Bundle Trust Board Public 13 May 2026

1 OPENING BUSINESS

1.1 10:00 - Welcome and Apologies

1.2 Declaration of Interests, Fit & Proper / Good Character

1.3 Minutes of the previous meeting held on 5 March 2026
- 1.3 Draft Public Board mins 5 March 2026

1.4 Matters Arising and Action Log
- 1.4 Public Trust Board Action Log May 2026

2 APPROVAL

2.1 10:05 - Business Plan 2026/27
- 2.1 2026-05_Business-Plan_PublicBoard FINAL

3 QUALITY AND RISK

3.1 10:15 - Q3 Incident Reporting and Risk Report
- 3.1a Q3 Risk Management report cover sheet
- 3.2b Q3 Risk Management Report

4 PEOPLE

4.1 10:20 - Health and Safety Quarterly Report
- 4.1a Trust Board HS Q3 cover sheet
- 4.1b HS Report FY2627 - Q3

5 GOVERNANCE

5.1 10:25 - NHSE Self Certification (Cos 7)
5.1a NHSE Licence Self-Certification - CoS7 - 2026-27 -
5.1b NHSE Licence Self-Certification - CoS7 - 2026-27 - 26.03.xlsm2

5.2 10:30 - Annual Review of Fit and Proper Persons
5.2 Fit and Proper Persons Annual Assurance Report

5.3 10:35 - Annual Review of Director's Interest
5.3 Annual Register of Interests Report 2025_26 - Trust Board
5.3a Board Declarations
5.3b Senior Staff 8d or Equivalent

5.4 10:40 - Annual Review of Gifts and Hospitlity
5.4a Annual Register of Gifts and Hospitality 2025_26
5.4 Annual Register of Gifts and Hospitality 2025_26 Trust Board

6 CLOSING BUSINESS

6.1 10:45 - Any Other Business

6.2 Agreement of Principal Actions and Items for Escalation

6.3 Public Questions

6.4 Date next meeting 4 June 2026

7 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 5th March 2026, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Eiri Jones (EJ)	Chair
Mark Ellis (ME)*	Group Senior Risk Officer
Nick Johnson (NJ)	Managing Director
Niall Prosser (NP)	Chief Operating Officer
Jonathan Hinchcliffe (JH)*	Chief Transformation and Innovation Officer
Judy Dyos (JD)	Chief Nursing Officer
Cara Charles Barks (CCB)	Group Chief Executive
Duncan Murray (DM)	Chief Medical Officer
Jude Gray (JG)*	Chief People Officer
Andrew Hollowood (AH)*	Group Strategic Clinical Transformation officer
Simon Wade (SW)	Group Chief Finance Officer
Richard Holmes (RH)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Richard Samuel (RS)	Non-Executive Director
Peter Knell (PK)	Non-Executive Director
Anne Stebbing (AS)	Non-Executive Director

In Attendance:

Alex Talbott (AT)	Director of Improvement
Kylie Sanders (KS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (for items 4.5 to 4.10)
Richard Pearce (RP)	Telecoms Manager (for item 1.2)
Caroline Corbin (CC)	Switchboard Operator (for item 1.2)
Ian Crowley (IC)	Director of Human Resources (for item 3.1, 3.2)
Tony Mears (TM)	Associate Director of Strategy (for item 5.3)

Apologies

Rakhee Aggarwal	Non-Executive Director

Observers

Jane Podkolinski	Governor
Mark Wareham	Unison (MS Teams)
Gillian Rennison	Care Quality Commission (MS Teams)
Emily Palmer	Head of Patient Experience (MS Teams)
Peter Russell	Lead Governor (MS Teams)
Yealin Chung	Registrar – Obstetrics & Gynaecology (MS Teams)

ACTION

TB1 OPENING BUSINESS

5/3/1 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 5/3/1.1 **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:

- January SOX of the month – Beverley Knowles, Farley
- January Patient Centred SOX – Maternity and Stars Appeal
- February SOX of the month – Ionela Balan, Elderly Therapy Team
- February Patient Centred SOX – Amesbury Ward

EJ confirmed that certificates would be presented by members of the Executive Team. JD reflected on the diverse staff represented through SOX and the value they add. The Board recorded its thanks to Sasha for her contribution in coordinating SOX and Board papers.

TB1 5/3/1.2 **Staff Story**

IR introduced the staff story, and the Board welcomed RP and CC from Switchboard to the meeting.

RP outlined the current operating model, noting a core team of ten operators (with six on rotation) and additional staff providing cover during peaks. The service has faced prolonged sickness within the team, creating resilience challenges and lone-working risk overnight (17:00–08:00). The removal of receptionists has also increased call-handling volumes for Switchboard.

The Board heard that the team manages approximately 800,000 calls annually (around 2,460 calls per day), excluding face-to-face enquiries at the window. Band 3 operators handle time-critical 2222 emergency calls. The service is exploring automation to reduce pressure and to address single-point-of-failure risks in emergency call routing.

CC described the operator role, including directing callers, providing information to distressed patients and relatives, and administering travel claims (averaging ten minutes per person). Lone-working during time-critical 2222 calls can heighten anxiety, and the team emphasised the importance of documented processes and clear communication.

Discussion:
ME welcomed progress on automation but highlighted that single-point-of-failure risks remain. AS asked whether calls are recorded to support staff after challenging contacts; RP confirmed recording is technically possible but raises information governance concerns. JH advised that the governance issues can be resolved. RH queried call wait times and drop-off rates. ME and CC discussed coordination with Central Booking, noting timing issues and ongoing improvement huddles. JH emphasised the case for redesign, digitalisation and visibility. NJ thanked the team, noting that solutions will include both workforce and technological changes.

EJ thanked RP and CC for their contribution and they left the meeting.

TB1 5/3/1.3 **Welcome and Apologies**

EJ welcomed everyone to the meeting,

Apologies had been received from Rakhee Aggarwal. EJ thanked RA for her contribution at SFT, noting this would have been her final Board meeting.

EJ welcomed Richard Samuel (RS) and Peter Knell (PK) as new Non-Executive Directors. Thanks were extended to RH for covering the Finance and Performance Committee chair role and noted that PK would be taking over from March.

TB1 5/3/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

TB1 5/3/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 8th January 2026**

EJ presented the minutes from the Public Board meeting held on 8th January 2026.

It was noted that Emma Halliwell's name had been spelt incorrectly.

Decision:
The Board APPROVED the minutes of the meetings held on 8th January 2026 as a true and correct record, subject to the minor amendments suggested above.

TB1 5/3/1.6 **Matters Arising and Action Log**

KS presented the action log. It was noted that all items were either on the agenda or otherwise being progressed.

The Board noted the action log and there were no other matters arising.

TB1 5/3/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 5/3/2.1 **Chair's Business**

EJ reported on activity since the last meeting, including year-end preparations, work on the Charity Strategy (with a session later in the day), Joint Committee and Trust workshops (including SRO interviews), consultant appointments, and a Council of Governors development session attended by Professor Tim Briggs. EJ also met with lead governors and took part in a maternity and neonatal safety visit.

The Board noted the Chair's report.

TB1 5/3/2.2 **Chief Executive/Managing Director Report**

CCB presented the Chief Executive's highlighting the continuing focus across the Group on year-end financial recovery, with a Month 10 position of £8.4m deficit and a recovery plan projecting a £42m year-end deficit that remains on track.

Emergency pressures have been significant, with escalation areas open to maintain safety. Risks remain in urgent and emergency care; there is a renewed focus on corridor care to eliminate its use. CCB noted that the Trust will submit an updated recovery plan to the Region.

Additional priorities include elective activity, industrial action, the national cancer plan, the Electronic Patient Record (EPR), clinical transformation, 90-day sprints, Corporate Strategy Refresh, and 2026/27 planning. Thanks were extended to staff, acknowledging the pressures on staff to maintain quality of care and safety for patients during extended busy periods.

NJ also thanked staff for their response during a period of high pressure, including a current Critical Incident, and noted that urgent and emergency care and elective performance has continued to sustain despite this.

The Trust received a CQC inspection report for Medicine rated “Good”. NJ thanked the team on behalf of the Board. NJ noted that work on the Urgent Treatment Centre continues, with it expected to open in Autumn 2026.

NJ reflected on the recent decision to remove birthday leave, acknowledging staff feedback and the need to balance financial constraints with wellbeing. The Group will codesign an updated wellbeing offer.

Discussion
AS queried if the decision relating to birthday leave had been discussed with Staff Networks before the leave had been removed. JG noted that the decision had been discussed with staff side and the additional birthday leave had always been subject to annual review. EJ noted there will be more difficult decisions to come as all three organisations attempt balance the financial position, staff well-being and patient care.

RH queried the operational benefits from the birthday leave decision and its impact on delivery of performance for next year. NJ noted that whilst the financial benefits have been recognised it is difficult to project the operational benefits at this point. RH understood, noting that it would be useful to reflect on the operational benefits to the Trust.

CCB explained that the decision was taken consistently across all three organisations in the Group and has prompted different reactions. While NJ has received a number of concerns from staff, others across the Group have questioned the previous offer. This has opened a wider discussion about what a future staff well-being offer should look like. The intention is to co-design this with staff. JD added that this will align with the emerging Group-wide Health and Wellbeing Strategy.

The Board noted the report.

TB1 5/3/2.3 **Integrated Performance Report (IPR) (M10 January)**

JD presented the Integrated Performance Report for Month 10 which set out operational performance, financial recovery challenges, urgent and emergency care pressures, and progress on transformation initiatives.

Discussion:

AS sought clarification on the static performance in pressure ulcers, with JD explaining that improvement in other breakthrough objectives improvements took six months to materialise and a further three months to sustain, noting that SFT continues to perform well in reducing harm. Amesbury Ward remains a key contributor, with targeted education and training underway, influenced by high dependency levels and longer lengths of stay. EJ referenced the impact of amber staffing, and NP, JD and DM were noted to have completed a quality review in December, which may be beneficial to repeat.

In relation to RTT, AS queried the longest-waiting patients. NP confirmed two patients remain and are scheduled to be treated in March, with the intention of eliminating all 52-week waits this month. EJ highlighted that CCB and NJ had confirmed the Trust is in a strong position for elective care. Responding to a query from RS, it was confirmed that plastics and gynaecology are the main drivers of longer waits, reflecting the national picture.

CCB outlined that development of Group performance reporting will enable comparison across all three sites and support triangulation, particularly within a financially constrained context. Enhancements to the national oversight framework will also strengthen visibility of core metrics. ME commented on the wider NHS challenge of identifying process measures that provide assurance on controls and mitigations, noting that cultural change in reporting will take time.

RS referenced the existing shared PTLs, and CCB reiterated ambitions for a single elective programme to maximise NHS capacity. Further discussion took place on activity data, with AS requesting baseline activity information to support triangulation and avoid overstating metrics without proper context. ME agreed, and NJ emphasised the importance of qualitative context when the organisation is operating under significant pressure. AH noted that percentages alone may mislead, citing pressure ulcer rates per 1,000 bed days, with JD confirming absolute numbers are included in narratives.

ME highlighted the need to refresh IPR presentation to align with NHSE-managed metrics while ensuring clarity within the new reporting model. NP reiterated that narrative and “go and see” activity support triangulation, and JH confirmed that development of a single PTL will enhance data quality. CCB and ME agreed that incorporating deep dives would strengthen reporting, particularly concerning pressures in the Urgent and Emergency Care (UEC) pathway.

An update on People and Culture was provided, with mandatory training and appraisal performance escalated to the People Committee. JDy noted that comparisons of pressure ulcer data will become more complex due to differing bed bases across the three hospitals, and that corridor care definitions should reflect the national position within the IPR. PK highlighted that deep dives provide valuable narrative for exceptions.

In relation to finance SW confirmed the recovery position has been submitted to the region. It was noted that further discussion on finance would take place in the private Board.

The Board noted the report.

TB1 5/3/2.4 **Finance and Performance Committee – 24th February**

RH presented the report from the meeting held on 24 February 2026.

Key points highlighted included:

- the committee's focus on deep dives into cancer performance and outcomes, and significant time spent examining the CIP position.
- The committee also discussed the worsening cash position and the indication that deficit support funding will not be received in Q4, prompting a renewed Group-wide emphasis on cash management.
- Consideration was given to the approval of the Salutem lease arrangements for both the Trust and Group; this is expected to benefit the current year's CDEL position. The Finance & Performance Committee has agreed the proposal in principle, with further detail to be brought forward for Board approval. The committee expressed deep concern regarding the lateness of a contract proposal, which allowed insufficient time for proper review.

Discussion:
AS noted that the advice indicating further work on CIP in Q1 of 2026/27 may be too late to support delivery against next year's programme. CCB acknowledged that one of the challenges has been the continually shifting CIP requirement following discussions with the region, with percentage changes arising incrementally each quarter. While the position is not ideal, teams have done a commendable job in developing visibility and worked-up plans at pace.

NP advised that more detailed information will be shared later that afternoon, reflecting the live position. He emphasised the importance of ensuring Q1 delivery of schemes and noted that this would also be part of ongoing discussions in PM around how to best enable delivery. NJ commented that the Trust is in a stronger position than in previous years.

SW added that the overall process has been robust, expressing confidence that a sound structure is in place and noting that the Trust is more advanced than many organisations at this stage. EJ suggested that it would be helpful for this to be demonstrated clearly at the next Finance & Performance Committee meeting.

AT highlighted the collective alignment around the plan and commended the extensive work undertaken by NP. AS reiterated that additional assurance should come through F&P. CCB and SW confirmed that work is underway to develop the Q1 forecast, provide greater certainty on the position, and identify any residual gap.

The Board noted the report.

TB1 5/3/2.5 **Clinical Governance Committee – 27th January and 24th February**

AS presented the report from the Clinical Governance Committee meetings on 27th January and 24th February, and highlighted:

- Escalation beds remain an area of focus following CQC engagement.
- The Committee received presentations from Specialist Services (Burns and Rehabilitation) and noted the high quality of care delivered to the local population.

AS noted that a number of items in her report were covered on the Board agenda.

The Board noted the report

TB1 5/3/2.5 **People and Culture Committee – 26th February**

PC provided an update from the meeting held on 26 February. He reported continued progress on the SOX refresh, with further work underway to strengthen patient input and commissioning pathways.

Improvements were noted in management practices, though appraisal completion remains low and the system continues to be challenging to navigate. Workforce targets, particularly WTE, remain a concern.

Early staff survey findings were reviewed, with agreement to maintain focus on the work plan and progress some early, simple actions.

Safeguarding training compliance remains incomplete pending a full dataset at the end of March, with mixed assurance due to low training rates in ED.

Updates were also received on internal audits and statutory/mandatory training, with actions on track for completion. The Committee reviewed the OD & MP SLA evaluation and received updates on actions related to sexual misconduct and a report from the Freedom to Speak Up Guardian.

The Board noted the report.

TB1 5/3/2.6 **Board Assurance Framework and Corporate Risk Register**

AT presented an update on the Board Assurance Framework (BAF). It was noted that the report had been reviewed through all key Board committees, including Finance & Performance, Clinical Governance, People & Culture, and TMC, with committee feedback summarised at the top of the paper.

AT advised that the overall risk profile remains reflective of the current organisational challenges as the Trust moves through Q4 and into Q1 of 2026/27. A slight deterioration in the BAF position was highlighted, indicating an increasing level of strategic risk. In contrast, a reduction was seen on the Corporate Risk Register, which committees attributed to effective mitigation and clearer operational alignment within clinical and corporate teams. The divergence between the BAF and Corporate Risk Register was explained as reflecting the greater complexity of system-level risks, many of which are influenced by external and societal factors that are less within the Trust's direct control.

It was noted that since the reports were drafted, further developments, provide some confidence that the organisation is moving towards strengthened controls and improved management of BAF risks. As part of the transition to the Group model, all committees had highlighted the need for clearer visibility of SFT-specific strategic risks on the Corporate Risk Register, and steps are being taken to implement this. The Board also noted that three new corporate risks had been identified through committee discussions.

Discussion:
A question was raised regarding the reduced BAF10 score and whether the Board could receive an update on Place-based activity, including developments with Health Care Resourcing Group (HCRG) and associated changes to community and hospital-at-home models. Given the relevance to bed capacity and flow, Board members asked that this work be brought back to a future appropriate forum.

It was confirmed that the ICB has now appointed a Place Director, strengthening local relationships and providing a helpful point of coordination. Work continues to refine the evolving care model, with recent stabilisation allowing the associated risk score to reduce.

The Board was informed that HCRG will shortly be launching a series of transformational initiatives, and there remain opportunities to integrate services more effectively over the coming year. Engagement with local GPs at Place level is strengthening, with a focus on collaborative service design and alignment of system initiatives. **The Board agreed that an update on this work should be scheduled for a future meeting. ACTION: ?OWNER**

EJ noted that the Board should also have a future discussion regarding risk tolerance and the decisions around out-of-tolerance risks.

The Board noted the update.

TB1 5/3/3 PEOPLE AND CULTURE

TB1 5/3/3.1 Health and Safety Quarterly Report

IC joined the meeting at 11:38.

IC presented the Health and Safety Quarterly Report which had been received at People and Culture Committee, noting this report had been deferred from January's meeting.

IC noted that the report is relatively dated, but it highlighted four key issues, including an increase in sharps injuries. Work is underway to understand the causes and to strengthen support for staff both in preventing injuries and responding effectively when incidents occur.

The report also noted that the Movement of Tug Policy is on hold whilst a general grievance is being investigated.

The Board was advised that the most recent position includes 651 open risks, with the next Health and Safety Committee, originally scheduled for the day of the Board meeting, postponed due to the ongoing critical incident. **That Committee will provide a more up-to-date assessment, and the Board requested that a note be circulated afterwards to strengthen assurance. A request was also made for the immediate updated number of active risks ACTION: IC.**

Discussion took place regarding recent events in other Trusts and the importance of robust local oversight. An update was provided that the fire safety issue identified in theatres is being actively mitigated. The Board also reflected on the absence of the Q3 report and sought reassurance regarding the manual

handling-related staff injury referenced. It was noted that the individual has returned to work, though no further detail was available.

The Board discussed the "red and yellow card" approach to addressing unacceptable patient behaviour, with yellow cards issued for policy breaches and red cards applied where patients with capacity present risk without life-or-limb justification, leading to removal from site. The Board emphasised the need for assurance that staff have the right tools and equipment and are not placed at unnecessary risk. It was acknowledged that not all harm to staff is intentional; while deliberate violence is always escalated to the police, other injuries can arise from unpredictable clinical or environmental factors. The manual handling lead is actively addressing these areas, with training and equipment provision monitored.

The Health and Safety team is implementing a proactive management system using a two-year rolling programme to identify risk areas and embed mitigations. **ACTION: to undertake a "Go and See" focused on staff safety, and to check with the Health and Safety Manager regarding the frequency and visibility of training metrics related to manual handling and related competencies - Board/ IC**

In response to a query about organisational alignment, it was confirmed that under the Group model, Health and Safety is expected to sit within Estates and Facilities rather than the People function, reflecting national variability but aligning with the Group's corporate services design.

The Board noted the report, recognising that the version presented is an older iteration and that further assurance will be received through the next Committee cycle.

TB1 5/3/3.2 **Gender Pay Gap**

IC presented the Gender Pay Gap Report, noting that it reflects an improving position for the Trust. The Board was reminded that publication of the gender pay gap is a statutory requirement and must be completed by 31 March, and approval to publish was therefore requested. It was confirmed that Agenda for Change provides equal pay for staff covered by that system. The report shows the average gender pay gaps, with a median gap of 0.09%, and highlights that the primary driver of the overall pay gap is the proportionately higher number of men in upper pay bands, rather than unequal pay for equal work.

Discussion

RH noted that the report is largely reflective in nature and asked what management levers the organisation might take forward as a result. JG explained that the key issue is progression, with men tending to enter at higher pay bands; therefore, development pathways and progression support will be important going forward. She also noted that the ethnicity pay gap analysis indicates further work is required.

