truth
- Analogue approach

Lack of alternatives to admission/ED attendanc

- No co-located UTC
- Limited links with 111
- Limited access to hot clinics
- Limited utilisation of virtual wards
- Limited community response

Internal ED performance

- No streaming / RATT
- Limited use of fit to sit
- Non adherence to IPS
- Department size and layout
- Nurse staffing ratios
- Variability in senior leadership

Bed Capacity

Internal ward round process

- Inconsistent delivery of SAFER model
- Variable consultant practice
- Weekend variation
- No CLD
- Limited availability of SDM
- No improvement culture
- IT interoperability

Underperforming SDEC (Medical)

- Consistently bedded down
- No dedicated staffing model
- Lack of clarity over function (process model)
- Lack of clear vision or improvement culture

Underperforming SDEC (surgical)

- Limited space
- Inconsistent senior staffing
- Limited clinical pathways
- Lack of clear vision or improvement culture

Underperforming Frailty Service

- Lack of dedicated AFU
- Limited OPAL cover
- Not valued or recognised as a specialty
- Limited senior staffing

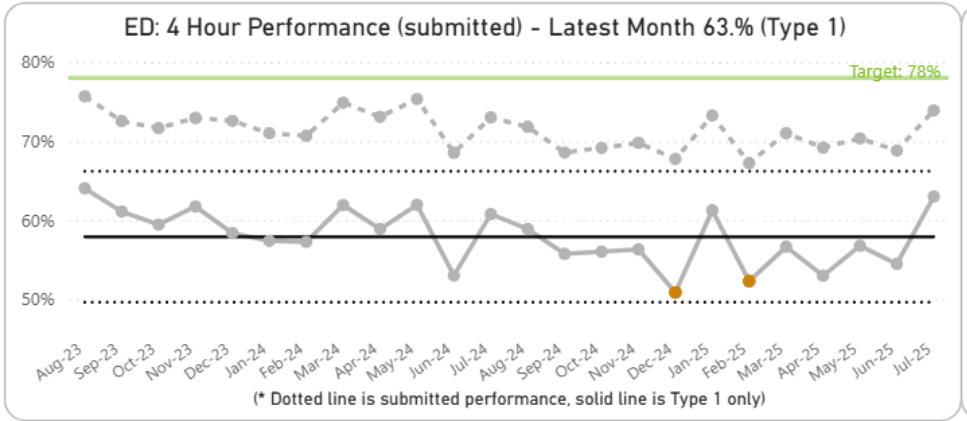
High Bed Occupancy

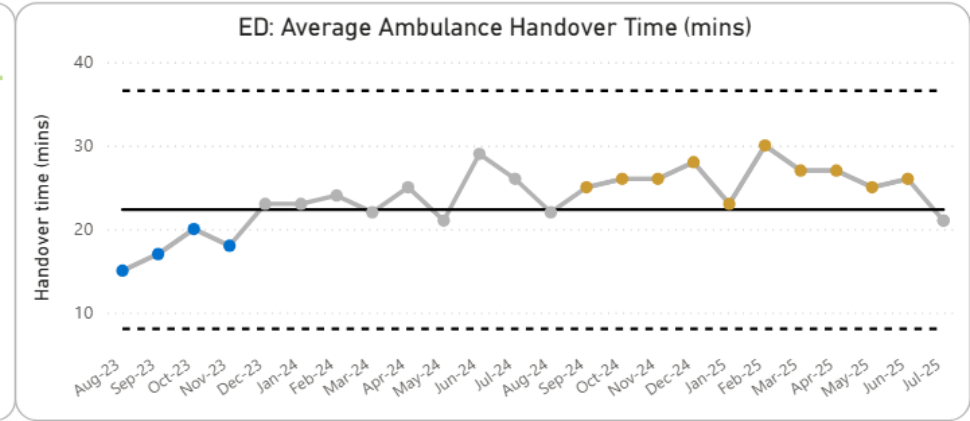
- High numbers of patients with NCTR
- Limited community capacity
- Staffing model
- Deconditioning of existing in-patients

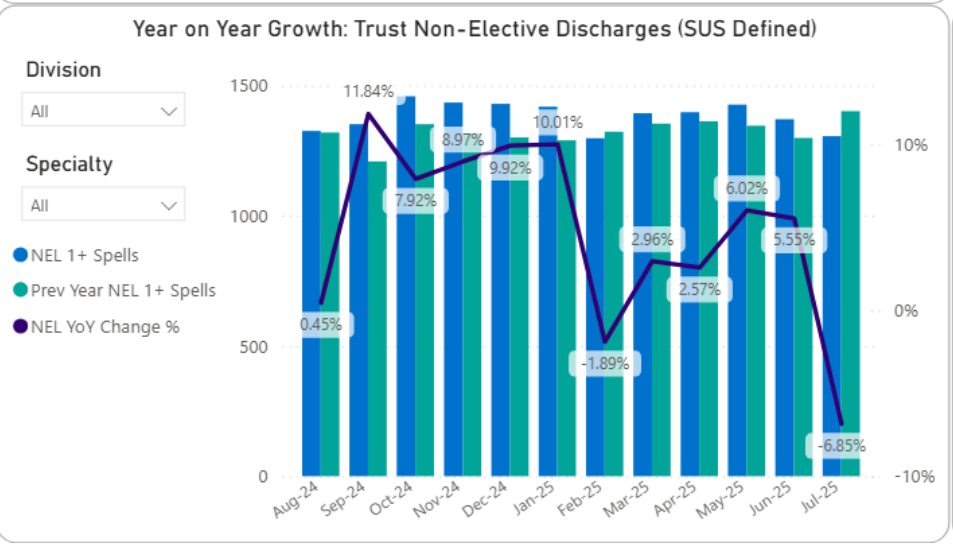
Original A3 and problem statement for 2023 (Working on / Complete

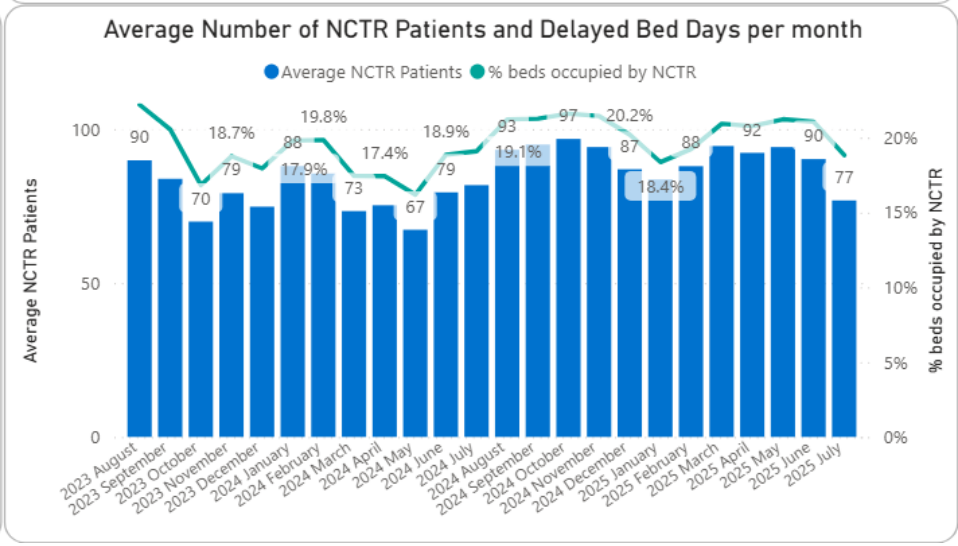
8. UEC Breakthrough Objectives 25/26

Salisbury NHS Foundation Trust









9. Planned Care Breakthrough Objectives 25/26

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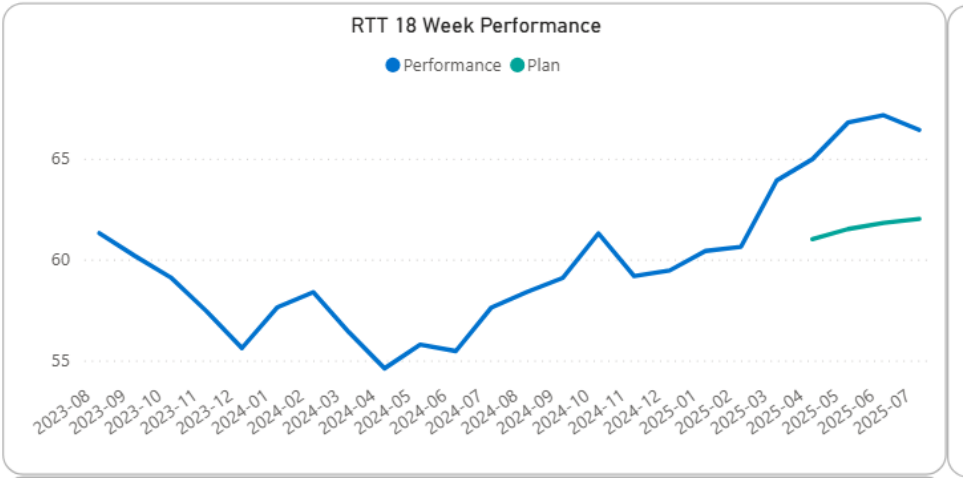

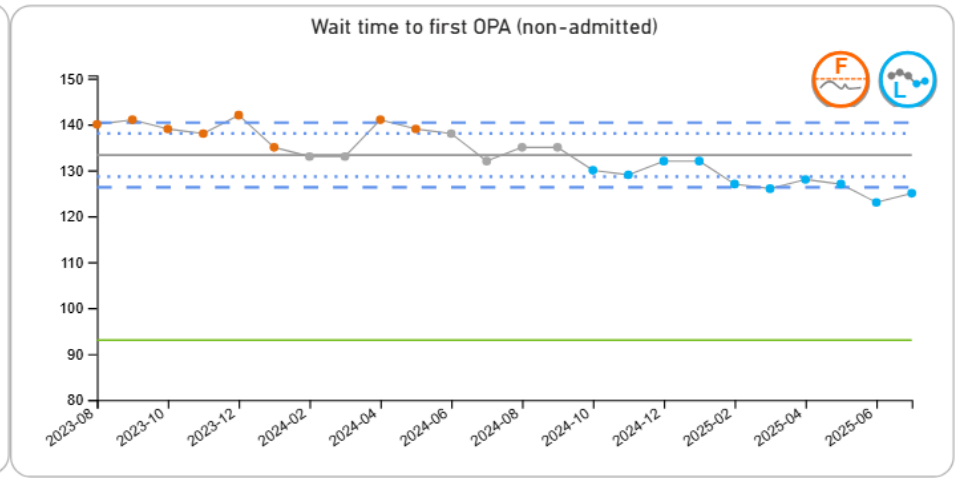

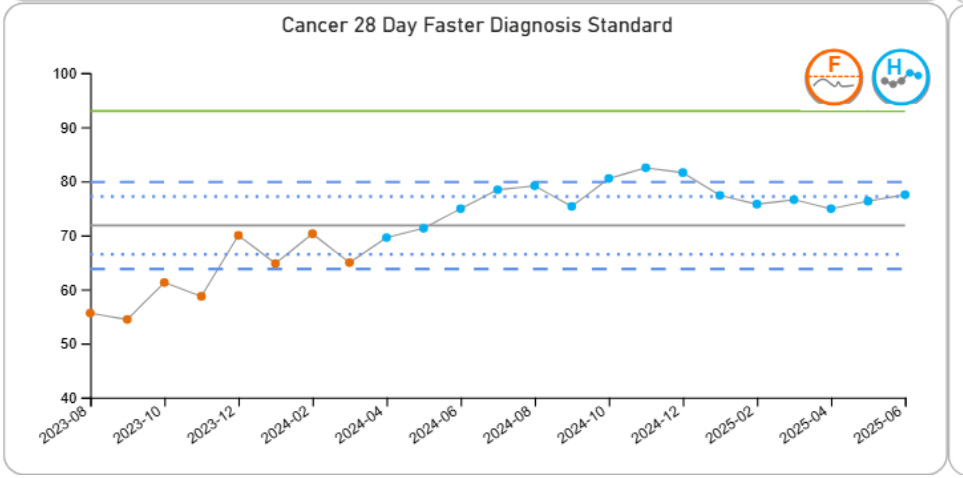

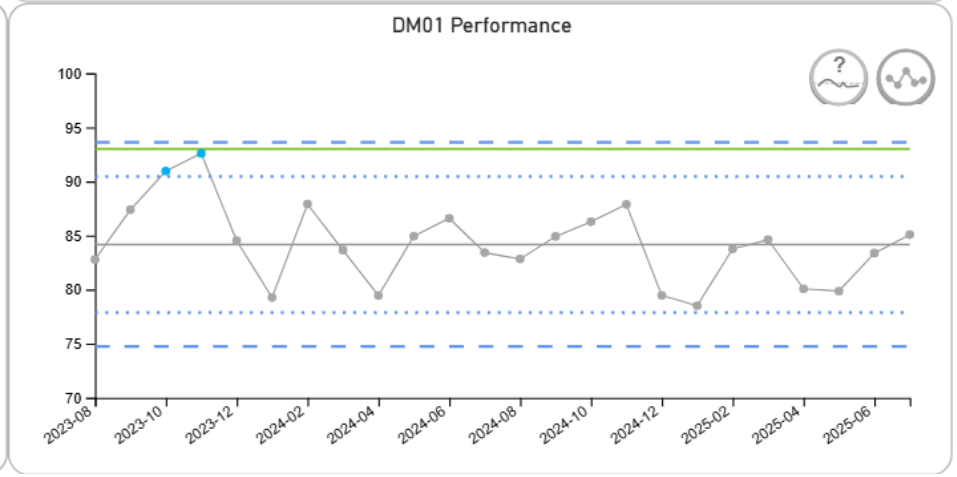

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11. The Winter Plan 25/26

11. Winter Plan Actions Status

	Actions	%
Complete	11	30%
On track	21	57%
In progress	0	0%
Not started	2	5%
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Total	37	100%

NHS Salisbury NHS Foundation Trust

Requirement	Division	Plan	Owner	Due Date	On track/Off track/Complete	Comments
SFT Capacity Escalation plan reflect the NHSE UEC Plan	Corporate	Update SFT Capacity Escalation Plan and SFT Time Handover Process to reflect current NHSE requirements	Sarah Needle	Jul-25	Complete	To be reviewed in line with changes as and when capacity changes
Demonstrate plans to improve vaccination rates in health and care workers	Corporate	Vaccination programme set up to run from October 25 - March 26	Angie Ansell/Jo Rowntree	Sep-25	Complete	Plan commenced.
Infection prevention and Control	Corporate	Testing Protocols For Respiratory viruses (admission and symptomatic	Lee Phillips Fiona McCarthy/Angie Ansell	Sep-25	Complete	For the Testing Protocols for respiratory viruses (admission and symptomatic) – protocol in place . The document is still on SALi in the EPRR section
	Corporate & Divisions	Flu & IPC Outbreak management plan	Fiona McCarthy	Sep-25	Complete	
		Fit testing programme	Holly Storey	Sep-25	Complete	Not recorded on ESR but all recorded on MLE. Scheduled appointments on MLE.
Have an accessible OH vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk in appointment	Corporate	Vaccination programme set up to run from October 25 - March 26	Angie Ansell/Jo Rowntree	Sep-25	Complete	
Acute Trusts to establish a defined improvement trajectory towards achieving 15 mins hospital handover target	Corporate	Trajectory in place to meet 18 mins average by March 26	Sarah Needle/Niall Prosser	Mar-26	On track	
Update OPEL Cards for the Trust	Corporate & Divisions	1 set of cards to be produced across the Trust and align with RUH & GWH	Sarah Needle/Stuart Henderson	Sep-25	Off track	BAU in OPEL 1 to move into ward processes group. SN & SH reviewing ward processes group along with A3 for LOS 8th Sept.
Workforce Resilience	Corporate	Staff wellbeing measures Rest areas, phychological support, hot food, fatigue monitoring	Ian Crowley	Oct-25	On track	Refurbed 14 rest areas and money to do 5 more. Secured funding for counselling support and explore option for extended hours including clinical pyschology.
		Sickness absense contingency Bank/Agency coverage, redeployment protocols	Ian Crowley	Sep-25	On track	Covered by sickness absense work. Review tolerances for cover arrangements. Temporary staffing supporting this work based on risk tolerance.
		Review annual leave against pinch point staffing (Christmas/Bank Holidays)	Ian Crowley	Nov-25	On track	Divisional reporting measure for winter. OD&P Board in Sept for discussion and next steps
		Staff communications Regular briefings, winter bulletons, escalation alerts	Yvonne Boateng	Oct-25	On track	Comms plan to be provided
Communicatons and Public messaging	Corporate	Internal comms Realtime status updates via intranet/sms/email	Yvonne Boateng	Oct-25	On track	Comms plan to be provided
		External Comms Website updates, collatboration with NHS 111, Local media campaigns	Yvonne Boateng	Oct-25	On track	Comms plan to be provided

Monitoring, Review and Continuous Improvement	Corporate	Key performance indicators (KPIs) ED 4 Hour Standard, ambulance handovers, delayed discharges	Louise Drayton Emily Carter	Jul-25	Complete	Content these are in place and will go to 7 day reporting from November to March
		Daily Operational Reporting SitRep submission processes	Emily Carter	Jul-25	Complete	Content these are in place and will go to 7 day reporting from November to March
		Post Winter Review Lessons learned session and improvement planning for next year.	Sarah Needle/Stuart Henderson	Apr-26	Not started	Will be put in place after Winter but monthly review of the plan will take place in UEC Board.
Acute Trust and local authorities to set local performance targets for pathway 1,2 and 3 patients	System partners	System work in place to deliver the bed reduction plan based on steady state NCTR numbers. Discharge trajectories is still a work in progress	Jo Williamson/Emma Cavill	Mar-26	On track	Slight reduction seen in July. Trajectories are on hold as further data is required to support this. ICB picking up with Acutes BI teams. Home is Best Programme in place for system partners to review progress against actions for Pahtway 3. DRD data being reviewed for accuracy in collaboration with other Acutes. BI team leading on this
Admission avoidance and Early Discharge	All Divisions	Dischare planning Daily Board rounds EDD setting Discharge to assess model	Sarah Needle/Stuart Henderson Danielle Bagg/Olly Sohan/Pedro Serra		Not started	SH and SN reviewing A3 for LOS 9th Sept. Work to be reviewed against current Ward Processes Group. Will report monthly through UEC Board.
Surgery Winter Plan	Surgery	Review use of DSU to support ward closures in July	Surgery DMT	Jul-25	Complete	
		Review use of DSU following opening of Tisbury to 23 hour elective unit alongisde theatre activity plan	Surgery DMT	Dec-25	On track	Reviewing current environment on DSU and staffing model
		SDEC pathways to bypass ED	Damien Mayo/Ardy Nasawanji	Sep-25	On track	Streaming from ED to SDEC start 4/9/25
		Review Preoperative assessment pathways to resolve/reinstate: 1. Swabbing issues that lead to extended lengths of stay 2. Patient expectation and information to prevent extended LOS 3. Weekly report from Preop assessment for elective activity	Katie Ramsby Champi Dona & Gary Dawson	Sep-25	On track	Reported via Planned Care Board
		Review Outlying bed suitability on Longford for plastics complex patients	Collette Byelong	Sep-25	On track	Initial meeting held. Proposal to be worked up between Surgery & FASS
		Changes to medical rota to support additional cover for review.	Vikki Insull	Sep-25	On track	In place from Sept.
		Golden Patients	Katie Ramsby	Sep-25	On track	Good progress working with wards to identify and appropriately prioritise patients in theatres and for discharge.
		ICU Escalation Plan	Collette Byelong	Jul-25	Complete	For review in November 2025

FASS Winter Plan	FASS	Vaccination programme for children - system action	Lou Pitton/ Andrea Robson	Sep-25	Complete	Group stay well campaign for the flu vaccination starting in September that targets: all children aged 2 or 3 years on 31 August2025 primary school aged children (from Reception to Year 6) secondary school aged children (from Year 7 to Year 11) all children in clinical risk groups aged from 6 months to less than 18 years.
To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young peoples specific services and standards		Relaunch of TOWARD Project in Q1to ensure that paediatrics patients arrive in Sarum within 1 hour.	Andrea Robson/Liam Gondelle	Aug-25	On track	2 Paeds SHOs recruited to support them being seen quicker and improve 4 hour performance. Monthly paediatric meeting looking at tends monthly. IPC Sarum respiratory pathway – This is to be added as an appendices to our escalation policy . Review current escalation policy – still meets our needs - ? no amendments needed . Communication Sarum / Children's ED ,2 recent examples to be discussed where communication could be improved CED Band 7's looking at checking of O2 cylinders at the end of the day shift CED core nursing staff group within paediatric area.
Medicine Winter Plan	Medicine	Roles and responsibilities of Silver,Site and MOD	Helen Benfield Laura Osman	Sep-25	On track	First meeting held. Second meeting planned for to review actions
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		Frailty Pathways Front door frailty assessment and community support	James Lee	Sep-25	On track	Recruitment of ACPs - interviews August. Likley 2 trainees and 1 fully qualified. More presence in ED as a result. Reporting to Urgent Csre Board
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		Flow Improvements Same Day Emergency Care (SDEC) discharge lounge utilisation	DMT	Nov-25	On track	SDEC expansion from November to 8 pm weekdays and weekend cover for both Sat/Sun, 6 hours per day. Direct streaming from ED work in progress
Facilities Winter Plan	Corporate	4x4 on lease Dec to Mar	Anja Richardson/Ian Robinson	Sep-25	On track	Met with Ian R 30/7 and confirmed that EPRR to check budget and organis

12. Bed closures & No criteria to reside (NCTR)

Salisbury NHS Foundation Trust

In principle there are more opportunities to close further beds if NCTR fall to planned levels, as the Trust has managed to close existing beds despite NCTR being on average at 19.5% bed occupancy compared to the planned 9%. The focus on ensuring SDEC is no longer part of the Trust escalation bed plan has helped reduce LoS further allowing the Trust to push closure of beds. There were **30 beds** associated with a reduction in NCTR which would provide minimum of an additional **40 wte reduction and £150k per** month saving should they be realised this year.

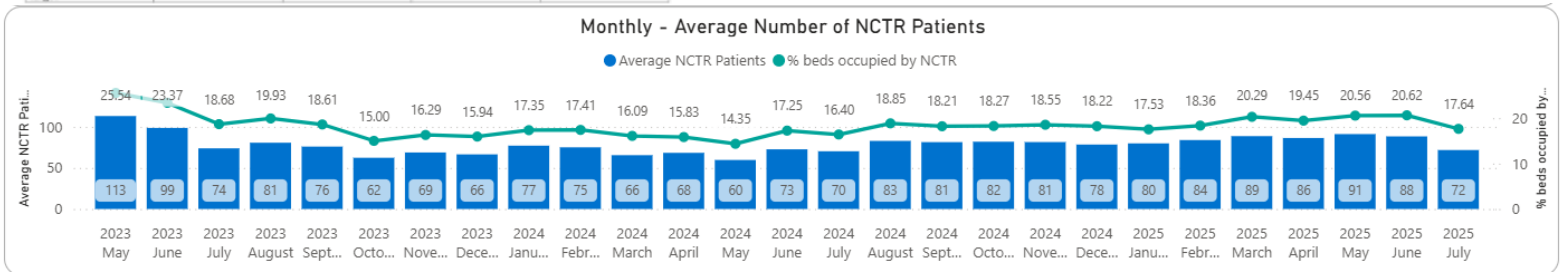
Wiltshire have been working with SFT has a system to address reductions in NCTR processes and pathways and have set pathway trajectories for improvement during June and July as outlined in the table below. The Trust currently has the highest time between Discharge Ready Date and discharge within the region, with 20% of patients taking over 21 days for their discharge.

BSW Locality Plans – NCTR Tolerance Mapping against Bed Reduction Plan

Provider/NCTR tolerance	To Date	June	July	August
Acute Reduction Plan				
GWH	11	8	0	12
RUH	4	4	22	0
SFT	0	0	24	16
Total	**15**	**12**	**46**	**28**
NCTR locality total tolerance (BSW)				
GWH		44 (39)	44 (39)	44 (39)
RUH		40 (34)	40(34)	40 (34)
SFT		41(31)	41(31)	41(31)
Total	**145**	**125 (104)**	**85 (104)**	**85 (104)**
Wiltshire NCTR tolerance target	109 (baseline)	Week 1 90 Week 2 80 Week 3 75 Week 4 70	68	68
BANES NCTR tolerance target	10	10	10	10
Swindon NCTR tolerance target	26	26	26	26

There are weekly target rates to achieve being monitored through the Wiltshire locality meeting, the actions include:

- Setting weekly tolerance limits for Wiltshire patients to ensure focus for all partners in NCTR pathway
- Launch of Wiltshire home is best programme on 30th June with multi agency operational engine room for oversight with focus on
    - Revised escalation process for SFT patients
    - Setting NCTR tolerance levels for non BSW patients
    - Pathway 3 worksteam on self funders
- Developing contingency plans for NC2R – focusing on bridging pathway 1, so pts in their own home whilst interface process takes place



13. NCTR Contingency plan...

Salisbury NHS Foundation Trust

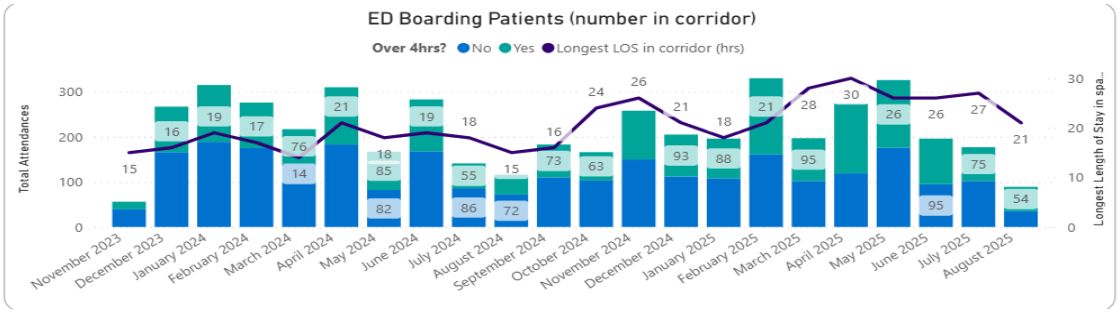
If NCTR remains high (above 9%), system partners are reviewing other options to support early discharge.

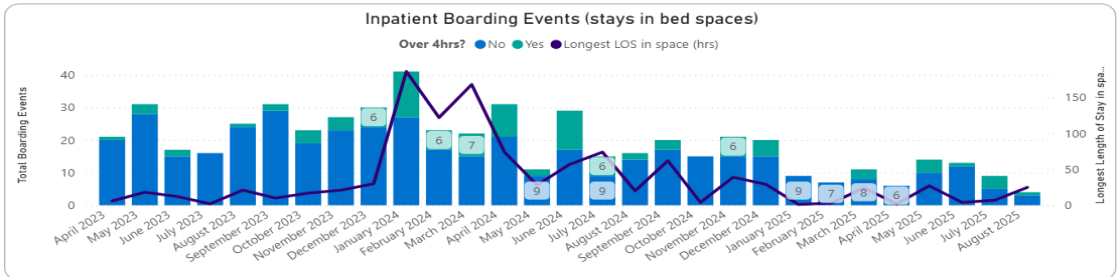
Proposal so far to support Pathway 1:

- 2 x qualified OT (discharge 20 patients per week)
- Cover a radius that include Wiltshire, Dorset and Hampshire patients
- Focus on proactive discharge, early identification for Medicine, Surgery and Orthopaedics. Work closely with DANA team
- Potential to bridge and handback care after 2 weeks to community providers.
- Seek support from NHS Volunteers services to support delivery of equipment, inputting of lifelines etc.

Paper to be submitted for review with costs by 29th August.

14. Management of Temporary Escalation Spaces





The use of TES spaces has remained below the mean since Jan 2025 for ward areas. Many areas used for escalation have been removed within the Trust Capacity Escalation Plan throughout 2025 and previously included Interventional Radiology, Surgical and Medical SDEC, ED Corridor space.

Since the closure of Tisbury ward in July the occurrence of use for TES spaces has reduced but with limited capacity to escalate, continued high numbers of patients with NCTR and high demand, some temporary boarding spaces in ward areas have been used in extremis to alleviate offloading of ambulances in ED.

Changes were made in earlier in 2025 so that patients no longer reside in corridors and have a dedicated escalation space if required. The Trust Escalation plan has been adapted to incorporate this. The aim to reduce NCTR and LOS will see the eradication of TES use altogether.

Intent is to eliminate but there will be a plan to use if needed. This can be found in SFT Bed Capacity Plan July 25

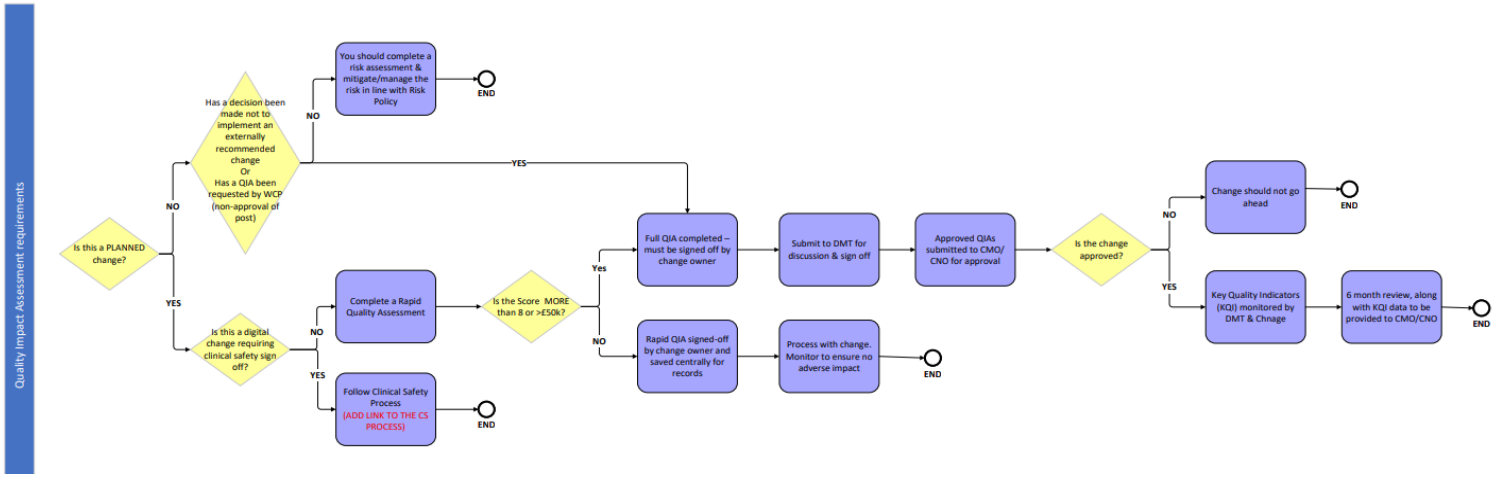
15. Risks and mitigations

NHS Salisbury NHS Foundation Trust

Anticipated risk	Mitigation
Demand higher than planned	• Direct access to SDEC pathways and bypass of ED. • Expansion of Medical SDEC in Sept • Expansion of Frailty team (ACPs) in ED and SDEC prior to Winter • DSU 23 hour unit to support right patient, right place and effective utilisation of beds
LoS and Flow	• Continue to work being done to get patients in the right place first time supports this. • Ward processes work to continue but further focus on BAU – consideration for separate UEC workstream • Steaming at the front door and pathway streaming to assessment areas is vital.
NCTR escalation and P1 pathway capacity.	• Work at system level to ensure enough funding and capacity in place to support P1 discharges. Joint proposals being developed in ESD. • Prevention of deconditioning A3 in Medicine to support optimised function and reduced LOS • Electronic D2A gone live to support quality of referrals • SRO in place for CTH. Work underway in Home is best programme to support P3 pathways • IDS team 7 day working. Staff recruited to support going into winter • New escalation process in place for delays in NCTR
Weekend working	• Discharge registrar shift for medicine at weekends in place. • Services moving to 7 day working with expansion - SDEC
Infectious disease outbreak (C19,Flu,Noro) increasing the need for protected bed capacity.	• Robust vaccination programme (Flu and C19) planned for staff commencing Oct. • Local IPC plans all up to date.
Demand for mental health services across adults and children.	• Demand continues to be a challenge. • Clear escalation process in place. • Access to acute and crisis beds remains a concern and contributes to the LoS experienced by patients in acute beds.
Use of TES spaces	• Reliance on SDEC pathways being in place • Ward processes work and BAU workstreams to support early flow • Requires all the above mitigations to take place to prevent use

Salsibury NHS Foundation Trust

Quality Impact Assessment Process



All PLANNED changes require a quality impact assessment. If the change has not yet taken place and can be assessed BEFORE being implemented it should follow the planned flow process above. A risk assessment should be used when the change has already happened (e.g. unexpected change) and then a risk assessment should be used.