NJ emphasised that the data should be used to inform and drive the Trust's wider EDI strategy, asking how the findings are being translated into strategic actions. RH reiterated the need to ensure the report leads to tangible improvements. EJ noted that some actions are already underway, and JG confirmed that SFT is in a stronger position than some comparator organisations across the Group.

AS raised a concern regarding the wording on slide 4 under the heading "Overall", noting it is unclear and will be published externally on the Trust website. **IC agreed to update this slide prior to publication ACTION: IC.**

AS also queried the accuracy of the bonus pay section, noting that eligibility for clinical excellence awards sits only with consultants and therefore the relevant employee numbers should reflect the male/female consultant split. AS further asked what support is being offered to female consultants to apply for the bonus schemes. DM advised that the Trust currently has one consultant in receipt of a national clinical award, but that the source of the bonus pay data requires checking, particularly the figures on slide 10. DM outlined ongoing work to accelerate clinical leadership development programmes for consultants and senior trainees, ensuring gender balance within those cohorts. IC noted that the data includes residual CEA elements, resulting in higher figures than expected; the narrative will need to be amended accordingly. **IC to review and correct the data and accompanying narrative. ACTION: IC**

The Board agreed that areas requiring clarification had been identified, and EJ asked JG, NJ and DM to review the report ahead of publication to ensure it is accurate and appropriate.

The Board noted the report.

EJ noted that the Board would have a 30-minute break and would return at 12:30. It was noted that some colleagues were joining a national call at 12:30 but the meeting would remain quorate.

TB1 5/3/4 QUALITY AND RISK

TB1 5/3/4.1 Patient Experience Report Q3

JD presented the complaints report, noting that the Trust continues to operate within a tight response timeframe. Complaint numbers remain stable, and re-opened complaints are low, which is a positive indicator of resolution quality.

JD also highlighted recent engagement activity within the Patient Experience team and introduced Emily Palmer, the new Head of Patient Experience, who joins with experience from the charity sector and as a governor at Wiltshire College.

Discussion
AS reflected on the earlier medical presentation, noting positive early results from clinicians proactively telephoning complainants at the outset to understand concerns and support early resolution. This approach appears to be improving both the tone and speed of responses, and AS expressed interest in whether broader adoption could enhance outcomes Trust-wide.

RH asked whether current response rates provide sufficient assurance. JD acknowledged the point and agreed to consider further detail on complaint volumes. EJ noted the need to set complaints performance within the context of national expectations and highlighted the Trust's 48% response rate alongside a low re-opening rate as part of that triangulation.
RH emphasised the importance of consistent data across the Group IPR, and JDy confirmed work is underway to ensure alignment of reporting mechanisms

across the three trusts. EJ referenced national work via the National Quality Board to standardise patient experience measures, which will support this alignment.

RS raised the question of capacity within the complaints team and asked how technology, including AI, might support more efficient management. JH confirmed that digital innovation will be governed at Group level, with opportunities to explore future technological solutions.

The Board noted the report.

TB1 5/3/4.2 **Learning from Death Report**

DM presented the report, which had previously been considered at the February meeting of the Clinical Governance Committee (CGC).

The Board noted that the Summary Hospital-level Mortality Indicator (SHMI) demonstrated that, over the 12-month reporting period, approximately 100 fewer people had died than expected when compared to the national average.

It was reported that there had been a higher number of recorded deaths among patients with serious mental illness. This reflected an increase in admissions for this cohort. Work is underway to review these cases, and early learning has highlighted the importance of recognising and addressing both mental and physical health needs.

Discussion
JH outlined ongoing pressures within clinical coding, noting increased demand and existing variation in coding practice across care organisations. The introduction of the EPR was identified as a significant enabler, supporting greater standardisation and improving the reliability of SHMI data. Further exploration of technological solutions and best practice approaches will also be undertaken.

NP confirmed that a programme of work to improve coding quality and consistency will be delivered during the year.

AS reported that the CGC continues to receive good levels of assurance, with the proviso that this is dependent on the accuracy and completeness of coding data.

DM added that the primary issue relates to under-coding rather than miscoding.

The Board noted the report.

TB1 5/3/4.3 **Incident Reporting and Risk Report**

D presented the Incident Reporting and Risk Report, noting that the paper had previously been considered at the February meeting of the Clinical Governance Committee (CGC).

JD highlighted an increase in the number of reported incidents; however, the majority were categorised as low harm. It was noted that incidents are labelled as such when first reported, and while some may appear concerning at face

value, further review often clarifies the position. JD provided context to support this.

JD informed the Board that there had been two never events: an NG tube incident and an eye injection incident. Both had resulted in no harm to patients, and Duty of Candour processes had been completed. JD also noted recent national media attention on Martha's Rule and confirmed that the Trust had activated the relevant processes.

Discussion:
The Board discussed the relationship between incident reporting, harm levels, and patient experience. JD noted an instance of opiate toxicity and highlighted that while the Trust's risk profile may suggest concern, patient experience continues to show positive outcomes.

The variance in national descriptors and language was also referenced, and JD explained the ongoing work to translate these into meaningful local measures. AT noted the benefits of exploring predictive approaches to help understand how patient experience might shift quarter to quarter. JD confirmed that a weekly Patient Safety Meeting takes place every Tuesday, where all incidents classified as moderate harm are reviewed. This supports learning, triangulation, and the continuation of a strong safety culture.

EJ asked about the triangulation of never events against staffing levels, particularly amber staffing days, to understand whether any triggers could be identified. EJ also queried how incidents relating to laser use were being overseen. AS confirmed that CGC had received extensive updates regarding laser governance, alongside updates from Surgery and the relevant clinical leads. This had also been referenced in the January upward report.

JH emphasised the importance of predictive analytics in strengthening safety oversight. NP highlighted that the future approach to challenged specialties was being considered as part of the wider transformation programme, the 2026/27 CIP planning cycle, and the development of the group governance model. DM informed the Board that an external technical laser review had been commissioned to assess equipment, policies, and processes. The findings would be reported through CGC once completed.

The Board noted the report.

TB1 5/3/4.4 **National Maternity Survey Results 2025**

VM joined the meeting at 1pm and presented the National Maternity Survey Results 2025, noting that the report had previously been considered by the Clinical Governance Committee (CGC). JDy provided a brief explanation to the new NEDS why several maternity-related reports were being escalated to the Board to ensure full visibility of maternity performance and assurance.

VM highlighted that the survey forms part of the National Maternity and Perinatal Audit and the NHS Maternity Survey Programme (NBSP). The results reflect the experiences of women accessing maternity services in January 2025, and the Trust achieved a strong response rate. VM provided an overview of the Trust's performance across the survey domains.

VM noted that women felt their concerns were taken seriously by staff, which was a positive outcome. However, the lowest-scoring areas related to care at home, support with feeding, and postnatal care following birth. VM highlighted that the current model includes only one postnatal home visit. The survey results are based on experiences from a year ago and therefore do not fully reflect recent changes.

Discussion
DM asked what the appropriate level of postnatal care at home should be and whether the Trust is delivering the expected standard. DM sought clarification on how the survey questions align with national requirements. VM and JDy explained that, under NICE guidance, women should be seen within 36 hours of discharge. However, the survey question asks whether women were seen at home "as much as they would have liked", which may create expectations beyond national requirements.

JDy also provided further context regarding the role of the health visitor and the launch of the new Healthy Child Programme, which may improve continuity and postnatal support in future.

The Board noted that the next national maternity survey is expected to take place in early 2027. The timetable is set nationally and forms part of the wider Care Quality Commission (CQC) survey programme and is therefore outside the Trust's control.

The Board noted the report.

TB1 5/3/4.5 **Perinatal Quality Surveillance Report December 2025 (November data)**

VM presented the Perinatal Quality Surveillance Report for December 2025, noting that the data covered activity and outcomes for November 2025.

VM reported that staffing levels had improved compared with the position six months ago. However, it was highlighted that the junior staff group, particularly newly qualified midwives, continued to require enhanced support as part of their consolidation period.

The Board was informed that there had been one maternal death, which had been reviewed and classified as unavoidable. There had also been two neonatal deaths during the reporting period. In addition, two MNSI referrals had been made, and the Trust was awaiting formal reports.

VM noted that 24 incidents had been recorded at moderate harm level or above, which was higher than usual. All incidents had been reviewed and re-classified where appropriate to ensure accuracy and robust oversight.

The Board noted the Perinatal Quality Surveillance Report for December 2025.

TB1 5/3/4.6 **Perinatal Quality Surveillance Report January 2026 (December data)**

VM presented the Perinatal Quality Surveillance Report for January 2025, noting that the data reflected activity for December 2024. VM highlighted that during December there were three key national workstreams underway, including national safety investigations.

VM confirmed that the Trust's stillbirth rate remained below the national average. VM also noted that January marked the next phase of the *Saving Babies' Lives* programme.

Discussion
RH queried whether the national work reflected new requirements and sought assurance regarding compliance. VM confirmed that the workstreams were part of ongoing national programmes and that the report provided assurance on the Trust's current position.

AS queried whether compliance with the new care bundle would require additional resources. VM responded that, based on current expectations, additional resource was not anticipated. However, VM cautioned that as more national guidance and standards are published, additional capacity may be required.

AS also referenced the expectation that CNST (Clinical Negligence Scheme for Trusts) contributions would be reinvested into maternity services. PC asked about the longer-term future of CNST. VM advised that CNST remains an assurance mechanism through which the Trust demonstrates compliance against national criteria. The programme has been revised for the coming year, with updated requirements due to be released in April.

AT provided an update on the maternity workforce, noting that staffing remains dynamic, with colleagues joining the service, progressing into new roles, or commencing maternity leave. AT explained that proactive workforce planning is essential, supported by knowledge of student midwives entering the service and potential retirements. Recruitment remains challenging for the remainder of the year.

JG queried compliance with children's safeguarding training, noting that the report stated 82% and sought clarification on whether this met the target. VM explained that there remain challenges, particularly among obstetric colleagues, due to the volume of mandatory learning. A manual tracking spreadsheet is in place, and the team is working to increase compliance. The trajectory aims to reach 85%, but this is dependent on ensuring training days are not cancelled, and that sickness or operational pressures do not require staff to be pulled from scheduled sessions.

The Board noted the Perinatal Quality Surveillance Report for January 2025.

TB1 5/3/4.7 **Perinatal Quality Surveillance Report February 2026 (January data)**

VM presented a report Perinatal Quality Surveillance Report for February (January data). VM highlighted the key points as noted within the report:

- The midwife-to-birth ratio was reported as 1:27 (1:26 including bank staff). Band 5 midwife vacancies have reduced.
- There was one stillbirth in January, meeting the criteria for MNSI referral, and this has been accepted. The 12-month rolling stillbirth rate is 3.01 per 1,000 births (national average 3.2).

- Seven incidents were reported at moderate harm or above following full MDT review. An increase in bladder-related trauma incidents has been identified and will undergo thematic review to determine causation and learning.
- Safeguarding children training compliance for medical staff is currently 61%. A trajectory has been set to achieve 82% compliance by April 2026.
- The new Maternal Care Bundle launched in January, with full compliance across all elements expected by March 2027. LMNS confirmed 91% compliance with Saving Babies' Lives for the November submission. The Trust declared full compliance (10/10) with CNST Maternity Incentive Scheme safety actions for year 7.

The Board noted the Perinatal Quality Surveillance Report for February

TB1 5/3/4.8 Maternity & Neonatal Quality and Safety Report Quarter 3 (October to December 2025)

VM presented the report. The Board was informed that there were no stillbirths reported in Q3. VM noted that, as a small maternity unit, performance metrics expressed as rates per 1,000 births can fluctuate significantly, and therefore the Trust often experiences natural peaks and troughs.

VM confirmed that neonatal nursing staffing remains non-compliant with BAPM standards, but a business case to address this was approved in summer 2025 and will support the service to achieve compliance.

The Board also noted that triangulation meetings continue to take place, bringing together complaints, incidents, and service-user feedback to ensure a comprehensive understanding of safety, experience and quality across maternity services.

The Board noted the report.

TB1 5/3/4.9 Prevention of Future Deaths Report published re Homebirth and Community Services

VM presented an update regarding the *Prevention of Future Deaths (PFD) Report* issued in relation to homebirth and community maternity services. VM reminded the Board that in November 2025 the Senior Coroner, following the tragic deaths of a mother and baby, wrote to all Trusts requesting specific focus on identified concerns. The coroner's letter and accompanying report set out ten actions relating to the operational running of services, governance and risk management.

VM reported that a full review had been undertaken and the service had been benchmarked against the ten actions. Assurance work was underway to address any gaps identified.

The Board discussed the challenges associated with homebirth services, noting that there is currently no national guidance specifically governing homebirth provision. VM highlighted the increasing complexity of women requesting homebirths, often with significant co-morbidities, and suggested that heightened national scrutiny of maternity safety may be contributing to this increased risk

profile. Work is also required to review community midwifery shift patterns to ensure safe and sustainable service delivery.

Discussion
EJ noted that national guidance on homebirth is awaited and emphasised the importance of ensuring the right narrative is shared with women regarding risks and eligibility.

PC asked about local community feedback. VM reported some negative comments but confirmed that homebirth activity remains small and there has not been significant pushback from community midwifery services. VM also noted an increase in women opting for elective caesarean sections.

JDy highlighted the role of the Maternity Voices Partnership, which provides independent service-user insight and engages directly with women through maternity champion meetings. This offers a valuable route for gathering further feedback. JDy also confirmed that CGC had asked for future reports to include specific activity and assurance relating to homebirths.

AT queried the consultation undertaken with midwives regarding shift patterns. VM reported that midwives providing first and second on-call arrangements work slightly shorter shifts, and that the service is proactively reviewing shift models ahead of expected national recommendations. RH asked whether similar concerns existed across other clinical areas. JD confirmed that maternity is the only area where this is currently relevant.

AS queried whether consultant working patterns presented any comparable risk. DM clarified that consultants in some specialties have opted out of the Working Time Directive and may work extended periods while on call; however, this is not applicable to maternity consultants and therefore does not directly relate to the PFD concerns discussed.

The Board noted the report.

TB1 5/3/4.10 **Maternity Self Certification NHS Resolution Maternity Incentive Scheme (Year 7) Board Assurance Report – January 2026, presented at Extraordinary Board on 27th January 2026**

EJ noted that an extraordinary Board had been held in January to receive the above report and declare 10/10 compliance to the Maternity Incentive Scheme requirements.

EJ thanked the team and JD in her role as executive lead.

TB1 5/3/5 **GOVERNANCE**

TB1 5/3/5.1 **Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance**

NP presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Compliance Report.

NP highlighted that overall assurance was strong, though there were a small number of areas requiring further work. These included improving CBRN training compliance within the Emergency Department, which has been affected by staff

turnover, and strengthening business continuity planning, ensuring all teams keep their plans up to date and explore digital solutions to support this work.

NP also noted the size and scale of the EPRR team, and ongoing work with the Group to ensure the Trust has the right model in place to support delivery of statutory duties.

RH confirmed that he would be observing one of the forthcoming EPRR exercises.

Discussion
The Board noted that the Trust had previously been fully compliant; however, team flux and operational pressures had created challenges over the past year.
AS queried whether Board-level EPRR training is a formal requirement. NP will confirm current expectations. The Board noted that RUH is planning to hold a joint EPRR exercise for its Board, and this could present opportunities for Group alignment.

JH raised operational readiness for the adoption of the new EPR system and noted ongoing discussions at RUH relating to cyber-incident planning. Although a cyber-reaction plan is in place at SFT, the next stage, divisional response planning, has not yet been rehearsed.

EJ highlighted that SFT had gained valuable learning from previous incident responses and emphasised the importance of sharing these insights across the Group. **An action was agreed to develop a Group-wide EPRR training plan. ACTION: NP**.

The Board noted the report.

TB1 5/3/5.2 **Register of Seals**

The Board was asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

It was noted that 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 5/3/5.3 **Interim Strategy Statement**

TM joined the meeting for this item and presented the proposal regarding the extension of the current Trust Strategy.

NJ outlined the intention to extend the existing strategy until the new Group Strategy is fully developed and approved. This approach would ensure continuity and alignment across the Group during the transition period.

Discussion

AS highlighted a typo within the slide pack and requested that the correct image be inserted. TM confirmed that this would be updated and clarified that the slide pack shown formed part of the Group Strategy template, including content relating to place-based priorities.

CCB suggested that, as GWH's strategy includes a dedicated page referencing the Group, consideration should be given to using the same format for SFT to ensure consistency across all providers. TM agreed to review this and incorporate appropriate content.

Decision

The Board APPROVED the extension of the current Trust Strategy until the new Group Strategy is in place.

TB1 5/3/6 CLOSING BUSINESS

TB1 5/3/6.1 Any Other Business

NJ noted that was the last official Board meeting with EJ as a Chair, and he acknowledged the support she has given to SFT throughout her tenure. He noted that EJ's commitment to improving patient care, quality and experience have consistently ensured these remain at the forefront of the Board's work and noted that her contribution will be greatly missed. EJ thanked members of the Board and noted that she intended to be an ambassador for the Stars Appeal.

TB1 5/3/6.2 Agreement of Principle Actions and Meeting Reflection

EJ noted the following from the meeting:

- **Financial Position:**
  Further detailed discussion on financial challenges to be held in Part 2.
- **IPR:**
  No specific action required; Board noted stable overall performance, with strong elective delivery despite the recent critical incident.

ACTIONS

- **BAF:**
  Action – NP: Schedule a future Board update on HCRG transformational initiatives and opportunities to strengthen integrated service delivery, including progress on Place-level engagement with local GPs and collaborative service design
- **Health and Safety**
  Action – IC/Health and Safety Manager: Provide strengthened assurance regarding fire safety compliance, including any outstanding actions or mitigations.
  Action – IC: That the Health and Safety Committee will provide a more up-to-date assessment, and the Board requested that a note be circulated afterwards to strengthen assurance. A request was also made for the immediate updated number of active risks
  Action - Board Members/IC: To undertake a "Go and See" focused on staff safety, and to check with the Health and Safety Manager regarding the frequency and visibility of training metrics related to manual handling and related competencies.

- **Gender Pay Gap Report:**
  Action - IC: Publish the Gender Pay Gap Report within required timescales subject to the changes discussed.
- **EPRR Compliance:**
  ACTION - NP /EPRR Team: Develop a Group-wide EPRR training plan.

TB1 5/3/6.3 **Public Questions**

None

Governor feedback

JP highlighted the interesting discussions, noting the particular focus on the group structure and its impact on SFT. JP noted her husband had undergone abdominal surgery the previous day and highlighted the great care he had received in the Day Surgery Unit.

TB1 5/3/6.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 4th June 2026.

TB1 5/3/7 **RESOLUTION**

TB1 5/3/7.1 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).