* Business cases which set out a change to a service should include a QIA as part of the business case pack (monitored via Trust Investment Group)

If you need an assistance in completing your QIA please con sft.transformationandinformatics@nhs.net

Quality Impact Assessment (QIA) Guidance

Purpose

QIAs should be carried out on all **planned** changes to services as service redesign. QIAs impacting on the workforce or the way services are delivered will always require a QIA. Where the **Workforce Control Panel** does not approve a new or replacement post - a QIA may be requested if the service make a case that this would have a detrimental impact on patient or staff safety, patient or staff experience, clinical effectiveness or a significant impact on retention or morale which may impact on safe and effective service delivery. Where the Trust make a conscious decision **not to implement a national recommendation** - a full QIA will be required to assess the impact of that decision and to set out how this will be mitigated. Completion of the QIA (and the gathering of any key quality indicators monitored during mitigation) will offer an opportunity for services to use this data for any investment business cases which may be requested as part of working towards meeting national recommendations. Where a digital change requires a full Clinical Safety Report and CSO sign off - this will replace the need for a QIA - but a CSO report will still require sign off via CMB.

The aim of the QIA is to i) assess the change in advance to ensure it does not have an adverse impact on quality of care and that any risks can be mitigated and ii) identify outcomes, processes or balancing measures for ongoing monitoring iii) assess any impact on the workforce which might affect staff experience, effectiveness, moral or retention; iv) assess the impact of not implementing a recommended change due to feasibility or cost and offer a mitigation plan. It also provides the opportunity to stop the change **before** it takes place is the risk if deemed too high or invest in a change if the risk of doing nothing is deemed to high.

Scope

The impact assessment is to be completed prior to a change being initiated.
All planned changes **must have a rapid quality assessment completed. Those which are of high value (>£50k) or have a risk score of 8 or above require a full QIA. Changes which affect the workforce or the way the service is delivered will always require a full QIA.**

Completing the QIA

For each planned change an assessment should be carried out against the domains of patient or staff safety, patient or staff experience, clinical effectiveness and workforce impact based on the current position i.e. does it make the position better or worse based on the current position. You should also consider any potential impact on other services, including the wider health and social care system.
The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). Where projects have a positive impact only and no potential risks have been identified this should be stated in the narrative.
Business cases which set out a change to services, or service development, should include a QIA as part of the business case pack to Trust Investment Group.

Risk Identification
Use the Risk Matrix on the Scoring tab to assess the risk score and identify the mitigating actions you will put in place against **each** risk you
Risks identified from the QIA must be entered in appropriate Risk Registers, including the project risk register.

Risk Management
Action to be taken following identification of QIA risk score:

Consequence		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
1	Negligible	1	2	3	4	5
2	Minor	2	4	6	8	10
3	Serious	3	6	9	12	15
4	Major	4	8	12	16	20
5	Catastrophic	5	10	15	20	25

Low risk Green 1-3	Moderate risk Yellow 4-6	Significant risk Orange 8-12	High risk Red 15-25

Key Quality Indicators & Monitoring

Full QIAs should include the Key Quality Indicators (KQIs) which you will **actively monitor** after the change has taken place to ensure the mitigations you had planned, and are deploying, are working. Plans should identify an indicator that can be used to monitor performance so any potential quality concerns can be identified and addressed early. Where a QIA is being completed where a **vacancy or new post has not been approved**; or **where a recommended change has not been made to a service** - the Key Quality Indictors should set out how you are going to monitor any identified risk so that this can be escalated should this need review at a later date.
In choosing a measurable, it may be helpful to think:
• Consider a measure that will allow you to monitor the change; monitor the impact of not making a recommended change; monitor the impact of not filling a vacancy - how will you know if your mitigation is working?
• Consider measures from your existing performance dashboards which will give an early warning of any unintended negative consequence, e.g. infection rate, readmission rate, LOS, patient complaints
• Consider whether the data readily available so that it can be collected easily

Scoring

Score each risk which you have identified separetely. You **do not** need to add the risk scores together. Once complete select the highest scored risk and this is the risk score of your change.

Approval & Monitoring

It is the responsibility of the change owner to complete the QIA. These are not the responsibility of Divisional Management Teams. Once complete, rapid assessments should be shared for information with your Divisional Management Team or Project Board and saved where they can be called up during a QIA audit. No further action is needed.
All full QIAs must be approved by the Divisional Head of Nursing/Clinical Director and then reviewed by the Chief Nursing Officer and Chief Medical Officer. Clinical Management Board will assume the role of the QIA review panel and these will be reviewed when a QIA arises. QIAs should be submitted for sign off to **sft.transformationandinformatics@nhs.net** . QIAs must be signed by your DMT clinical leaders or the SRO of the project **before** submission for final approval. On an annual basis CMB will report QIA approvals and risks to Clinical Governance Committee. Any concerns arising from QIAs discussed at CMB will be escalated on a case by case basis. Signed off QIAs for CMB should be sent to **rebecca.hawtin@nhs.net**

Legal Requirement

Section 242(1B) of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007 (LGPIH Act) came into force on 3 November 2008. It is still in force and provides that :
Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information or in other ways) in
(a) The planning of the provision of those services
(b) The development and consideration of proposals for changes in the way those services are provided
(c) Decisions to be made by that body affecting the operation of those services.
Subsections (b) and (c) need only be observed if the proposals would have an impact on:
- The manner in which the services are delivered to users of those services or
- The range of health services available to those users.

The duty to involve users or potential users under 242(B) is a legal requirement whether an OSC is consulted or not. The legal duty falls both on the commissioners of health services and onto those providing services, including FTs and private providers.

Salisbury Foundation NHS Trust

Likelihood		Consequence				
		Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Certain	5	5	10	15	20	25
Key:		Low Risk 1-3		Moderate Risk 4-6	High Risk 8-12	Extreme Risk 15-25

Domain	None	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. e.g. bruise or graze	Minor injury or illness, requiring minor intervention i.e. first aid	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity/disability	Incident leading to death
	No time off work	Requiring time off work for <3 days.	Requiring time off work for 4-14 days	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
	Pressure damage present on admission	Increase in length of hospital stay by 1-3 days	Increase in length of hospital stay by 4-15 days	Increase in length of hospital stay by >15 days	An event which impacts on a large number of patients
		Grade 1/2 pressure damage – hospital acquired.	RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	DUTY OF CANDOUR APPLIES FOR THESE INCIDENTS
			An event which impacts on a small number of patients	Grade 4 pressure damage – hospital acquired.	
			Grade 3 pressure damage – hospital acquired.	DUTY OF CANDOUR APPLIES FOR THESE INCIDENTS	
			DUTY OF CANDOUR APPLIES FOR THESE INCIDENTS		
Security	Verbal abuse +/- aggressive gestures	Staff physical assault but no injury	Staff physical assault causing injury	Staff physcal assault causing significant injury	Significant harm caused to multiple people +/- fatality of staff / patient / visitor
	Disruption requiring security guard attendance but no action.	Disruptive patient requiring prn low level sedation	Disruptive patient requiring mechanical restraint +/- full sedation / rapid tranquilisation	Security incident involving relocation of patients to another location e.g. bomb hoax	Security incident resulting in multiple causalities / death
		Security incident requiring isolation of individual causing disruption and security guard attendance for action/intervention	Security incident requiring isolation of individual causing disruption and physical protection of other patients		
Quality / complaints / audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/inquiry	Formal complaint (stage 1)	Formal complaint (stage 2) complaint	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
		Local resolution	Local resolution (with potential to go to independent review)	Low performance rating	Inquest/ombudsman inquiry
		Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
		Minor implications for patient safety if unresolved	Major patient safety implications if findings are not acted on		
		Reduced performance rating if unresolved			
Adverse Publicity/Reputation	Rumours	Local media coverage - short-term reduction in public confidence	Local media coverage –	National media coverage with <3 days service well below reasonable public expectation. MP concerned (questions in the House)	
			long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	
	Potential for public concern	Elements of public expectation not being met			Total loss of public confidence
Service/business interruption Environmental impact	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of core service or facility
	Minimal or no impact on the environment / service delivery	Minor impact on environment / service delivery	Moderate impact on environment / service delivery	Major impact on environment / service delivery	Catastrophic impact on environment / service delivery
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
		Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Failure to meet specification/ slippage
				Purchasers failing to pay on time	Loss of contract / payment by results
					Claim(s) >£1 million
Statutory duty / inspections / audit	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation	Single breech in statutory duty	Enforcement action	Multiple breeches in statutory duty
		Reduced performance rating if unresolved	Challenging external recommendations/ improvement notice	Multiple breeches in statutory duty	Prosecution
				Improvement notices	Complete systems change required
				Low performance rating	Zero performance rating
				Critical report	Severely critical report
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
			Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
			Low staff morale	Loss of key staff	Loss of several key staff
			Poor staff attendance for mandatory/key training	Very low staff morale	No staff attending mandatory training /key training on an ongoing basis
				No staff attending mandatory/ key training	
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5% over project budget	5–10% over project budget	10–25% over project budget	Incident leading >25 per cent over project budget
	Minor reduction in quality/scope	Schedule slippage	Schedule slippage	Schedule slippage	Schedule slippage
		Minor reduction in quality/scope	Reduction in quality/scope	Key objectives not met	Key objectives not met
			Reputation risk at local/regional/network level	Reputation risk with commissioners which may incur penalties	Reputation risk at national level (CQC)

Score	Descriptor	Description
1	Rare	Do not believe this event will happen again except only in exceptional circumstances e.g. once a decade, or a probability of <1%
2	Unlikely	Do not expect the event to happen again but it is a possibility e.g. once a year or a probability of 1-5%
3	Possible	The event may re occur occasionally e.g. at least once a month, or a probability of 6-20%
4	Likely	The event will probably re occur e.g. at least once a week or a probability of 21-50%
5	Certain	The event is likely to re occur on many occasions e.g. at least once a day or probability of >50%. More likely to occur than not.

Rapid Quality Impact Assessment (QIA)

Salsibury NHS Foundation Trust

insert name of project or change

Insert date of rapid QIA undertaken

Service Lead / Project Lead	Clinical Lead or Senior Responsible Officer (SRO)	Overall Description of the Project or Change being proposed OR Description of the vacancy or new post not approved by WCP OR Description of the recommended change or service model not being implemented	Projected Financial Savings (if applicable)
Insert name of Service /Project Lead (owner of the change)	Insert name of Clinical Lead or SRO	Insert 1-2 sentences outlining what the project or change is	insert projected financial saving and type e.g. cash releasing, efficiency, cost avoidance

Rapid Assessment	Yes	No
Is the proposed change or decision not to implement a recommended change going to impact on the workforce? *Where WCP have not approved a vacancy or new post - answer yes and complete a full QIA.		
Is the scheme going to impact on the way the service is delivered? *Where a decision has been made not to implement a national or recommended change - answer yes and complete a full QIA		
Is the financial benefit or investment required over £50k?		
Does the initial risk review score 8 or above ? (circle risk score on matrix to the right)		
If you answer YES to any of the questions above - or the risk score is 8 or more - you will need to complete a full QIA. [If you answer NO to the questions above and the risk score is less than 8 - then you can stop at this rapid assessment. This should be filed safely to be retireved during a QIA audit]		

Risk Score =

Consequence		Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
1	Negligible	1	2	3	4	5
2	Minor	2	4	6	8	10
3	Serious	3	6	9	12	15
4	Major	4	8	12	16	20
5	Catastrophic	5	10	15	20	25

Low risk Green 1-3	Moderate risk Yellow 4-6	Significant risk Orange 8-12	High risk Red 15-25

Does the project or change impact two or more organisations? *If yes a full QIA will also be required*	Insert Yes or No	Please provide further details

Rapid Assessment Sign-Off	Signature *(e-signatures accepted if supported by e-trail)*	Date
Service/ Project Lead Sign-Off	insert name and signature	dd/mm/yyyy
Divisional Head of Nursing /Clinical Director/ Senior Responsible Officer Sign-Off	insert name and signature	dd/mm/yyyy

Divisional Managmeent Teams should save Rapid QIAs in a central place so that these can be provided as part of any routine audits.

Salisbury NHS Foundation Trust

Full Quality Impact Assessment (QIA)

Date of Initial Assessment:	21/08/2025
Next Review Due By:	30/09/2025

Division:	Trustwide
Speciality:	Trustwide
Title of planned change OR: Name of scheme, QI project approved by WCP QIP, Description of national change or recommendation not being made for which a quality assessment is needed and the reason for not implementing the change (e.g. cannot recruit, unaffordable model)	SFT Winter Plan 2025/26
Service or Project Lead:	Sarah Needle, DCOO and Stuart Henderson DCMO
Change or Project value if applicable:	N/A

Sign-Off	Signature (e-signatures accepted if supported by e-trail)	Date
Divisional Sign-Off	insert name and signature	dd/mm/yyyy
Chief Nurse Sign-Off	insert name and signature	dd/mm/yyyy
Medical Director Sign-Off	insert name and signature	dd/mm/yyyy

INDICATORS (Add more rows as required so each impact is individually stated)		Impact Details (include mitigation/control - do these measures address the risk?	SCORE EACH RISKS LISTED		
			Consequence	Likelihood	Score
Risks to Patient Safety or Staff Safety	**How will this planned change potentially impact the saftey of patients, staff or any other person? [If this change is not made/if this vacancy is not approved - what will be the impact on the safety of patients, staff or any other person?**	**Risks: There are a number actions within the winter plan that are focused on improving quality and safety. If we are unable to deliver projects that have a direct impact on demand and numbers of NCTR reductions prior to going into Winter, we will be faced with extended lengths of stay for patients, longer waits within the Emergency Department, potential increases in ambulance handover delays, impact to theatre recovery by increased use of outlier capacity. Vaccination programmes are also in place for staff and patients returning to care homes. Without the uptake of vaccinations there is a potential for more staff sickness and management of patients returning to care homes.**	**3**	**4**	**12**
		Mitigation: Winter plan actions to include streaming direct to SDECs, SDEC expansion, increased frailty services in ED. Improved ward processes to support earlier discharge. See the winter plans for further details. The workstreams are aligned with UEC workstreams already underway and each have individual QIAs.			
Risk to Clinical Effectiveness or staff effectiveness	**Have clinicians been involved in developing the planned change? Is there evidence to support the change (case studies, best partice, NICE guidelines etc.)? What will the impact be on helping people to stay well? What will the impact be on clinical workforce capability care and skills? What will the impact be on reducing variations in care? How will this impact on staff retention or ability to attract staff? [If this change is not made/if this vacany is not approved - how will clinical or staff effectivenss be affected?]**	**Risks: Clinicians are leading on many of the changes that are likely to support improvement. There is other work being led by division and corporate management teams. A data driven approach has been used in transformational work but other areas of work are based on the result of previous learning from winter. Delivering the actions within the winter plan will support, staff and relatives quality of service they provide and recieve.**	**3**	**4**	**12**
		Mitigation: Specific action areas on clinical effectiveness and staff effectiveness are included within the plan.			
Risk to Patient Experience or staff experience	**Consider healthcare environment, dignity and respect of patients, families and carers etc. waiting times, access to services, equality and diversity. What impact may this have on staff morale? [If this change is not made/if this vacancy is not approved - how will it impact on patient experience or staff experience?]**	**Risks: Delivery of the winter plan will enable proactive management and prevention of patients being inappropriately cared for in areas of escalation. The aim of the winter plan will be to provide care for patients in the right place, first time. This will also impact on staff and patients relatives.**	**3**	**4**	**12**
		Mitigation: Workstreams to support redirection of patients to the right place first time, including SDECs, and assessment areas. Prevention of delayed offloading through expansion of current services such as SDEC (medical and surgical), frailty assessment.			
Equality & Inclusion	**Consider whether the change affects one or more equality target group(s) in a different way to other groups? Could or do different equality groups have different needs in relation to the planned change? Does the planned change actually or potentially contribute to or hinder equality of opportunity? Does the planned change offer opportunities to promote equality & inclusion?** Equality Impact Assessment guidance and form (All planned changes should complete a more detailed Equality Impact Assessment at this link)	**Risks: the changes apply to all patients and staff groups to positively improve quality, safety and experience.**	**2**	**3**	**6**
		Mitigation:			
Overall risk score:	**12**	The overall risk score should be the highest scoring quality risk from above (e.g. 20 in this example). It does not require you to add up all the risk totals.			
QIAs with a score of >12 must be added to the Divisional Risk Register		**Datix reference:**			

Salisbury NHS Foundation Trust

Key Quality Indicators (KQIs) and Monitoring

Benefit for patients:	
Key Quality Indicators (KQIs): Ensure any quality indicator listed here is measurable and can be directly linked to the schemes performance. You will rely on this section when completing the 6 month review to be able to measure the impact the scheme has had.	(Detail any perfrormace measures or KPIs that will be used to monitor the impact of this scheme) Where WCP have not approved a vacancy or new post - include here the metrics you will use to provide data/evidence of any risk you have set out in the QIA. Where a decision has been made not to implement a recommended change set out the metrics here you will monitor to continually risk assess the impact of that decision
Interdependencies with/support required from other departments: e.g Other directorates/IT/HR etc.	(Provide overview and disccusion with other areas)
Discussed at DMT meeting:	dd/mm/yyyy
Name of meeting or Programme Board where this QIA will be monitored	Insert name of meeting or Programme Management Board
Date of meeting at which QIA will be formally reviewed:	dd/mm/yyyy

Salisbury NHS Foundation Trust

Approvals

Sign-Off	Name	Signature (e-signatures accepted if supported by e-trail)	Date
NON-PAY ONLY Approved by Clinical Sponsor:	insert name and designation:	insert signature	dd/mm/yyyy
Approved by CLINICAL DIRECTOR *or* EXECUTIVE LEAD for Facilities/Corporate Divisions:	insert name:	insert signature	dd/mm/yyyy
Approved by HEAD OF NURSING *or* HEAD OF DEPARTMENT for Facilities/Corporate Divisions:	insert name:	insert signature	dd/mm/yyyy
ONCE SIGNED ABOVE, PLEASE SEND BY EMAIL TO	sft.transformationandinformatics@nhs.net		
FOR COMPLETION BY THE CHIEF MEDICAL OFFICER AND CHIEF NURSING OFFICER			
If the CMO or CNO have any significant concerns regarding implementation this should be escalated for discussion to Execs prior to sign off			
Date of Execs meeting at which QIA was discussed: dd/mm/yyyy			
Approved by Chief Medical Officer:		insert signature	dd/mm/yyyy
Approved by Chief Nursing Officer		insert signature	dd/mm/yyyy
PLEASE RETURN TO:	sft.transformationandinformatics@nhs.net		

Salsibury NHS Foundation Trust

6 Month Review

6 MONTH POST IMPLEMENTATION REVIEW			
QIA was reviewed formally at the following meeting/s: *The purpose of the subsequent reviews is to ensure that proposed mitigating actions or other measures are put in place and are effective in managing risks.*			
Have the risks identified in the QIA been mitigated? Provide evidence against each KQI (Key Quality Indicator). *Reference the KQIs from the original quality impact assessment and describe the impact the scheme has had on them.*			
Have you identified any further risks or unintended adverse consequences of the implementation of this scheme? How will these be/were these managed? *What scheme amendments or other measures will you implement to mitigate this risks?*	**New Risk:** **New Mitigation:**		
A) What impact is this scheme having on the quality of service delivery? (i.e. Reducing, Improving or Maintaining Quality) *Please specify which aspect of your service has been affected.* **B) Do you consider this to be acceptable and sustainable?** (*Please give your reasoning)*	**DMT Recommendations:** *(e.g. continue/cease change etc)*		
Sign off	**Name**	**Signature**	**Date**
Approved by CLINICAL DIRECTOR or EXECUTIVE LEAD for Facilities/Corporate:	insert name:	insert signature	dd/mm/yyyy
Approved by HEAD OF NURSING or HEAD OF DEPARTMENT for Facilities/Corporate:	insert name:	insert signature	dd/mm/yyyy
FOR FURTHER SIGNATURES PLEASE SEND TO	sft.transformationandinformatics@nhs.net		
FOR COMPLETION BY THE CHIEF MEDICAL OFFICER AND CHIEF NURSING OFFICER			
Approved by CHIEF MEDICAL OFFICER	insert signature	dd/mm/yyyy	
Approved by CHIEF NURSING OFFICER	insert signature	dd/mm/yyyy	
PLEASE RETURN TO TRANSFORMATION TEAM	sft.transformationandinformatics@nhs.net		

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	To be presented at Executive Directors Meeting 26/8/25
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	To be presented at Executive Directors Meeting 26/8/25
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Various meetings to discuss winter plan with BSW. HC collating the Acute hospital winter plan
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	23/7 – regional event 2/8 – BSW event
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Niall Prosser, COO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	Part of recovery plan
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Part of recovery plan
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	Part of recovery plan

Provider CEO name	Date	Provider Chair name	Date

Provider:	Double click on the template header to add details

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Urgent_and_Emergency_Care_Plan_Reponse_Vaccinations_June_2025_SFT_V2.docx
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Trust undertook modelling as part of business planning – we are matching planned demand demand growth for admissions but above plan for ED activity. ICB undertaking furter work.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	SDEC expansion for Medicine from November Additional Surgical medical cover in place from Sept. Additional ACP cover in place from October for frailty front door support
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Work being undertaken by ICB and Acute Trust BI leads.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Modelled sufficient bed capacity to meet elective requirement.
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and	Yes	Policies relating to winter reviewed and available on the intranet

	are confident in the planned actions.		
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Schedule to be shared by FIT testing team. Currently compliance is uploaded to MLE and not ESR but this does provide a live picture.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Updated plan available on the intranet
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Work to support BAU and OPEL escalation to be added to UEC Board
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

Report to:	**Trust Board (Public)**	Agenda item:	**6.1**
Date of meeting:	**4th September 2025**		

Report tile:	**Freedom to Speak Up Annual Report 2024-25**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	Yes	**Yes**	**Yes**	
Approval Process: (where has this paper been reviewed and approved):	**This paper has been reviewed and approved at People & Culture Committee 26th June 2025**			
Prepared by:	**Elizabeth Swift – Freedom to Speak Up Guardian (presenting)**			
Executive Sponsor: (presenting)	**Ian Crowley, Chief People Officer**			

Recommendation:

The Board is asked to discuss and note this report.
Continue active support for FTSU initiatives and the People Promise Detriment Project.
Prioritise safe channels for ethnically diverse and disabled staff.
Ensure all Board members have completed 'Follow Up' training and participate in the Board Self-Reflection Toolkit by September 2025.

Executive Summary:

For information:

FTSU Annual Report 2024-25

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	✓
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	✓
Other (please describe):	

NHS Salisbury NHS Foundation Trust

What is Freedom to Speak Up?

In healthcare, Freedom to Speak Up is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviours or attitudes at work, or an idea which could improve processes or make things even better.

1 Purpose

1.1 To provide an annual overview of Freedom to Speak Up (FTSU) activity within Salisbury NHS Foundation Trust, including thematic analysis, national benchmarking, key risks (such as detriment), and improvement actions. The report aims to inform, assure, and seek continued strategic support from senior leadership.

2 Background and Strategic Context

The Freedom to Speak Up agenda, initiated in response to the Francis Report (2015), continues to be a central pillar in shaping an open and transparent NHS culture. The Trust remains committed to embedding the FTSU vision, aligned with strategic objectives around staff wellbeing, inclusion, and excellence in patient care.

The National Guardian's Office (NGO) plays a pivotal role in supporting Guardians and driving national consistency. Recent developments, such as the NGO's *Speak Up Review on Overseas-Trained Workers* (May 2025), reinforce the importance of intersectional barriers and the role of leadership in creating psychologically safe environments for speaking up.

3 National Guardian's Office

Our vision: that speaking up is business as usual in the healthcare sector in England.

Our mission: to improve workplace cultures, ensuring workers are confident to speak up, by providing expert support, guidance and challenge.

The National Guardian's Office (NGO) leads, trains, and supports a network of over 1,300 **Freedom to Speak Up Guardians** across NHS and independent sector organisations, hospices, and national bodies in England. These guardians offer an alternative route for workers to speak up when they feel unable to do so through other channels, or when their concerns have not been adequately addressed.

Speak Up Reviews are carried out to identify learning and drive improvements in the speaking up culture within the healthcare sector.

The Annual Report from the National Guardian's Office—now in its seventh edition—is a key commitment made by the government in response to the Gosport Independent Panel. To increase transparency, accountability, and support culture change, the government requested that the NGO produce an annual report to be laid before Parliament. In her foreword to the report, the Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health, Baroness Merron, said:
"There is more work to do to create a culture in which workers feel safe to speak up and where managers and senior leaders welcome speaking up and are ready to listen and act on what they hear. Despite this Guardians are continuing to provide vital support to workers across the NHS, hospices, and the independent sector and I am very grateful for their work.
"From the outset, this government has been clear: we will not tolerate NHS managers who silence whistleblowers. It is hugely important that to change the culture in the NHS, NHS staff have the confidence to speak out and come forward if they have concerns."

Last November, the Department of Health and Social Care launched a consultation on options for regulating NHS managers. This is a first step towards ensuring that the NHS has strong and effective leadership in place, and to help drive cultural change.

A Speak Up Review has been undertaken by the NGO to understand the speaking up experiences of overseas trained workers. Overseas-trained healthcare workers are reluctant to speak up about issues such as patient safety fearing it could lead to losing their right to work in the UK, according to the review published in May 2025.
Listening and learning: Amplifying the voices of overseas-trained workers, a review of the speaking up experiences of overseas-trained workers in England highlights the unique challenges faced by NHS workers trained outside the UK when speaking up.
Overseas-trained workers are a vital part of the NHS workforce. This review has been conducted to shed light on their experience, looking at the specific issues faced by overseas-trained workers in speaking up. The report also highlighting examples of good practice.
The review finds that overseas-trained workers experience additional barriers to speaking up compared to domestically trained colleagues.
To make it easier for overseas-trained workers to speak up, we are calling for action to:

- Ensure recruitment and retention guidance support speaking up
- Design speaking up arrangements that work for everyone
- Use better data to understand and improve experiences
- Build cultural competence and awareness to remove barriers to speaking up.

Sam Bereket, National Lead for Intelligence and Learning at the National Guardian's Office said: "Overseas-trained workers make a vital contribution to patient care. But too often, they face extra barriers to speaking up. If we want safer, more inclusive care, we must make sure every voice is heard. This review shows how leaders can take practical steps to make that happen."
The report draws on what we heard directly from more than 850 overseas-trained workers and 150 Freedom to Speak Up guardians through interviews, surveys and focus groups.

The recommendations in this review are being considered with colleagues from recruitment, EDI, HR and organisational development to form an action plan that will be shared with this Board in early 2026.
https://nationalguardian.org.uk/wp-content/uploads/2025/05/NGO-Overseas-trained-workers-report_May-2025.pdf

Other highlights over the 2024/25 period include:

- Requirements for recruiting and embedding Freedom to Speak Up Guardians, a framework for organisations and leaders has been published to apply consistency across roles and organisations. Here at SFT we meet all the recommendations in the framework:
https://nationalguardian.org.uk/wp-content/uploads/2025/05/NGO-recruitment-framework.pdf

4. Detriment –

In 23/24 national data submitted by Freedom to Speak Up guardians, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment as a result of speaking up.
It takes courage to speak up, and there are many barriers preventing workers from raising concerns. Those barriers range from fear about career impact, through to lack of confidence that anything will be done to address issues raised. It is therefore vitally important to clearly communicate how to raise concerns, what workers can expect if they do speak up, and how they will be protected from detrimental treatment as a result of speaking up.
Following a collaborative piece of work with Freedom to Speak Up guardians, Protect, and Andy Noble, Head of Speak Up at NatWest Group, detriment guidance has been published for all organisations, including the NHS.

The detriment guidance discusses the benefit of completing a detriment risk assessment. Protect has given Freedom to Speak Up Guardians access to its risk assessment which can support those responding to reports of detriment following speaking up.

The FTSUG at SFT is currently undertaking a dedicated People Promise project focused on detriment. This project aims to analyse its causes and effects, assess the current SFT position, and develop actionable

recommendations to minimize detriment for those who raise concerns. A key priority is the development of clear guidance and protocols to be followed when detriment is identified, thereby fostering a culture of psychological safety and encouraging colleagues to raise concerns without fear.

5 Freedom to Speak Up Guardian Activity – National and Regional Developments

5.1 National Overview

- NGO has published frameworks for recruiting Guardians and managing detriment.
- New guidance focuses on overseas-trained staff, identifying barriers and promoting culturally competent leadership.
- Speak Up Reviews offer actionable intelligence. The 2025 review involving over 850 overseas-trained staff highlights common fears around visa status and retaliation.

5.2 Regional Collaboration

- The FTSUG supports new Guardians regionally and co-develops strategies with Royal United Hospitals Bath and Great Western Hospitals partners.
- FTSUG provides ongoing mentorship to new and existing Guardians in the South West region.

5.3 Local work –

Triangulating Feedback: "We Are Safe and Healthy"

Throughout 2024/25, leads from Health and Safety, Employee Relations, Occupational Health, Wellbeing, Equality, Diversity and Inclusion (EDI), and Freedom to Speak Up (FTSU) have worked collaboratively to triangulate data and organisational intelligence. The aim is to enhance both patient and staff experiences through a more integrated understanding of concerns and cultural trends.

Care Quality Commission (CQC) Engagement

The Well-Led domain of the CQC Single Assessment Framework has placed greater emphasis on raising, responding to, and learning from concerns. The FTSUG continues to liaise with the local CQC team, offering assurance and contributing relevant insights.

Policy Development

A new universal Speak Up Policy was ratified and launched in January 2024, supported by a comprehensive communications plan and aligned to the Trust's FTSU strategy.

Training and Awareness

- **Speak Up Training**: Mandated from 1 April 2021, this training remains a requirement. Between 1 April 2024 and 31 March 2025, 1,024 staff completed the module.
- **Listen Up**: Targeted at line managers, this package is delivered via the Trust's leadership and management programmes.
- **Resident Doctors**: Raising Concerns training is embedded in their core programme.
- **Induction**: Over 1,000 staff received face-to-face training with the FTSUG, including through Trust Induction.

Organisational Development

In 2024/25, 442 staff received FTSU and Civility and Respect training as part of the Trust's leadership development programmes (Transformational, Aspiring, Rising Team Player, and Clinical Leadership). This compares to 144 attendees in 2023/24, with an additional 400 delegates scheduled for 2025/26.