Master Action Log

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	Deadline in future

PUBLIC TRUST BOARD ACTION LOG

Contact Kylie Nye, kylie.Sanders1@nhs.net for any issues or feedback

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Kylie Sanders	TB1 5/3/2.6 Board Assurance Framework and Corporate Risk Register	28/04/2026	Niall Prosser, NP Nick Johnson, NJ	Schedule a future Board update on HCRG transformational initiatives and opportunities to strengthen integrated service delivery, including progress on Place-level engagement with local GPs and collaborative service design.	08/04 Proposal to add into forward plan for Finance and Performance Committee. CLOSED.	N	3
Trust Board Public	Kylie Sanders	TB1 5/3/3.1 Health and Safety Quarterly Report	31/03/2026	Ian Crowley, IC	The Health and Safety Committee will provide a more up-to date assessment of risks to be circulated to Board, including an updated number of active risks.		N	2
Trust Board Public	Kylie Sanders	TB1 5/3/3.1 Health and Safety Quarterly Report	07/05/2026	Board/ Ian Crowley, IC	To undertake a “Go and See” focused on staff safety, and to check with the Health and Safety Manager regarding the frequency and visibility of training metrics related to manual handling and related competencies		N	2
Trust Board Public	Kylie Sanders	TB1 5/3/3.2 Gender Pay Gap	31/03/2026	Ian Crowley, IC	AS raised a concern regarding the wording on slide 4 under the heading “Overall”, noting it is unclear and will be published externally on the Trust website. IC agreed to update this slide prior to publication.		N	2
Trust Board Public	Kylie Sanders	TB1 5/3/3.2 Gender Pay Gap	31/03/2026	Ian Crowley, IC	Review and correct the bonus pay data to ensure it accurately reflects eligibility for clinical excellence awards (consultants only), amend employee numbers to reflect the male/female consultant split, confirm the accuracy of figures (including residual CEA elements) on slide 10, and update the accompanying narrative to reflect the corrected data and current support for female consultants applying for bonus schemes.		N	2
Trust Board Public	Kylie Sanders	TB1 5/3/5.1 Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance	04/06/2026	Niall Prosser, NP	Develop a Group wide EPRR training plan	08/04 Update from NP: EPRR – group model in development and relevant CSR processes being followed. Training will be a key part of future model. Model in place and moving into implementation. CLOSED.	N	3

BSW HOSPITALS GROUP

NHS

SFT Business Plan 2026-27

Public Board

Salisbury NHS Foundation Trust | Public Board Meeting | May 2026

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

What we delivered together in 2025/26

Top-25 elective Trust

Salisbury remained one of the top 25 Trusts in England for elective care, and at times matched that standard for urgent and emergency care.

52-week waits virtually cleared

By April 2026 we will have virtually eliminated 52-week waits — a position few Trusts have achieved since the pandemic.

Patient flow improved

Length of stay and long-stay delays both reduced. The Early Supported Discharge team enabled 83% of NCTR patients to leave within five days.

£15m saved while improving safety

£15m of efficiency savings delivered in 2025/26 — and our patient safety metrics held or improved across the year.

Why this matters as we enter 2026/27

These foundations show that the Trust can deliver with care for staff and patients, and within tight resources.

But last year we still ended with an underlying deficit of £55m. That position is not sustainable, and the year ahead is about putting Salisbury on a financial footing that protects the services our community relies on.

The context for 2026/27

Three forces shape the year ahead. They are common across the NHS — but they show up at Salisbury in our own particular way.

A challenged financial position

Salisbury enters 2026/27 with an underlying deficit of around £55m on a turnover of £410m.

The NHS regional and national funding settlement removes a significant portion of last year's non-recurrent support.

The Trust must close the gap through a mix of efficiency, productivity, and Group-wide transformation.

NHSE has accepted our plan with conditions on de-risking and reporting.

Growing demand from our community

South Wiltshire's population, particularly the older adults who use our services most, is growing faster than national funding assumptions.

Non-elective admissions have grown around 4% per year for the last three years.

Meeting that demand sustainably means working differently with primary care and community partners, not simply doing more in hospital.

A changing national landscape

NHS England is reshaping the outpatient model through Discuss and Refer (although this is currently subject to discussion regarding pace and depth).

A new Electronic Patient Record arrives across the BSW Group in 2027.

The Dorset, Somerset, and BSW ICBs are coming together, creating a much larger (strategic) commissioner.

The Trust must prepare for each of these, and the BSW Hospitals Group strengthens our voice in that landscape.

Financial Position Summary

£410m

Our annual turnover

Salisbury turns over ~£410m a year.

Representing patient care, our staff, and the buildings and equipment that support them.

£55m

Underlying deficit without action

Without action, the Trust would end 2026/27 around £55m overdrawn.

National funding has reduced the gap we must close to £32.5m.

£32.5m

Savings target after national support

We will close it through a £32.5m programme of efficiency, productivity, and Group-wide transformation.

QIA and EQIA

We are establishing a Trust-wide approach to ensure QIAs and EQIAs are conducted for all changes to reinforce our patient safety red-line and commitments to making access to, and outcomes from our services, fairer for our population.

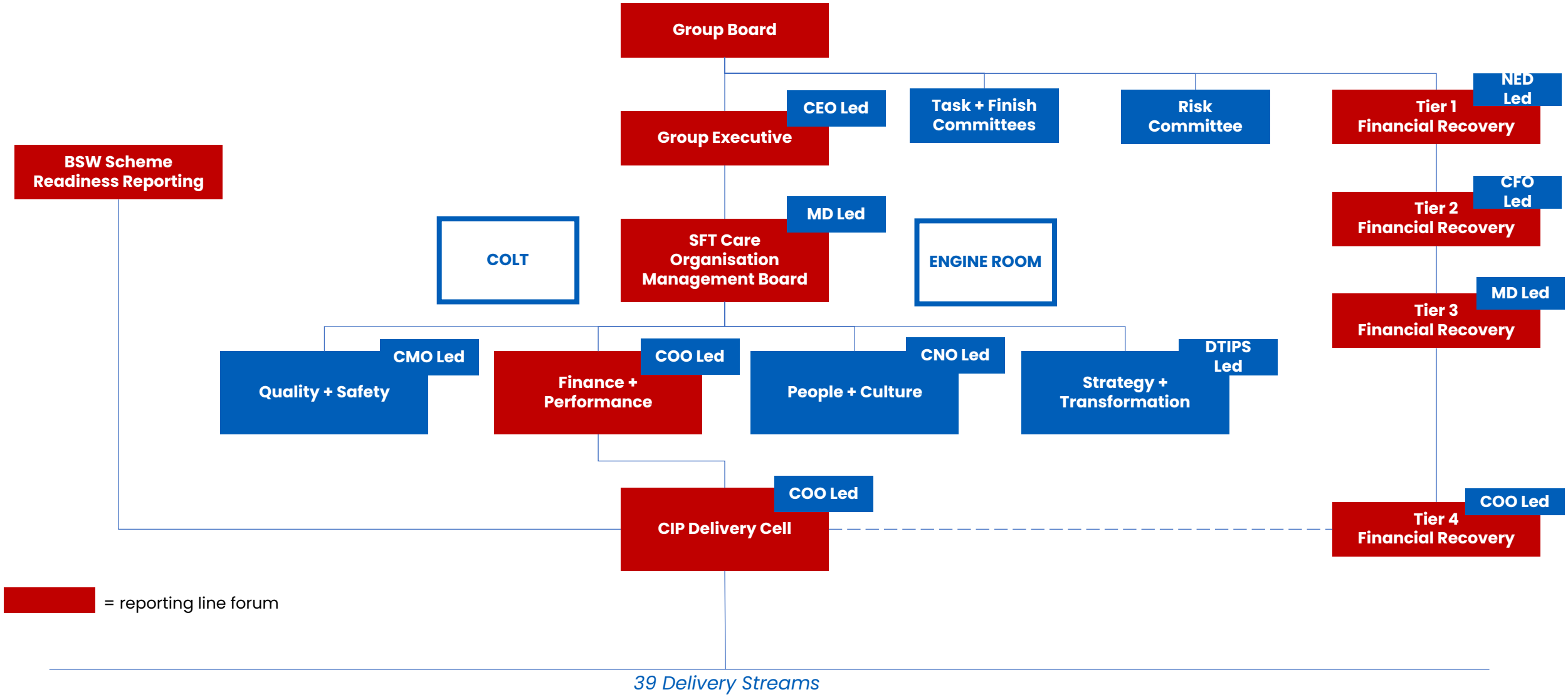
Regional response to our plan

NHSE Plan Feeback + Asks	Current Position
Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly.	Currently in place, programme operational oversight forum fortnightly CIP/Transformation cell, escalating to Executives through COLT, and F&P Next milestone 80% risk-weighted average by 1st June. CIP plan fully identified
Clear plan to derisk the financial plan, with agreed milestones and progress updates to be provided monthly. The expectation is risks should be fully mitigated.	Currently in place, programme operational oversight forum fortnightly CIP/Transformation cell, 100% risk-weighted average target by 1st September
Retriangulation of financial and workforce plans once savings proposals are confirmed, to ensure workforce assumptions remain robust and deliverable.	Financial and workforce plans currently triangulated at plan submission stage, triangulation of ongoing plan developments to be assured through Workforce efficiencies group (fortnightly) and F&P/People Committee
Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay.	Contract finalisation discussions ongoing with several live disputes being actively pursued between SFT and commissioners
Full implementation of all controls set out in the 2025/26 Financial Management Arrangements and continue with any recovery actions implemented during 2025/26.	Controls remain in place from 2025/26 as well as some additional controls on purchasing, and all 25/26 Recovery plan actions have developed into 26/27 submitted plans. HfMA Checklist to support assurance
Establishment of a formal Cash Management Committee, with agreed terms of reference and agenda, aligned to best practice examples available on the ONF site. Organisations should appreciate that securing revenue cash support is likely to be challenging and therefore they should endeavour to manage cash constraints internally or with the use of system support. It is unlikely that any provider is able to access cash support greater than the value of its planned deficit.	Cash Committee is in process of implementation at Group level
All investments and discretionary cost pressures over £50k should be subject to organisational, system and NHSE review in line with existing 'Triple Lock' arrangements.	Currently in place at SFT

CIP Identification Progress

			Week commencing date											
Pillar	Summary of workstreams	2026/27 Target (£m)	3/16/2026	3/23/2026	3/30/2026	4/6/2026	4/13/2026	4/20/2026	4/27/2026	5/4/2026	5/11/2026	5/18/2026	5/25/2026	% Risk-weighted average vs Target
Operational Productivity	Elective productivity (Theatres, Endoscopy and Cath Lab) and Outpatient productivity	3.06	1.39	1.7	1.7	2.0	2.0							66%
Bed Rationalisation	Bed rationalisation (drivers NC2R reduction and demand management)	1.64	0.73	0.9	0.9	1.2	1.3							81%
Workforce Efficiencies	Agency and Bank reduction	5.39	2.21	2.7	2.7	3.1	3.1							58%
Service Transformation	Clinical Services and Corporate Services redesign	9.62	3.31	3.6	4.0	4.0	4.2							44%
Transactional savings	Procurement, specialties challenge, commercial opportunities	12.79	4.24	3.78	5.25	6.15	6.38							50%
		32.5	**11.9**	**12.6**	**14.5**	**16.5**	**17.1**							**53%**

CIP Governance + Oversight



Performance

These are the performance standards the Trust has agreed with NHS England for 2026/27 and beyond.

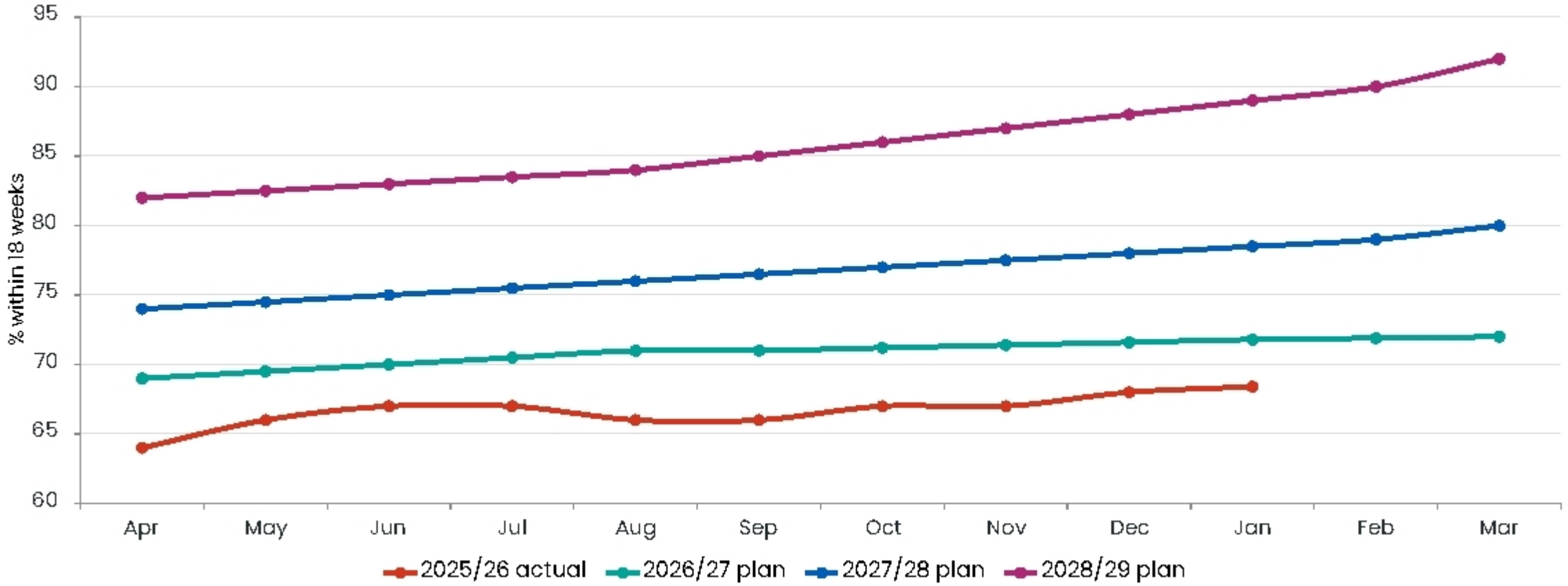
Area	Metric	Position (Dec '25)	Commitment by Mar '27	By Mar '28	By Mar '29
Urgent & Emergency Care	Patients seen, treated, admitted or discharged within 4 hours (A&E)	75.7%	**82%**	83%	85%
	Average ambulance handover time	20 minutes	Toward 15 mins	—	—
Planned care & Diagnostics	Patients seen within 18 weeks of referral	68.4%	**72%**	80%	92%
	Patients receiving a diagnostic test within 6 weeks	83%	**90%**	95%	99%
Cancer	Patients receiving a cancer diagnosis or ruling-out within 28 days	74.2%	**80%**	81.4%	83.1%
	Patients beginning cancer treatment within 62 days	62%	**80%**	82.5%	85%

What this means for patients

Shorter waits for elective and diagnostic care, faster cancer pathways, and steady improvement in A&E performance — with the biggest step change in cancer 62-day performance, where tumour-site improvement plans are already in place.

Reducing the wait — our 18-week trajectory

Patients on the waiting list will see steady, sustained improvement across the next three years. The chart shows the trajectory year-by-year.



How we will close the £32.5m gap

Operational productivity

£3.1m

Theatre, endoscopy, cath lab and outpatient productivity to upper decile.

Bed rationalisation

£1.6m

NCTR to 40, LoS down 0.5d, second ward closure Aug–Nov.

Workforce efficiencies

£5.4m

Agency and bank reduction within NHSE limits.

Service transformation

£9.6m

Clinical and corporate redesign. CDC endoscopy, group plastics/OMFS, dermatology.

Transactional savings

£12.8m

Procurement, specialty productivity challenge, commercial opportunities.

Quarterly delivery profile (£m)

What will change

Workforce

The Trust will move from around 4,450 to 4,150 whole-time equivalent staff over the year. Primarily through reduced agency and bank spend, tighter vacancy controls, and productivity gains.

Safe staffing on wards remains a protected commitment. The Trust will not balance the plan on the back of unsafe rotas.

The NHS England national agency target applies to all Trusts, and we are within it.

Beds and patient flow

At least one ward will remain closed across the year. A second ward may close from August to November.

This is only possible if non-criteria-to-reside numbers reduce from around 70 to 40 and if length of stay falls by half a day. A new 24/7 acute frailty model and continued strong performance from the Early Supported Discharge team support both.

If flow does not improve, beds will reopen.

Pathways and outpatients

This year we will roll out the new NHS England Discuss and Refer outpatient model. With up to 20% of GP referrals resolved or redirected within two weeks, without a face-to-face outpatient appointment.

This may temporarily disrupt 18-week performance for up to six months — but improves time to first appointment thereafter.

Investment continues where it must.

Stroke (SSNAP), frailty, and the new urgent care centre will all see additional resource in 2026/27.

The risks we are managing

Risk	Description	Our response
Cash position	National cash support likely needed in the second quarter of the year.	A Group-level Cash Management Committee is being established. The Trust is engaged with NHS England on the cash position.
Drug inflation	National planning assumes 0.58% inflation; actual drug inflation is running at around 9% — a £3m risk for Salisbury.	We are working with regional and national NHS colleagues to mitigate the exposure, including with the Group's procurement team.
Cost Improvement Plan delivery	The £32.5m programme is materially larger than recent years. Around 53% was identified at submission.	Fortnightly delivery cell chaired by the Chief Operating Officer. NHSE milestones: 80% risk-weighted by 1 June; 100% by 1 September.
Patient flow (NCTR)	If non-criteria-to-reside numbers do not reduce, the bed-closure plan cannot proceed safely.	Daily operational grip; Early Supported Discharge team; refreshed urgent care strategy; partnership work with system commissioners.
Discuss and Refer	The new outpatient model may temporarily disrupt 18-week performance for up to six months.	Starting early — April 2026 — to allow benefits to flow through before year-end. Working closely with primary care and the BSW system.
Estate	Continuing pressure on the day-surgery estate until the Diagnostic and Surgical Hub (DASH) opens.	DASH capital funding secured nationally. The Trust will continue to bid against further regional and national funding streams.

Why the BSW Hospitals Group matters for Salisbury

Around two-thirds of our savings target depends on shared work with our Group partners. The Group makes possible what Salisbury could not deliver alone.

£21.9m of our CIP depends on Group working

Without shared transformation, corporate redesign, and pooled flow improvements, the gap would not close.

Acute service review — clinical leadership at scale

Group CCTO takes six priority specialties through radical redesign across three sites; depth and pace SFT could not achieve alone.

Shared corporate services

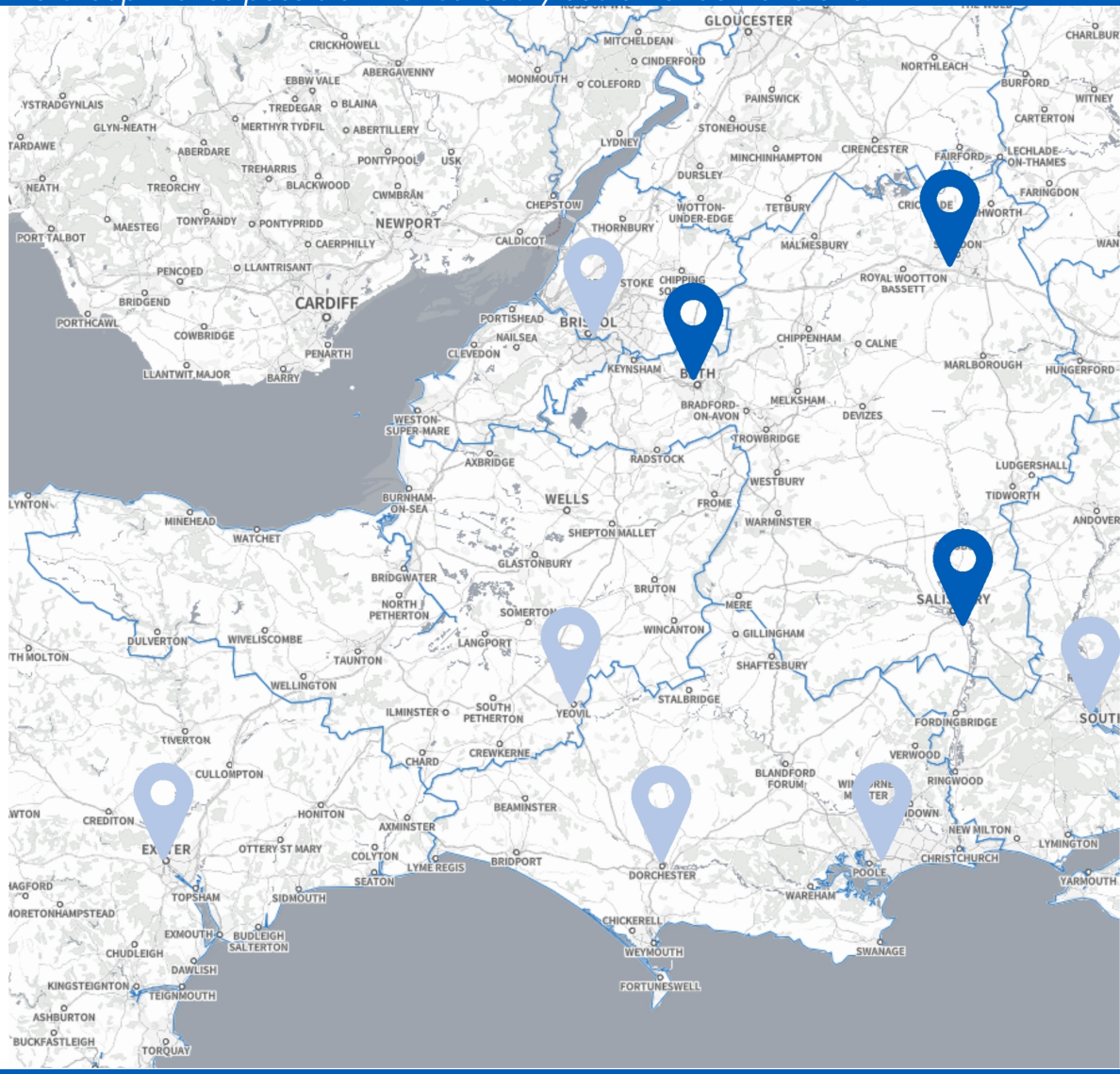
Finance, HR, digital, and procurement consolidating across Group — recurrent savings without touching front-line care.