Staff Induction – "My First 90 Days"

The Trust's induction event has been refreshed with an increased focus on staff wellbeing and support. The FTSUG regularly presents, promoting an open and compassionate culture from the outset of employment.

Education Engagement

In collaboration with the Director of Medical Education, the FTSUG meets with medical trainees across all levels, an initiative developed in response to the GMC survey. These sessions aim to support a positive and safe learning environment for doctors in training.

Promoting Speaking Up

- Contact details for the FTSU service are featured in Trust-wide bulletins, the intranet homepage, posters across the estate, and new digital screens.
- Six dedicated FTSU bulletins are issued annually by the Managing Director and Chief People Officer.
- All new staff receive wallet-sized cards with FTSU contact details.
- Targeted materials, including leaflets for student nurses, have been developed.
- Two staff stories have been presented to the Board, illustrating the impact and outcomes of speaking up.

Volunteers and Work Experience

FTSU guidance has been included in both the Volunteer and Work Experience Handbooks to ensure early awareness of the Trust's speaking up culture.

Listening Clinics

Out-of-hours listening clinics, co-facilitated by the Chief People Officer and FTSUG, provide staff with opportunities to share experiences and offer valuable insights. These clinics will continue into 2025/26.

Cross-Team Collaboration

The FTSUG maintains strong working relationships with People Business Partners, Divisional Management Teams, Risk, PALS, Occupational Health, Clinical Psychology, Litigation, Chaplaincy, Staff Side, the Guardian of Safe Working, and key staff networks. These collaborations support a consistent, healthy speak-up culture across the organisation.

FTSU Ambassadors

The Ambassador Network is fully compliant with National Guardian's Office guidance. Ambassadors come from diverse backgrounds, helping to reach underrepresented groups and promote the Trust's values. They have dedicated time to support colleagues in speaking up.

Cases and Trends

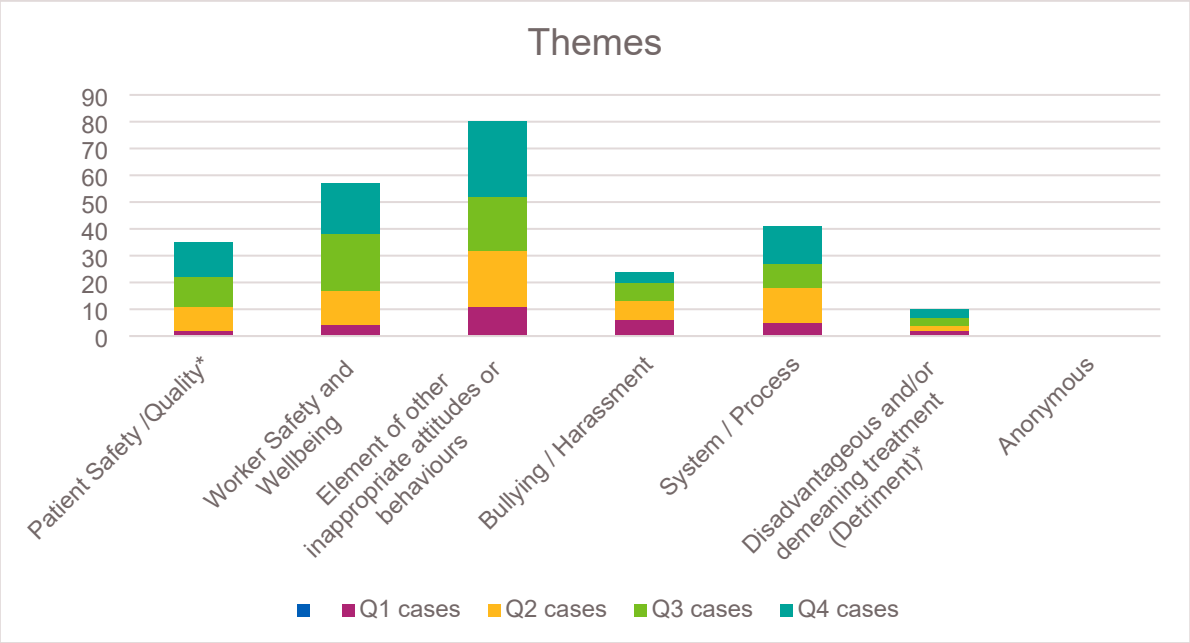
In 2024/25, 129 concerns were raised to the FTSUG—a 21% reduction from the previous year. Of these, 14% were from staff who subsequently left the organisation (up from 11% the prior year), highlighting the need for focused work on addressing detriment in 2025/26. Where appropriate, external investigations have been commissioned by the Executive Team.

6. Summary of Concerns 2024-25

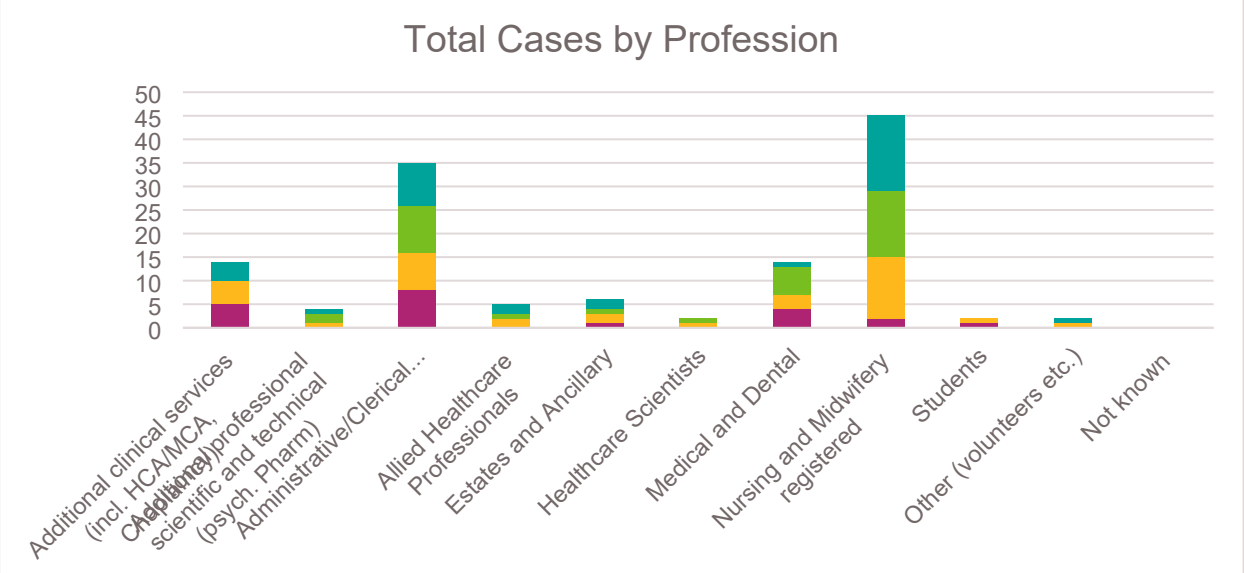
Salisbury NHS Foundation Trust

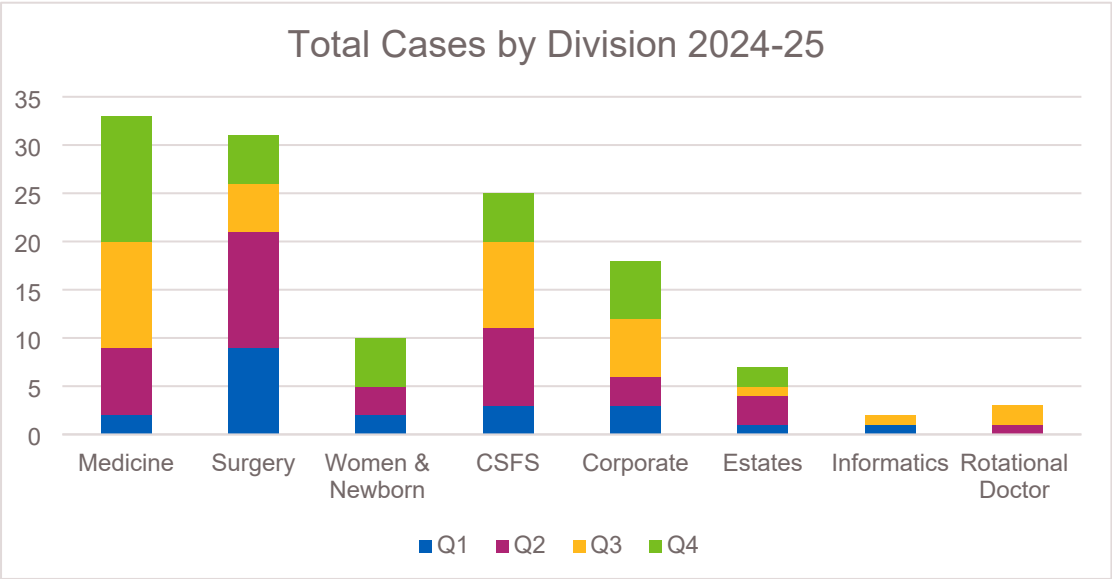
6.1 Annual data - summary of issues raised 1st April 2024 – 31st March 2025

During this period 129 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes and trends.



Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.





As we can see from the data, there are varying amounts of concerns being raised in the clinical divisions, with the Medicine Division being the highest and Women and Newborn the lowest, although this is to be expected as it is the smallest clinical division.

Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

Below are some examples of anonymised staff concerns capturing the complexities of some of the issues staff are raising:

Cases with an element of worker safety	• Staff safety concerns connected to sexual harassment • Staff reporting concerns about fear in relation to speaking up
Examples of patient safety concerns	• Staff feeling inadequately trained to treat patients with confidence • Poor working relationships having impact on patient care
Examples of bullying & harassment concerns	• Staff member had racial slur in front of entire team at meeting • Staff reporting public humiliation
Examples of system & process concerns	• Lack of clarity regarding fixed term contract, felt unfairly treated • Inappropriate redeployment with no regard for disclosed disability
Examples of cases with inappropriate attitudes or behaviours	• Lack of confidentiality in relation to personal details being inappropriately shared • After long career at SFT, now being made feel surplus to requirements

WRES data – during this period at SFT approximately 27% of the 5632 including bank staff, were from a Black, Asian or Minority Ethnic background. 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 FTSUG works closely with the Culture and Equity Staff Network to ensure that speaking up is promoted and 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 when it was 12%. The reinvigorated staff networks and wellbeing offers that have been introduced will give more support and guidance in the future.

14% of colleagues who raised a FTSU concern left the organisation.

Line Manager Competency and Behaviour-Related Concerns

A total of 53 concerns (49% of all concerns raised) involved issues related to line manager competency, behaviour, or both. This represents a decrease from the previous year, when such concerns accounted for 63% of the total. Of the 29 managers who raised concerns, 10 did so regarding their own line managers. Additionally, 20 concerns were identified as potentially resolvable through Human Resources, Employee Relations, Payroll, or Counter Fraud channels. In several instances, individuals had attempted to escalate these concerns through the appropriate channels but reported receiving no response.

7. Benchmarking

7.1 The national data is summarised below for 2017/18, 2018/19, 2019/20,2020/2021, 2021/2022, 2022/2023, 2023/2024 and 2024/25. There has been an 18.6% increase in the cases recorded from 2023/24.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Total cases	7,087	12,244	16,199	20,388	20,362	25,382	32,167	38,158
Element of Patient Safety/Quality	2,267	3,523	3,732	3,668	3,838	4,898	6,015	6,792
Worker Safety	No data	No data	No data	No data	2,757	6,953	10,390	14,171
Element of Bullying & Harassment	3,189	4,969	5,831	6,131	6,471	5,506	6,369	7,021
Inappropriate attitudes/behaviours	No data	No data	No data	No data	No data	7,621	12,384	15,130
Suffered Detriment	361	564	544	632	856	1,000	1,287	1,107
Anonymous	1,254	1,491	2,037	2,379	2,120	2,373	3,056	4,426

SFT data for the same period:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Total cases	28	21	85	105	89	134	163	129
Element of Patient Safety/Quality	16	11	44	43	36	37	52	35
Worker Safety	No data	No data	No data	No data	14	25	34	57
Inappropriate attitudes or behaviours						80	100	80
Element of Bullying & Harassment	9	12	60	49	37	24	25	24
Suffered Detriment	No data	No data	16	11	8	5	13	10
Anonymous	1	0	1	1	1	2	1	0

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, reflects the picture seen nationally.
- Nurses and midwives continue to be the staff group who raise the most concerns both nationally and locally closely followed by Administrative and Clerical.
- The Guardian has received no anonymous concerns.
- Inappropriate attitudes or behaviours is significantly higher than other themes.
- SFT reported 10 cases where there was a perception of negative treatment for speaking up.

Anonymous reporting is highlighted by the NGO as an indicator of staff potentially feeling a lack of trust in the organisation and a fear of detriment. SFT appears to be consistently reporting low numbers of anonymous FTSU concerns which indicates a level of trust in the FTSU service.

Comparisons in current cases:

Royal United Hospitals Bath	Salisbury NHSFT	Great Western Hospitals
122 (48 anon)	129 (0 anon)	58 (13 anon)

7.2 **Feedback -** Verbal and written feedback indicates varied experiences, from positive resolution to disillusionment when action was perceived as insufficient. Nonetheless, the lack of anonymous reporting and increased engagement in FTSU activities are promising indicators of a maturing culture. Below are a few examples:

"You are a star – I would definitely speak up again. The outcome is better than I could have hoped for."

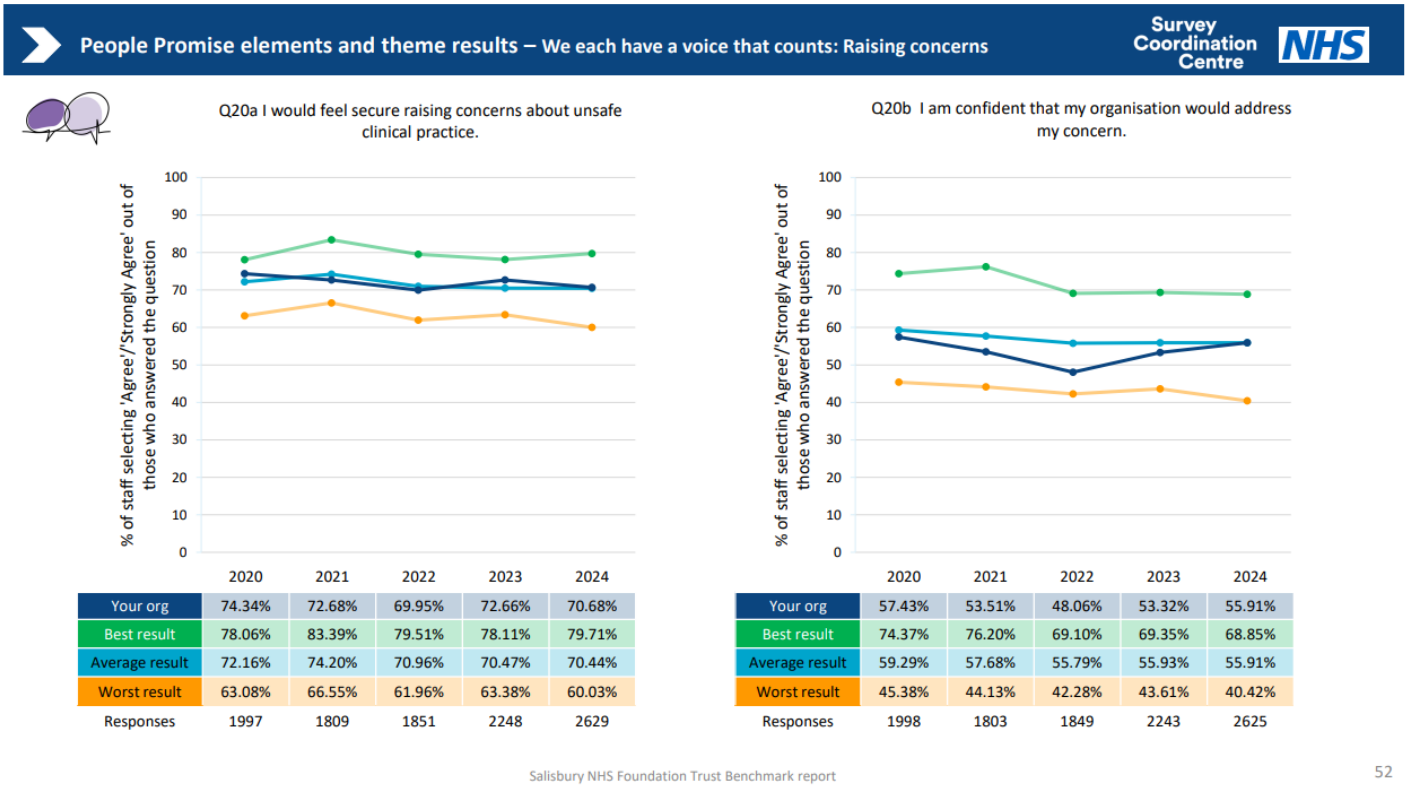
"Very friendly and reassuring. Would recommend others to speak up."

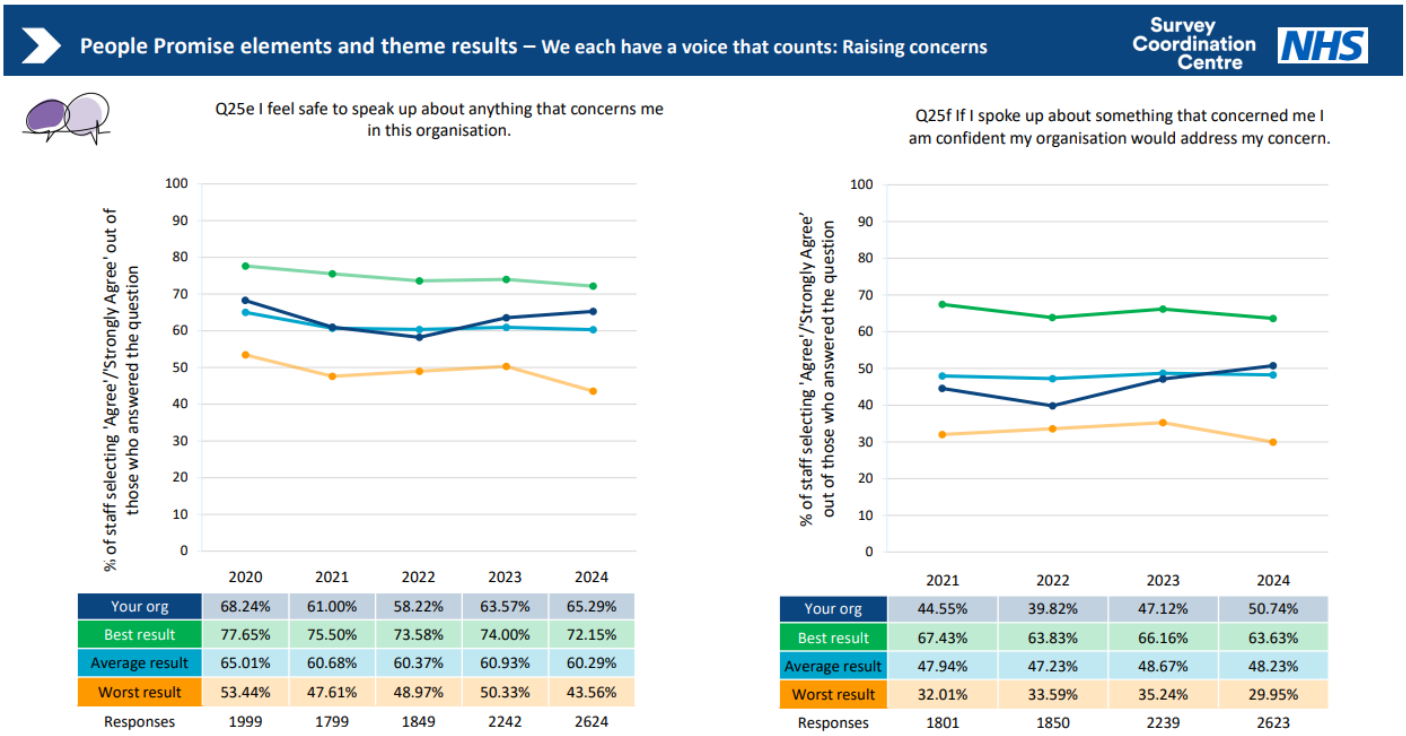
"I will just shut up and put up with how things are. If XX and XX say things are in place, then they must be. I have spoken up and will leave things there".

"Since I spoke up I can confirm that things are moving on well and that I am beginning to concentrate well at work and have better understanding of my daily tasks."

7.3 **NHS Staff Survey – SFT Results**

The staff survey results reflect the increase in staff feeling safe to raise concerns at SFT, although a slight drop in feeling secure about raising clinical concerns. There is also continued increase in staff feeling that concerns are being addressed when raised.





7.4 NHS People Promise – We each have a voice that counts.

The positive response reflected in the recent staff survey results demonstrates the effectiveness of the work undertaken by the FTSUG in collaboration with the wider OD&P team to advance this key element of the People Promise. Key actions included the refresh and publication of the FTSU Policy and Strategy, the implementation of a clear communications plan to promote the FTSU service, and the use of expert data triangulation to develop thematic analysis that informs targeted interventions. Additionally, close collaboration with staff networks helped identify and address barriers to speaking up. Collectively, these efforts have contributed to the significant improvement observed in the staff survey outcomes.

8.0 Summary of Learning from Speaking Up

The majority of concerns raised through the Freedom to Speak Up (FTSU) process during 2024/25 have resulted in meaningful learning and improvement across the Trust. Key themes and actions arising from these concerns include:

- **Secondments and Role Clarity**: Processes around secondment opportunities have been clarified to ensure equity, appropriate backfill, and clear delineation of responsibilities.
- **Retention Support**: Recognition of the need to support the employment prospects of spouses of international recruits, particularly in rural areas, to aid workforce retention.
- **Flexible Working**: Improved communication around the flexible working policy, with emphasis on aligning service needs with reasonable working patterns.
- **Ward Clerk Roles**: Enhanced clarity around responsibilities and expectations for Ward Clerks.
- **Support for Trainees**: Increased oversight and support for nurse-to-midwife trainees to ensure they are treated respectfully and not asked to work outside their scope.
- **Addressing Poor Behaviours**: Openness, visibility, and accountability of managers reinforced; disciplinary action taken where appropriate.
- **Cultural Reviews**: Organisational Development has initiated cultural reviews in areas where repeated concerns have been raised, with a focus on staff wellbeing and experience.
- **Reasonable Adjustments**: Occupational Health recommendations have been implemented following escalation, with support provided to empower line managers in making necessary adjustments.

- **Addressing Discrimination**: Instances of discriminatory behaviour have been addressed through targeted training and support for those affected.
- **Service Recovery**: Targeted divisional support provided to a clinical area facing significant staffing challenges, with preventative measures put in place.
- **Communication Lessons**: An incident involving poor communication from the Senior Leadership Team led to concerns about patient safety. Lessons have been captured to improve clarity and timeliness of communication going forward.
- **Pay and Contract Discrepancies**: Identified issues with pay and contract arrangements have been resolved, with process improvements introduced to prevent recurrence.
- **Behavioural Performance Management**: Action has been taken to address persistent unprofessional behaviour by a senior colleague, with performance management processes enacted.
- **Thematic Reviews**: The FTSUG continues to work closely with Divisions to identify trends and develop action plans based on raised concerns.
- **Fixed-Term Contract Expectations**: A case involving unrealistic expectations about contract renewal highlighted the need for open and honest communication with colleagues about employment status.

These improvements directly contribute to the Trust's goal of delivering an outstanding experience for every patient, every time, by fostering a culture of openness, learning, and continuous improvement.

Speaking up is about anything that gets in the way of delivering high quality care.

9.0 Summary

The Trust continues to make steady progress towards a robust, inclusive, and psychologically safe speaking-up culture. The reduction in cases this year may reflect multiple factors—including improved early resolution—but vigilance is required to ensure that reduced volume does not indicate suppressed voice.

Recommendations

- Note the annual report and its findings.
- Complete the FTSU Board Self-Reflection Toolkit by September 2025.
- Monitor progress of the People Promise Detriment project.
- Champion inclusive speaking-up channels, particularly for staff from minoritised backgrounds.
- Maintain Board-level visibility and accountability, ensuring leadership training and role modelling continue.

The author wishes to thank the Board for the continued support, scrutiny and awareness of our plans and their critical support in addressing the cultural changes and that appropriate resource is in place to enable.

Elizabeth Swift
Freedom to Speak Up Guardian

NHS Salisbury NHS Foundation Trust

Report to:	Trust Public Board	Agenda item:	6.2
Date of meeting:	4th September 2025		

Report title:	OD&P Directorate Annual Report FY 24/25			
Status:	Information	Discussion	Assurance	Approval
	Yes			Yes
Approval Process: (where has this paper been reviewed and approved):	OD&P Management Board 22nd July 2025 People and Culture Committee 31st July 2025			
Prepared by:	Ian Crowley, Deputy Chief People Officer			
Executive Sponsor: (presenting)	Ian Crowley, Deputy Chief People Officer			

Recommendation:

The Trust Board is requested to **approve** the OD&P Directorate Annual Report for FY 2024/25.

Executive Summary:

This report captures the work undertaken in the delivery of the Salisbury Foundation Trust people plan for FY 2024/25 and the impact that work has created. The people plan comprises one of the three pillars of the Trust's strategic planning framework.

This has been a challenging year shaped by financial pressures, increased demand for services and significant change with the formation of the BSW Hospitals Group and adjustment to ICS and NHSE structures. The impact of this change has been most keenly felt through a requirement to reduce spend to meet financial pressures, with a concomitant impact on staffing levels and funding available to support new workstreams and projects.

This report is split into two parts, the first celebrating the achievements of the directorate against the seven People Promise elements, and the second marking good progress against our Service Level Agreements, set in place to meet the expectations of Trust staff and deliver professional, effective people services.

SFT completed its 2-year spell as an NHSE sponsored People Promise Exemplar site and continues to plan and deliver improvement projects and activities supporting all seven elements of the People Promise. Throughout the year, 26 People Promise Projects were in progress, with every department in the OD&P directorate managing at least one project in addition to their routine activities.
In the 2024 NHS Staff Survey, SFT was rated as the 'most improved' acute trust for the second year running

and the highest of all acute trusts as the place where more staff look forward to coming into work. The Trust exceeded ambitions in terms of 'Morale' and 'We are always learning' and met all other ambitions, bringing them to above average in all 9 areas. As financial year 2025/2026 enters, SFT will refresh its ambitions and agree a 2-year workplan of People Promise projects.

The 'Business as Usual' work that makes up a significant amount of staff time in the directorate has been delivered effectively as described in section 3 of this report and evidenced by our successes against our key performance indicators. This work has tested our teams against our leadership behaviours of curiosity, perseverance, compassion and self-discipline, and it is pleasing to note that our teams have risen to the challenge and delivered an excellent service for the trust.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	X
Other (please describe):	N/a

Appendix:

1. OD&P Directorate Annual Report 2024/25.

Organisational Development and People Directorate

Annual Report 2024/25

'Supporting our **People** to make Salisbury NHS Foundation Trust the Best Place to Work'

1.0 Executive Summary

This report captures the work undertaken in the delivery of the Salisbury Foundation Trust people plan for FY 2024/25 and the impact that work has created. The people plan comprises one of the three pillars of the Trust's strategic planning framework.

This has been a challenging year shaped by financial pressures, increased demand for services and significant change with the formation of the BSW Hospitals Group and adjustment to ICS and NHSE structures. The impact of this change has been most keenly felt through a requirement to reduce spend to meet financial pressures, with a concomitant impact on staffing levels and funding available to support new workstreams and projects.

This report is split into two parts, the first celebrating the achievements of the directorate against the seven People Promise elements, and the second marking good progress against our Service Level Agreements, set in place to meet the expectations of Trust staff and deliver professional, effective people services.

SFT completed its 2-year spell as an NHSE sponsored People Promise Exemplar site and continues to plan and deliver improvement projects and activities supporting all seven elements of the People Promise. Throughout the year, 26 People Promise Projects were in progress, with every department in the OD&P directorate managing at least one project in addition to their routine activities.

In the 2024 NHS Staff Survey, SFT was rated as the 'most improved' acute trust for the second year running and the highest of all acute trusts as the place where more staff look forward to coming into work. The Trust exceeded ambitions in terms of 'Morale' and 'We are always learning' and met all other ambitions, bringing them to above average in all 9 areas. As financial year 2025/2026 enters, SFT will refresh its ambitions and agree a 2-year workplan of People Promise projects.

The 'Business as Usual' work that makes up a significant amount of staff time in the directorate has been delivered effectively as described in section 3 of this report and evidenced by our successes against our key performance indicators. This work has tested our teams against our leadership behaviours of curiosity, perseverance, compassion and self-discipline, and it is pleasing to note that our teams have risen to the challenge and delivered an excellent service for the trust.

2.0 Delivering the People Promise

2.1 **Introduction**. SFT completed its 2-year spell as an NHSE sponsored People Promise Exemplar site but has continued to plan and deliver a programme of improvement projects and activities that support all seven elements of the People Promise. Ambitions for each element were set at the start of the year and an action plan of improvement activity identified from Staff Survey response data to help us to reach these ambitions.

Throughout the year a total of 26 People Promise Projects were in progress, which are outlined in *figure 1* below.

People Promise Storyboard 2024-2026 (as at Jan 2025)

NHS Salisbury NHS Foundation Trust

Compassionate Leadership • Talent Management & Succession (NH/MW)	**Inclusion** • Internationally Educated Nurses (IEN) Development (High Impact Action 5) (HB) • Disability Confident (SG)	**Events** Tent Talks & Spring Lectures (CL/DR) Bhangra Night (HB/DR) A range of inclusion events (HB/SG) including: South Asian Heritage, Black History, Disability History, LGBTQ+ history and more	Nicola Howells
Employee Value Proposition • EVP (DR)	**Recognition** • Sox Review	**Events** Thank-you Week (DR) Christmas (DR)	Dave Roberts
Listening • Listening Report (DR) • Staff Council (DR)	**Widening Participation** • NHS Ambassadors and Work Experience (JJ) • Diversity of Volunteers (JJ) • NHS Cadets / Reservists / Care2Career/U18s (LB) • Coventry Partnership – Anchor Institution (LB/DR)	**Events** Open Day (DR)	Dave Roberts
Health and Wellbeing support • Refresh wellbeing offer against NHS baseline (HB) • Wellbeing activities (HB) • Physical Environment (IC) • Financial Wellbeing (HB)	**Health at Work** • SEQOHS (JR) • Violence and Aggression (TR) • Health Strategies (JR) • Health Intelligence data triangulation (IC)	**Events** Neurodiversity (HB) Menopause (HB)	Ian Crowley
Development • Safe Learning Charter (CM) • Coventry Partnership – Training (LB)	**Appraisals** • Uptake of appraisals (MR/NH)	**Events** Facilities Careers (CM/LB)	Nicola Howells
Work/Life Balance • Team Based Rostering (PM)	**Flexible Working** • Working group programme (PM) (contributing to the retention breakthrough objective)		Mark Robinson
Team working • My first 90 days Induction(LB)	**Line Management** • Licence to Manage (LW/JS)	**Events** ODP Conference (IC)	Nicola Howells

Figure 1: SFT People Promise Storyboard (as at Jan 2025)

Every department in the OD&P directorate manages at least one People Promise Project, with the overall programme expertly coordinated by the Widening Participation and People Promise Manager. Progress is monitored through Deputy Chief People Officer (DCPO) and Associate Director (AD) led working groups that report into the Chief People Officer (CPO) through the OD&P Management Board and then onto the People and Culture Committee. As a Trust wide programme, progress within the People Promise work is monitored through the Improving Together Engine Room, providing assurance to the Trust Executive team.

2.2 **People Promise Survey results.** The NHS Staff Survey provides an annual picture of how staff perceive their experiences at the Trust. In the 2024 NHS Staff Survey, SFT was rated as the 'most improved' acute trust for the second year running, and significantly also scored highest of all acute trusts as the place where more staff look forward to coming into work. The overall results are grouped by People Promise element in *figure 2* demonstrating that SFT was above the national average in all areas of our staff survey results, an excellent achievement.

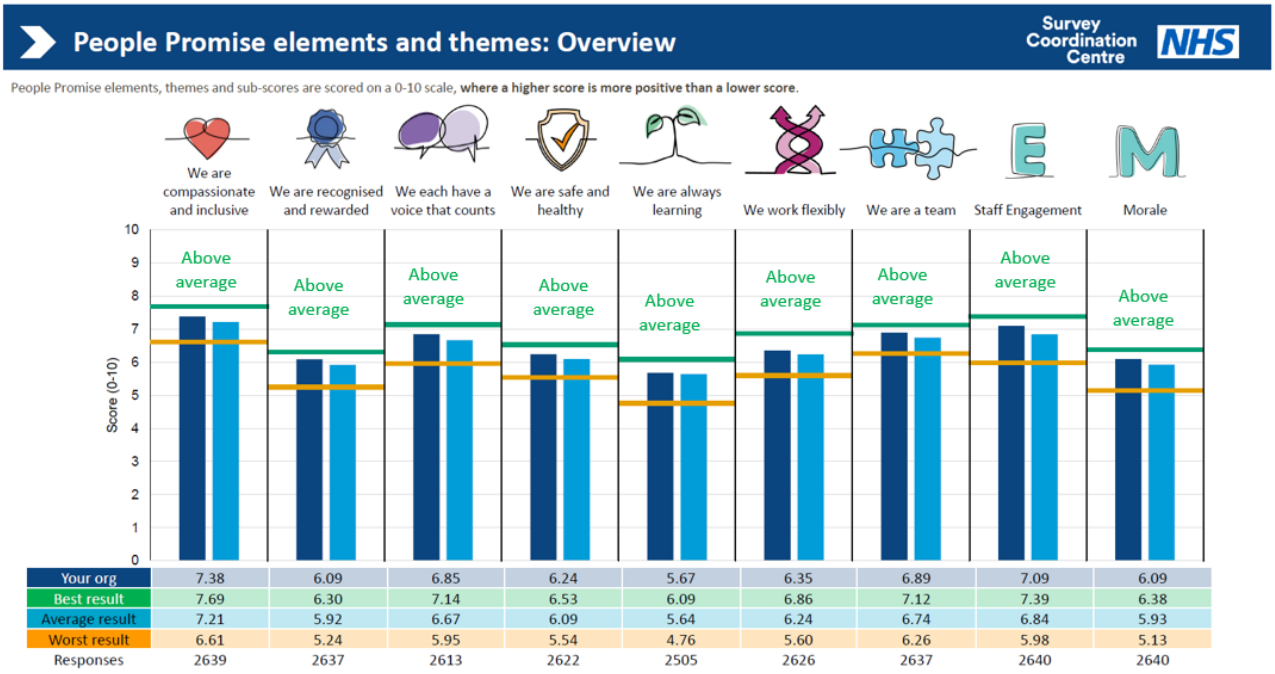


Figure 2: SFT 2024 Survey Results

Figure 3 outlines the ambitions we set for ourselves. We exceeded ambitions in relation to 'Morale' and 'We are always learning' and met all of our other ambitions, bringing us to above average in all 9 areas (compared to only one area in 2022 and 3 areas in 2023).

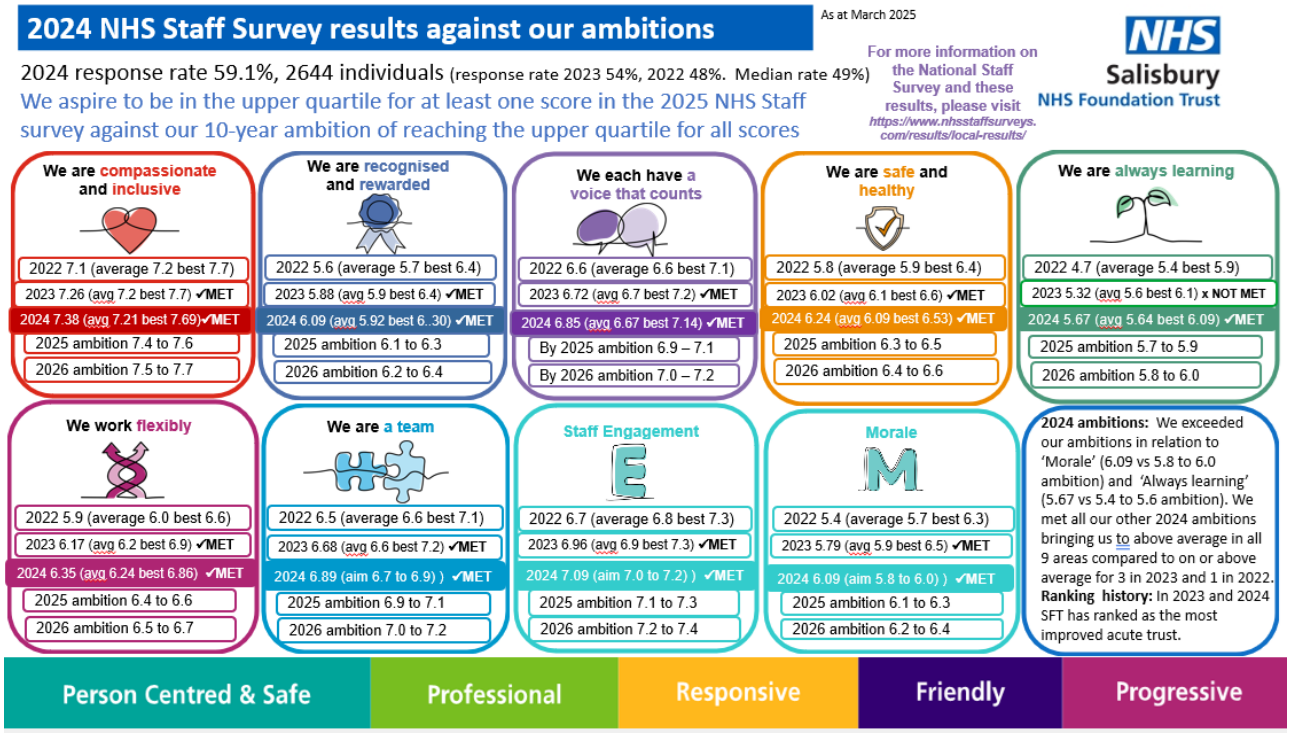


Figure 3: SFT People Promise Ambitions (as at March 2025)

Our performance against other trusts can be further analysed both in terms of how we rank in order/position (ie 1 to 123) and how close we are in terms of actual scores to the top 25%.

- We ranked in the upper quartile of trusts for 7 of the 9 areas, and upper half for the remainder. This far exceeds our ambition to reach at least one upper quartile ranking by 2025.

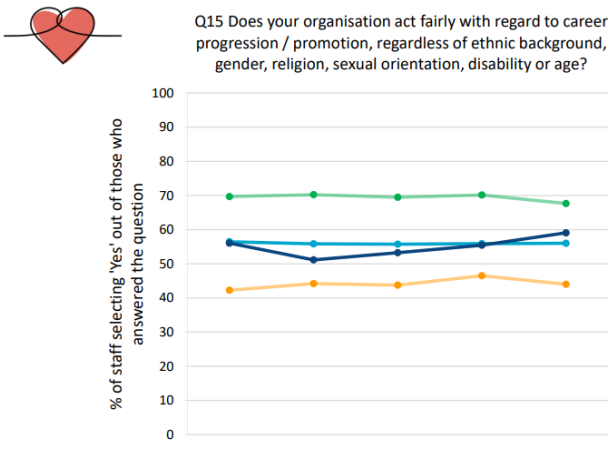
- ‘We are recognised and rewarded,’ ‘We are a team; and Engagement were within 0.03 points of the top 25% scores.

People Promise Area	Score Gap (to reach top 25% scores)	Ranking (out of 123 trusts)	Quartile
We are compassionate and inclusive	0.07	26th	✓ Upper quartile
We are recognised and rewarded	0.02	24th	✓ Upper quartile
We each have a voice that counts	0.06	23rd	✓ Upper quartile
We are safe and healthy	0.07	25th	✓ Upper quartile
We are always learning	0.20	56th	• Upper half
We work flexibly	0.20	37th	• Upper half
We are a team	0.03	27th	✓ Upper quartile
Staff engagement	0.03	18th	✓ Upper quartile
Morale	0.07	25th	✓ Upper quartile

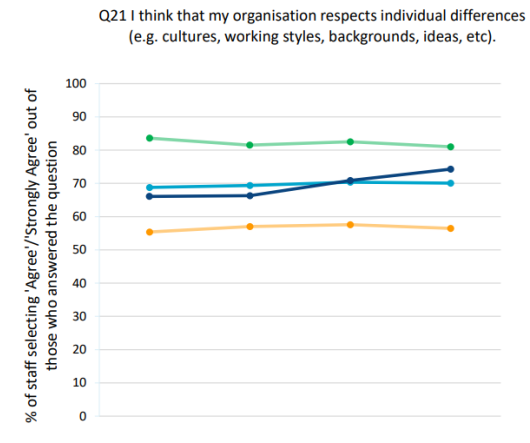
Figure 4: SFT People Promise Ranking (as at March 2025)

As we enter financial year 2025/2026 we will again refresh our ambitions and agree a 2-year workplan of People Promise projects.

2.3 **We are Compassionate and Inclusive.** Over the past year, we have continued to build a more compassionate and inclusive workplace. SFT is a vibrant, diverse Trust, with over 85 nationalities making up our workforce and we fully appreciate the contributions of our internationally trained colleagues. Global perspectives enrich our outlook, enhancing the care we provide to our local community. It was pleasing to note that our staff survey scores in relation to career progression and respect for individual differences both increased as a result of action plans to support these areas of concern. There remains further work to do, using our EDI Long Term Plan and analysis of 2024 results as our guide to prioritise resource and effort.



	2020	2021	2022	2023	2024
Your org	56.06%	51.15%	53.25%	55.43%	59.09%
Best result	69.72%	70.24%	69.47%	70.15%	67.66%
Average result	56.45%	55.88%	55.75%	55.91%	56.02%
Worst result	42.27%	44.21%	43.77%	46.52%	43.99%
Responses	2005	1805	1842	2241	2607



	2021	2022	2023	2024
Your org	66.07%	66.29%	70.89%	74.28%
Best result	83.61%	81.51%	82.55%	81.02%
Average result	68.79%	69.37%	70.37%	70.07%
Worst result	55.39%	57.03%	57.59%	56.47%
Responses	1812	1853	2249	2636

Figure 5: Staff Survey Scores for Career Progression and Respect for Individual Differences (as at March 2025)

Our seven staff networks[1] play an important role in amplifying diverse voices, advocating for their members and fostering a supportive environment in which everyone feels they belong. We actively promote these networks to ensure they can give a meaningful voice to their members and thus support the wider workforce. Our comprehensive calendar of inclusion and wellbeing activity enables regular updates and signposting to relevant information, advice and guidance on shared areas of interest via our Staff Access, Learning and Information (SALI) Intranet site.

The calendar also helps us raise awareness and celebrate significant events, including exhibitions in the Healthcare Library throughout the year. Some notable exhibitions covered LGBT History Month, Black History Month, Dementia Awareness, Women in the NHS, Men's Mental Health Awareness, Windrush, Stephen Lawrence Day, Neurodiversity Awareness, the History of Reggae, Diwali, Holi, and the cultural contribution of the Black LGBTQA+ community. Our first-ever Bhangra evening was a phenomenal success, demonstrating the incredible enthusiasm within our team. It was inspiring to see over 200 colleagues from all backgrounds wholeheartedly embrace the high-energy moves, creating a vibrant atmosphere and a true sense of community.

This commitment to celebrating our diverse workforce continued as we marked South Asian Heritage Month. The event was a vibrant showcase of inclusivity, with over 250 colleagues actively participating and enjoying a feast for the senses. From the delicious array of authentic food to powerful storytelling and dazzling cultural performances representing Bangladesh, India, Nepal, Pakistan, the Philippines, and Sri Lanka, it was a meaningful and joyful celebration of the rich contributions of our South Asian colleagues and the broader community.

Our Black History Month celebration featured impactful storytelling, notably "A Duty Calls: A Soldier's Wife, a Nurse's Journey," which shared a compelling tale of love overcoming distance and solitude. The event also explored the history and global impact of reggae music, complemented by a live African percussion performance that connected attendees to ancestral heritage. The day culminated in recognising the significant global contributions of the Black LGBTQ+ community to creative culture, literature, music, and the performing arts.

We have made steady progress against our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans. The 2024 staff survey questions relating to WRES and WDES metrics indicate that, with only one exception, all metrics show an improved experience for our BME and disabled colleagues since 2023. Importantly, we performed to, or better than the benchmarked average for comparable trusts across all 13 metrics. Although this is a welcome improvement, we do recognise that the gap in positive experience for our BME and disabled remains and requires continued focus through our action plans.

To enhance support for disabled colleagues, we updated our "Supporting People with Disabilities at Work" policy, launching a Health Passport to provide an effective tool for line managers to discuss staff needs in this key area. In Autumn 2024 we piloted neurodiversity awareness workshops and rolled them out from March 2025. Following good work from our EDI team, the Trust achieved validation as a Disability Confident Scheme Leader (Level 3) in Spring 2025, a nationally recognised accreditation. 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.

Our ongoing collaboration within the Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS) further demonstrates our commitment to promoting a compassionate and inclusive culture across the wider region. We look forward to increased collaboration with our BSW Hospitals Group partners in the coming months.

2.4 **We are a Team.** Over the past year, the Organisational Development and Leadership (OD&L) team has expanded its capacity. This growth has facilitated a comprehensive increase in

[1] Ability Confident, Armed Forces, Staff Carers, Men's Health, Multicultural, Pride Community, Women's Network

our leadership development offering, broader staff engagement and tangible cultural shifts aligned with SFT's strategic objectives. In 2024/25, this strategic investment allowed the Trust to more than triple participation in leadership development interventions—from 144 delegates in the previous year to 442. These programmes span a full spectrum of leadership levels, from those in starting their leadership career with small teams to senior managers and lead clinicians.

As illustrated in *Figure 5*, SFT has experienced measurable improvements in leadership culture since the introduction of these programmes in 2021, with the most significant uplift observed in the past year.

Question Area	2021	2022	2023	2024
Compassionate Leadership	6.69	6.74	6.92	7.19
Compassionate Culture	6.99	6.69	7.04	7.16
Development	6.07	6.08	6.39	6.55
Team Working	6.34	6.39	6.6	6.75
Line Manager	6.53	6.56	6.76	7.03
Motivation	6.95	6.96	7.17	7.25
Morale	5.48	5.43	5.79	6.09
Autonomy and Control	6.91	6.96	7.06	7.20

Figure 5: Staff Survey results for sub elements of 'We are Team

Figure 6 reinforces this trajectory, demonstrating a clear correlation between increased programme delivery and improved organisational outcomes.

Figure 6: Staff Survey average scores showing increases against leadership interventions

Our **Leadership Behaviours Framework (LBF)** remains central to the success of these programmes. In 2024/25, the LBF was actively socialised with 1,234 employees across the Trust and is now embedded into key processes such as recruitment, appraisals and 360° feedback mechanisms. These efforts have contributed to the development of a consistent leadership culture focused on delivering outstanding patient care.

Coaching as a Catalyst for Cultural Transformation. In 2024/25, the Trust supported 57 active internal coaching relationships, with a focus on critical development themes such as confidence-building, leadership transitions, career planning, and burnout mitigation. Notably, 28 of these coaching relationships originated through our leadership programme pathways, enhancing the application of formal learning into everyday leadership practice.

Following a successful pilot, coaching is now fully embedded in the leadership development pathway, with a projected 33% increase in uptake for the coming year. Engagement with the

internal coaching network remains strong, with an average return rate of 62% on bi-monthly activity reports. Key milestones in coaching capability development include:

- Onboarding of five new qualified coaches, with an additional 13 in the training pipeline.
- Introduction of two certified coaching supervisors, supporting cross-organisational supervision through the BSW Hospitals Group.
- Record participation in coaching skills training, with over 420 staff trained, exceeding annual KPI targets.

This investment in a skilled and ethical coaching community supports a deliberate cultural shift from traditional, hierarchical leadership models toward more transformational, people-centric leadership—reflected in improved outcomes in the 2024 Staff Survey.

Strengthening Management Capability. OD&L has significantly expanded its line management development offer, increasing the number of active workshops from 5 to 30. These sessions are designed to support managers at all levels, equipping them with the tools needed to thrive in their roles. This expansion has resulted in an 82.2% increase in attendance, reaching 911 participants in FY 2024/25. Moreover, this capability uplift has been accompanied by a 50% reduction in Freedom to Speak Up (FTSU) cases related to poor management behaviours, suggesting a measurable improvement in management effectiveness.

To ensure alignment with national priorities, the OD&L team has collaborated with NHSE and the Chartered Management Institute (CMI) to align offerings with the revised national Leadership and Management Framework.

Looking ahead to 2025/26, our **'Licence to Manage'** initiative will integrate existing development frameworks into a structured, certificated pathway. This approach ensures tailored, continuous professional development for managers—whether new to role, new to the organisation, or seasoned in their careers and just wanting to refresh their skills.

Targeted Team Support and Collaborative Development. OD&L has continued to offer bespoke support to teams experiencing considerable challenges. Preliminary data (*Figure 7*) from the 2023–2024 Staff Survey, Turnover and Sickness rates indicates that teams who actively engaged with OD&L interventions demonstrated statistically significant improvements across the seven People Promise-aligned metrics.

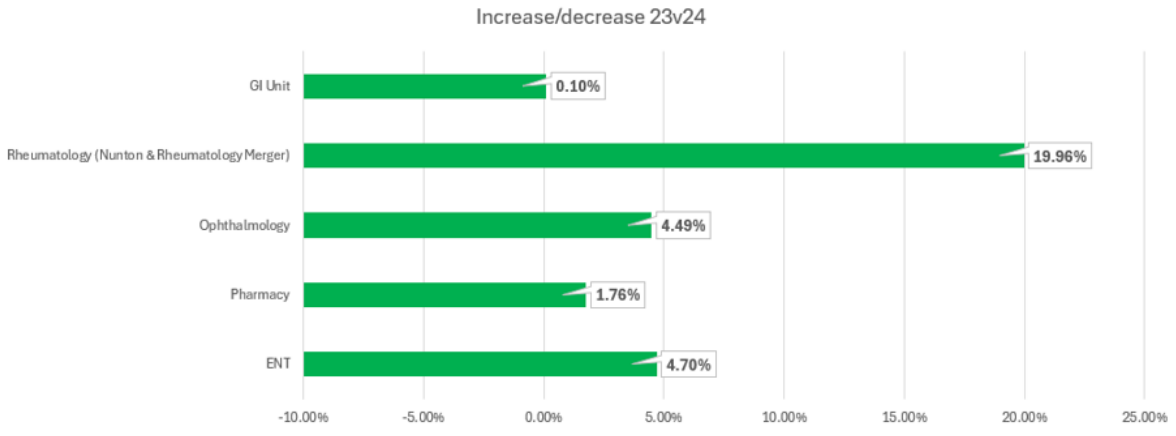


Figure 7: Change in Staff Survey Results 23-24 for services supported by OD&L Interventions

In parallel, OD&L has partnered with Coach House and the Transformation team to form the **Change Collaborative**—a joint initiative aimed at harmonising our collective expertise and driving an integrated organisational capability. OD&L also continues to provide developmental input into

the Improving Together programme, further embedding this methodology into our Transformational Leadership Programmes.

The OD&L team has delivered substantial, data-backed impact over the past year, driving improvements in leadership behaviour, management capability, and organisational culture. These efforts are directly aligned with the Trust's 3P's strategy and broader ambitions to deliver consistently outstanding care for patients and a supportive environment for staff. The strategic direction for 2025/26 will continue to build on these foundations, embedding sustainability, capability and continuous improvement at the core of our leadership and organisational development approach.

2.5 **We are Always Learning.** Having not met our ambitions last year, it was very pleasing to see our ambitions for the 'We are always Learning' element of the People Promise met, scoring a combined total of 5.67 against our ambition of 5.4 - 5.6. Much hard work has taken place to support delivery of education and training for our staff and we remain committed to the development of a highly skilled workforce.

This year SFT completed alignment to the **National Core Skills Training Framework** (CSTF). The key elements of this programme of work have included alignment of mandated training to a core e-learning programme and enabling an agreed process for new starters into the organisation to enable automated import of in-date Statutory and Mandatory Training (STATMAND) training, saving valuable staff time.
A new Mandatory Learning Oversight Group (MLOG), designed to monitor both core and locally mandated training has been established and we have also nominated subject matter experts to join "communities of practice" that will be led by new, nationally appointed SME's in each of the 11 core subject areas. These measures will ensure that we provide greater assurance of the quality and outcomes of the statutory and mandatory training delivered in the Trust and to prepare for the implementation of the NHS Digital Staff Passport when it is delivered.

Training interventions are delivered via our on-line Managed Learning Environment (MLE), LEARN. The system, provided by Kallidus has been used by the Trust for three years and provides an effective system for booking and delivery of e-training. This year significant issues were uncovered relating to the assurance of the quality of data held by the system, which necessitated a significant programme of work to make modifications to the reporting process and cleanse obsolete data held by the system. Contract renewal is due at the end of March 26 which should enable a procurement process to ascertain which is the best system suited to SFT in the medium term and whether there are collaborative opportunities available with the BSW Hospitals Group.

Through collaboration with our BSW colleagues we have continued to support the programme for delivery of the Oliver McGowan Learning Disabilities and Autism training and so far, have trained over 20% of staff at SFT. BSW has achieved one of the highest training outputs for this work and is set to receive continued funding from NHSE to maintain this provision for at least the next twelve months.

Additional training for **Continued Professional Development** (CPD) has 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 that traditionally have no access to the NHSE CPD funds. The table below (*Figure 8*) identifies the funding distributed and the numbers of staff who have accessed the funds. In total 622 clinical and non-clinical staff received funded support for training and development delivered by external trainers / providers. These numbers have built on the positive work of previous years and represent the biggest investment in training for a number of years.

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

Figure 8: Numbers of Staff accessing funded CPD courses.

SFT has again funded access to NHS ELECT for all staff. A national organisation, NHS ELECT helps individuals, teams and organisations in health and care to thrive and improve the quality of care they deliver. Through membership all staff can access a range of courses, webinars, training programmes and resources under the licence. Access is flexible and learning can range from bitesize webinars to longer courses which suit a wide cross section of our staff. Throughout the year nearly 300 staff took advantage of the training offers on the platform.

Apprenticeships. The apprenticeship levy is an alternative source of funding for training and development and is a significant element in the Trust's commitment to a sustainable workforce and our role as an anchor institution. The levy funds are allotted directly to training providers to deliver Apprenticeship Standards for our existing staff, potential new staff and can also be transferred to support local organisations that are non-levy contributors. Training providers 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 2023-24. In 2024/5 the Trust spent £621,054, which is a 2.1% increase of spend compared to last year. 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.

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) with 37 staff members having completed their apprenticeship in 2024-25.

Figure 9, below, identifies the uptake of apprenticeships, and the monies provided to support our apprentices from the national levy over the last 4 years.

	2021/2022	**2022/23**	**2023/24**	**2024-25**
Total Number of apprentices	153	143	160	165
Current Funds	£1,481,729.00	£1,575,253	£1,788,691	£2,077,075
Total Spent to Date	£1,265,125.39	£1,972,717.77	£2,513,451.77	£1,073,735
Total Spend in Year	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations	£579,197.20 Of which £71,377.58 (12.3%) 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

Figure 9: Apprenticeship spend at SFT FY 21/22 to FY 24-25.

Qualifications gained by SFT staff are wide ranging and not restricted to clinical positions, they 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.

Practice Education. Core clinical skills and targeted situational clinical event management is delivered through our Practice Education Team and clinical Simulation Team. During 2024 the Practice Education team delivered 126 training sessions with a capacity for 1644 staff. Of this 1086 places were used (66%) and 140 places (9%) were lost to staff who did not attend (DNA). Training

offers are subject to continuous development and the development of new courses of which the launch of a new, quarterly training session, Central Venous Access Devices (CVAD) training that comprised an e-learning package and study day was notable.

The team also supported 178 new Health Care Assistants (HCA) into the trust achieving an excellent 99% compliance rate for the care certificate. Fifty international nurses and 2 return-to-practice nurses were supported within the programme. In addition to this,15 staff members have been supported through the Legacy mentor's scheme.

The **Simulation Team** continue to provide a service for staff to practice care delivery, increasing individual confidence and building team performance to improve the delivery of safe patient care. The team support teaching and learning through simulation-based evaluation within our education centre and at the point of care. This year their capacity and breadth of training has been enhanced with the successful recruitment of a Simulation Practitioner and a Simulation Technician, bolstering operational resilience. Alongside their routine training delivery, the team have also:

- Designed, created and developed a simulated pharmacy within the department.
- Hosted the first National course 'Becoming Simulation Faculty' in the Southwest.
- Supported the creation of an educational video of caring for a child with a burn's injury, which was presented at a national conference.
- Developed a sharing site and network through TEAMS for all our simulation faculty.
- Developed a new system for storing data of training numbers and feedback and have a new request process in place.
- Reached agreement to re-launch "deteriorating patient" training under the licenced ALERT course provision for the Trust. Roll out is expected from August 2025 for ward leads, doctors in training, nurses/AHP's and HCA's.

The education team has also continued to provide high quality staff and learner support through the Dementia Training Team, the Manual Handling team and the Resuscitation Team.

Despite significant challenges driven by staff vacancies and workforce restrictions, the Education Admin Team have maintained a level of support to learning in the Trust that has been effective, notably dedicating time to create new learning environments offsite, delivering the improvement project for our Managed Learning Environment, refining the My First 90 days SFT Trust induction programme and working towards an Education Centre Behaviours Charter.

2.6 **We Each have a voice that Counts.** Identified as a vision metric within the Improving Together methodology, Staff Engagement is a key element of the People pillar of the Trust Strategy. We aim to achieve top quartile status against peer organisations in our staff survey results for engagement. Questions cover Staff involvement, Motivation and their willingness to advocate for the Trust as both a place to work and a place to be treated. Hearing our staff voice, and acting on what we hear, is front and centre of our work in this element of the people promise. In 2024 the National Staff Survey score of 7.09 placed SFT as 18th for staff engagement, thus meeting our ambition.

Listening events, led by our Managing Director and Chief People Officer (known as '*Hearing It')* have continued and been expanded. These events represent a significant opportunity for all staff to engage directly with our senior management raising areas where staff are excited by what we do and also enabling issues and concerns to be heard. To capture the experience and ideas new staff bring, all new staff are invited to provide feedback on their experience in the trust at their first 100 days and 1-year point after joining, this allows us to adjust induction and onboarding processes and share experience from other organisations. We run a quarterly Pulse Survey, making good use of the local questions option to way mark our progress between annual staff surveys. Board safety walks also continue to give Executive Directors the opportunity to engage

directly with staff. These occur monthly and visit 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.

2024 saw the second Hospital Open Day. With over 1000 members of the community visiting the hospital to meet staff and partner organisations. The year also saw an improved '*Tent Talks'*, supported by the Stars Appeal, this was a two-day festival of learning, wellbeing and fun for staff, volunteers and partner organisations, with family and friends invited to a groundbreaking Bhangra Night, which celebrated the South Asian culture and provided great entertainment for all.

2.7 **We work flexibly.** Colleagues' perceptions of the Trust as a supportive, flexible employer continue to improve. Our most-recent NHS Staff Survey results showed improvement in all relevant scores for the fourth straight year, surpassing both Picker peer group and NHS National averages. Our results are shown in Figure 10 below.

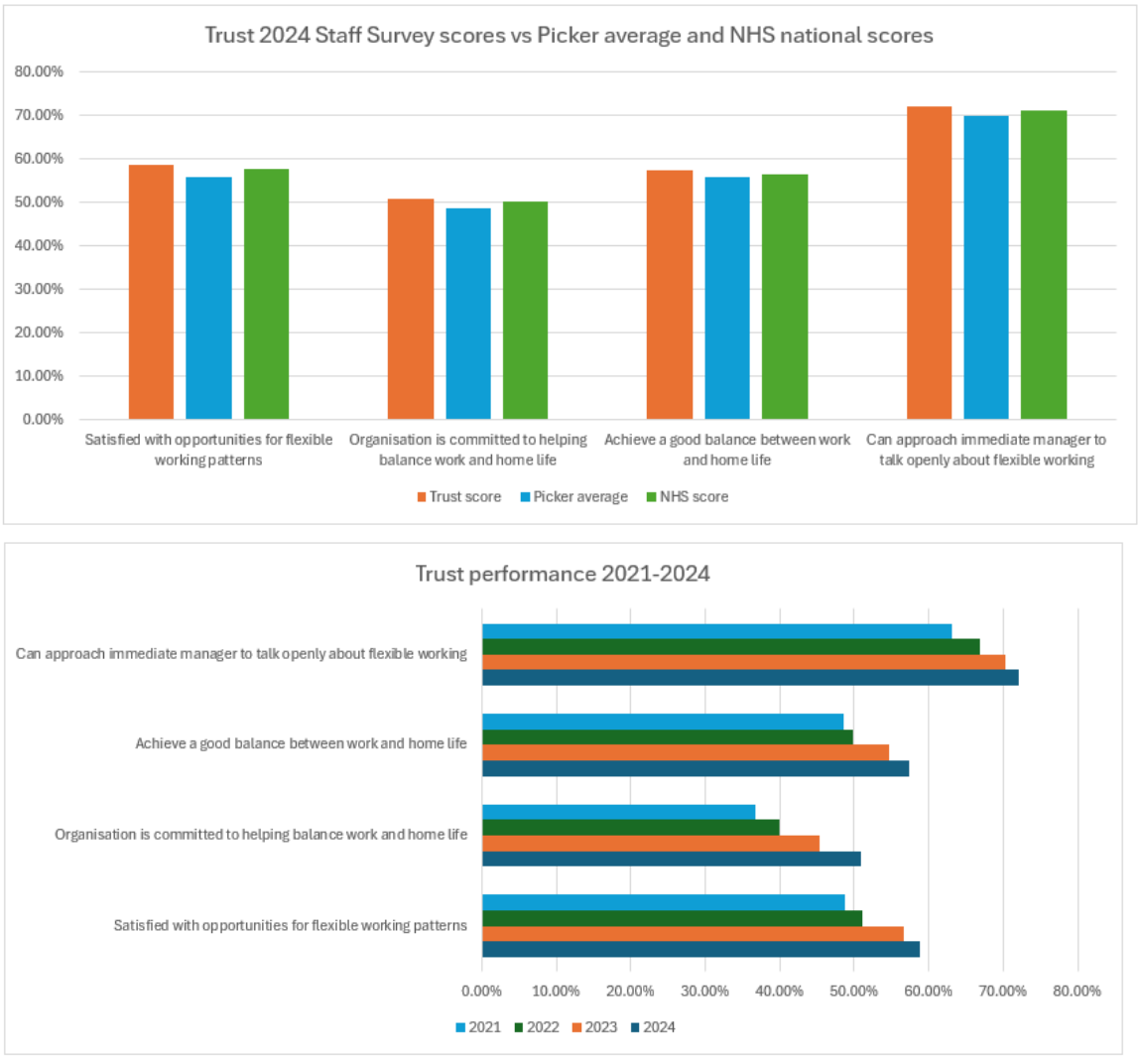


Figure 10: We work Flexibly question scores and average comparisons

Predictable working patterns and hours, that we have a say in agreeing, make a real difference to our lives and our wellbeing. In 2024/25 request volumes for flexible working rose by 82% to 393 compared to 216 in 2023/24. Key flexible working developments in the past 12 months include:

- Introducing Trust-branded imagery depicting what makes a successful flexible working arrangement from the perspective of the requestor, the Trust, our patients, and the requestor's colleagues.
- Adding Allocate and ESR system demonstrations to the "Manager's Toolkit for Flexible Working" workshops and achieving an overall feedback score of 4.6 out of 5 from attendees.
- Completing a pre-implementation survey of existing rostering practice prior to further roll-out of Team-based Rostering (TBR). Across CSFS, Medicine, Surgery, and Women & Newborn 227 respondents took part. Of these respondents, 55% were satisfied or highly satisfied with rostering practice, but valuable learning included their ward/area offering insufficient requests, rotas not being released early enough, and night shifts being dominated by staff with fixed work patterns. This feedback is now informing our TBR offer (increasing requests to 13 per person per roster) and plans for line manager learning and development in managing changes to work patterns (to be delivered in 2025/26).
- Based on national research and our own pilot feedback, we commissioned a bespoke teamwork package from OD & Learning to prevent negative behaviours impacting Team Based Rostering benefits realisation. We have recently started to use the package in the roll out on Sarum and will evaluate its success there and on Longford Ward.
- Commissioning additional videos[2] on flexible working and TBR, highlighting the positive benefits to staff and roster managers and having an honest conversation with staff about how imbalanced rosters impact on patients, colleagues and the Trust.