EPR and digital

Single patient record across the Group from 2027 — a foundation for productivity, audit, and research that single trusts cannot afford.

Voice in the new commissioning landscape

The ICB cluster merger in April 2027 means a much larger commissioner. The Group gives Salisbury a stronger seat at that table.



Our commitment to quality, safety, and our patients

The red line that runs through this plan

Patient safety and care quality are not for negotiation. Every change passes a Quality and Equality Impact Assessment before it is approved. Where a scheme cannot be delivered without compromising safety, it will not progress.

Safer staffing

Our commitment to safer staffing is maintained across all services. Nursing structure and fixed establishment are protected; agency reductions come through tighter vacancy controls and productivity, not the front line.

Investment where it matters

Additional funding for stroke services (SSNAP). Investment in frailty services to meet the needs of our older population. A new urgent care centre opening in the second half of the year.

Reducing inequalities in our care

Active work to reduce inequity in waiting times. SOP changes for patients with learning disabilities and autism. Recognition of the needs of our military families. CORE20 inequalities work with system partners.

How we will hold ourselves accountable

- Monthly public reporting of performance against the targets shown earlier in this pack.
- Quality and Equality Impact Assessments published with significant service changes.
- Regular updates to Council of Governors and to this public Board on financial and operational delivery.
- Open dialogue with Healthwatch, patient groups, and our local communities.

NHS Salisbury NHS Foundation Trust

Report to:	**Trust Board**	Agenda item:	**3.1**
Date of meeting:	**13 May 2026**		

Report title:	**Q3 Risk and Patient Safety Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	Yes	**Yes**	**Yes**	**Yes**
Approval Process: (where has this paper been reviewed and approved):	**Clinical Management Board: 18th February 2026** **Clinical Governance Committee: 31st March 2026**			
Prepared by:	**Louise Jones- Head of Risk Management** **Emma Hodgson – Head of Patient Safety**			
Executive Sponsor: (presenting)	**Judy Dyos- Chief Nursing Officer**			
BAF Risk link				

Recommendation:

The report aims to provide an overview of risk management and patient safety activity in Quarter 3

Executive Summary:

Patient Safety Incident Investigation (PSII)

- PSIIs Initiated in Q3:
  - October: Never Event – wrong site surgery – injection in wrong eye (National Priority)
  - December: Never Event – misplaced nasogastric tube (National Priority)

Incident harm levels

- Moderate and above harm incidents decreased to 1.88% in Q3 (from 2.5% in Q2).
- Note: Q3 incident reviews are ongoing; figures may be updated.

Incident Reporting by Division

Medicine recorded the highest number of reported incidents, with a total of 1,357. This was followed by Surgery, which reported 854 incidents. FASS recorded the lowest number of incidents among the divisions, with 624 reported cases.

Themes and trends from incidents

- MNSI (Maternity and Newborn Safety Investigations)
  - There have been a further 3 maternity Incidents that have been reported to the MNSI in Q3. (a total of 8 this year). These cases have all been discussed and noted at the weekly Patient Safety Summit.
- Violence and Aggression
  - Increase in the number of reported patients on staff abuse (verbal and physical)
- Medicines management
  - There has been an increase in the number of preparation and administration of medications in relation to insulin management. A thematic review is being undertaken to explore the system-based learning.

- Pressure Ulcers
  - An increase in non-hospital acquired pressure ulcers and a decrease in hospital acquired pressure ulcers is indicating a greater recognition and documentation of pressure ulcers on admission

Patient safety reviews (PSR)

- Q3 there have been 80 PSR1's discussed at Patient Safety Summit (PSS) compared to 89 in Q2. Of these 80, 12 have proceeded to a further PSR2 review

Key Learning from PSRs

- Importance of consistent and accurate monitoring of urinary catheters and timely completion of fluid balance charts
- Importance of strict compliance with the non-mobile infant safeguarding policy, highlighting the need for staff awareness, consistent application of the policy, accurate documentation, and effective communication within the multidisciplinary team to ensure safe, high-quality care for non-mobile infants who present with an injury.
- Continuous and accurate monitoring and escalation of patient's vital signs, symptoms, and responses to treatment allows clinicians to make informed decisions, improve patient safety, and enhance the quality of care.
- Regular pressure ulcer education is required, with emphasis on early identification and pressure ulcer staging

Datix Upgrade

- The Trust is due to upgrade our current version of Datix to enable adoption of the NHS-mandated V6 Learning from Patient Safety Events (LFPSE) taxonomy.
- Datix version 14.6, released on 16th January 2026, introduces this taxonomy alongside a significant visual modernisation of DatixWeb while retaining the existing navigation.
- Consideration is being given to delaying the upgrade until version 14.6.1, expected in May 2026, as it includes additional functionality.

Risk Register Deep Dives

- Total Deep Dives undertaken in Q3: 26
  - 0 - Divisional
  - 22 - Service-level mini deep dives
  - 4 - Non-clinical

- Risks without mitigation reduced to 11% from 18% in the previous quarter
- 0 risk escalated to Corporate Risk register in Q3
- 13 risks were escalated from service/department to divisional (4 Surgery, 4 Medicine and 6 FASS)

Martha's Rule (Call for Concern)

- 3 calls were made to Call for Concern (2 from the family and 1 from the patient) compared to 7 in Q2
- 0 calls were made due to concerns with deterioration; 1 call was a concern re management of a patient with a long-term condition.

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):	

Risk and Patient Safety Report

Salisbury NHS Foundation Trust

Quarter Three (October, November, December 2025)

Louise Jones & Emma Hodgson

Summary

NHS Salisbury NHS Foundation Trust

Incident Reporting

- Strong reporting culture maintained with high volume of low harm incidents.
- Moderate harm reduced and oversight strengthened through PSIRF and risk deep dives
- 2963 incidents reported (↓54 in Q2)
- 98.2% low harm; moderate + harm 1.8% (↓2.3 in Q2)
- Key themes: MNSI (Maternity and Newborn Safety Investigations), Violence and Aggression, Medicines management, Pressure Ulcers.

Patient Safety Reviews (PSIRF)

- 80 PSR1's (↓ from 89 in Q2);12 PSR2 (↑10 in Q2)
- 2 PSII's commenced (Never Events: wrong site surgery- ophthalmology and misplaced nasogastric tube).

Risk Registers

- 512 Open risks. (154 tolerated; 358 mitigated)
- 72 new risks added; 53 closed
- 26 deep dive completed (0 divisional, 22 service, 4 non-clinical)

Martha's Rule (Call for Concern)

- 3 calls were made to Call for Concern (2 from the family and 1 from the patient) (↓from 7 in Q2).
- 0 calls were made due to concerns with deterioration; 1 call was a concern re management of a patient with a long-term condition.

Key Learning from PSRs

- Importance of consistent and accurate monitoring of urinary catheters and the timely completion of fluid balance charts
- Importance of strict compliance with the non-mobile infant safeguarding policy, highlighting the need for staff awareness, consistent application of the policy, accurate documentation, and effective communication within the multidisciplinary team to ensure safe, high-quality care for non-mobile infants who present with an injury.
- Continuous and accurate monitoring and escalation of patient's vital signs, symptoms, and responses to treatment allows clinicians to make informed decisions, improve patient safety, and enhance the quality of care.
- Regular pressure ulcer education is required, with emphasis on early identification and pressure ulcer staging.

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Annual Review of Incidents
January – December 2025

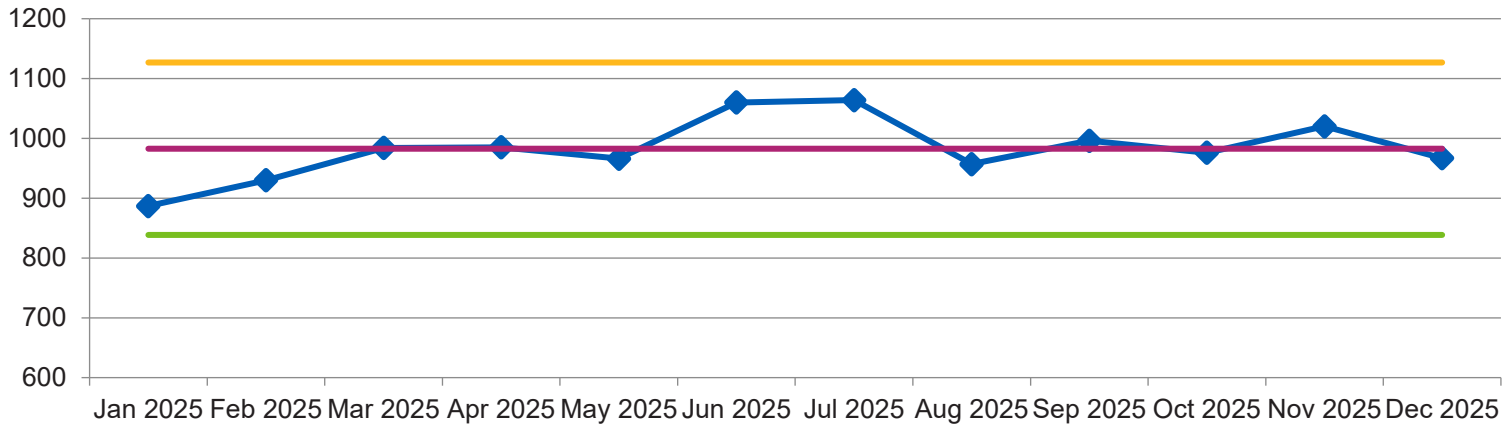
Incident Reporting Overall Profile

***please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed*

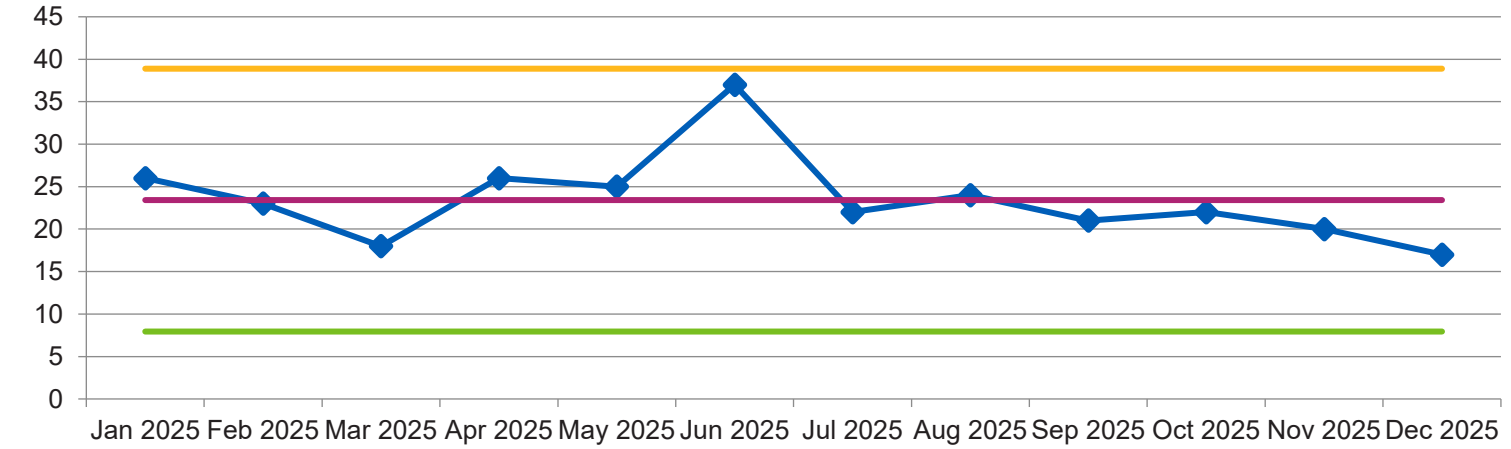
(data correct as of 21/01/2026)

Salisbury NHS Foundation Trust

Incidents by Date Reported (Month and year)



Moderate and Above Incidents by Date Reported (Month and year)



The SPC charts reflects a good reporting culture. We continue reporting with a two-month lag to reflect the harm reconciliation post-review of incidents at PSS and PSOG.
There continues to be additional vigilance and discussion for each high harm incident and significant near miss that is reported at the morning Datix incident huddle.

Themes and Trends

MNSI (Maternity and Newborn Safety Investigations)
There have been a further 3 Maternity Incidents that have been reported to the MNSI in Q3. (This gives a total of 8 this year). These cases have all been discussed and noted at the weekly Patient Safety Summit.

Violence and Aggression
Increase in the number of reported patient on staff abuse (verbal and physical)

Medicines management
There has been an increase in the number of preparation and administration of medications in relation to insulin management. A thematic review is being undertaken to explore the system-based learning.

Pressure Ulcers
An increase in non-hospital acquired pressure ulcers and a decrease in hospital acquired pressure ulcers is indicating a greater recognition and documentation of pressure ulcers on admission

Total Annual Incidents Overview- 1st January – 31st December 25

(data correct as of 22/01/2026)

From 1st January to 31st December 25, a total of 11,718 incidents occurred. Of these 2.42% were classed with a Moderate or above level of harm. The number of moderate and above incidents per month during this time period fluctuates from a minimum of 14 (March 25) to a maximum of 36 (May 25)

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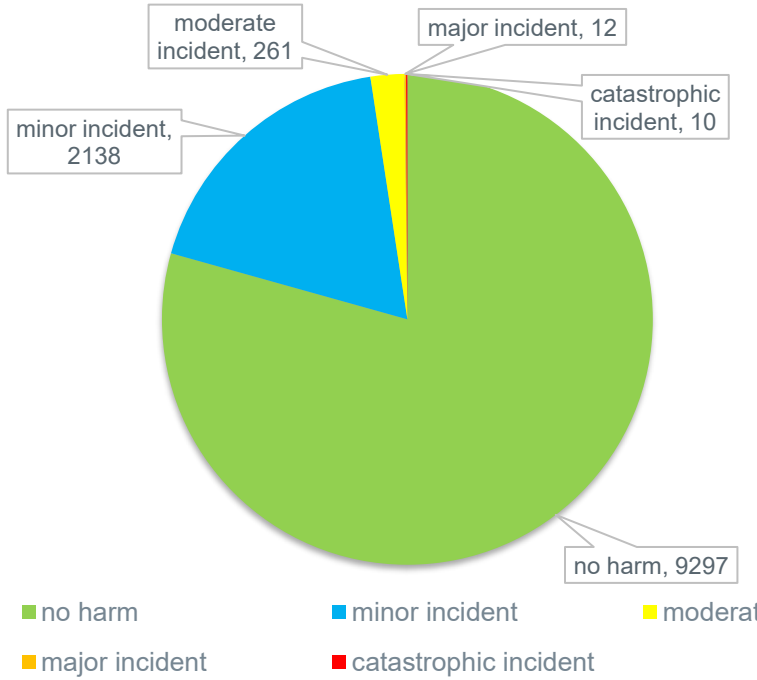
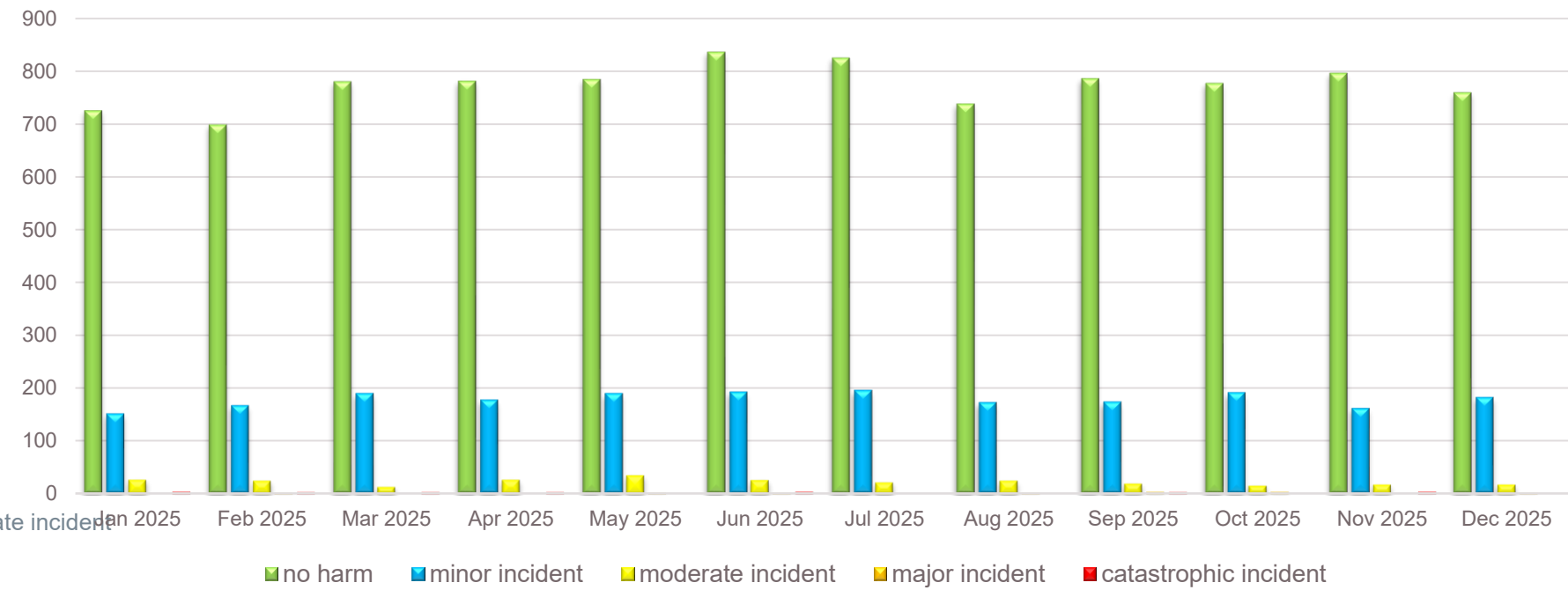
	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Total
no harm	726	699	781	782	785	837	826	739	787	778	797	760	9297
minor incident	151	166	189	177	189	192	195	172	173	191	161	182	2138
moderate incident	26	24	13	26	34	25	21	24	19	15	17	17	261
major incident	0	1	0	0	2	1	0	1	3	3	0	1	12
catastrophic incident	2	1	1	1	0	2	0	0	1	0	2	0	10
Total	905	891	984	986	1010	1057	1042	936	983	987	977	960	11718