2.8 **We are Safe and Healthy.** We met our ambition for this element of the people promise in 24/25, with particularly pleasing uplifts demonstrating that staff felt much more able to meet conflicting demands on time at work and that they felt there were enough staff at the organisation to do their job properly. This year we have continued to seek to generate an environment which is safe for staff both physically and psychologically, and to support staff with advice, guidance and where necessary practical interventions when issues and concerns have been raised.

A key area of development this year has been the launch in February of the **Sexual Safety Charter** for SFT, this nationally led piece of work has been implemented within SFT through the development of a reporting mechanism which enables anonymous reporting and has the necessary capacity and capability to respond to concerns in a timely and effective manner. Supporting the reporting mechanism have been a suite of new training interventions to provide basic understanding and knowledge for all staff, as well as guidance for line managers to improve their ability to support their teams. Thie charter has been underpinned by the development and issue of a new policy supporting the work.

The Health and Safety team have continued to implement an audit and inspection regime to empower staff to ensure their work areas meet health and safety regulations, but principally to ensure staff are physically safe in their environments. In addition to this, the team has led on the **prevention of violence and aggression** towards staff. This work has led to the joint signing of the UNISON Charter to prevent violence and aggression in Apr 25. All staff subject to acts of violence and aggression are now supported following the event by a member of the H&S team to assess the incident and learn lessons with line management. For their work the H&S Team were awarded best non-clinical team at the Annual Staff Awards in Sep 24.

A community of practice for **Mental Health First Aiders** has been developed this year, seeking to bring together those staff who have volunteered to support Mental Health in the workplace. This community met for the first time in October and has met again to provide mutual support for

[2] "A Conversation about Team-based Rostering" https://www.youtube.com/embed/lLSDYqzYV0c?feature=oembed
"Team-based Rostering on the Ward". https://www.youtube.com/embed/t9fS1884ZRs?feature=oembed

members, enable supervision pf practice and training and identify trend across the trust that can be acted upon to support staff.

A thorough revamp of our **wellbeing offer** was conducted, with new guidance and support added and access to the wellbeing portal enabled through a QR code, thus making the portal available to all staff through a personal device.

Finally, despite having to overcome a number of staffing and funding issues, the **Occupational Health** team have continued to provide advice and support to line managers with reasonable adjustments enabling staff to work safely within their capacity. Physiotherapist and Counselling services have continued to be utilised to capacity supporting staff with their recovery from physical and mental health conditions.

2.9 **We are Recognised and Rewarded.** 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 improve inclusivity, to be assessed against EDI data and professions. The 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 was now far more representative of the SFT workforce.

In 2024 there were 4694 requests for tickets at staff events.

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 – which provides discounts on retail and services in Salisbury for SFT staff, including this year an exclusive discount with new department store Bradbeers.

3.0 Service Delivery

3.1 **Chaplains.** It was particularly pleasing to see the work of the Chaplaincy recognised at the SFT Annual Staff Awards, the team receiving the Chairman's award. This award was thoroughly well deserving as it reflected the enormous impact delivered by a small team across the totality of the Trust, Patients, Families and Staff. The team have continued to provide an excellent level of service for our patient population, providing a reassuring and supportive presence on the wards for inpatients and available on call '24/7' to react to patient needs. The chapel has been refurbished and plans agreed to further develop the space to ensure it provides space and facilities for those of all faiths and those of none, our chaplains are proud to remain available for everyone

The engagement of the chaplaincy team in our networks has continued, and work providing pastoral support and guidance to staff increased. Particular attention has been paid in supporting our Hospice team and the staff in Maternity. The presence of our chaplains across the Trust also enables signposting of support for staff across several staff groups and work areas.

3.2 **Occupational Health.** The team have continued to manage their workload in support of trust activity and have broadly met Key Performance Indicators (KPI) relating to Practice Nurse, OHA and OHP first appointments through the year. Where timings have slipped it has been due to staff sickness or vacancies – the service is designed lean and the impact of single staff members being away is keenly felt.

Musculo-Skeletal Injuries continue to account for a high percentage of sickness absence within the Trust and the provision of an in-house physiotherapy service is very much welcomed by those staff that need it, enabling staff to return to work and offering sound advice seeking to prevent future injury.

The impact of a single system to triage mental health support requirements has enabled staff to be quickly signposted to the best intervention to support them, be that through the Clinical Psychologist team or our Counselling service. Appointments for both teams are fully booked and the service continues to prioritise support and manage the volume of requests, seeking to support staff in the workplace.

The Head of OH remains actively involved supporting attendance management training and increasing knowledge of OH services and the support available for staff and managers.

The team have also delivered significant effort to meet the requirements of the Safe Effective Quality Occupational Health Service (SEQOHS) Industry standard. Assessments have recently taken place and a positive result is expected in August 25, delivering accreditation against this industry standard and thus enabling an income generation opportunity for the Trust.

3.3 **Health and Safety.** The H&S function provides an assurance, response and technical support role for each Division. The 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 24/25 members of the H&S team have completed formal H&S audit training and continue to conduct audits against the schedule which has 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 this year. The H&S team is tasked with responding to 90% of H&S related incident reports on Datix within 1 working day and responded to over 560 incidents within this timeframe (92%). There is also a legal obligation imposed on the Trust to meet HSE timeframes for all reportable injuries. Injuries, 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 24/25, all injuries that fall under the HSE definition were reported within 10 days of being reported on Datix.

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 provide an FFP3 mask and 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. This year several challenges with masks being discontinued or rationed have been managed. The Fit Test Team continued to provide a fit test service and ensured the availability of masks for staff to use by reducing appointment 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 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.

Violence and aggression remains the most reported incident and injury. Over the past 18 months the Trust, with the support of the Violence Prevention and Reduction Working Group as chaired by the H&S Manager, has taken a significant number of steps to reduce the risk of violence and aggression and improve the support offered to staff exposed to violence and aggression. An overview of the tools, resources and actions available to manage violence and aggression, in addition to the resources available to support managers is seen in figure 11 below:

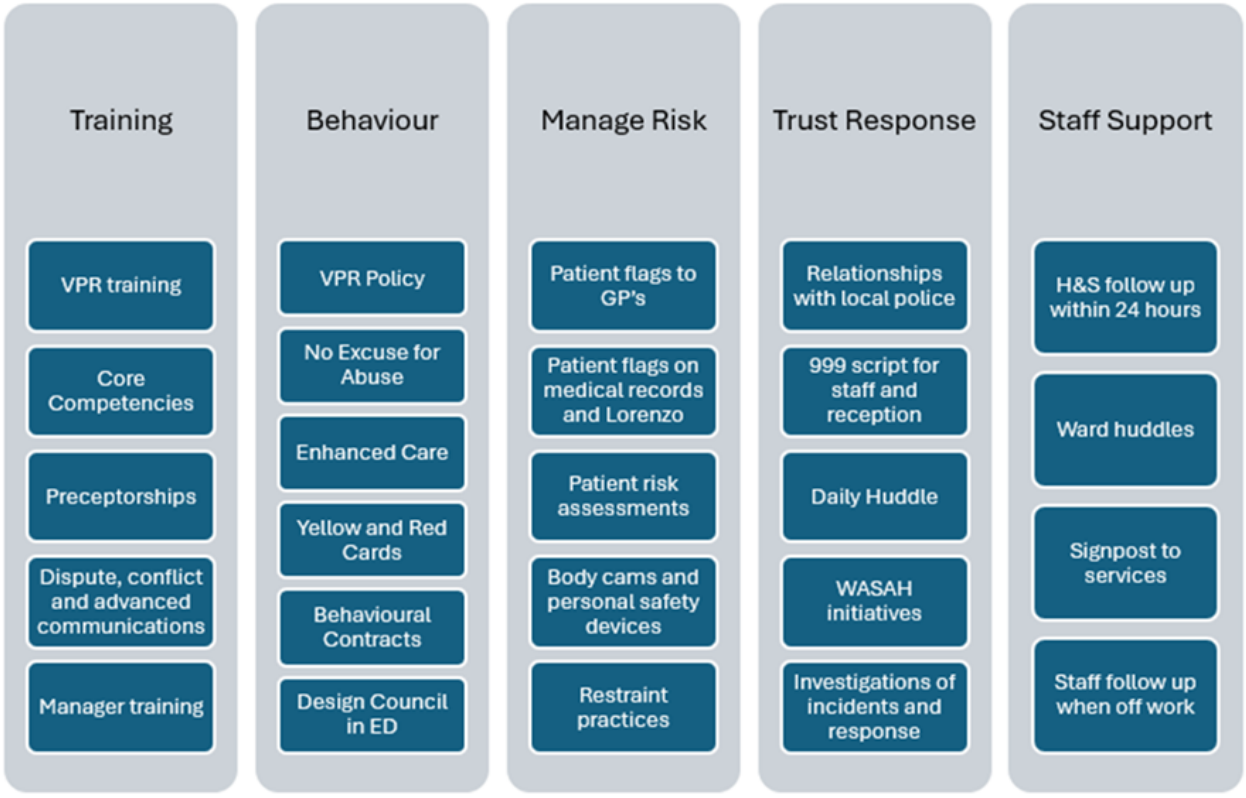


Figure 11: Violence and Aggression Support Framework.

3.4 **Workforce Informatics.** The Team have had a great year. Meeting their KPIs consistently month on month has demonstrated the attention to detail and team work required to provide **effective workforce information** power BI dashboards, enable management decisions with data requests and support trust compliance requirements through ESR data analysis.

Having implemented the ESR Establishment Control module last year, the team have now commenced using ESR data to complete the provider workforce return, freeing the finance team from this activity.

Finally, the team have continued to provide the support service for the Trust, enabling **manager self-service** of the system through the provision of training, information updates and direct support when required. Of note has the been the support provided in the management of appraisals data into ESR, which has increased the assurance placed on the data relating to the completion rates for the trust, a key watch metric.

3.5 **Recruitment.** Over the past year, the recruitment team has made significant strides in enhancing the overall **recruitment process** for both managers and candidates, through a continuous focus on identifying areas for improvement, ensuring a smoother and more efficient experience for all involved. A key achievement has been the implementation of manager and

candidate surveys, which provide valuable insights into their recruitment experiences and help to refine our approach. Additionally, the team has undergone significant changes, adapting to new structures and responsibilities. Despite these transitions, they have remained committed to overcoming challenges such as the WCP/ICB approval process, which has presented obstacles throughout the year. By actively developing solutions to streamline this process and ensuring it aligns with evolving requirements it continues to support our recruitment goals effectively.

Over the past year, certain areas of our KPIs have consistently been met, reflecting the team's dedication and focus on recruitment efficiency. However, a continued area of concern has been the time it takes for managers to shortlist candidates, which has impacted our overall timelines. We are actively addressing this issue by working closely with managers to provide better support and encourage more timely decision-making in the shortlisting process.

Towards the end of last year, several team members left which led to a temporary dip in some of our KPIs. However, in the new year, we adapted by restructuring the team, with each member taking responsibility for a specific division. This new model has led to a notable improvement in our KPI performance, with one of our biggest achievements being the reduction of our time to hire to around 30 days. This progress demonstrates the positive impact of our new approach and highlights our continued efforts to refine and improve our recruitment processes.

Key achievements for FY 24/25 include:

- Achieved an average time to hire of 30 days
- Rolled out manager and candidate surveys, providing insights into areas of success and opportunities for improvement within the recruitment process.
- Adopted new ways of working within the team, with each member taking responsibility as the dedicated recruitment specialist for a specific division. This approach has ensured continuity for candidates, a better onboarding experience, and stronger relationships and support for hiring managers.
- Successfully managed continuous recruitment campaigns for Healthcare Assistants (HCAs) and Newly Qualified Nurses (NQNs) throughout the year.
- Successfully managed the recruitment and onboarding of 37 International Registered Nurses and 5 International ODP's.
- Created e-brochure for Medical Recruitment for the Medicine Division which has now been replicated and new versions created for different recruitment campaigns in other Divisions eg Consultant Radiologist
- Moved job descriptions for Medical posts to an e-brochure format
- Launched the Recruitment and Selection training program, with sessions running approximately every 4-6 weeks. 120 individuals have attended since the launch. Based on feedback, we are currently reviewing the training materials to include more TRAC "how-to" guides and a deeper focus on the WCP/ICB approval process.

3.6 **Temp Staffing.** Over the course of 24/25 the Temporary Staffing Team have continued to revise current processes and redesign process flows, proactively managing agency contracts with the input from Procurement and the involvement of the Team in other staff groups eg agency for Medical, AHP and HCS. The SW Pan Regional work to align and reduce cost for both nurse and medical agency and bank has been a key piece of work in 2024/25.

KPI's for the Temporary Staffing Team have been revised with more emphasis on the delivery of the service in its entirety, rather than being nurse led. These SLA's/KPI's will be implemented in 2025/26.

The Temporary Staffing Team's structure has also been revised with the introduction of a new job role, Clinical Nurse Lead from May 2025 who will be responsible for the quality of the care being given by bank RNs and HCA's along with a Temporary Staffing Operations Manager who will lead and manage the Temporary Staffing service.

The % Agency Bill improved in 2024/25 compared to 2023/24 as shown in *Fig 12* below

Level 4 CC	Agency %
Clinical Support and Family Services	10.3%
Corporate	0.0%
Corporate - Other	0.3%
Facilities	NaN
Medicine	7.8%
Surgery	1.8%
Women and Newborn	-0.1%
Total	**5.1%**

2023/2024

Level 4 CC	Agency %
Clinical Support and Family Services	1.2%
Corporate	4.7%
Estates	0.0%
Facilities	0.0%
Medicine	5.0%
Surgery	3.2%
Women and Newborn	4.9%
Total	**3.4%**

2024/2025

Figure 12: Comparison of Agency Spend FY23/24 to FY 24/25

Nursing. The Trust implemented cap rates for general nursing from 1 June with specialist areas (Theatres, ED, ITU and Paediatrics) going to cap from 1 July 2024, which was in advance of the NHSE requirement to be at cap from 1 October 2024. The Trust continues to maintain its position and not use agency to fill band 2 or 3 HCA.

During 24/25 Temporary Staffing also worked with the Deputy Chief Nursing Officer (DCNO) and AD for HR Operations to implement the change in band for Bank HCA's from 2 to 3.

Acknowledgement on the reduction of agency spend for nursing agency and bank needs to be given to the Deputy Chief Nursing Officer who has worked with the wards to continue to drive down the number of shifts required to be filled either by bank or agency. This also includes continuing to reduce the number of off framework for nurse agency.

Medical. In August 2024 Temporary Staffing supported the implementation of a revised bank rate card for doctors which are applied to shifts booked via Locums Nest. At the same time a new process was implemented to seek approval for breakglass rates (rates applied outside of the bank rate card). In September 2024 the SW Region produced an Agency Rate Card for Medical, with the expectation that incumbent agency doctors would transition to the revised rates, whilst new bookings would adhere to the revised rate card.

We have been reporting an average of 80% compliance against the rate card.

AHP/HCS and Non-Medical Non-Clinical Agency. Whilst the expectation is that rates within these staff groups are at cap, this is proving difficult to achieve due to the specialist nature of some of the roles (eg Echo Cardiographer, Cardiac Physiologist). Whilst some adherence to cap rates in some roles (eg Biomedical Scientist) can be reported, overall, we remain non-compliant with cap rates in the AHP and HCS staff groups.

3.7 **Employee Relations.** Another proactive year in the Employee Relations Team with 115 employee relations cases brought to a satisfactory conclusion across categories ranging from disciplinary interventions and grievance resolutions to support for performance management concerns.

The team continue to **support line managers** with the challenges of manging complex teams and ensuring they have the confidence and competence to challenge poor behaviours and tackle work related issues quickly, before minor concerns escalate. In order to enhance the support coaching and 1-2-1 support already provided by the team of Employee Relations Advisors the team now run monthly line manager workshops on managing Sickness Absence, supporting Performance Management issues and tackling and dealing with grievance and disciplinary matters. Quarter 4

saw the launch of a pilot 'licence to lead' development day with over 60 supervisors and line managers attending training delivered over two, one day sessions aimed at developing and gaining confidence in their line management competence.
Managing sickness absence through encouragement of return to work meetings and managing staff through the sickness absence management process where improvements in attendance levels are not seen, remains a key activity for the team. Absence levels remain on average at around 4% per annum, with some ward areas experiencing higher levels. The principal reason for sickness absence continues to be stress/anxiety/mental health issues, closely followed by infectious diseases and muscular skeletal problems.

The adoption of NHS Employers '**Health passport**' and a revised policy supporting our disabled employees has helped to support managers and our workforce in dealing with more complex health concerns and ensuring that staff can access disability leave when appropriate. Other more targeted interventions in this space have included running a joint ER and Occupational Health workshop for Ward Leaders in supporting and managing pregnancy related absence, supported by the obstetric team giving managers practical advice in how to support our pregnant staff and reduce unnecessary pregnancy related absence.

Ensuring we have a **legally compliant workforce** is also a key activity for the team and this year the team co-led audit activity in relation to Right to Work compliance. The audit focused on ensuring the data we hold in ESR and in personal files in relation to Right to Work compliance is accurate and up to date. This audit activity enabled assurance of 100% compliance in this area and has also led to continuous improvement work in this field improving our processes in relation to our sponsored international workforce and our skilled worker visa renewal processes. A new dedicated e-mail address and single point of contact has also helped to resolve and speed up queries and concerns in relation to right to work and visa renewals. Further work in this area will continue in the next financial year as we continue to monitor and understand the ever changing complexities of UK immigration law and its implications for our workforce. The team already regularly provide advice, guidance and support for our international colleagues who are taking the next steps to obtain indefinite leave to remain in the UK or support the paperwork required for our staff to bring dependents to the UK to join them.

Formal Job Matching panels have now been running for over a year following an overhaul of the **Job Matching process** and there are now 24 staff trained in formal job matching enabling us to run rostered weekly job matching panels made up of 4 staff side/management representatives in line with NHS Job Evaluation best practice guidelines. Following approval at workforce control panel, the majority of jobs can be matched and consistency checked within 2 weeks.

3.8 **Volunteers.** Volunteer numbers have been maintained through FY 24/25 and our range of volunteers deliver a huge amount of time and love to support a range of activities across SFT. Our volunteers were again recognised through a general invitation to join staff for a free Christmas lunch, and a special lunch was held during Awards week to recognise the commitment to the Trust of our volunteers.

Voluntary Services have continued to attended local school career events to promote work experience opportunities at the Trust and aid with attraction to the NHS as an employer of choice as part of our widening participation activity.

Work Experience has continued and the sight of young people in their red work experience t-shirts has become a common and welcome sight across the Trust.

3.9 **Freedom to Speak Up.** The Freedom to Speak Up Guardian, alongside the wider OD&P team has worked hard to seek 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' are the primary areas of focus for Freedom to Speak Up, but FTSU data contributes across all aspects. Actions have included socialising and promoting the refreshed FTSU Policy in

conjunction with the refreshed people policies that now have a restorative approach when dealing with work related issues, leading to a less punitive and improved learning culture. Expert data is triangulated 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 the Staff Survey results.

The FTSUG also delivers training at a variety of events, such as Trust Induction, Resident Doctors Core Training, to influence the creation of psychological safety in order that colleagues can raise concerns with confidence and an assurance that they will be listened to and action taken in response. To support her work, the Trust's Guardian has direct access to all senior leaders including the Chief Executive, Managing Director and all Board members.

Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. This year 129 concerns have been raised to the Freedom to Speak Up 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	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*
Figure 13: FTSU Case Themes.

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

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 FTSUG works closely with the Multicultural Network to ensure that speaking up is promoted and barriers that this particular staff group may face are discussed and addressed. Disability issues were connected to 6% of staff who raised concerns, a significant drop compared with 2023/24 when it was 12%. The reinvigorated staff networks and wellbeing offers that have been introduced will give more support and guidance in the future.

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.

3.10 **Library Services.** Our vision remains to Utilise knowledge and evidence for outstanding care. Our mission is to deliver an outstanding knowledge and library service that empowers evidence-based decision making, underpins a culture of learning and development, and contributes to an outstanding experience for all. This year the Healthcare library celebrated three key successes:

Literature searches saw an increase of 16% in the number completed compared to last year. The team applied Improving Together methodology to identify ways to improve promotion of the

literature search service and the jump in the total number of searches completed shows the expansion of this service. Literature searches allow clinical and non-clinical staff to request a search for best practice, evidence, research articles and other materials, so these can be used in service redesign, clinical decision making and research.

Online resources membership. The number of people signed up to Open Athens to access all our online resources jumped by 6.7% compared to last year. This means more staff than ever are registered with Open Athens and therefore have '24/7' access to all our online journals, databases and clinical decision-making tools. For the first time our biggest staff group is Nursing and Midwifery, historically the medical profession has been our biggest user group of our online resources. This follows promotion of the service to Nursing colleagues. More staff are now able to access our online resources at any time and from anywhere meaning they have access to best practice and clinical decision making as and when they need the information and can easily access information to inform patient care and improve services.

Article requests up by 130%. The number of article requests the Healthcare Library dealt with in 2024/25 increased by 130% over 2023/24. Partly due to the change in national systems and other libraries requesting our articles and also due to the increase in literature searches and evidence bulletins which result in more requests for articles.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.4
Date of meeting:	4 September 2025		

Report title:	Modern Slavery & Human Trafficking Statement 2025/26			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	Organisational Development and People Management Board (OD&P MB) on 22.07.25 People and Culture Committee (P&CC) on 31.07.25			
Prepared by:	Harjinder Bahra, Head of Inclusion, Health and Wellbeing			
Executive Sponsor: (presenting)	Ian Crowley, Deputy Chief People Officer			

Recommendation:

The Trust Board is asked to:

- Approve the 2025/26 Modern Slavery and Human Trafficking Statement for publication on the Trust's public website.
- Take assurance that the Statement has been reviewed by the OD&P MB and endorsed for Board approval by the P&CC.

Executive Summary:

To comply with Section 54(1) of the Modern Slavery Act 2015, Salisbury NHS Foundation Trust (SFT) has a legal obligation to publish an annual statement outlining the steps it has taken – and continues to take – to prevent modern slavery and human trafficking within the Trust and its supply chains. This statement must be published within six months of the end of the financial year.

SFT provides acute and specialist healthcare to over 270,000 people across Wiltshire, Dorset, and Hampshire. With a wide-ranging and complex supply chain, the Trust is committed to ethical practices and maintains a zero-tolerance approach to all forms of modern slavery.

For 2025/26 the Tryst has updated the Statement with key actions and commitments that include:

- **Policy Framework**: SFT upholds strong policies and governance structures, including safeguarding, procurement, and recruitment policies, all aligned with modern slavery legislation.
- **Due Diligence**: Robust procedures are in place to assess and monitor supplier compliance, embed human rights clauses in contracts, and ensure ethical procurement practices.
- **Risk Management**: Risk is evaluated using platforms such as Atamis and the Evergreen Portal, with targeted action focused on high-risk suppliers and contracts.

- **Training and Awareness**: All staff are required to complete safeguarding training that includes modern slavery awareness. Additional training and ethical practice initiatives are in place for the Procurement team.
- **Performance Monitoring**: KPIs are in place to track training compliance, and work is underway to develop broader procurement metrics to assess ongoing effectiveness.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	X
Other (please describe):	N/a

Modern Slavery and Human Trafficking Statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015. It serves as Salisbury NHS Foundation Trust's (SFT) official statement on slavery and human trafficking for the financial year ending 31 March 2025.

In line with NHS England's Group Statement on modern slavery and human trafficking, this document outlines the steps SFT has taken — and continues to take — to prevent modern slavery and human trafficking within the Trust and its supply chains.

1. Organisational Structure and Supply Chains

SFT provides a wide range of clinical services to a population of over 270,000 people across Wiltshire, Dorset, and Hampshire. Our core business is the provision of acute and specialist healthcare, supported by a complex supply chain essential for delivering high-quality patient care.

Our supply chains include the procurement of:

- Clinical goods and services: medical equipment, pharmaceuticals, and surgical instruments.
- Non-clinical goods and services: including high-risk sectors such as construction, facilities management (e.g. cleaning, catering), IT equipment, and textiles (e.g. uniforms, bedding).

Modern slavery encompasses slavery, servitude, human trafficking, and forced labour. SFT adopts a zero-tolerance approach to all forms of modern slavery. We are committed to acting ethically and with integrity in all our business dealings. We recognise our responsibility to understand the risks within our supply chains and to work collaboratively to mitigate them — including with partners in the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS).

2. Policies in Relation to Modern Slavery and Human Trafficking

We are committed to ethical practices and take all reasonable steps to prevent modern slavery and human trafficking across our operations and supply chains. Our policies are designed to meet the diverse needs of our patients, staff, and wider community, while ensuring our suppliers uphold the same values.

Our Procurement Policy includes specific clauses requiring compliance with the Modern Slavery Act 2015. Awareness of modern slavery is embedded within our safeguarding policies, and all staff are required to report any concerns, which are addressed through appropriate procedures.

This commitment is reflected in the following key Trust policies:

- Procurement Policy
- Adult Safeguarding Policy
- Safeguarding Children and Adults Training Policy
- Overseas Visitors' Policy

3. Due Diligence Processes

To identify and mitigate risks in our operations and supply chains, we have implemented a comprehensive due diligence framework. This includes:

- Collaborating with NHS Supply Chain and partners to ensure suppliers are selected via robust criteria.
- Expecting suppliers to endorse the BSW ICS Supplier Charter and its mission to deliver ethical and strategic procurement.
- Including human rights clauses, as per NHS Terms and Conditions, in all relevant procurement and tender documents.
- Evaluating tender specifications with consideration for ethical sourcing and social value.
- Using NHS contract templates to ensure modern slavery clauses are embedded in all supplier agreements.
- Encouraging suppliers and contractors to take responsibility for compliance within their own operations.
- Adhering to professional procurement codes of conduct.
- Requiring staff to engage with the Procurement team when appointing new suppliers, to ensure appropriate checks are conducted.
- Operating a robust recruitment policy, incorporating pre-employment checks aligned with national NHS Employment Checks/Standards on directly employed staff, potential employees, bank workers, volunteers and governors.
- Ensuring that all agency workers adhere to the NHS Employment Checks/Standards prior to commencing in the Trust. Assurance is given by temporary staffing checking documentation submitted by the agency against a checklist.
- Implementing controls to protect staff from poor treatment or exploitation, including fair pay, employment terms, and access to training.
- Engaging with Trade Unions and staff-side representatives on employment matters.

- Maintaining systems to encourage reporting of concerns, including a Whistleblowing Policy.
- Promoting the Freedom to Speak Up Guardian and Ambassadors, enabling staff to report concerns without fear.
- Reporting regularly to the Trust Board on Freedom to Speak Up cases, including the categories of concern raised.

4. Risk Assessment and Management

SFT employs a data-driven, risk-based approach to modern slavery risk within its supply chains.

The Procurement team uses the national Atamis platform to assess the risk level associated with different spend categories — classified as high, medium, or low. Where risks are identified, the team uses the Evergreen Portal to determine whether suppliers have completed the Modern Slavery Risk Assessment Tool (MSRAT). Responses are used to guide follow-up actions as part of contract management.

Contract management is currently being implemented, with an initial focus on our “Gold” tier suppliers — contracts with high risk, complexity, or value.

As part of our tender process, suppliers for contracts exceeding £139,000 must confirm whether they have a Modern Slavery Act Statement. This requirement is built into our standard contract terms and conditions.

5. Key Performance Indicators (KPIs) to Measure Effectiveness

SFT is dedicated to monitoring the impact of its actions through clearly defined key performance indicators.

A key KPI that the Trust is working towards is to ensure that at least 90% of staff complete the mandatory Level 1 Adult Safeguarding Training, which includes modern slavery awareness.

All members of the Safeguarding Team complete Level 3 training. Level 1 training is required only for non-patient-facing staff, while all patient-facing staff are required to complete Level 2 training.

A broader KPI framework is in development. Over the coming year, we will define and implement new indicators to improve tracking, accountability, and continuous improvement.

The rollout of Atamis will further strengthen our oversight, allowing enhanced visibility of modern slavery risks across procurement categories and supporting data-driven supplier engagement and contract management.

6. Training and Capacity Building

All staff have a personal responsibility to help prevent modern slavery and human trafficking. Guidance and training are provided through our safeguarding framework and are accessible to all staff.

6.1 Mandatory Training for All Staff

Modern slavery awareness is part of the Level 1 Adult Safeguarding Training and includes:

- Types of modern slavery (e.g. forced labour, debt bondage, human trafficking)
- How to recognise potential victims
- How to report concerns
- How to support potential victims

6.2 Ongoing Resources

Resources available via the Trust's intranet include:

- Definitions and types of modern slavery
- Who may be affected
- What to do if you suspect someone is a victim
- Information on NHS Employment Checks, including right to work, address verification, and reference checks

6.3 Procurement Team Training

In 2025/26, the Procurement team will continue promoting ethical practices by:

- Participating in CIPS Corporate Ethics Training
- Encouraging staff to complete the annual CIPS Ethics Test
- Ensuring adherence to the CIPS Code of Ethics
- Repeating the 'Lunch and Learn' awareness session later in the year

Confirmation

This statement has been reviewed by the Trust's Governance and Risk Committee and approved by the Board of Directors. It will be reviewed and updated annually in line with our

legal obligations and ongoing commitment to preventing modern slavery and human trafficking.