*please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed

Incidents by Severity



Incidents by Incident Date and Severity



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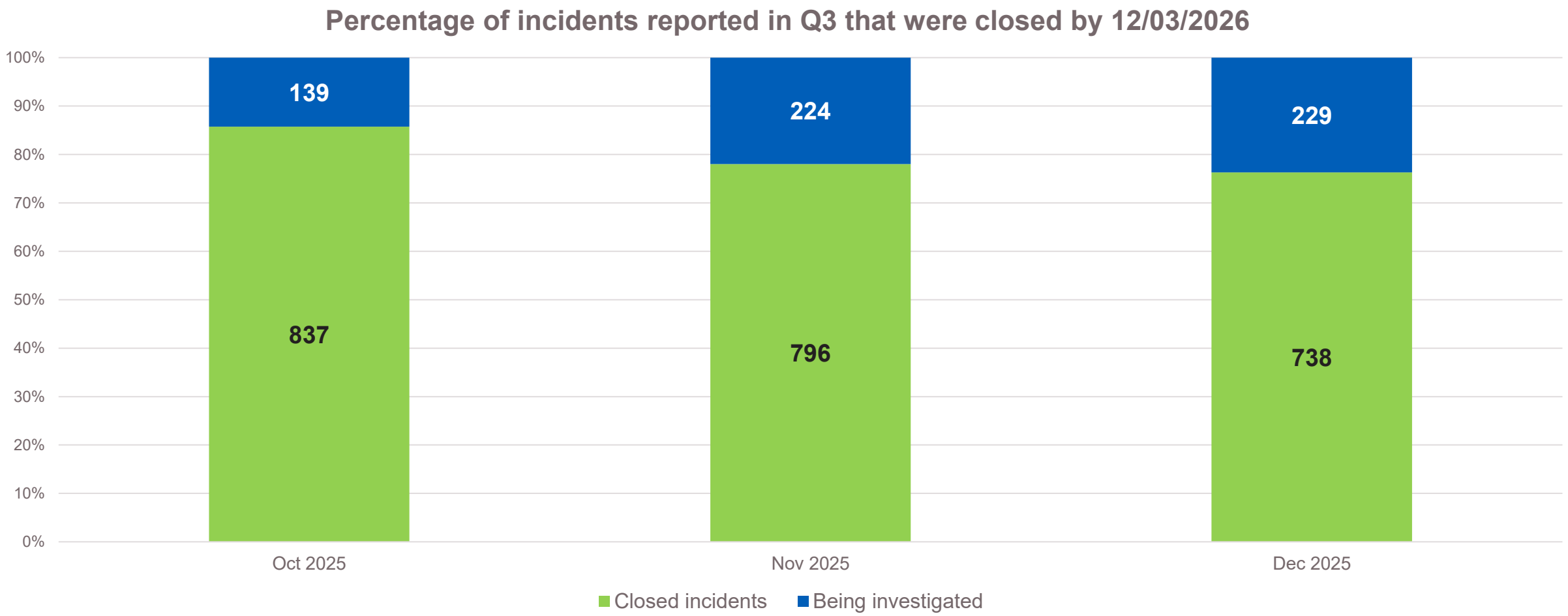
Quarter 3 Incidents
(October – December 2025)

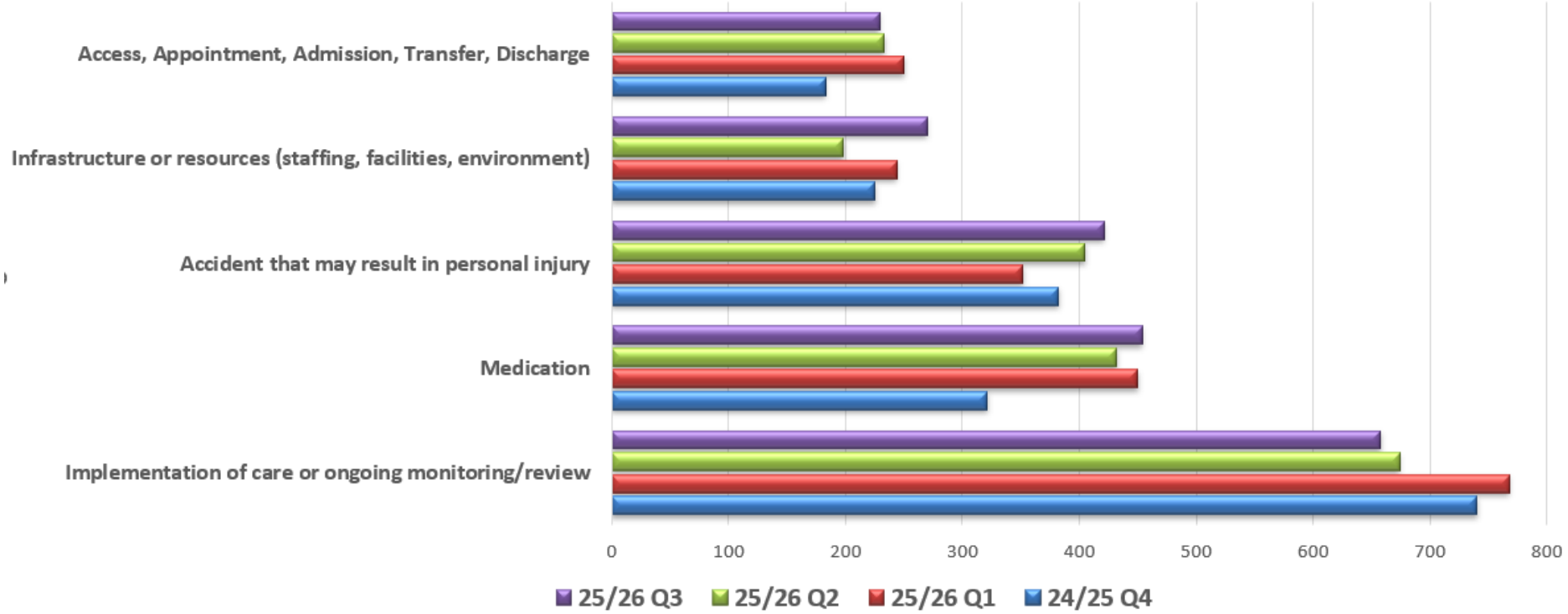
Total Reported Incidents in Q3

In Q3 there were a total of 2963 incidents reported, a decrease of 54 in comparison to Q2 where 3017 were reported. The below table breaks this down by month and by the number of incidents that have been closed, and the number still being investigated.



(data correct as of 12/3/2026)

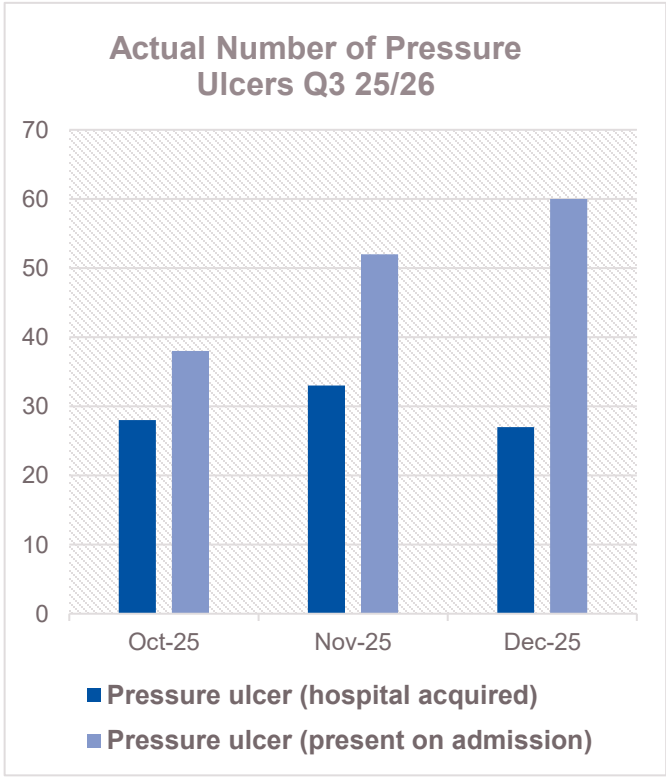
Q3 25/26 Incidents by Stage of Care (Top 5)



The highest reported type of incident in Q3 is implementation of care or ongoing monitoring/review.
There are several ongoing workstreams, breakthrough objectives and national safety improvement programmes that are in place to focus on the areas identified in the data, these include:

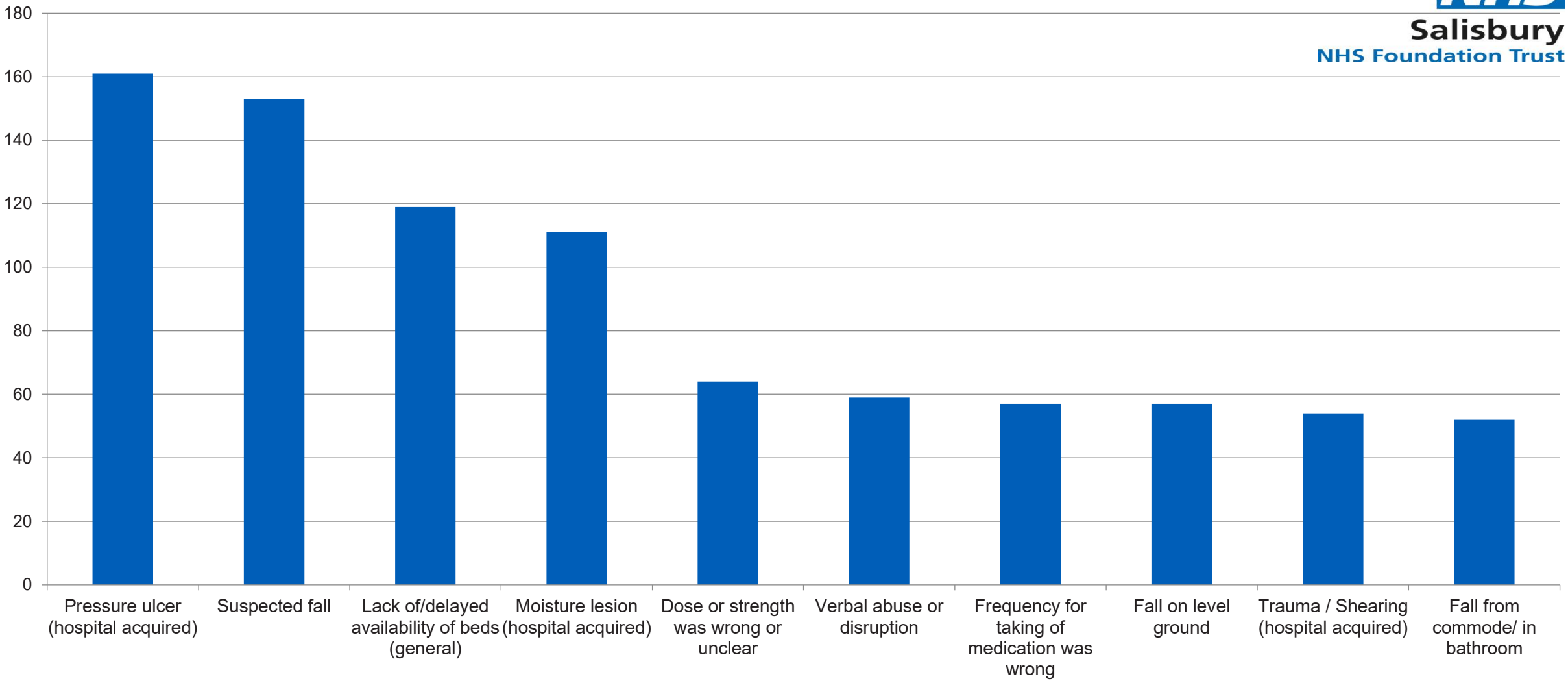
- Recognising the deteriorating patient
- Pressure damage reduction (Breakthrough objective 25/26)
- IPC working group
- Falls Working group
- VTE working group
- Medication management
- Maternity and neonatal
- Mental Health Governance Board

These workstreams all feed into the patient safety steering group on a quarterly basis for ongoing monitoring and updates.



Data correct as of 22/01/2026

Q3 25/26 Incidents by Adverse Event (Top 10)



The top 10 types of incident (based on adverse event) can be seen in this graph. Lack of delayed availability of beds within the surgical division has seen a large increase in this quarter compared to previous quarters where its not flagged. (Present on admission pressure ulcers and moisture associated skin damage (MASD) were in the top ten but have been removed from this data set)

Medicine: Breakdown of Q3 (October – December 2025)

(data correct as of 22/01/2026)

	Oct 2025	Nov 2025	Dec 2025	Total
no harm	351	346	347	1044
minor incident	103	96	92	291
moderate incident	7	7	6	20
major incident	0	0	1	1
catastrophic incident	0	1	0	1
Total	461	450	446	1357

*please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed

In total 1357 incidents occurred in Medicine during Q3 25/26 (in Q2 25/26 there were 1396 incidents)

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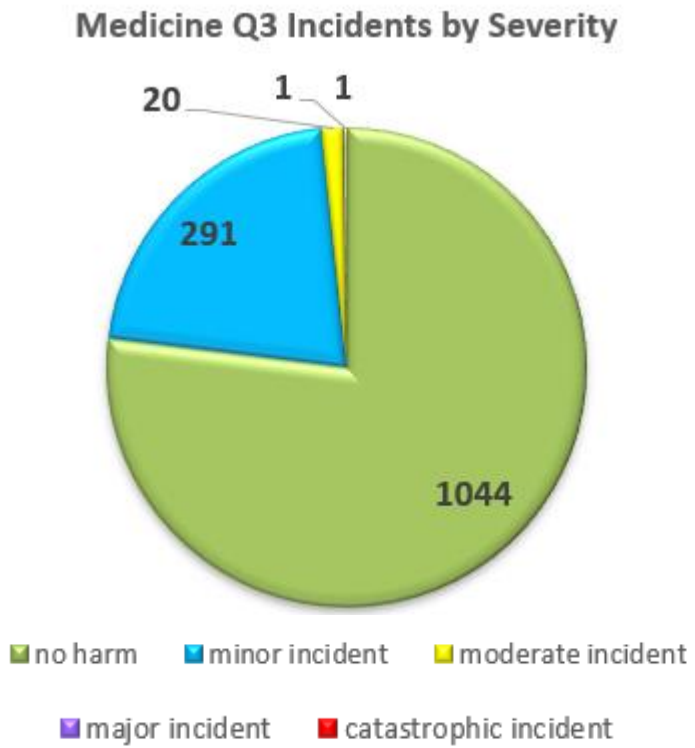
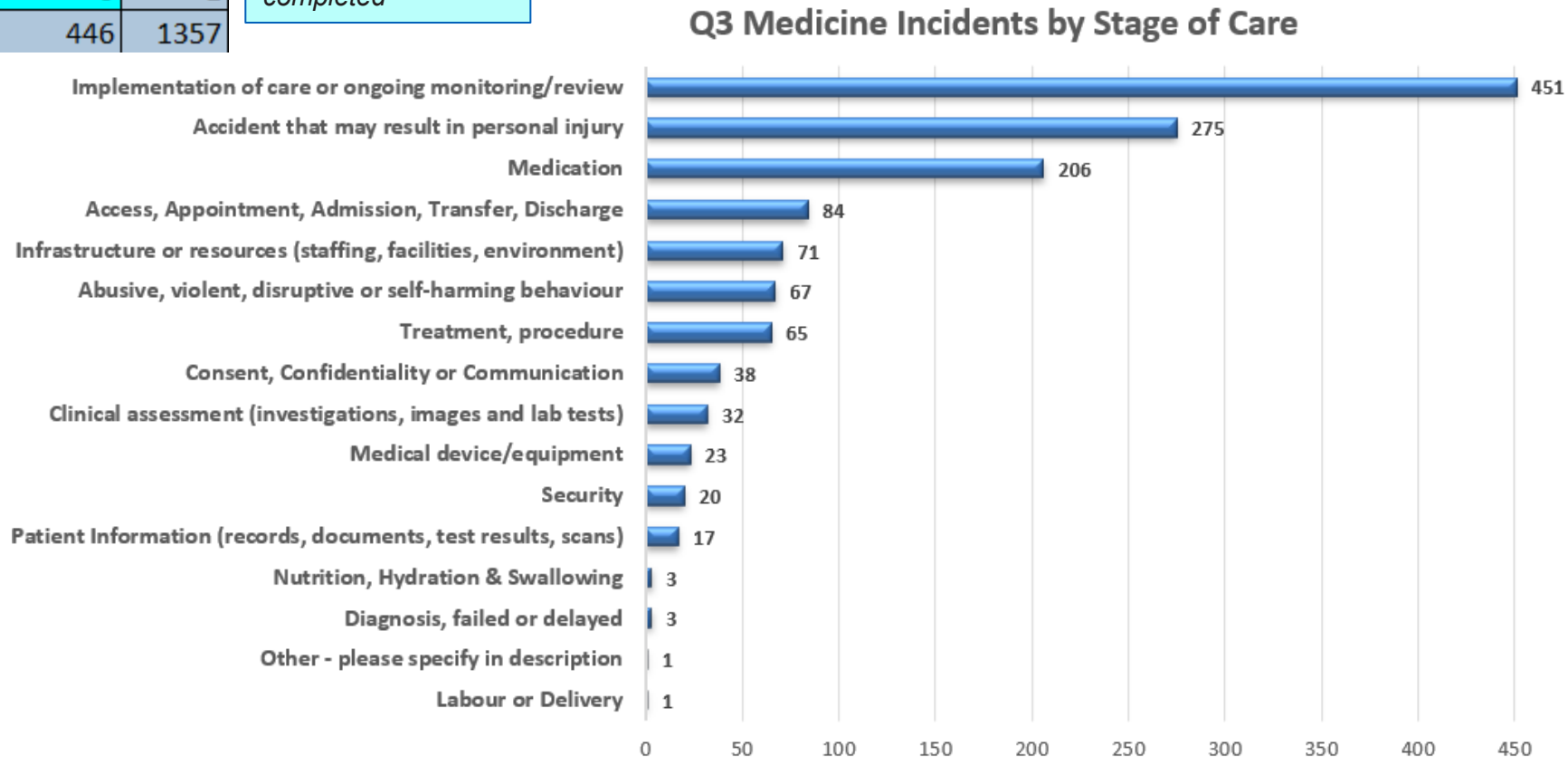
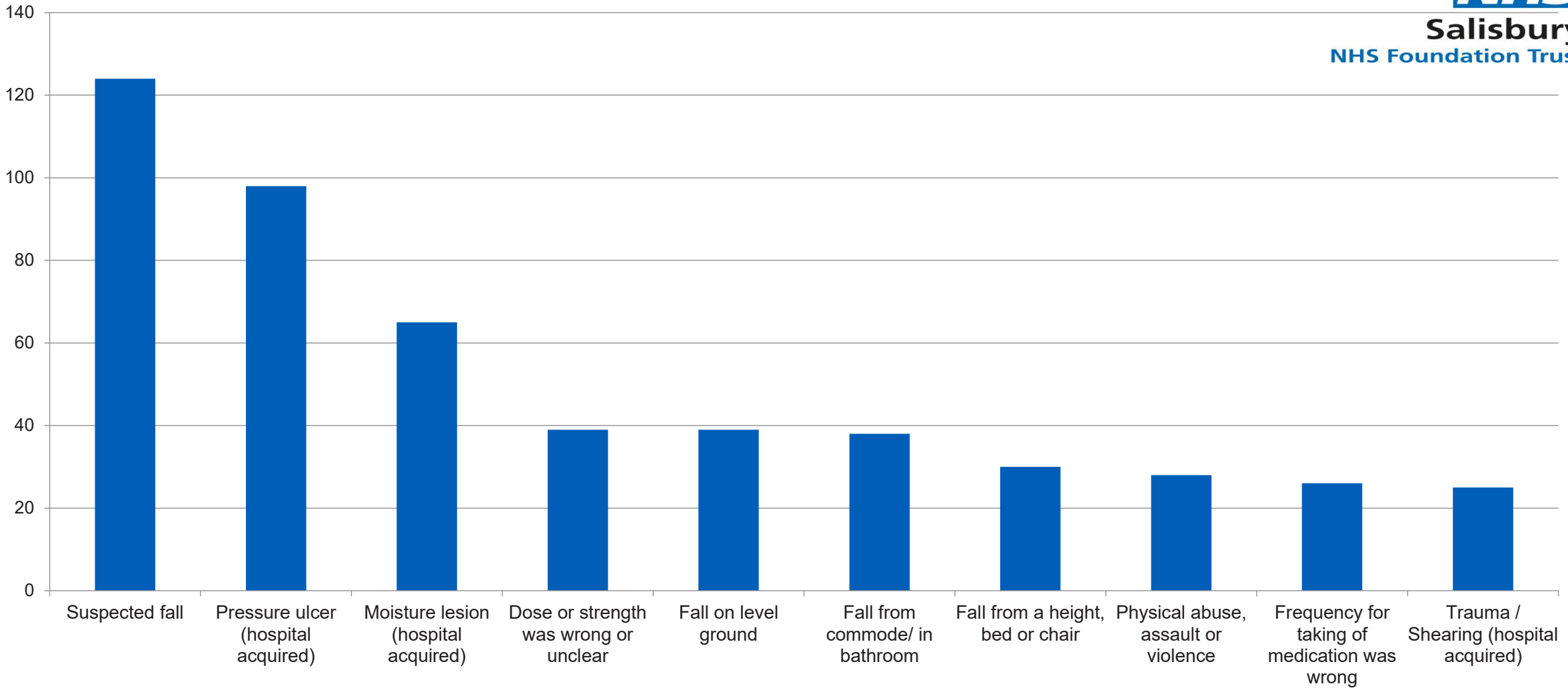




Medicine Q3 25/26 Incidents by Adverse Event (Top 10)



The top 10 types of incident (based on adverse event) can be seen in this graph (present on admission pressure ulcers and moisture associated skin damage (MASD) were in the top ten but have been removed from this data set)

Surgery: Breakdown of Q3 (October – December 2025)

(data correct as of 22/01/2026)

	Oct 2025	Nov 2025	Dec 2025	Total
no harm	235	223	226	684
minor incident	58	41	55	154
moderate incident	4	4	7	15
major incident	1	0	0	1
Total	298	268	288	854

*please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed

In total 854 incidents occurred in Surgery during Q3. In Q2 there were 804 incidents.