4 September 2025

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.5
Date of meeting:	4th September 2025		

Report title:	Annual appraisal and revalidation report from the Responsible Officer			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Duncan Murray – Responsible Officer Zoe Cole – Trust Lead for Medical Appraisal Mark Pountney – Appraisal and Revalidation Administrator			
Executive Sponsor: (presenting)	Zoe Cole			
Appendices	N/A			
BAF Risk link				

Recommendation:

To receive the annual NHSE assurance document regarding the Responsible Officer function for medical appraisal and revalidation and the maintaining of professional standards for doctors
To approve the signing of the statement of compliance with the Medical Profession (Responsible Officers) Regulations 2010 The Medical Profession (Responsible Officers) Regulations 2010 No. 2841

Executive Summary:

This templated report sets out the information that SFT as a designated body for revalidation is required to report upwards to the Higher Level Responsible Officer (the SW Regional Medical Director) to provide assurance that the Trust maintains effective processes for the effective revalidation of doctors. The Responsible Officer is accountable for implementing and overseeing the processes allowing any doctor with a prescribed connection with the Trust (any doctor whose main work is for the Trust and who is not in a formal training program) to collect the required information to support successful revalidation on a five yearly cycle.

There are no significant gaps in assurance against the key lines of enquiry.

The reporting period for 2024/25 extends a period of renewed continuity post pandemic with missed appraisal dates during this period now rectified. During this period there were 361 prescribed connections. The completed (327), approved exceptions (19) and missed appraisals (9) add up to 355. 56 prescribed connections as of 31st March 24 were not due an appraisal until the 2025-26 cycle, mainly due to relatively late Trust start dates. Whilst we see that 22% of doctors' appraisals are overdue on date of appraisal, only 9% have been overdue for more than 3 months. Most of these appear to be junior Trust Grade/Local Employed Doctors who have shorter contracts and need more support understanding the appraisal system.

This has improved over the year as the new system for monitoring appraisal compliance has become embedded.

Appraisal rates are monitored on a monthly basis and continue to be above 90% compliance. An email reminder process was introduced with monthly reminder emails in the 3 months prior to their anniversary dates and monthly reminders for the 3 months after ending in a personal email from CMO for non compliance at this period. This has ensured that compliance improved markedly and remains high.

Appraisal audit is performed using the validated ASPAT tool incorporated within the Premier IT system which is used by many of our colleagues in the South West.

Regular appraisal update training and development is provided by the Trust for registered appraisers and this has included a training session on professional standards run by the GMC. The SW NHSE team support the RO and lead appraiser with quarterly HLRO update/network meetings.

Work over the next year will include:

- renewal or replacement of our digital appraisal platform.
- Further improvement of the MHPS consistency panel/Responsible Officer Advisory Group delivering improved reporting and assurance, including measures to identify bias and discrimination within structures and processes
- Writing of policies to support governance of Physician Assistants, and implementing local recommendations within the Leng report
- Updating Trust policies relevant to governance of the medical and PA workforce
- Identifying and implementing improved processes for overseeing the appraisal, revalidation and professional standards of the steadily growing cohort of ‘professional locums’ who connect with SFT on the back of doing ad hoc locum work through our collaborative bank.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: Salisbury District Hospital

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	Deputy CMO is to attend RO training in 24/25.
Comments:	New CMO commenced 1 August 2024. Responsible Officer (RO) duties are part of the CMO portfolio. CMO undertook F2F RO training in December

	2024 at the GMC and has attended one follow up online training consolidation session subsequently. Trust appraisal lead also attends the RO updates
Action for next year:	Consider RO training for DCMOs and to attend regional HLRO updates

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	The licence for Premier IT was renewed for a further year. Considering options with group partner/s for renewal/replacement
Comments:	RO duties formally recognised within CMO office roles and responsibilities, and aspects of role delegated to Deputy CMOs as appropriate. Further funded support to the RO function by a Trust appraisal lead with demarcated job-planned time, as well as an Appraisal and Revalidation manager who maintains an appraisal tracking system to support doctors and the RO in administering the revalidation process. The Trust maintains a digital appraisal platform (Premier IT) for administering the appraisal system for all non-Deanery medical staff.
Action for next year:	Re-procurement of current digital appraisal platform for this year with view to exploring options for a replacement system next year potentially aligned with group partners

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue current system
Comments:	The CMO and appraisal and revalidation administrator update a list of connected medical practitioners on a bimonthly basis and this is triangulated with electronic staff records and HEE information
Action for next year:	Continue current system

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Recent reviews/rewrites that have been completed include study leave and professional leave policy (now merged) and job planning policy, and the Managing Concerns for Doctors and Dentists Policy which is compliant with the MHPS framework document.
Comments:	Medical staff appraisal policy needing review. All other policies have been reviewed by our solicitors and deemed compliant with regulatory and legal requirements and are therefore in date.
Action for next year	Update medical staff appraisal policy Annual leave, acting down and additional payments policies are sitting with LNC for review prior to ratification at JLNC.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	Discussion and advice have been sought re appraisal and revalidation within BSW and South West Region
Comments:	We are included in the peer review cycle within the SW NHSE program, but it is several years since last review. We currently have regular appraisal leadership meetings within the BSW Hospitals group to discuss appraisal processes and learn from/share best practice.
Action for next year:	To continue to prepare for peer review and engage with review process once date identified.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continued training for those that are appraising locally employed doctors.
Comments:	All temporary medical staff receive induction tailored to duration of appointment. CPD, appraisal and revalidation of agency employed doctors is overseen by the RO of the agency, but we support these doctors by including them in local clinical governance activities. We also employ bank doctors through a collaborative bank. The majority of these are current or recent employees of the organisation, and so are connected either with SFT, or with their new contracted employer, usually another hospital within the area. We support them in engaging in clinical governance activities and with appraisal and revalidation, although we do not fund any developmental activities under this arrangement. There is a new risk emerging of a growing number of "permanent bank locums" who have no formal contract of employment with any hospital, and who connect to SFT as their designated body. Their employment in SFT and elsewhere is difficult to track, and work is required to develop a process for better oversight of this group, and provision of support for appraisal and revalidation. All fixed term doctors within the organisation who are expected to remain at the Trust for 6 months or longer are supported in undertaking an appraisal. For those who are in training this is performed by their educational supervisor. These doctors are incorporated into clinical teams and receive support and guidance as required with continuing professional development, appraisal and revalidation, and included in departmental and organisational governance activities. Appraisers are identified for locums when required.
Action for next year	Work with BSW and collaborative bank partners +/- support from GMC to develop a better oversight of permanent bank locum doctors

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work

carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	To ensure sufficient appraisers and training
Comments:	There is a mechanism for all doctors to undergo formal appraisal with access to the Trust's electronic system, which is set up to facilitate the submission of suitable supporting information and reflective activity aligned with the domains of Good Medical Practice in preparation for the appraisal discussion, as well as the recording of a meaningful output from that discussion. Enough appraisers are trained, updated and allocated SPA time to perform this duty. Appraisal quality is now audited using the Premier IT ASPAT facility.
Action for next year:	To continue to monitor number of appraisers against the rising demand, and to encourage new appraisers to support the appraisal work of the Trust. Continue to audit appraisal quality and appraisee satisfaction, and to report data upwards.

B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Emails to be sent from lead appraiser when appraisals are overdue reminding them that this is a mandatory part of their contract with a sterner one at 3 months. If still no engagement this is escalated to the responsible officer
Comments:	All doctors are now sent monthly reminder emails starting 3 months before their appraisal due date reminding them of the requirements of the GMC and SFT with respect to appraisal. If an appraisal deadline is missed, monthly reminders are then sent from the appraisal lead for the next 3 months. If at 3 months the appraisal remains incomplete, and no special circumstance is recorded then a personalised email is sent from the RO. As a result, special circumstances can be recorded much sooner, and appropriate support/intervention actioned. Appraisal compliance rates are now consistently above 90% across all clinical divisions.
Action for next year:	Continue current process

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes, but beyond review date
Action from last year:	None recorded
Comments:	An updated appraisal policy was agreed by the Joint Negotiating Committee and the Trust's internal governance processes in 2021
Action for next year:	Appraisal policy currently being updated with anticipated completion date end of October.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance

Y/N	Y
Action from last year:	To monitor and maintain enough appraisers, to train appropriately and ensure sufficient SPA time is given
Comments:	Ongoing training this year included a professional standards workshop from the GMC. Increasing demand for appraisal capacity for locally employed doctors is being mitigated by appraisal for these doctors being undertaken by educational supervisors. There is also an increasing cost for licence provision for use of electronic appraisal platform.
Action for next year:	To continue to monitor appraiser demand and maintain enough appraisers with ongoing training/updates. Explore options for use of unused medical study leave funds to support appraisal training.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	To continue with current training program and updates and to investigate how other trusts organise updates for appraisal.
Comments:	GMC delivered training session on revised professional standards New appraisers are trained via Miad Healthcare and certification is essential. There is a yearly quality assurance process using the ASPAT audit tool which provides feedback to appraisers and internal assurance. At RUH and GWH, specific new appraiser workshops are organised by external providers to maintain current appraisers. RO and lead appraiser attend regional High Level Responsible Officer (HLRO) updates for appraisal and revalidation.
Action for next year:	To explore and develop opportunities for joint training sessions for appraisers within BSW Hospitals group

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	The appraisal assurance process described above has been reported to the board via the annual ROs report Action from last year
Comments:	N/A
Action for next year:	The appraisal assurance process will be reported to the board on an annual basis by the RO.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Ensure a consistency panel (ROAG is in place to assist the RO with decision making for doctors who have had concerns raised about them. Embed and improve the effectiveness of the consistency panel and ensure that there is an annual assessment of protected characteristic data.
Comments:	Regular (6/52 to two monthly) meetings are held between the RO and the revalidation manager to review the compliance of doctors with upcoming revalidation dates against the GMC requirements and RO protocol. Recommendation decisions to revalidate or defer are made in this meeting, with advice occasionally sought from the GMC ELA particularly in instances of non-engagement. The recommendation is then enacted on the GMC Connect application, and a message is sent to each doctor communicating the decision, with support offered where necessary for deferral or non-engagement decisions.
Action for next year:	Continue current system

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the

doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No changes proposed
Comments:	All doctors receive email confirmation of actions taken. Doctors are involved in deferment decisions usually by direct correspondence with the CMO. Non engagement decisions are only considered after the repeated attempts at engagement with the doctor and offers of support and always involve discussion with the GMC Employment Liaison Adviser.
Action for next year:	No changes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	To encourage all doctors to take part in regular governance days by giving them appropriate SPA and time to ensure this is possible.
Comments:	There is effective clinical safety and governance structure with well attended meetings and evidence of positive assurance in all significant domains such as audit, medicines management, mortality and morbidity and incident reporting. The governance structure feeds into clinical effectiveness, patient safety and patient experience. Divisions have their own governance structure which links into these three main themes and they seek assurance through regular senior leadership meetings with departments and wards. There is a rolling program of clinical divisional attendance at our Clinical Governance Board subcommittee where divisional representatives deliver a review of divisional governance activity.

Action for next year:	Continue current systems

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	**Y**
Action from last year:	To further embed and develop the MHPS consistency panel
Comments:	There are mechanisms in place for the reporting and escalation of concerns about doctors from several routes (performance concerns, involvement in serious incidents, staff or patient concerns or complaints, freedom to speak up guardian reports and doctors 360 feedback) with a new MHPS consistency panel which started in April 24 to escalate concerns to the RO. Information on serious incidents and complaints are provided to doctors to use at the time of their appraisal and forms part of their input form.
Action for next year:	The MHPS consistency panel remains relatively undeveloped and not well embedded. Reviewing ToR and membership of this panel and CMO to attend an equivalent meeting at group partner organisation to share learning

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	N/A
Comments:	Information on serious incidents and compliments and complaints are provided to all doctors as part of their input forms.

	The Trust uses Premier IT which is a digital appraisal system. Documents to support governance can be provided digitally and are available to upload into this system. If confidential a paper version can be brought to appraisal as supporting evidence and an output form generated on seeing this. Appraisers are required to provide evidence that covers the whole scope of their practice.
Action for next year:	Procurement exercise for renewal or replacement of current system within group arrangements

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	None recorded
Comments:	There is a current process described in the Trust's Managing Concerns for Doctors and Dentists policy which has been updated to ensure it includes elements of compassion and a just and restorative culture. Potentially serious concerns are discussed with the local GMC ELA officer who provides ad hoc advice and support outside of the scheduled quarterly update sessions with the CMO and Appraisal and Revalidation lead. Since the last report, regulation of physician assistants (PAs) has been taken over by the GMC, and the Leng review into PAs has been published with a small number of actions requiring local implementation. SFT has successfully employed four PAs across ED/AMU for several years now and is already compliant with the majority of Leng review actions.
Action for next year:	To continue to engage with local GMC ELA officer and regular regional updates to ensure the process is sufficient. Produce policies and revise processes for governance of the Physician Assistant workforce and produce and implement action plan in response to the Leng review into Physician assistants.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of

concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	**Y**
Action from last year:	To ensure smooth running of new quarterly consistency panel and update as required dependent on feedback
Comments:	Reporting of concerns raised about doctors or dentists in the trust are collated by the CMO and Medical HR Business Partner. There are regular meetings with the trusts ELA to ensure external triangulation and consistency. Learning from these events is shared at the regional RO updates. There is now a quarterly consistency panel (April 24) to support the CMO in agreeing an appropriate and consistent response to any performance or conduct concerns that are raised about doctors, with work ongoing to further improve and refine the effectiveness of this panel.
Action for next year:	Further embed the quarterly consistency panel and align with and learn from group partner Trust, and to include reporting mechanism within our governance systems

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	N/A
Comments:	Information transfer requests from next employer to SFT (“pull mechanism”) are responded to by a combination of Medical HR, appraisal lead/administrator with CMO sign off.
Action for next year:	To audit how the (Medical Practitioner Information Transfer form) MPIT is currently used to ensure this data is shared

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	N/A
Comments:	The Trust has a policy in place for the reporting and investigation of concerns raised by practitioners regarding any form of discrimination or bias. The CMO has accountability for assuring the Board that all processes managing doctors (including recruitment, job planning management of conduct or capability concerns and career progression) are fair and free from bias
Action for next year:	Further embed MHPS/ROAG and to include clear focus on ensuring mechanisms for identifying and mitigating/eliminating bias and discrimination

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	**Y**
Action from last year:	N/A
Comments:	The Trust routinely monitors NHS Employers initiatives and other Organisational Development guidance from National and Regional teams through membership of Regional HR and Medical forums, weekly system meetings and provider correspondence. The Trust's People and Culture Committee receive assurance of activity concerning Organisational Development and Culture. SFT joined the NHS People Promise exemplar program in the first wave and has implemented mechanisms to capture development requirements through the OD, Culture and Learning Working Group, which meets quarterly and reports to the People and Culture Committee. An example of the work

	done has been the development of a clinical leaders' development program, which launched with its first cohort last year and will build on this work in the coming year. The CMO and Appraisal and revalidation lead attend HLRO updates regularly which are attended the GMC ELA, in addition to quarterly meetings between the CMO and ELA at which regulatory and governance developments and issues are discussed.
Action for next year:	To continue

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/A
Comments:	SFT maintains oversight of professional healthcare standards through several mechanisms which include the Clinical Governance Committee and People and Culture Commitee, Safe Staffing committee, Medical Education and Training Committee and OD, Culture and Learning Working Group.
Action for next year:	To continue

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	N/A

Comments:	A robust set of pre-employment checks is carried out on all doctors employed by the trust in line with GMC guidance. Oversight is provided by the Trust's medical workforce group with assurance to Trust Board through People and Culture Committee
Action for next year:	To continue

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	N/A
Comments:	The Trust has adopted "Improving Together" as its operational excellence/continuous improvement methodology. An extensive training program is being rolled out across the organisation as we embed the approach into "the way we do business". The Improving Together approach is now adopted by all Trust committees, including those which oversee professional standards activities as identified above. We have become something of an exemplar site for embedding a continuous improvement methodology and have hosted learning visits by several organisations across the UK, North America and Europe to showcase our work
Action for next year:	To continue the roll out of Improving Together across all departments as part of the five year program

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	**Y**

Action from last year:	N/A
Comments:	The Trust refreshed its long term EDI Plan for 23-27 in Jun. This identifies actions against the SW Leading for Inclusion Strategy, and the NHS 6 High Impact Actions for Inclusion.
Action for next year:	A priority task this year is to implement Cultural Development Objectives to reduce the percentage of staff with protected characteristics who experience bullying, harassment and discrimination, and introduce Masterclass training for all staff to support our vision metric of an inclusive place to work. The SFT EDI LT Plan also identifies action required to meet the recommendations of the 'Improving the Working Lives of Doctors" report

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	N/A
Comments:	This activity is led by Trust Executives and supported by the Organisational Development Team. A new Leadership Behaviours Framework has been developed; a series of Leadership training interventions at 3 levels through the Trust, which utilise the Framework as its key methodology are being successfully delivered; use of the Improving Together methodology (and the associated training to support this delivered by our Coach House); use of the Behaviours framework to support all recruitment activity.
Action for next year:	To continue to embed leadership behaviour framework using improving together methodology

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y

Action from last year:	N/A
Comments:	We have a 'Managing concerns for doctors and dentists' policy which is aligned with the Maintaining High Professional Standards (MHPS) framework. This was updated and ratified in April 2024. We also hold regular consistency panels to assure ourselves that we are applying this policy in a consistent manner. We also have PALS and FTSUG as additional routes for raising complaints/concerns. Regular dialogue sessions are scheduled between the CMO and the Chairs of the BMA Local Negotiating Committee as well as the Chair of the Medical Staff Committee which provides a further forum for concerns/comments about the Trust's professional standards processes to be raised.
Action for next year:	To continue

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Y
Action from last year:	N/A
Comments:	As part of the consistency panel, mentioned above, we collate and review demographics / EDI data for all cases.
Action for next year:	To continue to develop and mature the MHPS/ROAG panel

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	N/A.
Comments:	Regular HLRO network meetings are attended by the RO and lead appraiser to ensure that professional standards are being adhered to. Scheduled quarterly meetings between CMO and appraisal and revalidation lead with the GMC ELA as described
Action for next year:	To continue to attend regular networking events and engage with the GMC to ensure that all professional standards are met.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	361
Total number of appraisals completed	327
Total number of appraisals approved missed	19
Total number of unapproved missed	9
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	83
Total number of late recommendations	0
Total number of positive recommendations	76
Total number of deferrals made	7
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	44
Total number of trained case managers	44
Total number of concerns received by the Responsible Officer[2]	11
Total number of concerns processes completed	6
Longest duration of concerns process of those open on 31 March (working days)	12 weeks
Median duration of concerns processes closed (working days)[3]	6 weeks
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	180
Total number of new employment checks completed before commencement of employment	180
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

The reporting period for 2024/25 extends a period of renewed continuity post pandemic with missed appraisal dates during this period now rectified. During this period there were 361 prescribed connections. The completed (327), approved exceptions (19) and missed appraisals (9) add up to 355. 56 prescribed connections as of 31st March 24 were not due an appraisal until the 2025-26 cycle, mainly due to relatively late Trust start dates. Whilst we see that 22% of doctors' appraisals are overdue on date of appraisal, only 9% have been overdue for more than 3 months. Most of these appear to be the junior Trust Grade/Local Employed Doctors who have shorter contracts and need more support understanding the appraisal system. This has improved over the year as the new system for monitoring appraisal compliance has become embedded.

Appraisal rates are monitored on a monthly basis and continue to be above 90% compliance. An email reminder process was introduced with monthly reminder emails in the 3 months prior to their anniversary dates and monthly reminders for the 3 months after ending in a personal email from CMO for non compliance at this period. This has ensured that compliance improved markedly and remains high.

Appraisal audit is performed using the validated ASPAT tool incorporated within the Premier IT system which is used by many of our colleagues in the South West.

Regular appraisal update training and development is provided by the Trust for registered appraisers and this has included a training session on professional standards run by the GMC. The SW NHSE team support the RO and lead appraiser with quarterly HLRO update/network meetings.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Work over the next year will include:

- renewal or replacement of our digital appraisal platform.
- Further improvement of the MHPS consistency panel/Responsible Officer Advisory Group delivering improved reporting and assurance, including measures to identify bias and discrimination within structures and processes
- Writing of policies to support governance of Physician Assistants, and implementing local recommendations within the Leng report
- Updating Trust policies relevant to governance of the medical and PA workforce
- Identifying and implpenting improved processes for overseeing the appraisal, revalidation and professional standards of the steadily growing cohort of 'professional locums' who connect with SFT on the back of doing ad hoc locum work through our collaborative bank.

Actions still outstanding

Decision on re-procurement of Premier IT or replacement with an alternative system aligned with BSW Hospitals group partners

Current issues

As already described:

- Governance of ad hoc bank locum doctors
- Oversight of Physician Assistants
- Immaturity of MHPS panel

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Dr Murray and Dr Cole +/- Deputy CMOs, where able, to attend HLRO updates

Licence for Premier IT extended/replaced as currently looking at joint procurement with group partner/s

Policy reviews

Improved oversight of bank locum doctors

Implement governance arrangements for PAs

Update medical staff appraisal policy

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Overall SDH has maintained high levels of compliance with medical appraisal over the year 2024/25. There has been a change of RO during the reporting period who has supported revalidation. There has been a smooth transition and monthly meetings with the appraisal administrator has helped enable this.

There are several opportunities for improving the governance of the medical and physician assistant workforce that have been described in more detail in the body of this report.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	4 September 2025		

Report title:	Research Annual Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee			
Prepared by:	Tumi Kaminskas Head of Research			
Executive Sponsor: (presenting)	Zoe Cole on behalf of Duncan Murray			
Appendices	N/A			
BAF Risk link				

Recommendation:
The paper is provided for information and assurance purposes.

Executive Summary:

Executive Summary – Research Department Annual Report 2024/25

- Research Capacity and Growth:
  Patient recruitment was largely sustained throughout 2024/25, with a modest increase of 148 participants compared to the previous year. While there was a slight reduction in the number of studies open and actively recruiting, this reflects the conclusion of several large studies that reached completion during the reporting period.

  However, the overall research portfolio continues to grow. As of April 2025, there has been a notable increase in study set-up activity, with eight new non-commercial studies and five new commercial studies opened. In addition, two further commercial studies are currently in the pipeline, indicating continued momentum and engagement from industry partners.

- Delays in Administrative Staff Recruitment:
  Recruitment to administrative roles was adversely affected by the additional workforce controls, despite the posts being externally funded. This led to an underutilisation of NIHR Research Capability Funding during the year.

- Capital Funding Returned Due to Infrastructure Constraints:
  A total of £80,099 in capital funding was returned to the NIHR. This resulted from internal support departments being unable to proceed with equipment purchases due to a lack of IT software readiness and technical support.

- Partial Repurposing of Underspent Funds Approved:
  Following proactive negotiation, a portion of the underspent capital funding was approved for repurposing. Payment of these funds is expected during the current financial year.
- Additional Funding Forfeited Due to Spend Constraints:
  An additional £35,000, awarded in January 2025, was returned to the NIHR RDN as the funding conditions proved unworkable within the specified timeframe. The criteria required purchases of less than £5,000 per item to made and full spend achieved within three months of award. However, due to delays in approval for recruitment, the funding could not be used against pay, leaving limited viable options for timely expenditure.
- Successful Bid for Additional Pharmacy Support:
  NIHR RDN funding has been secured to support one additional day per week of 8A Pharmacist time during 2025/26, strengthening the department's research delivery infrastructure.
- Increased Capacity Through Full-Time Research Manager Post:
  The appointment of a full-time Research Manager has positively impacted study throughput, enabling faster study reviews and reduced setup times.
- Ongoing Finance Support Deficit:
  The lack of dedicated finance support, where we are an outlier compared to group partners and unaligned with national expectations, remains a challenge. A research-focused finance role would provide essential functions such as trial income tracking, invoicing, multi-funder reporting, internal grant costings for home grown studies, and expenditure forecasting. Most importantly, it would also enable consistent representation at Wessex CRDC finance meetings, now particularly relevant given Salisbury's status as a new spoke partner.
- Research Hub Equipment Spend Completed Successfully:
  Pharmacy and Laboratory equipment for Salisbury's Research Hub was successfully procured, amounting to a spend of £58,000 in research finance income, as required before the close of the 2024/25 financial year.
- The Research Team adopted the Improving Together model to support a culture of continuous improvement. The three departmental motivational drivers: growth, increased profile, and morale are reflected throughout this report.
- The R&I Board has been stood down due to consistently low attendance from quorate members. Work is underway to establish a replacement research governance function as a bridge to a group aligned function pending the appointment of a group Director of Research.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/A

1. Background

This annual report provides a strategic overview of the activities and performance of the Research Department at Salisbury NHS Foundation Trust for the period April 2024 to March 2025. It outlines the department's contribution to the Trust's objectives and its alignment with national research priorities set by the National Institute for Health and Care Research (NIHR) and the wider NHS research strategy.

The report includes an update on the work of the Research and Innovation Board, established in 2023, with the aim to guide the strategic direction, oversight, and integration of research across the organisation. The Board plays a key role in ensuring that research remains embedded within clinical services, drives innovation, and supports improvements in care quality, patient outcomes, and staff development.

Focus areas covered in this report include:

- **Patient recruitment into research studies**, demonstrating the Trust's continued engagement in research initiatives
- **Performance against the NIHR High Level Objectives (HLOs),** providing assurance on delivery, timeliness, and access to research opportunities
- Findings from the **Patient Research Experience Survey**, informing improvements in patient and public involvement
- A summary of **research grants** secured, supporting capacity, capability, and research growth within the Trust
- Progress and **performance of sponsored (home-grown) studies**, reflecting internal research leadership and delivery
- Details of **capital funding and research equipment investment**, enhancing infrastructure to support current and future research activity
- An update on the **Research Culture Review**, including actions to support an inclusive and research-positive environment

The report also highlights key achievements across 2024/25 and sets out the strategic priorities for 2025/26, with a continued focus on impact, collaboration, and the **sustainable growth** of research across the organisation.

2. Patient recruitment into research studies

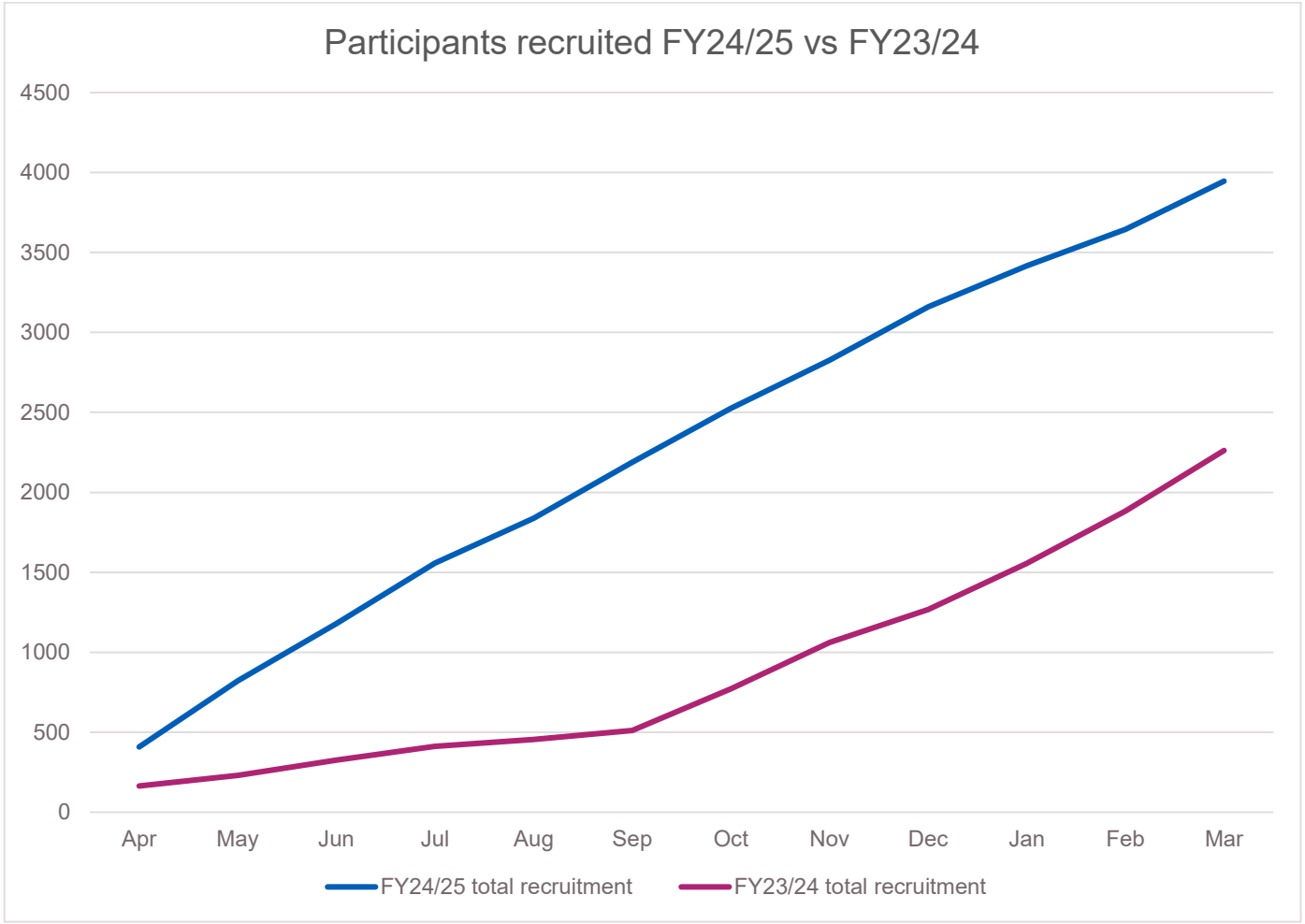
Patient recruitment throughout the 2024/25 financial year has remained steady, with the Trust maintaining consistent involvement in national research activity. Salisbury NHS Foundation Trust performed particularly well in larger, high-profile studies, achieving results comparable to those of much larger organisations.

The Trust made a significant contribution to the SMA: Newborn Screening for Spinal Muscular Atrophy Study, recruiting 1,796 babies from approximately 2,500 births. This represents one of the highest levels of participation nationally and reflects strong collaboration between the Research Team and Maternity Services. The Trust also ranked second nationally in the ASPECT Study (Aspirin after hospitalisation with Pneumonia to prevent cardiovascular Events randomised Controlled Trial), demonstrating strong capability in delivering complex interventional research.

A slight decrease in recruitment was noted during the first quarter of 2025. This has been linked to the conclusion of several high-recruiting studies and the transition to new internal processes for reviewing and expressing interest in newly advertised studies. Measures are in place to support a smooth transition and ensure continued engagement with upcoming research opportunities.

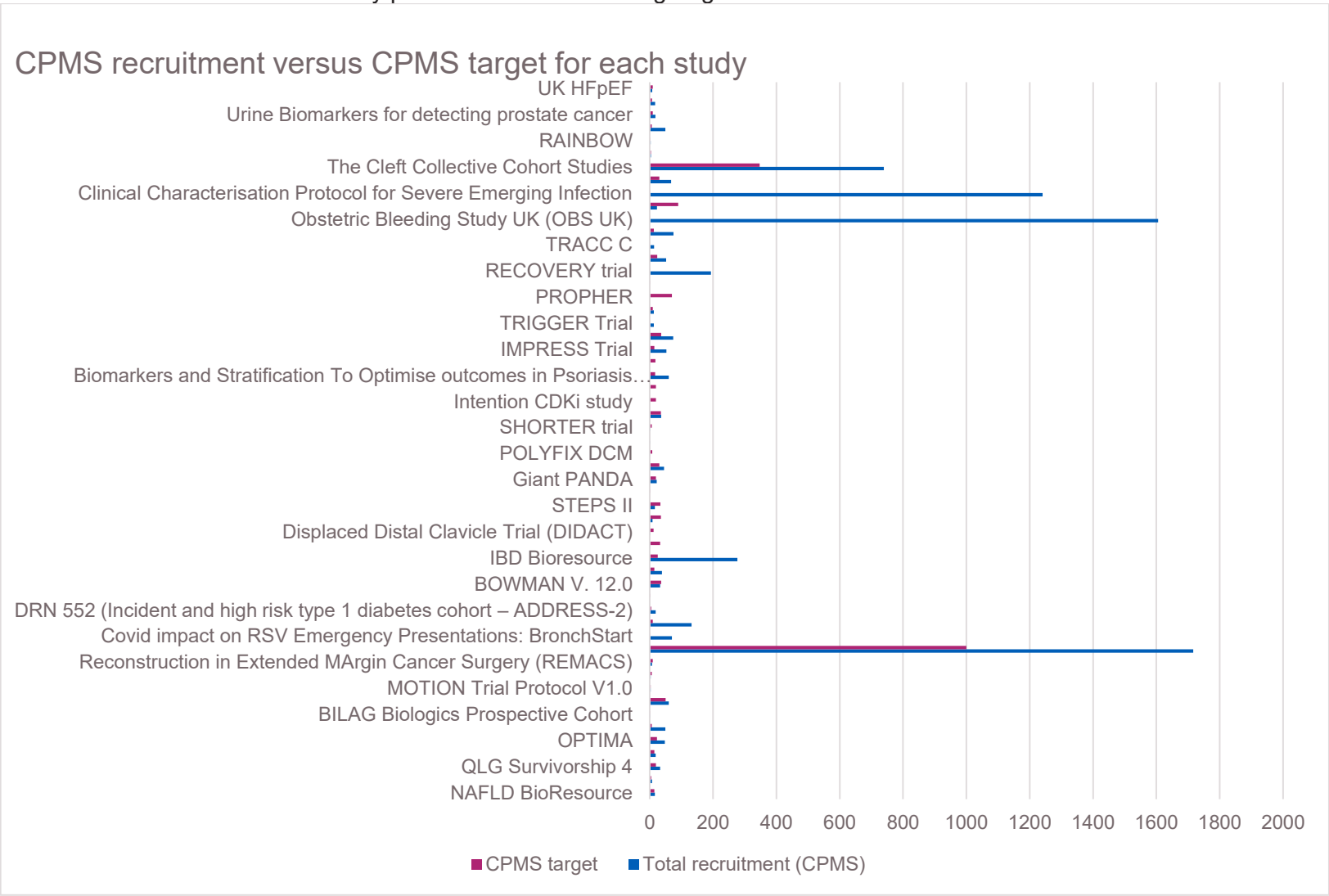
Cumulative recruitment

Recruitment Date _Month	FY24/25 total recruitment	FY23/24 total recruitment
Apr	408	164
May	822	230
Jun	1179	326
Jul	1557	412
Aug	1838	455
Sep	2189	511
Oct	2526	772
Nov	2827	1062
Dec	3160	1268
Jan	3417	1556
Feb	3645	1884
Mar	3946	2262
	FY24/25	FY23/24
Total number of recruiting studies	55	62

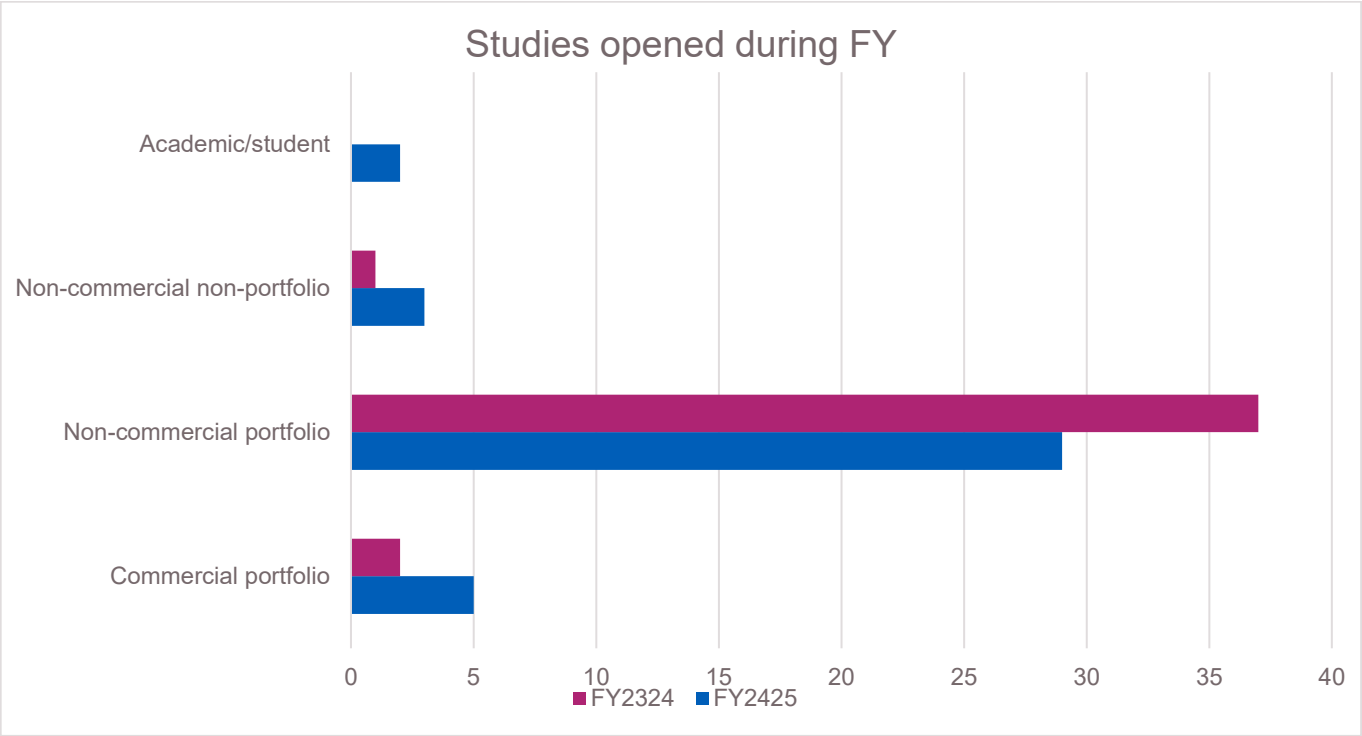

Participants recruited FY24/25 vs FY23/24
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
FY24/25 total recruitment
FY23/24 total recruitment

Performance against the NIHR High Level Objectives (HLOs)

The table below indicates Salisbury performance on achieving targets for non-commercial studies.

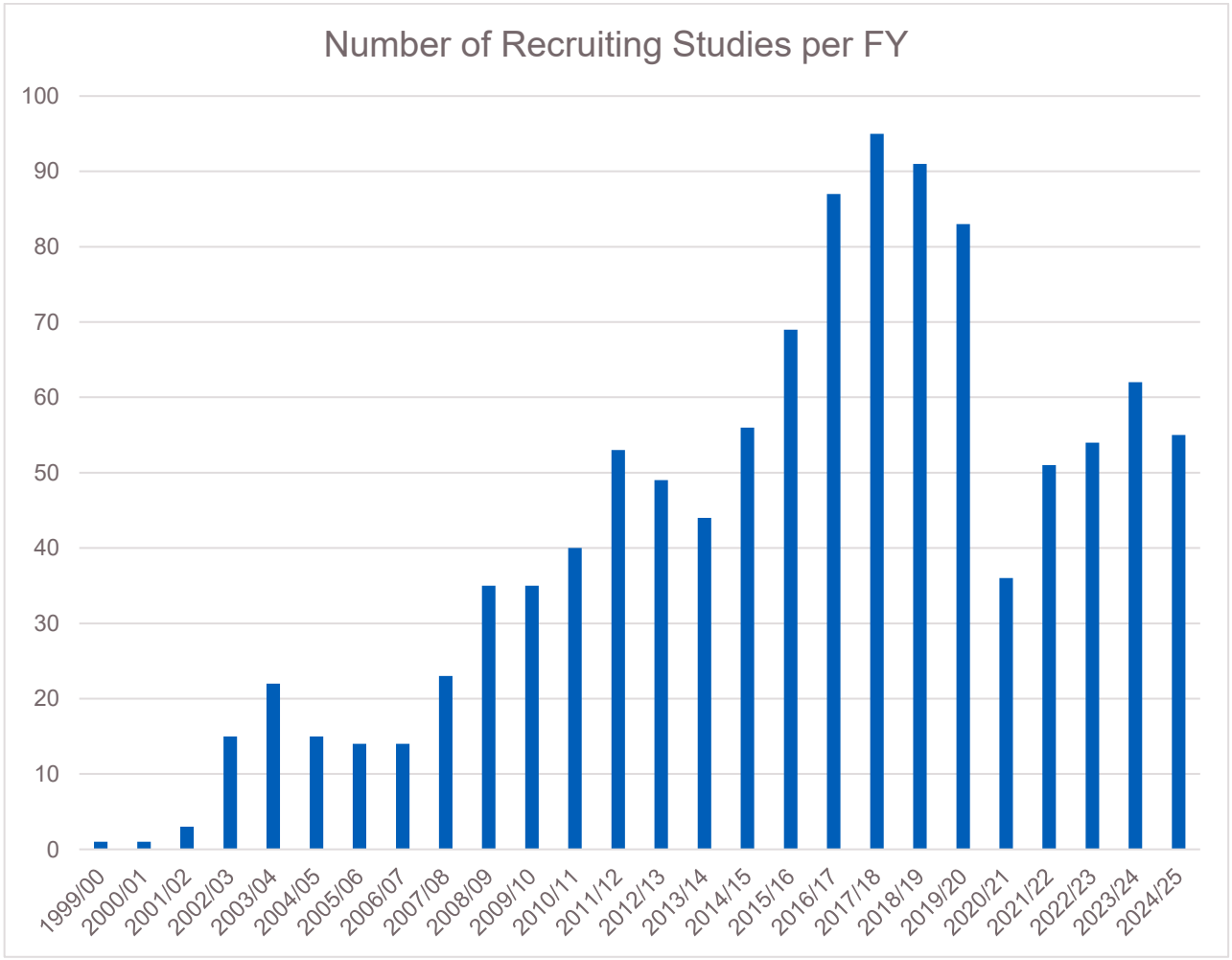


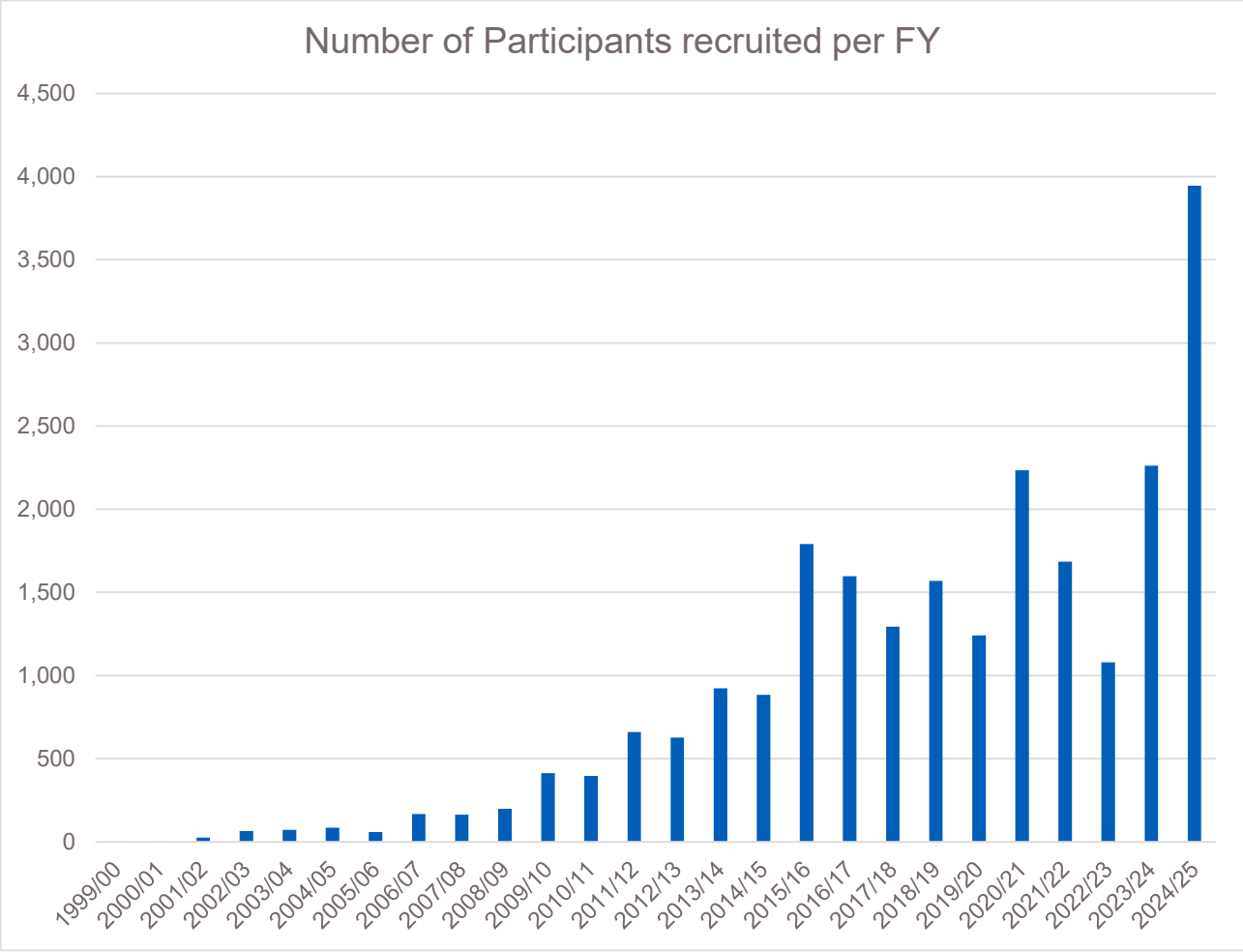
The table below indicates Salisbury performance commercial and non-commercial studies open



Studies opened in FY	FY2425	FY2324
Commercial Research Studies open	5	2
Non-commercial Research Studies open	29	37.0
Non-commercial non- NIHR portfolio adopted Research studies open	3	1
Academic/student	2	0

Growth of SFT research activity




Number of Participants recruited per FY
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1999/00
2000/01
2001/02
2002/03
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2023/24
2024/25

Patient Research Experience Survey (PRES)PRES

This is an NIHR tool designed to collect feedback from research participants, with the goal of enhancing their experience by gathering insights on various aspects of the research process. We anticipate a decline in uptake for this national survey as the paper-based format is gradually phased out, with the digital version set to be fully implemented in the final quarter of 2025.

Whole FY 2024-25
PRES responses to SFT

86 responses

10 separate research studies

97% of responders felt prepared for the study experience

100% of responders felt treated with courtesy and respect

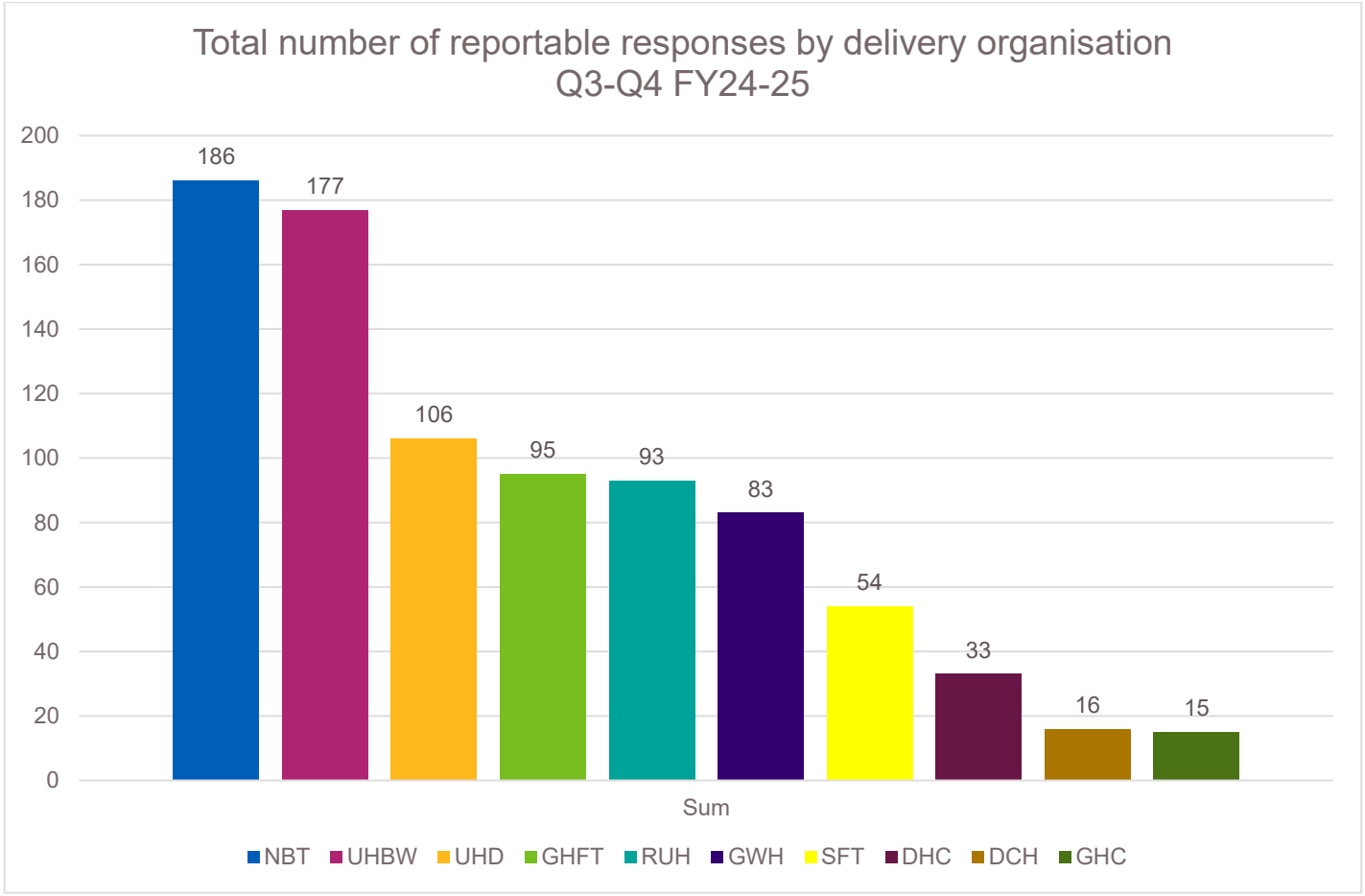
82% of responders knew how to contact someone from the team

91% of responders felt valued by research staff

82% of responders felt they had been kept updated

96% of responders would consider taking part in research again

47% of responders knew how they would receive study results


Total number of reportable responses by delivery organisation
Q3-Q4 FY24-25
200
180
160
140
120
100
80
60
40
20
0
186
177
106
95
93
83
54
33
16
15
Sum
NBT
UHBW
UHD
GHFT
RUH
GWH
SFT
DHC
DCH
GHC

Research grants

During 2023/24, Salisbury NHS Foundation Trust hosted four sponsored studies, which attracted a total of **£705,320.00** in NIHR research grants. Two of these studies concluded in 2024, leaving **BOWMAN** and **STEPS II** as the remaining active, home-grown studies in 2024/25.

The Trust continues to collaborate with other regional sites to develop a shared resource, enhancing support for clinicians who wish to apply for research grants. Additionally, we remain committed to supporting our clinicians, particularly NMAHPs, by providing funding for backfill positions, ensuring they have the opportunity to focus on research alongside their clinical duties

Performance of sponsored (home-grown) studies

BOWMAN V. 12.0 – The recruitment is on track and has successfully met the target of 36 participants.

STEPS II – actual start date January 2024 and planned closure date is in August 2025. The study is currently recruiting at a lower rate than expected. There were also delays in set-up, recruitment is now going well and discussion with funder regarding an extension to the recruitment period.

Capital funding and research equipment investment

Salisbury NHS Foundation Trust successfully secured £247,653 in capital funding from the NIHR, disbursed on a quarterly basis throughout the 2024/25 financial year. We are reporting an underspend of £80,099, primarily due to the inability to proceed with the purchase of the Ophthalsuite software for the Ophthalmology service and the Portable Ultrasound for Women's Health.

The following equipment was successfully acquired:

- Magstim Super Rapid +1 Transcranial Magnetic Stimulator (TMS)
- Brainbox Neuronavigation System
- Portable ECG
- -80 Freezer

Research Culture Review

While communication within the team has improved, leadership has also prioritised enhancing transparency. Management meetings have become more focused, with their frequency reduced to improve productivity. These meetings are now minuted, and the information is centrally stored for easy access by the wider team.

Despite these improvements, morale remains low, with some historic behaviours re-emerging. Development opportunities has been provided to the senior leadership team by Neville Bonner – OD and P. The wider team is encouraged to share ideas for improvement through bi-weekly team huddles, weekly wellbeing surveys and meetings.

Conclusion

The Salisbury NHS Foundation Trust Research Department continues to position itself as a vital contributor to the regional and national research landscape, with a clear ambition to expand its capability and visibility through the development of a fully operational Research Hub. This will act as a focal point for research delivery, supporting increased recruitment, enhanced collaboration, and stronger integration with both commercial and non-commercial partners.

Our strategic priorities include:

- Growing our research portfolio through participation in CRDC (Clinical Research Delivery Centres) Hub studies, alongside the development of our own home-grown non-commercial and commercially sponsored studies.
- Encouraging and enabling research activity within the NMAHP (Nursing, Midwifery, and Allied Health Professions) workforce to ensure our research culture is inclusive and multidisciplinary.
- Strengthening infrastructure to support sustainable research delivery, with a focus on capability, diversity, and long-term planning.

However, several barriers and risks remain. A key concern is the inability to utilise available funding at pace to secure the infrastructure required to grow — particularly in terms of building and retaining a diverse and skilled workforce. This is a recognised strategic priority for the NIHR, and one that directly underpins our capacity to deliver high-quality research at scale.

Another significant risk is the absence of a dedicated finance function within the research team. As Salisbury becomes more embedded in the Wessex CRDC partnership, a research-specific finance presence is critical. This will ensure accurate reporting on partner share, income tracking from sponsors and collaborators, and representation of Salisbury's NHS FT financial and strategic interests within the broader CRDC network.

Despite these challenges, our commitment to delivering impactful, inclusive, and scalable research remains strong. With structural support, we are confident in our ability to achieve the vision of a fully functioning Research Hub that reflects the needs of our population and the ambitions of our Trust.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.2
Date of meeting:	4th September 2025		

Report tile:	Perinatal Quality Surveillance Report - Salisbury NHSFT Maternity & Neonatal services –**July 2025 (June 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Maternity Governance 10.07.25 Maternity and Neonatal Assurance Committee 17.07.25 CGC July 27th 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the Board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – Year 7 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (Safety Action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The Perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance Report for SFT for June 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW.

Summary:

Escalation

- **Escalation to Trust Board of Maternity and Neonatal Voices Partnership (MNVP) infrastructure and funding as inadequate. MNVP funded by ICB and not adequately resource at present**

against national asks. In view of this escalation to SFT, RUH, GWH Trust Boards to enable knowledge and oversight – in view of CNST requirements.

Staffing:

- Midwife to birth ratio 1:28– SFT recommended ratio 1:24.
  - Increase in vacancy and maternity leave
  - Increase in band 6 Midwifery vacancies to 6.93 WTE
- Neonatal nursing staffing remains non-compliant to BAPM standards, business case presented to TMC and agreed to take to system for consideration.
- Neonatal Paediatric workforce non-compliant to BAPM standards, workforce review in progress pre business case as per action plan in December 2024.
- 1:1 care in labour achieved 100% of time.
- Supernumerary status of labour ward maintained 100% time.

PMRT:

- 1 PMRT review in June, graded B and A

Incidents reported as moderate:

- 6 Incidents reported as moderate or above. Immediate review complete, but more detailed review not yet complete due to access to notes and new Badgernet system causing delay in review.
  - 2 Term admission to Neonatal Unit.
  - 3 PPH >1500 ml.
  - 1 high risk patient with omission around Obstetric referral.

Service user and staff feedback:

- Significant feedback re IT challenges and connectivity, particularly in community which is compromising care and place of care.
- Maternity Dashboard not available, meaning no ability to compare trends and benchmark outcomes locally and nationally.

Compliance to National Standards:

- Saving babies lives – 87% compliant in May submission against 7% compliance in October 2023.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

NHS
Salisbury
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

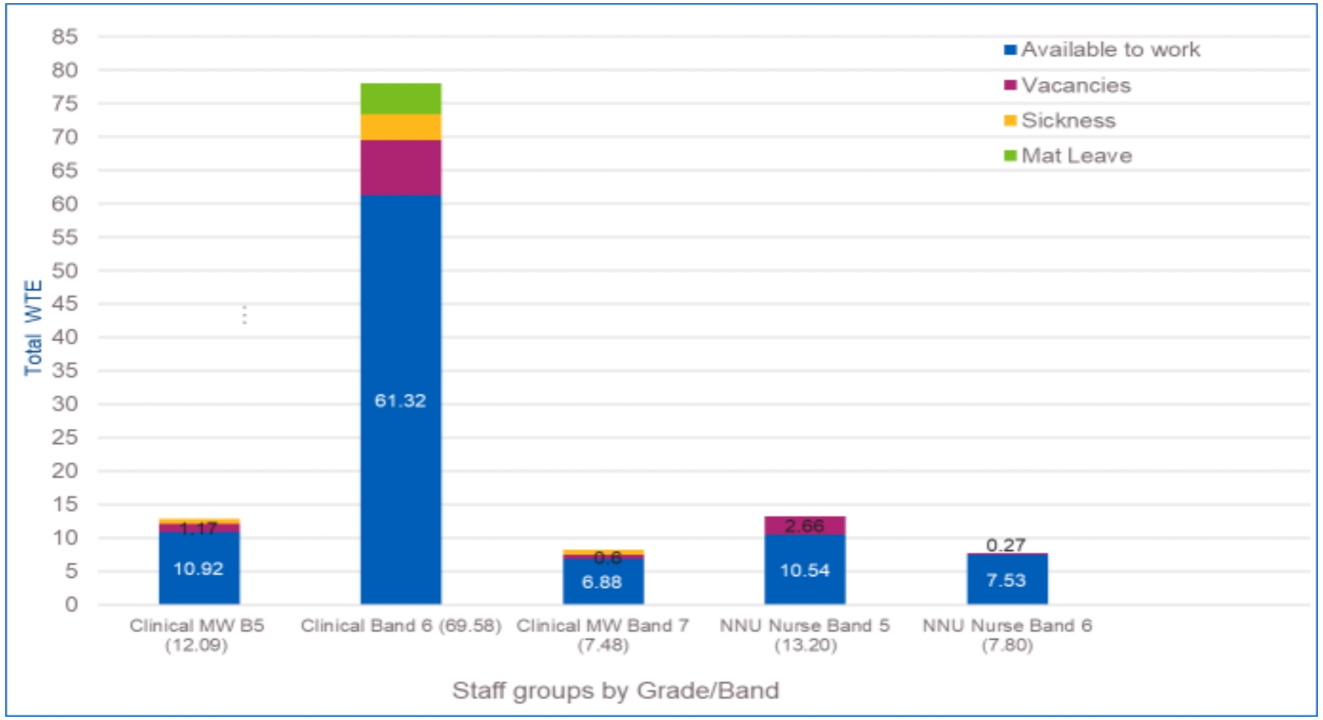
July 2025 (June Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was favourable this month showing 95% compliance of required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show a marginal decrease due to one leaver in month.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this and is ongoing.

NHS Salisbury NHS Foundation Trust

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Apr '25	May '25	June '25
Midwives	Day	93.6%	96.2%	90.7%
	Night	95.4%	97.5%	95.1%
MCA / MSWs	Day	83.8%	78.3%	78.1%
	Night	89.7%	86.7%	89.7%
NNU Nurses	Day	89.7%	93.7%	87.8%
NNU Nurses	Night	98.0%	99.8%	99.2%

Countermeasures / Action (completed last month)	Owner
• Review of sickness absence management compliance – new process implemented.	HOM

Countermeasures / Action (planned this month)	Owner
• Monitoring of new sickness absence management process. • MCA recruitment	HOM MCA Lead

Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		April '25	May '25	June '25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1:28	1:29	1:28	Ratio increased this month due to an increase in births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	81.11%	79.03%	87.7%	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		60	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	56%	37.1%	55%	Neonatal staffing on Risk Register and acuity being assessed daily, Datixed as appropriate. Business case being written and recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	

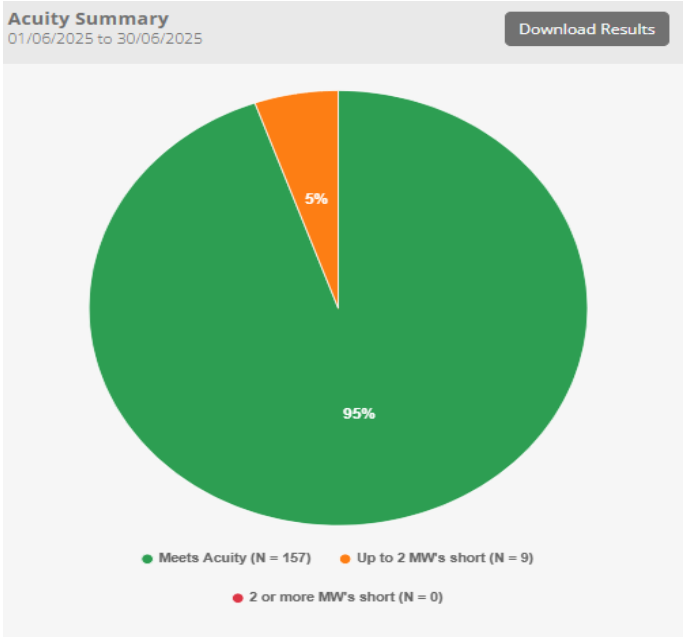
Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.
- BAPM compliance improved since last month, activity being monitored and support given on a shift-by-shift basis to maintain safe care.

What are the top contributors for under/over-achievement?

- The Midwife to Birth ratio decreased this month due to decreased acuity and births.