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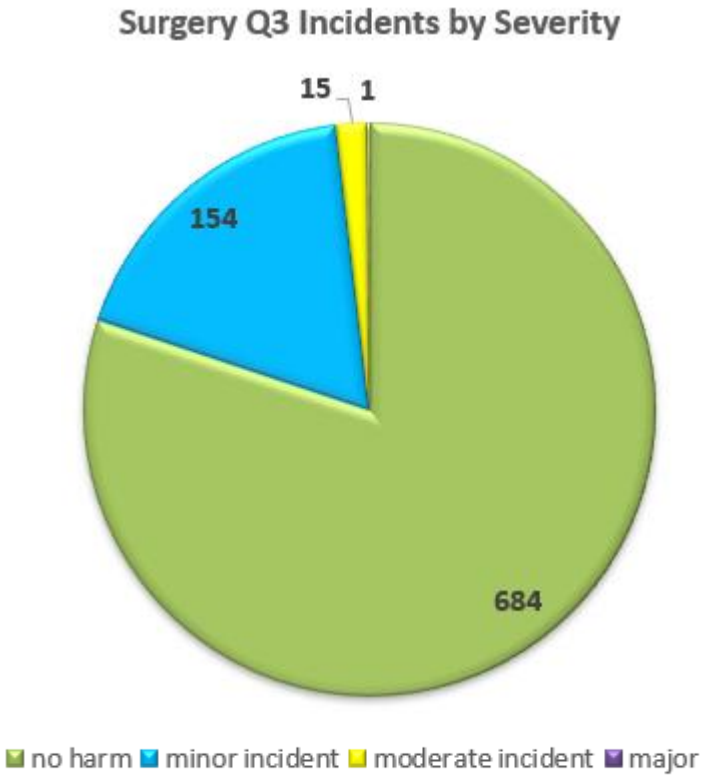
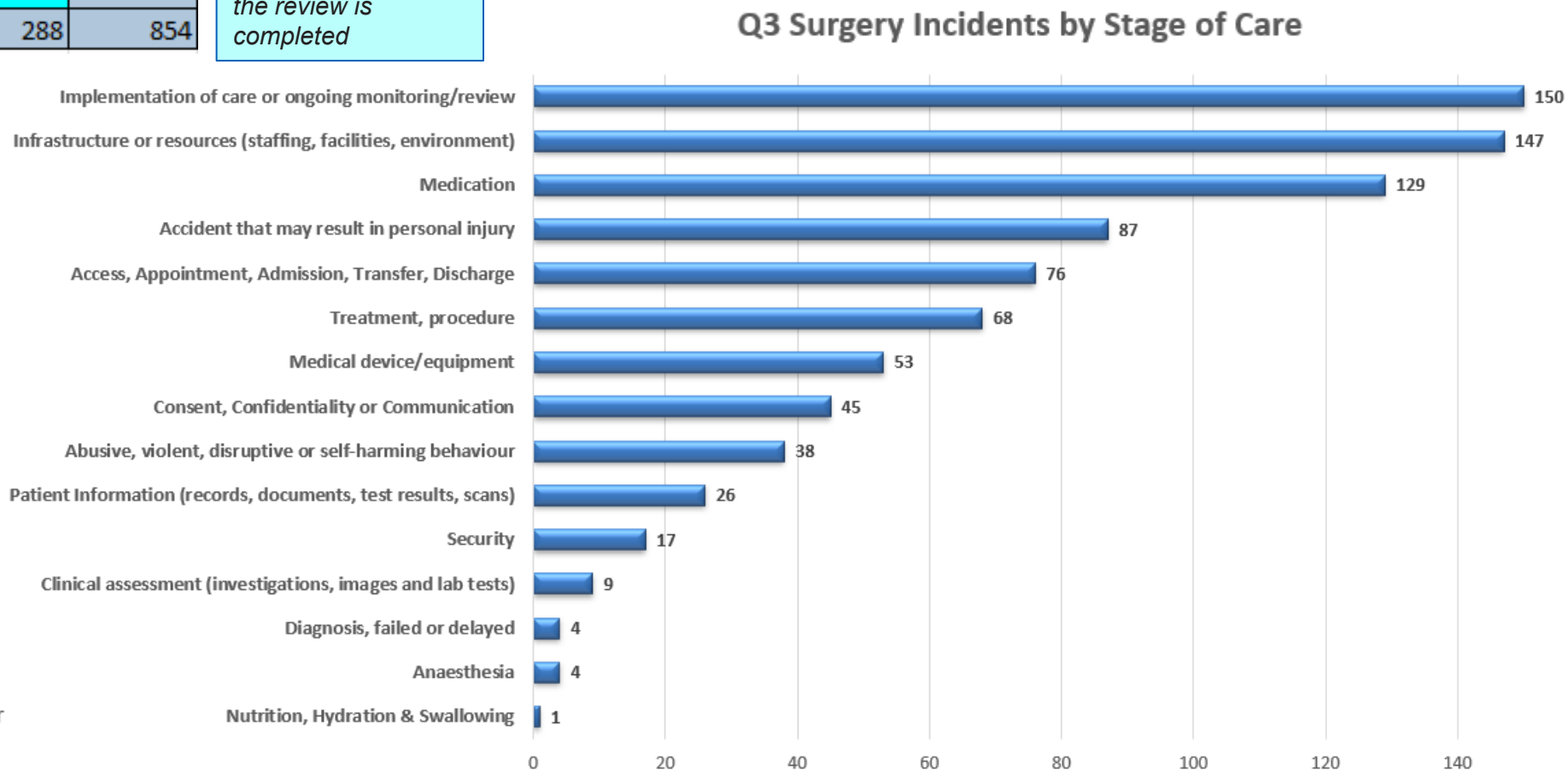
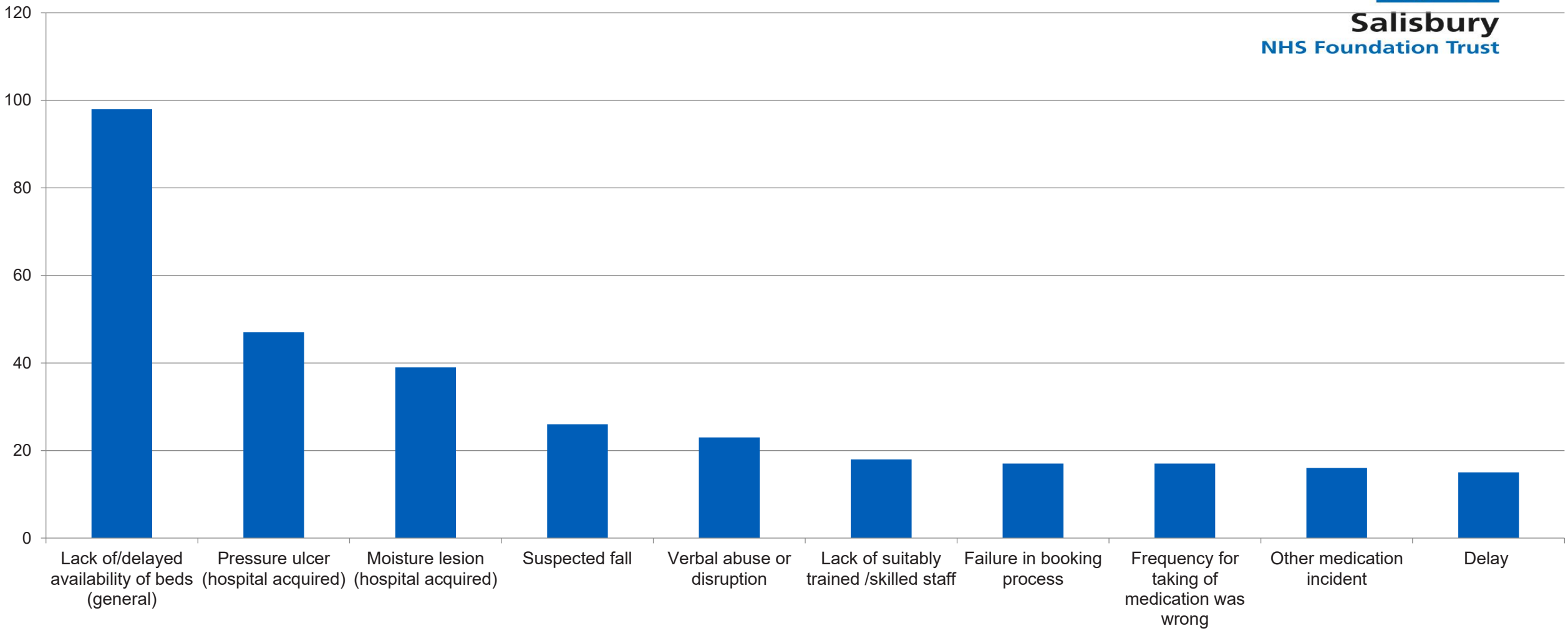




Surgery Q3 25/26 Incidents by Adverse Event (Top 10)



The top 10 types of incident (based on adverse event) can be seen in this graph (present on admission pressure ulcers and moisture associated skin damage (MASD) were in the top ten but have been removed from this data set).

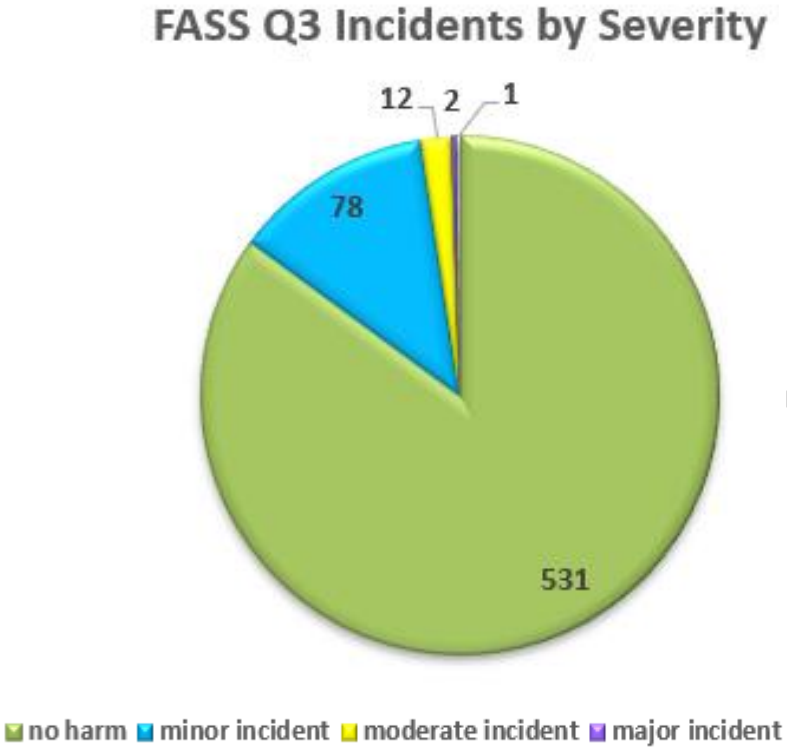
FASS: Breakdown of Q3 (October – December 2025)

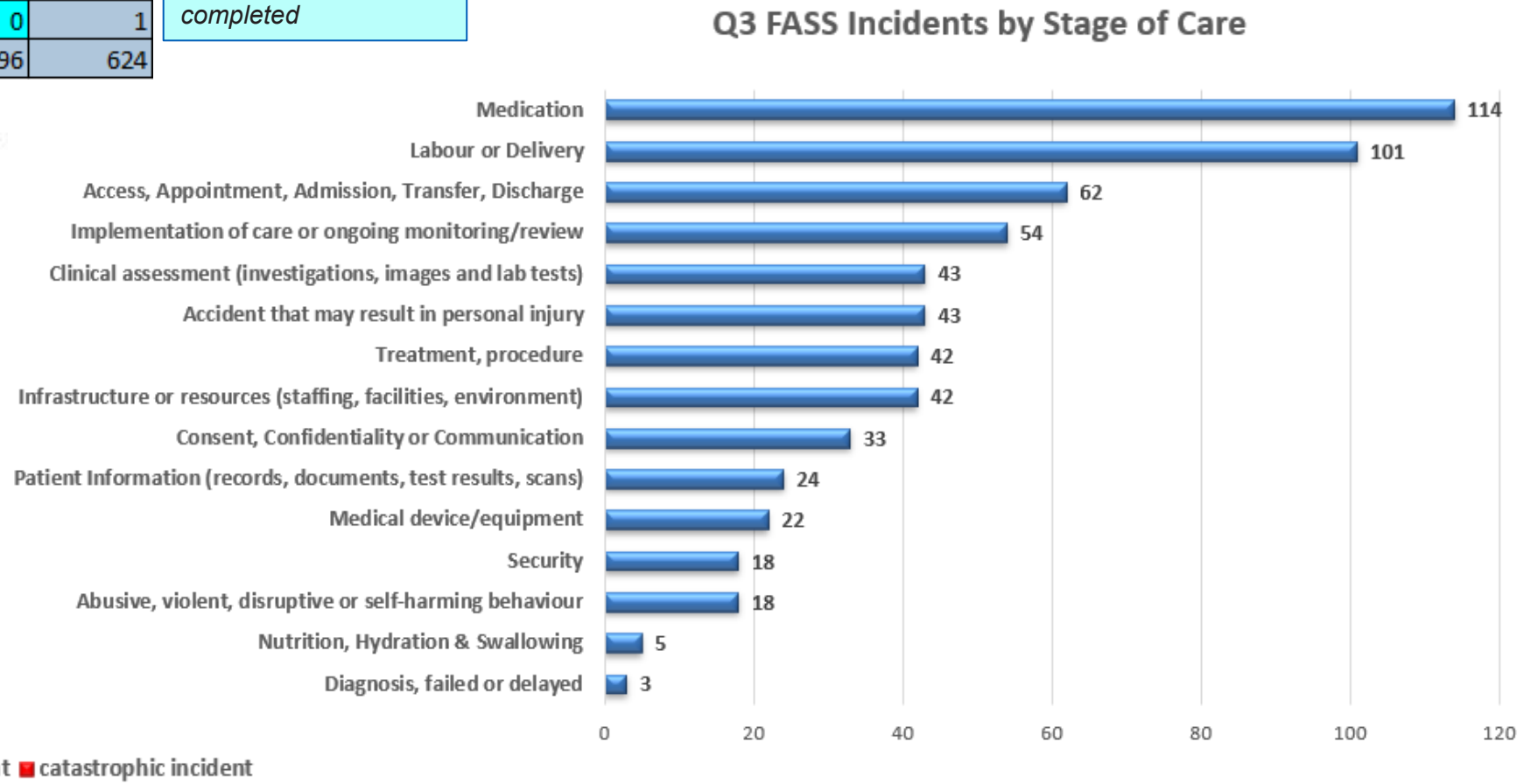
(data correct as of 22/01/2026)

	Oct 2025	Nov 2025	Dec 2025	Total
no harm	164	206	161	531
minor incident	25	21	32	78
moderate incident	3	6	3	12
major incident	2	0	0	2
catastrophic incident	0	1	0	1
Total	194	234	196	624

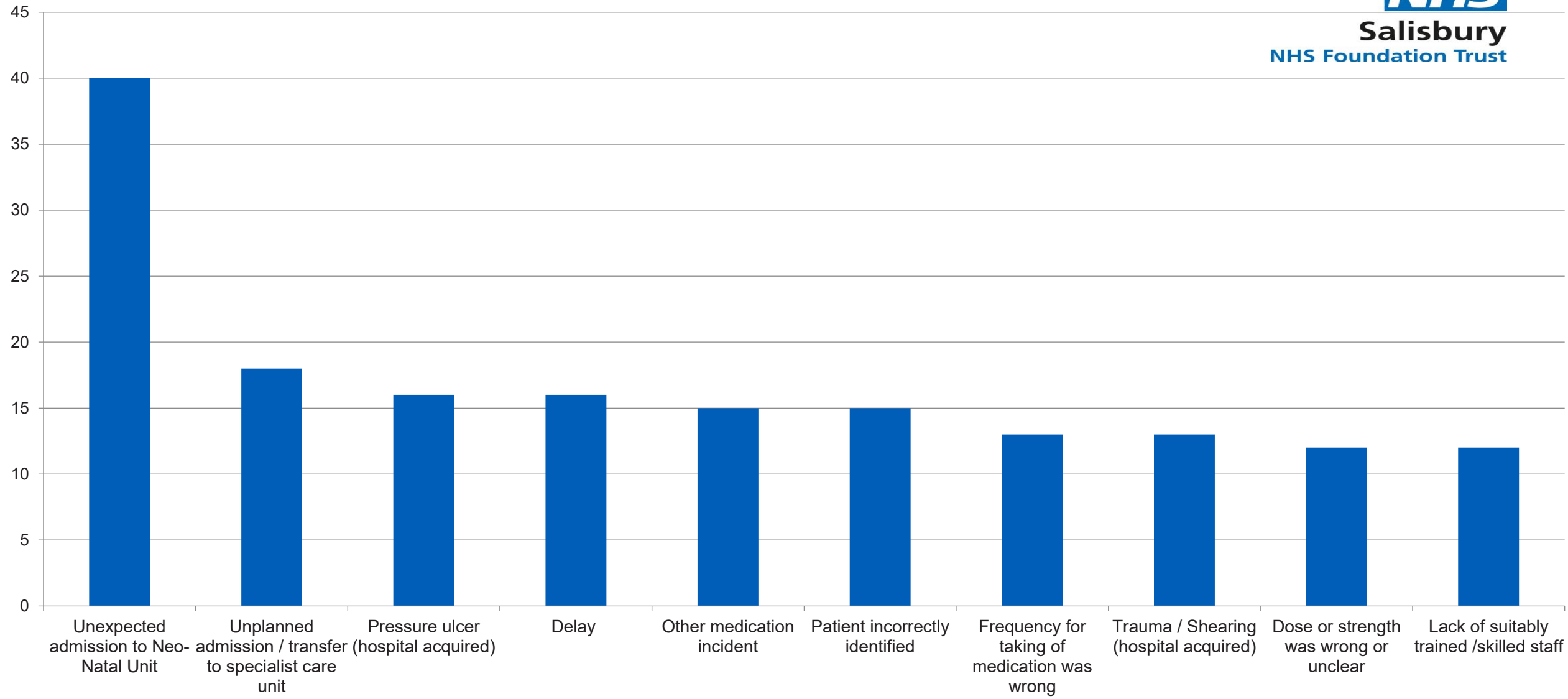
*please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed

In total 624 incidents occurred in FASS during Q3. In Q2 there were 636 incidents.