Graph 1. Acuity by RAG vs staffing data:

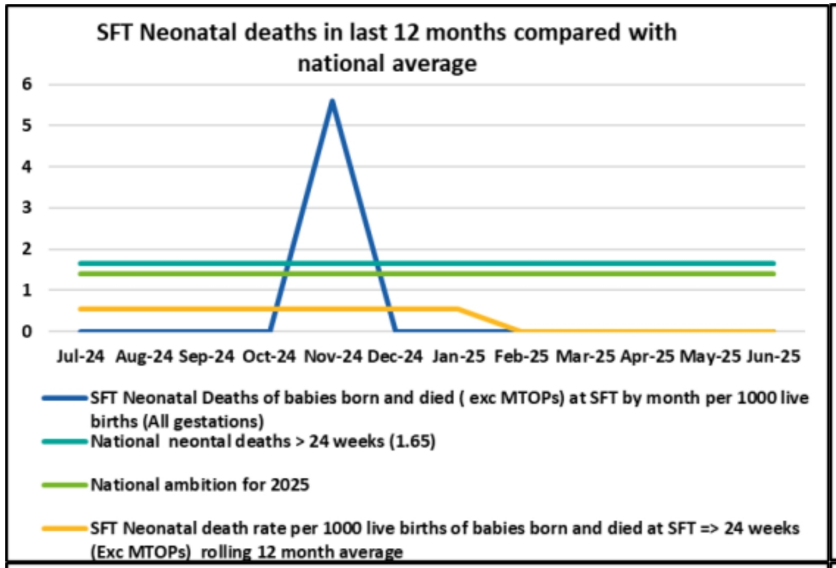


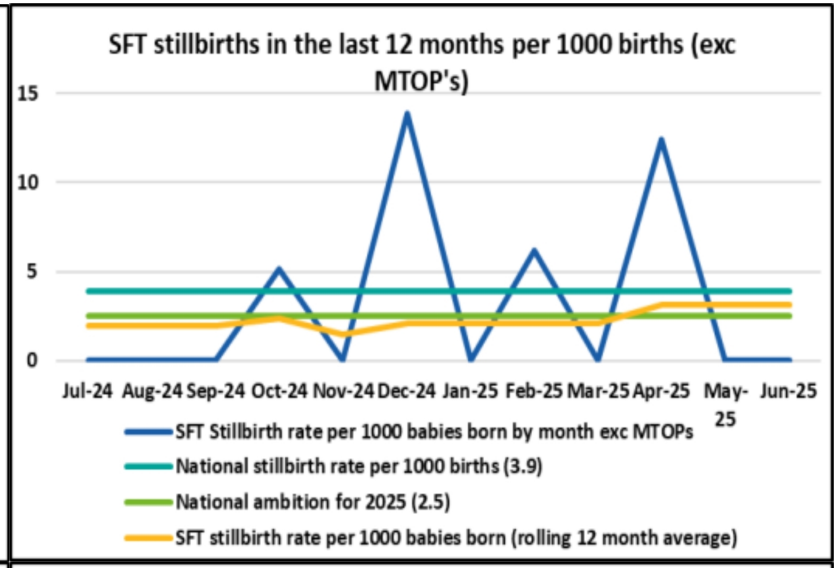
Countermeasures / Action (completed last month)	Owner
- Neonatal Matron recruitment - Neonatal Quality and Safety Lead Nurse recruitment	HOM Interim Neonatal Matron(s)/ HOM

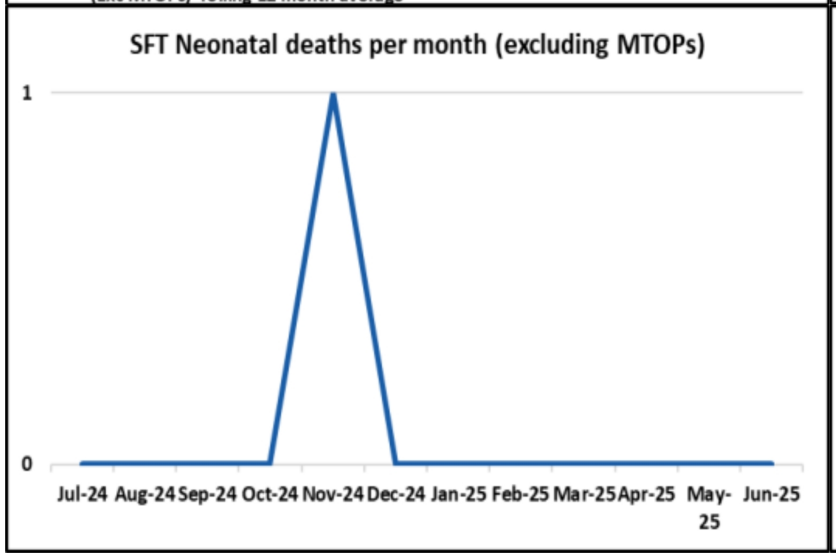
Countermeasures / Action (planned this month)	Owner
- Neonatal Matron recruitment - Neonatal Quality and Safety Lead Nurse recruitment	HOM Interim Neonatal Matron(s)/ HOM

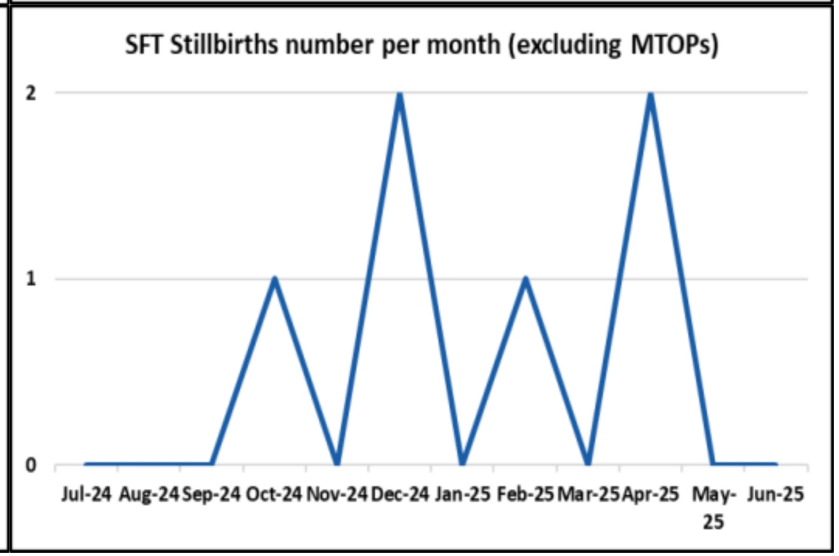
Safe: Perinatal Mortality Review Tool (PMRT)

Salisbury NHS Foundation Trust









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 7. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- June's stillbirth rate means SFT rate just over national ambition, however, remains under national stillbirth rate.

- There was 1 perinatal loss in June>12 weeks.
- One miscarriage at 13-14 weeks.

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

PMRT ID and PMRT Review date	Incident	Grading of care	Outcome/Learning/Actions	MNSI Reference	SI? Reference
98122 5/6/2025	Antepartum stillbirth at 37 weeks and 4 days	Grading of care up to the point the baby had died: GRADE B Grading of care of the mother after the baby had died: GRADE A	All care was in line with guidance and appropriate. There were no actions generated from the tool regarding issues, however parental feedback on feelings around appointments and uncertainty around accessing information on the new electronic notes system were recognised and the grading of care reflected this. The parents have had a debrief appointment which included discussion around the electronic notes. Teams have been given the feedback around feeling rushed in appointments.	NA	NA

INCIDENTS: Moderate Incidents and PSRs

Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (Datix)	Date of Incident	Category	Incident Summary	Comments	PSII Commissioned?	MNSI Ref	PSII Ref
177627	8/6/25	Moderate	1500ml PPH with brief ITU admission	Still under review pending staff insight		N/A	
177875	13/6/25	Moderate	High risk patient with no obstetric referral	Still under review pending further investigation		N/A	
177940	15/6/25	Moderate	Term admission APGAR 6@5	For part 1 PSR		N/A	
178036	18/6/25	Moderate	2000ml PPH	Under review		N/A	
178062	18/6/25	Moderate	2000ml PPH	Under review		N/A	
178165	19/6/25	Moderate	Term admission	Under review		N/A	

INCIDENTS: Investigation update

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Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date of Incident	Category	Incident Summary	Outcome / Learning / Actions
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report

PSR's Submitted

Datix	Date presented	Category	Incident Summary	Outcome / learning / actions
175349	3/6/25	Moderate	Incorrect dosage of Atosiban	Guidance amended with clearer flowchart.
177109	10/6/25	Moderate	Ferinject staining to arm	PSR 2 to be presented at PSOG 10/7/25.
174396	10/6/25	Moderate	In-utero transfer of twins	Part 2 ready to submit following awaited further insight.
177164	17/6/25	Moderate	Breech IOL with no presentation scan	PSR 1 - Guidance to be amended to include scan upon transfer from DAU to LW & reminder for abdo palp prior to VE.
177363	17/6/25	Moderate	OASI – blunt episiotomy scissors	PSR1 - Assurance that all episiotomy scissors are fit for use and clear pathway to escalate those that are not.
177475	17/6/25	Moderate	PPH 1900ml	Reiteration around closed loop comms.
177305	17/6/25	Moderate	PPH 2000ml with low BMI	Well managed while simultaneous emergencies ongoing.

Responsive – Patient Experience

Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Supportive & amazing midwives
- Respectful of birthing wishes
- Great continuity of community care

"If I could give the Midwives 100/10 I would - everything was amazing!"

Areas for improvement:

- Very noisy/ lots of talking during caesarean birth.
- Rushed scan and consultant appointments.

Complaints and Concerns

Complaints received	Summary / themes
1	• Lack of communication between service providers, resulting in a patient receiving a letter from the HV, when the patient experienced an early pregnancy loss.

Concerns received	Summary / themes
0	None.

Safety Champions

Concerns from staff	Action
• Maternity Dashboard not available since February, meaning no trends to review and ensure care benchmarked appropriately. • Numerous IT issues since movement to Badgernet from community services meaning compromised care, inability to view results in real time etc • IT connectivity in Tidworth Clinic not working meaning clinic relocated to SFT.	• JD setting up meeting with IT lead to explore all IT issues. VM to provide clear list of challenges.

Friends and Family Test

- **As Maternity Services moved to BadgerNet in February, this has had an impact on FFT maternity reporting during March-June 5.**
- **No responses in June.**

- **Mitigations in place: FFT cards have been circulated. QR codes are available on the wards.**

Service User Compliments

- **3 compliments reported on Datix in May for NNU and maternity services.**

Compliments - top themes	Numbers received
Gratitude	1

Items for escalation...

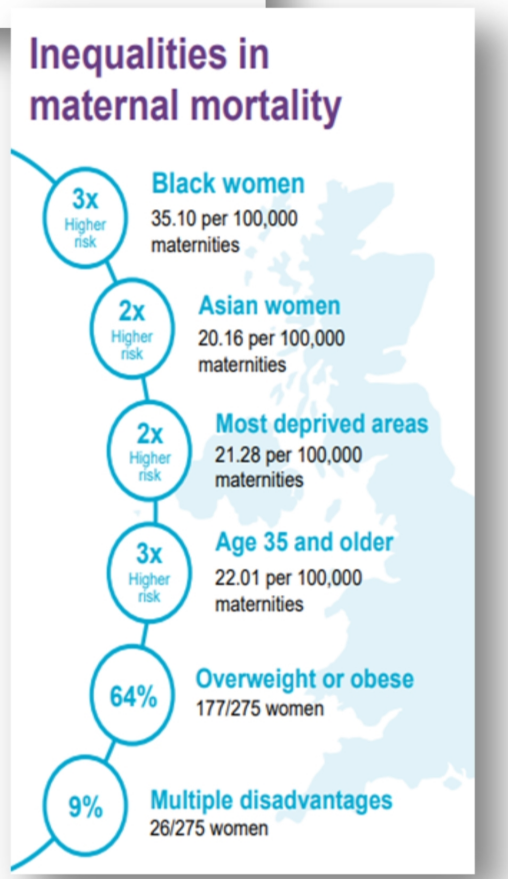
Maternity Dashboard – this work has been delayed due to the data warehouse migration project within the Trust – data needed to support maternity assurance.

You said, we did...

Improve the environment on labour ward.

Work to be completed to support improvements with labour ward décor from estates.

Health Inequalities –Priorities



Listening events: MNVP 15 Steps assessment was undertaken in June 25.

Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data.

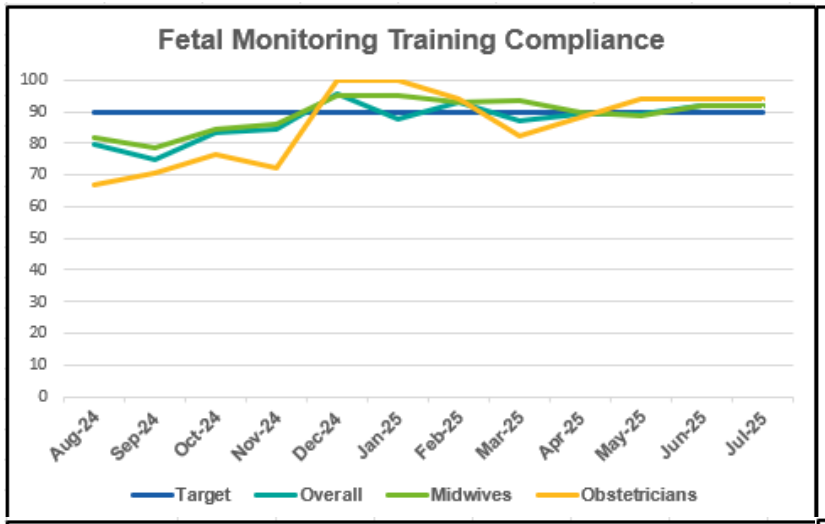
Translation service:

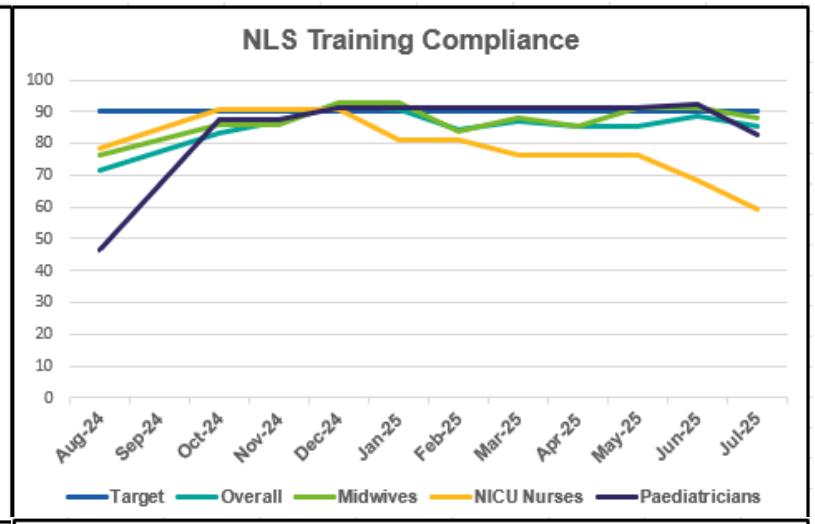
- Renewed emphasis has been placed on the implementation of the Translation toolbar on the Trust's website. The Translation toolbar is on the risk register. IT department are in talks with the provider, in the hope of securing a competitive quote for all three Trusts. June update – No further updates on the implementation of this device. Escalation to the Safety Champions

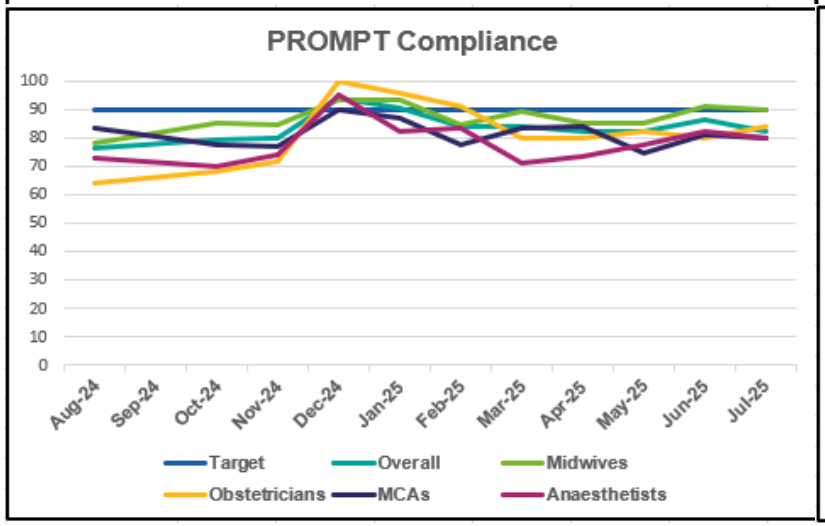
- Implementation of Pocketalk: Steady progress has been made. CSA and Hazard Log has been approved in principle by the CSO. Application has been submitted to the Wessex Health Innovation Real World Evaluation. If successful, the Insights team will support the evaluation of the Pocketalk device.

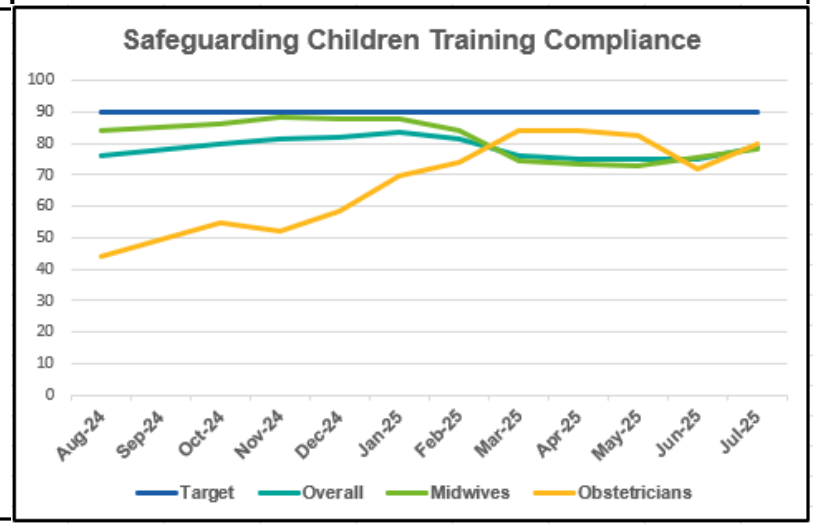
Well-led: Training

Salisbury NHS Foundation Trust









Training:
Training plan commenced in 2025 to meet the Core Competency Framework Version 2 (CCFv2) requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/ action:
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team). All out-of-date midwives are now booked onto training this year.
- NICU staff are trained in NLS on an adhoc basis when staff are available. This has fallen recently due to shift patterns (nights/weekends) and no update was available in June.

Risks:
- MDT attendance (obstetric) at all PROMPT and fetal monitoring training has been achieved in 2025 however overall obstetric compliance remains below the 90% target for PROMPT. All obstetricians continue to be booked to attend these study days but often have competing workloads on the day meaning they do not attend or drop in and out of training.
- Obstetric face-to-face SBL Elements training has been incorporated into rotating obstetricians' induction programmes, scheduled for July and August.

Compliance to National Guidance (1)

Salisbury NHS Foundation Trust

CNST Maternity Incentive Scheme (Year 7)

Maternity Incentive Scheme (CNST)

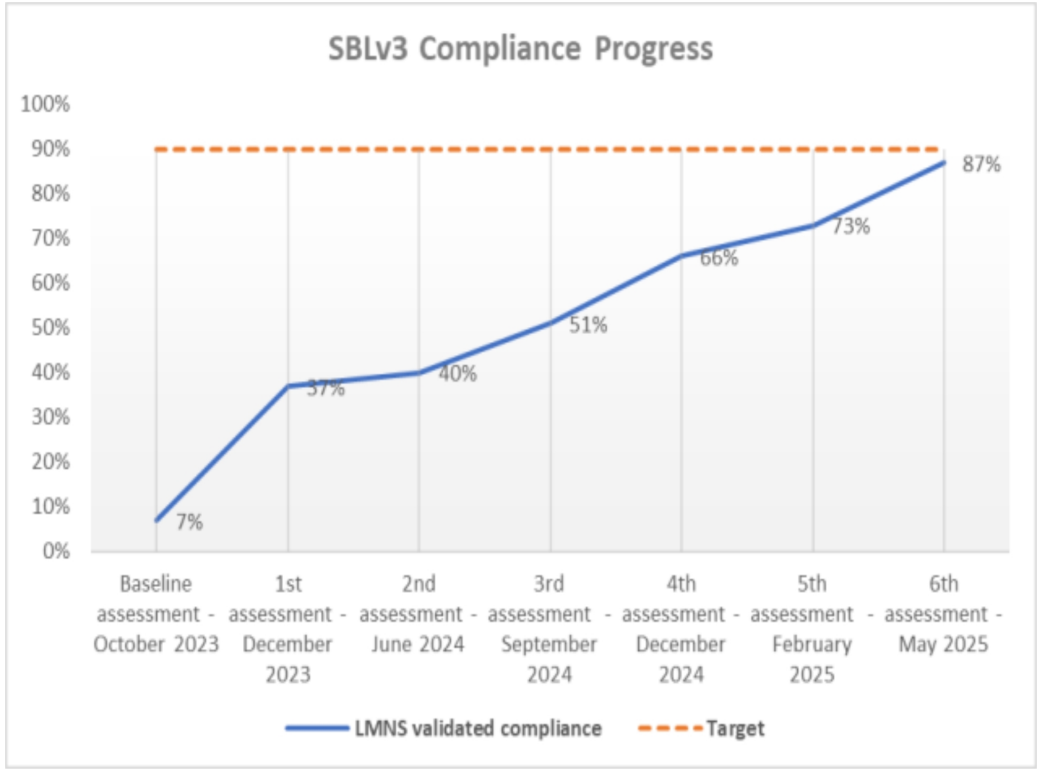
Progress within month:

- The working group continues to meet monthly to monitor compliance of all Safety Actions and have an opportunity to raise any concerns.
- Business Case for Neonatal Nursing workforce presented to Trust Management Committee meeting in June, in line with action plan for Safety Action 4.

Next steps for progression:

- Action holders to confirm reporting timeline for each safety action and minimum evidence requirements – for discussion at July's working group.
- Work around paediatric medical workforce review and subsequent business case in progress.

Saving Babies Lives v3



Saving Babies Lives v3

Key Achievements:

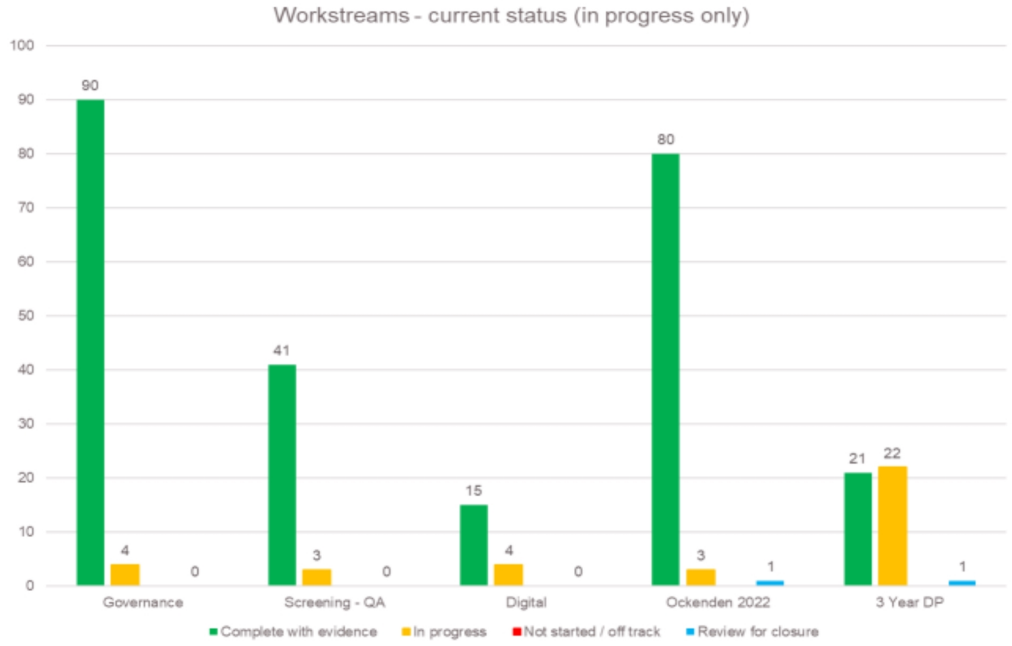
- SFT have achieved 87% compliance with the May 2025 submission.
- Next submission 070/8/25.

Next steps for progression:

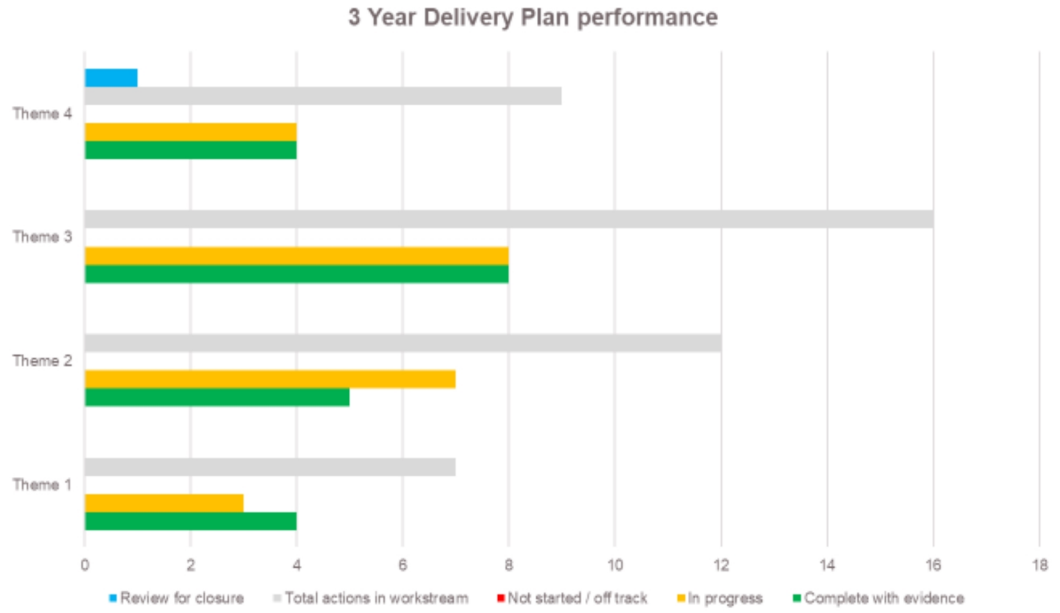
- Updated SBL v3.2 implementation tool received and being reviewed re. changes.

Compliance to National Guidance (2)

Maternity Improvement Plan



3 Year Delivery Plan



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Maternity Improvement Plan

Key Achievements:

- Continue to progress all actions month on month.
- Majority of workstreams now included in monthly Maternity Improvement Group meetings.

Next steps for progression:

- Continue to focus on remaining 5 open workstreams; Governance, Screening – QA, Digital, Ockenden 2022 & 3 Year Delivery Plan.

3-Year Delivery Plan

Key Achievements:

- Of the 44 actions; 21 have been completed with 1 proposed to close in July.
- The remaining 22 are in progress and no concerns identified.

Next steps for progression:

- Continue to meet with action holders.
- Provide evidence of completed actions for sign off at MIG.

Themes

Including PSIRF 'continuous audits' & DATIX

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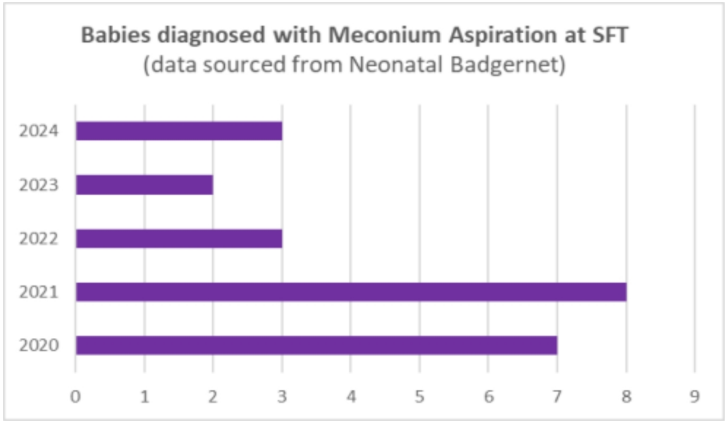
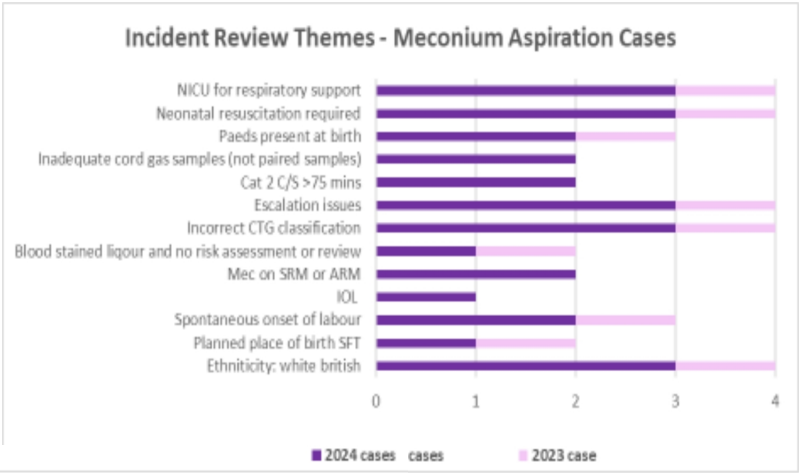
Review of local meconium aspiration cases

Local incidence* of meconium aspiration:

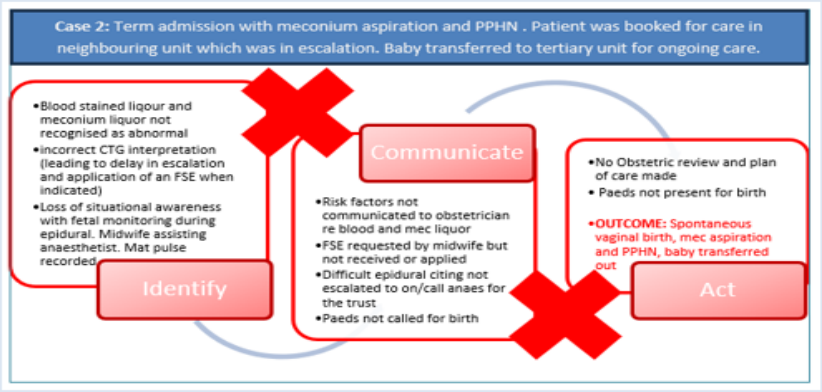


*national incidence is 1-3% births



Clinical escalation is a three-step process: IDENTIFY ▶ COMMUNICATE ▶ ACT

Each case was reviewed to identify at what points in the escalation process a problem(s) occurred e.g.



The escalation challenges were then analysed to consider the behaviours using the COM-B key influencers of behaviour model to understand if the problem was associated with **capability** (knowledge/skills), **opportunity** (systems, time, resources, cultural norms) and **motivation** (believing it is a good idea and in the habit of doing it)

Review of local meconium aspiration cases from 2023-24

e coe commissioning of this review was agreed at Patient Safety Summit.

sulesults and findings

T loT local incidence of meconium aspiration are below the national incidence of 1-3%. Sample size was small (4) although vidioviding rich qualitative data available. All cases reviewed identified incorrect CTG interpretation (identification of eriocterioration) and involved escalation failures. Actions noted in all cases were: education for staff, shared learning and staff hincminders. Two made recommendations for the introduction of the RCOG escalation toolkit.

tiorctions

Dati Datix incident proforma for unexpected admission to NICU developed by Q&S Matron and approved by
Mat Maternity Governance group.
Con Continue RCOG escalation toolkit campaign now that BadgerNet is more embedded.
Star Standardise description of meconium liquor as per NICE and associated descriptors (Significant and Non-significant).
mpl Improve local awareness of when to call paediatrics for attendance at birth and audit effectiveness.
mpl Improve CTG interpretation through centralised CTG, awaiting national Avoiding Brain injury in Childbirth (ABC)
colla collaborative recommendations re risk assessment, monitoring and staff training.

Escalation required from Trust Board to ICB of infrastructure and funding of Maternity and Neonatal Voices Partnership as being inadequate

Salisbury NHS Foundation Trust

NHS England

Escalation (see technical guidance)

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- Staff event undertaken on Friday 25th April 2025; with a focus on OD&L, Wellbeing, opportunity to learn what we are doing as a quad and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024. It was very positively received, and staff appreciated the time to come together and celebrate the team.

Actions in progress:

- Follow up staff event planned for September.
- Progressing a "who's who" leadership board for staff groups, following initial SCORE survey and culture conversations.