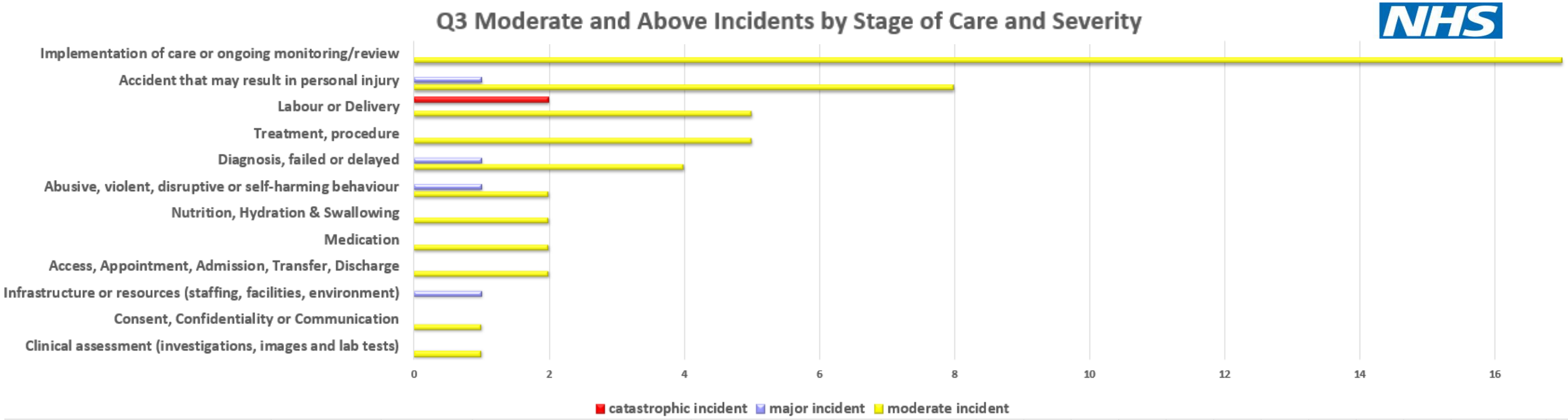


FASS Q3 25/26 Incidents by Adverse Event (Top 10)



The top 10 types of incident (based on adverse event) can be seen in this graph.

Breakdown of all Moderate and above harm incidents in Q3



Of the 2925 incidents that occurred in Q3, 55 of these were moderate or above harm.

	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
% of incidents with Moderate and above harm	2.45	2.98	2.33	1.88

please note that the Nov and Dec 25 moderate+ incidents are awaiting their final grading confirmation once the review is completed

This will look slightly different to the IPR data as these figures include all reported incidents on Datix not just patient safety incidents.

(data correct as of 22/01/2026)

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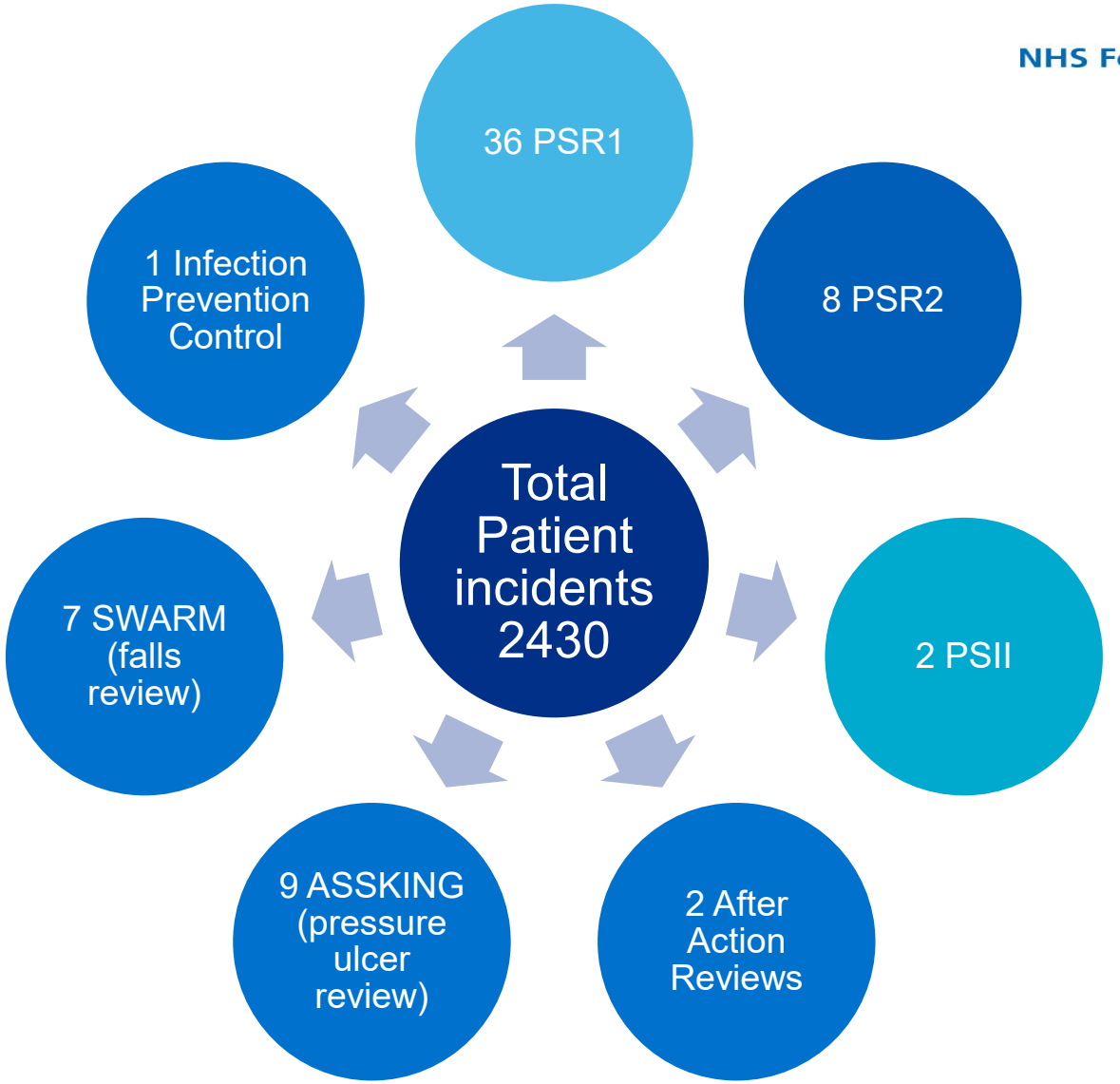
Patient Safety Incident Response Framework (PSIRF)

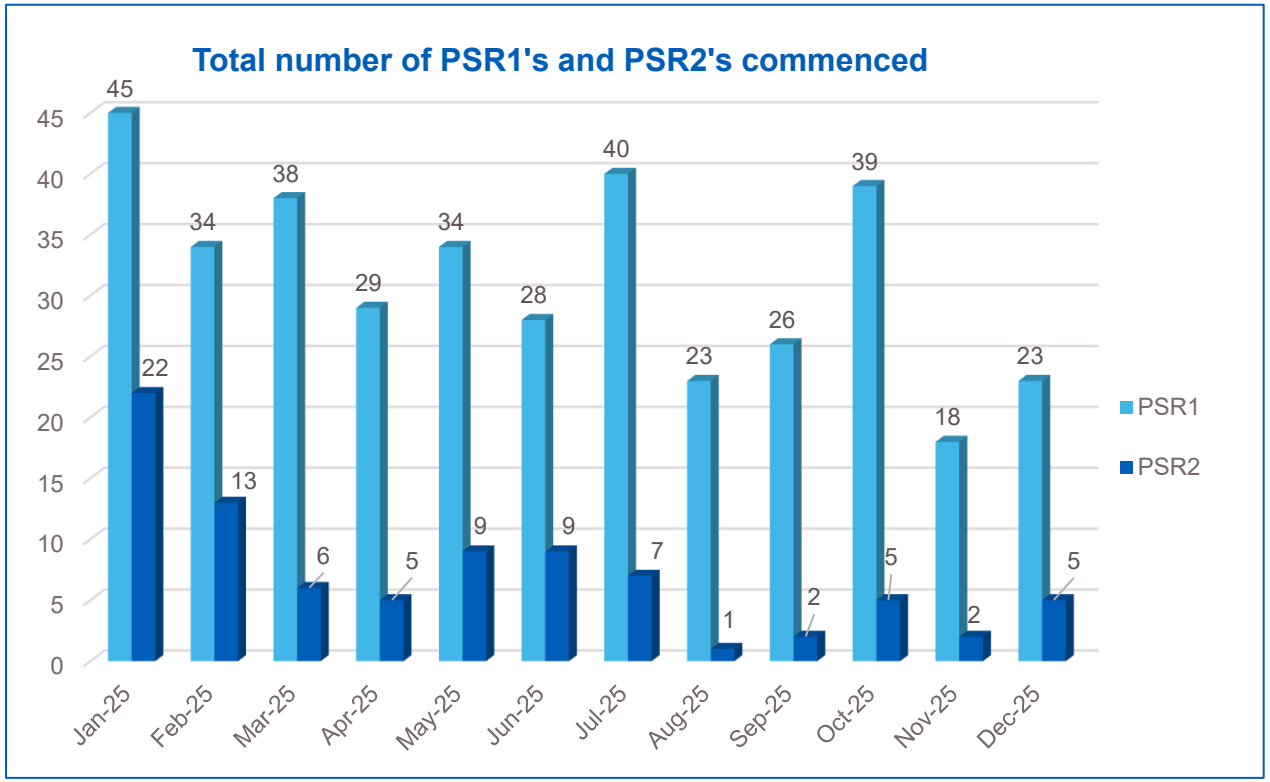
Patient safety tool kits

Oct – Dec 2025

In Q3 there were 2430 patient safety incidents reported. Of these 65 had a review in addition to the Datix.

A patient safety review can be undertaken via a number of methodologies. At SFT the most utilised tools are the PSR1 and 2 templates. These are aimed to frame the questions for the reviewers to incorporate what did happen, what was expected to happen and what can be learned. This is taken from the After Action Review tool kit and this approach is aimed to be developed further within the Trust which will help staff in how they respond to any incident.





In Q3 there were 80 PSR1s that were discussed at the weekly Patient Safety Summit.
Of these, 12 have proceeded to a further PSR2 review.

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Patient Safety Incident Investigations (PSII)

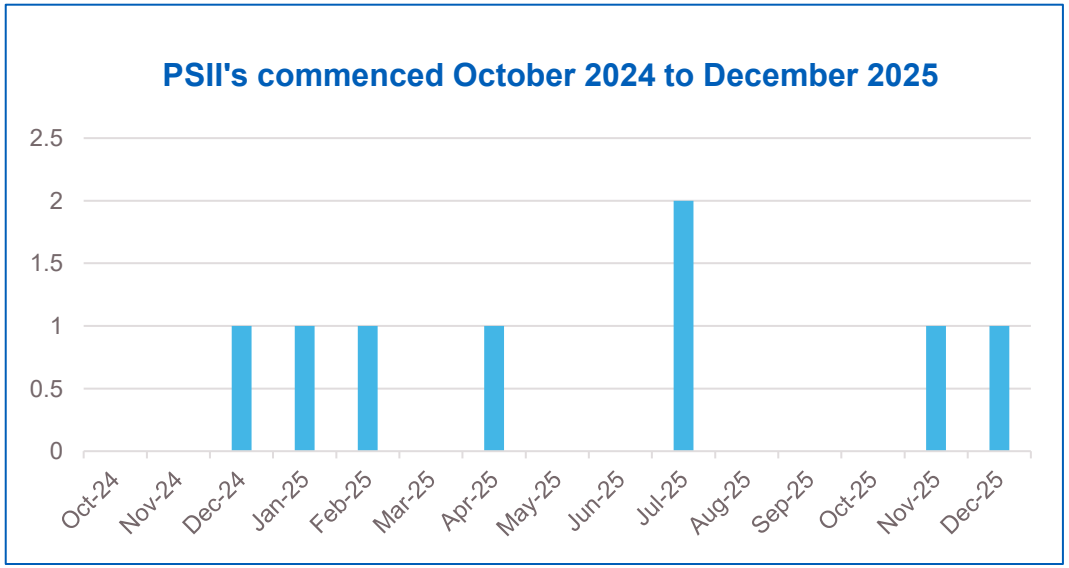
There has been 2 PSII's commenced in Q3 25/26:

- **November** – Never Event wrong site (Ophthalmology)
- **December** - Never Event NG tube misplacement

Both PSII's are investigated under the national priority for PSIRP

Since PSIRF was implemented in January 2024, a total of 17 PSII's have been commenced.

Of those 11 have been completed and shared with the patient/family.



Patient Safety Incident Investigations (PSII) commenced Q3

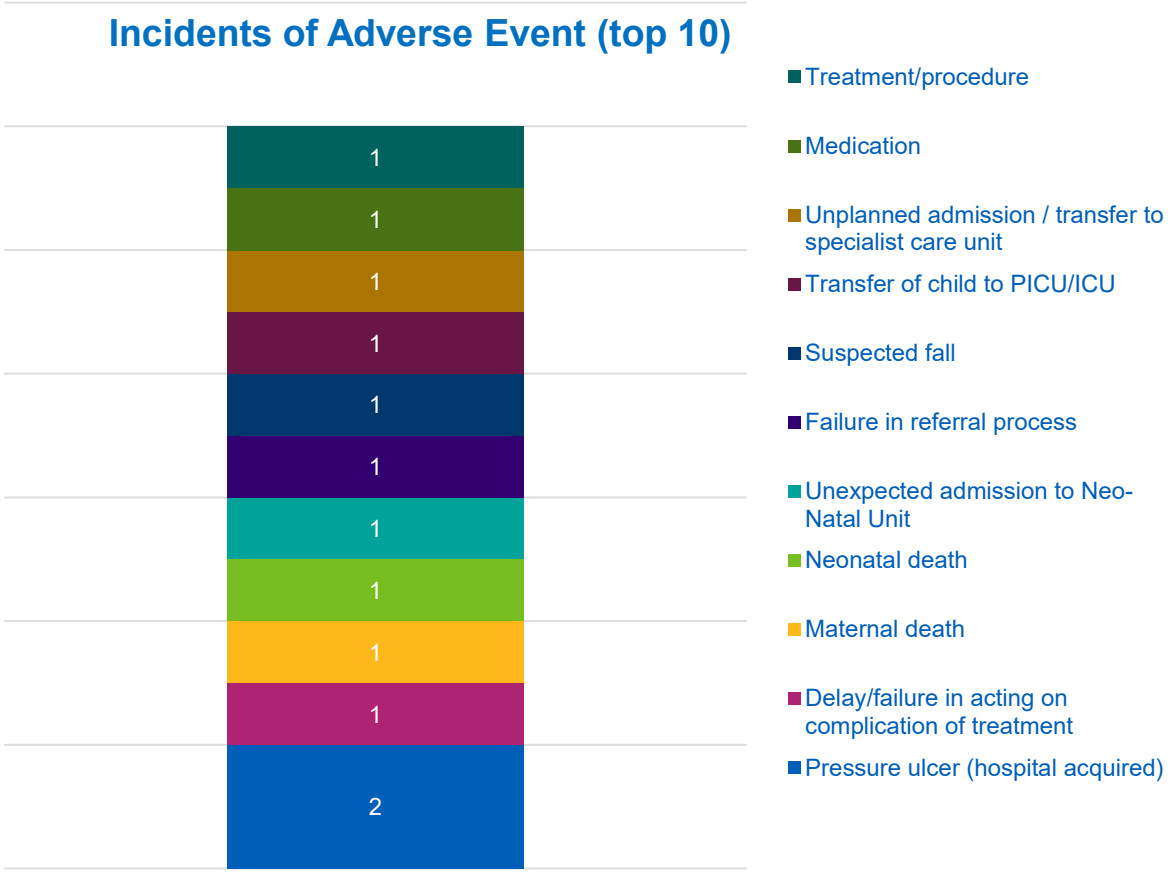
	Date commenced	Summary	PSIRF priority	Progress
PSII 16	14/10/2025	Ophthalmology Never Event; Injection administered to incorrect eye.	National	Initial fact finding complete. Awaits date for After Action Review
PS11 17	13/12/2025	Nasogastric tube misplacement Never Event;	National	Undertaking initial fact finding; Awaits date for After Action Review as one key staff member is away overseas until late Feb.

Datix categories recorded for the Patient Safety Reviews

October 2025 – December 2025

Salisbury NHS Foundation Trust

Incidents of Adverse Event (top 10)

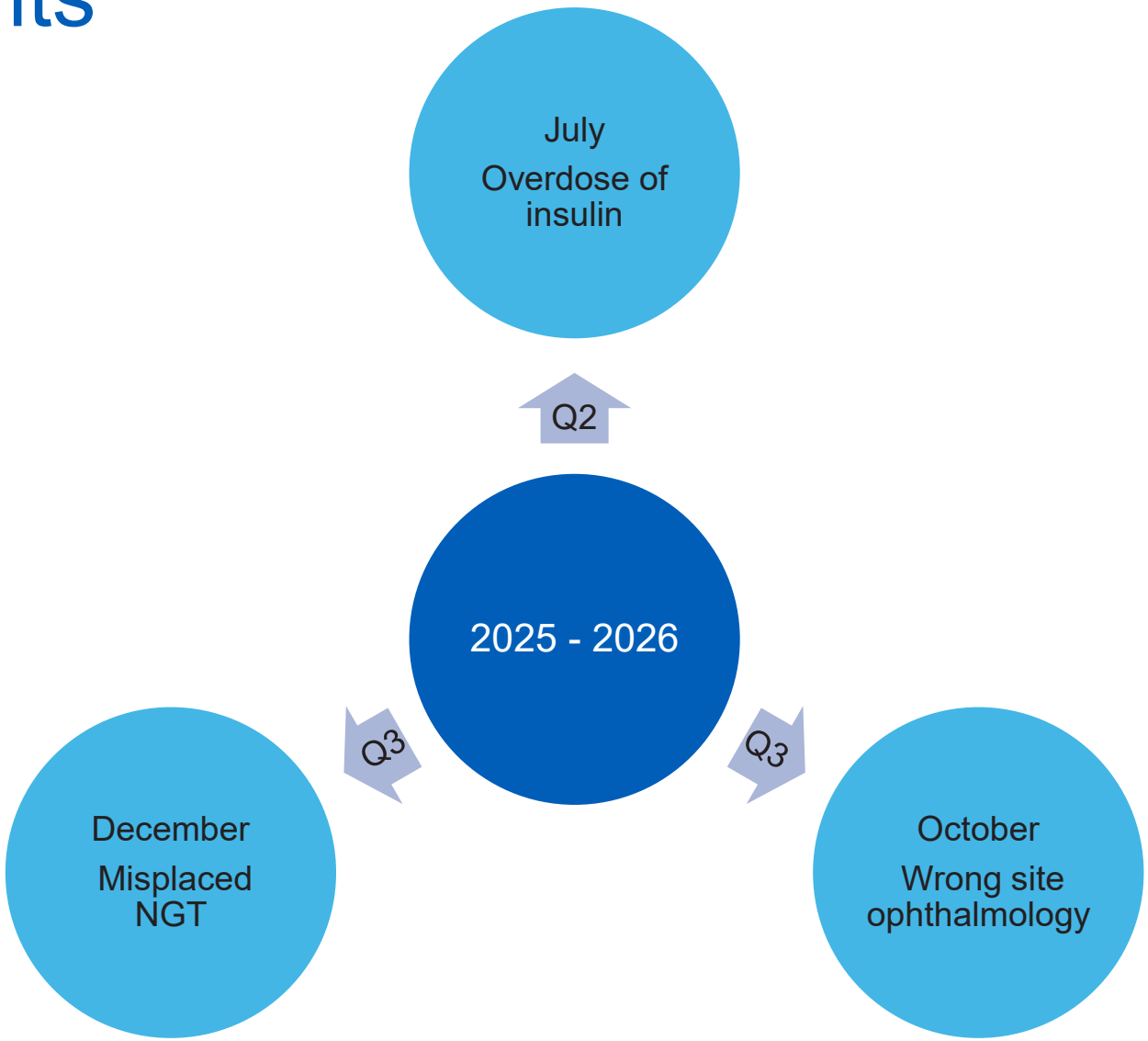


Key Learning – Summary

Key Learning

- **Importance of consistent and accurate monitoring of urinary catheters and the timely completion of fluid balance charts**
- **Importance of strict compliance with the non-mobile infant safeguarding policy, highlighting the need for staff awareness, consistent application of the policy, accurate documentation, and effective communication within the multidisciplinary team to ensure safe, high-quality care for non-mobile infants who present with an injury.**
- **Continuous and accurate monitoring and escalation of patient's vital signs, symptoms, and responses to treatment allows clinicians to make informed decisions, improve patient safety, and enhance the quality of care.**
- **Regular pressure ulcer education is required, with emphasis on early identification and pressure ulcer staging**

Never Events



Patient Safety Programmes

No further changes in addition from Q2

NHS Salisbury NHS Foundation Trust

National Medicines Safety Improvement Programmes

- Improve care for people with a learning disability by reducing the burden of medications that act on the brain.
    - Stakeholder input to the West of England Health Innovation Network working group with the opportunity to share resources and learning from current work.
    - Any updates are shared with the Learning Disability and Autism Operational Group and Medicines Safety Group.
- Improve care for people by ensuring that they receive the critical medication they need on time.
    - Self-directed cohort member in the Specialist Pharmacy Service and NHSE National Quality Improvement collaborative for Time Critical Medicines.
    - Work undertaken as a workstream of the Medicines Safety Group with multidisciplinary input from Coach House, Business Intelligence, Divisional Nursing representatives, Pharmacy and Patient Experience Experts.

Maternity and Neonatal Safety Improvement Programme

- Reported separately through the monthly Perinatal Quality Report and the annual Maternity Quality and Safety Report
- SFT remain in sustainability phase of the programme with a vision to exit the programme in 2026.

Local Patient Safety Programmes

Martha's Rule

- Call for concern was implemented at SFT in February 2025
- Patient Wellness questions currently being piloted in 5 ward areas plan to roll out in Trust wide in December 2025
- In Q3 there were 3 calls made to Call for Concern
  - There were no calls related to deterioration
  - 2 were other / unrelated
  - 1 was clinical concern re management of a patients with a long-term condition
  - 1 call was made by the patient
  - 2 calls were made by the family/carer

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Risk Registers

Divisional and Service Level Risk Registers

Salisbury NHS Foundation Trust

The Mini Deep Dives that review all service level risks continue within all service areas across the Trust. These deep dives support standardisation and education for the service level teams across the trust and continue to raise awareness of new risks, risks that are increasing in score and risks that require closure.

The table below shows the number of service and divisional deep dives that have taken place since April 2025, and how many are booked so far for January 26.

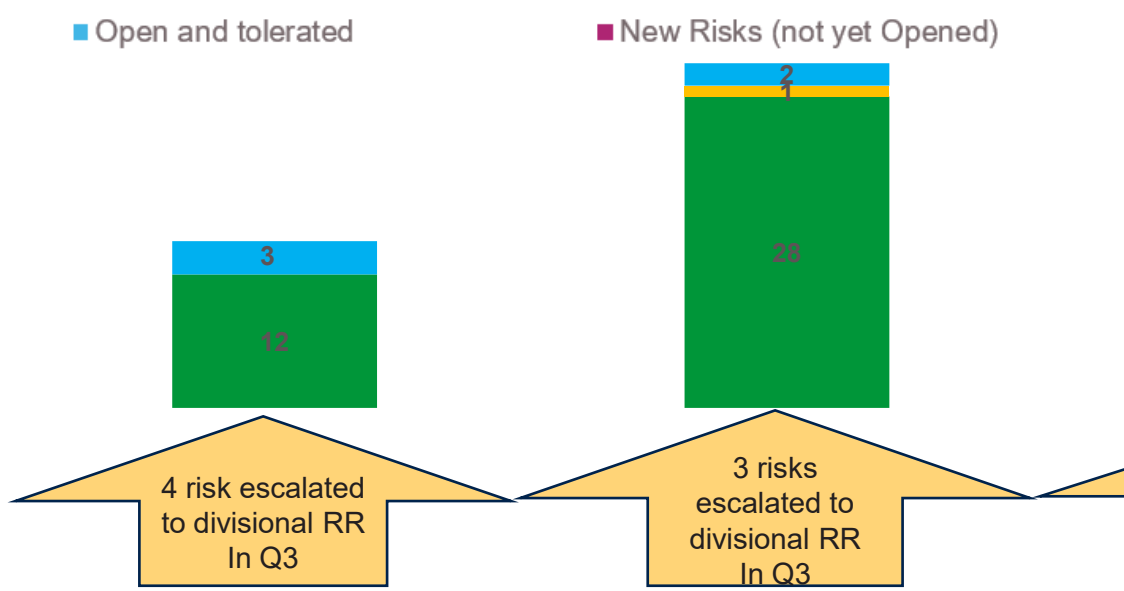
In total 26 risk register deep dives were completed in Q3 (compared to 27 in Q2).

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Booked so far for Jan 26
Service level mini deep dives - Medicine	0	0	3	2	2	3	3	3	0	1
Service level mini deep dives - Surgery	0	0	1	3	2	3	4	2	1	1
Service level mini deep dives - FASS	2	5	4	0	1	4	6	2	1	7
Divisional Deep Dive - Medicine	1	0	0	0	1	0	0	0	0	1
Divisional Deep Dive - Surgery	0	0	1	0	0	1	0	0	0	1
Divisional Deep Dive - FASS	0	1	0	0	1	0	0	0	0	(booked for Early Feb)
Non-Clinical deep dives	2	0	1	2	2	0	0	2	2	0
Total	**5**	**6**	**10**	**7**	**9**	**11**	**13**	**9**	**4**	**11**

The following slides show summaries of the service level and divisional level risk registers in Surgery, Medicine and FASS.

Clinical Division Risks: Mitigation and Escalation

Divisional



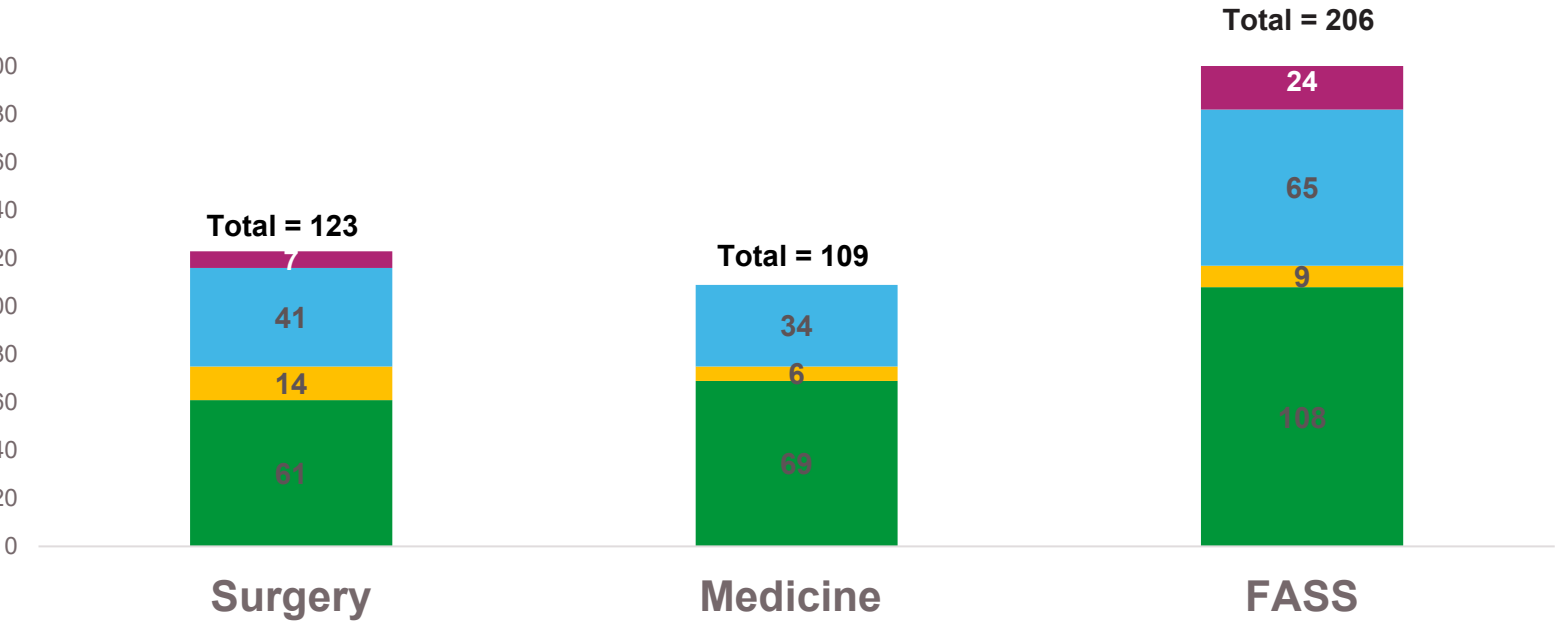
4 risk escalated to divisional RR In Q3

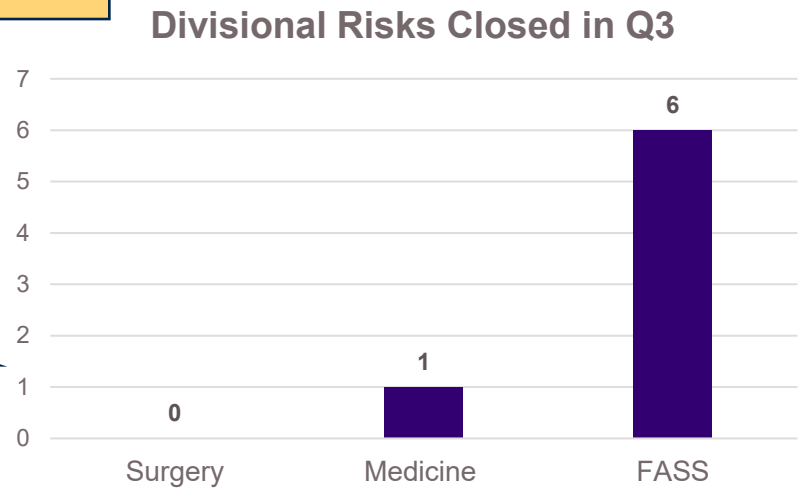
3 risks escalated to divisional RR In Q3

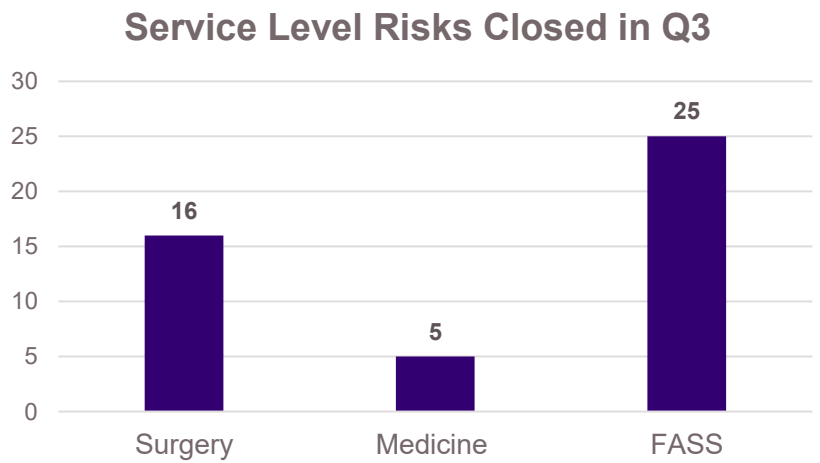
6 risks escalated to divisional RR In Q3

0 risks were added to the Corporate Risk Register (RR) in Q3 25/26

Service Level







(data from Datix @ 22/01/2026)

Risks Escalated to Clinical Division Risk Registers in Q3

Divisional Risk Registers

4 risks escalated to divisional RR in Q3:

- **6989**. Loss of **cleft** surgeon programmed activity **(Score= 9)**
- **7043**. ERF Risk: **DSU** in escalation - impact on elective recovery **(Score= 9)**
- **8607**. Reduced clinical capacity in **Ophthalmology (Score= 15)**
- **8688**. Insufficient administrative and clinical capacity to achieve compliance with POPSUI requirements for **Urology Score = 12)**

3 risks escalated to divisional RR in Q3:

- **8593**. **Plastic Outpatient** Hand Therapy Capacity **(Score= 15)**
- **8679**. Risk of Harm to patients and staff from reduction of activity in **Wessex outpatients** to support early adoption of new **ESD service (Score= 15)**
- **8490**. Clinical staffing - locum cover request process (**ED**). **(Risk Closed in Jan 26 as new process agreed) (Score= 10)**

6 risks escalated to divisional RR in Q3:

- **8293**. Lack of podiatry cover in the **Spinal centre (Score= 9)**
- **8587**. **Aseptics unit** - ability to offer a service- **Pharmacy (Score = 25)**
- **8596**. Unable to recruit impacting on the **aseptic** compliance process - **Pharmacy (Score = 20)**
- **8646**. Increased risk of breaching time to baby hip screening, as defined by national NIPE guidelines. (**Children's Physiotherapy**) **(Score = 12)**
- **8683**. Reduced access to specialist children and young peoples (CYP) community physiotherapy impacting upon SFT children's services. . (**Children's Physiotherapy**) **(Score = 9)**
- **8694**. Risk of delay to reviewing urgent results on review (**Clinical Radiology**) **(Score = 9)**

Surgery

Medicine

FASS

Service Level Risk Registers

Summary of Clinical Division Risks

As of 23rd January 26, there were 512 New and Open risks across the Clinical Divisions. Of these, 154 are being tolerated while 358 are being mitigated.

Of the 358 mitigated risks, 38 of these do not have actions, these are at service level and work continues to address this with the risk owners (**2 are DIVISIONAL-8583 and 8044**). There is continued focus on education around mitigated risks and the requirement for actions to be in place.

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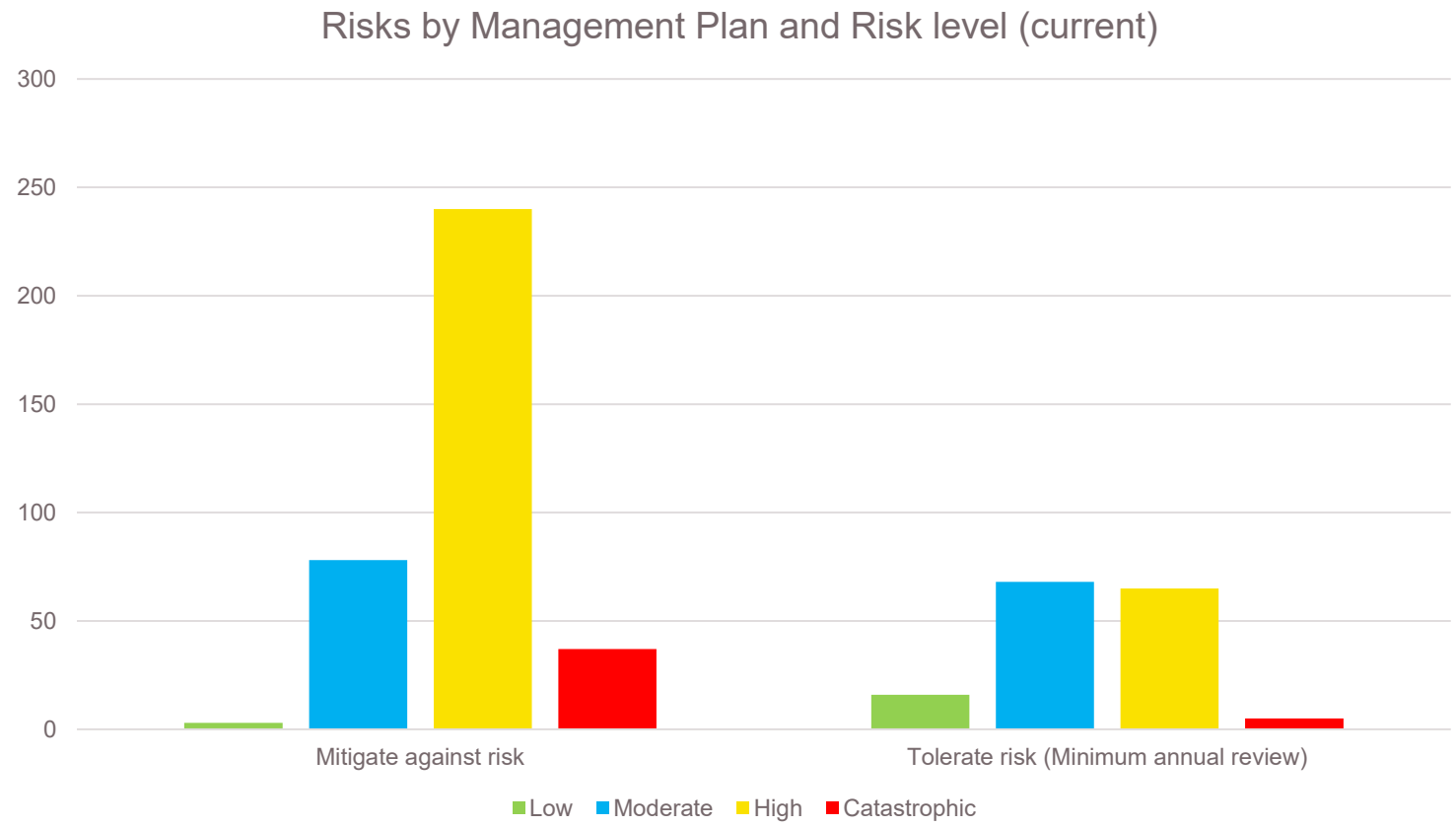
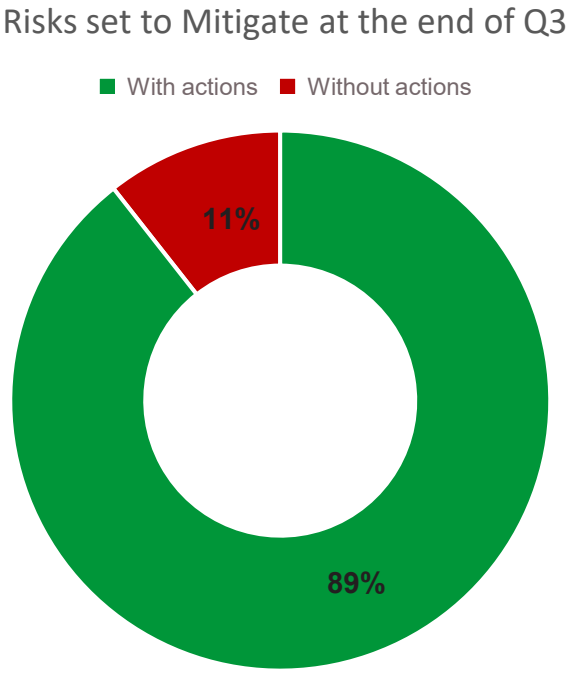
	24/25 Q4	25/26 Q1	Q2 25/26	Q3 25/26
New Risks Added	78	106	70	72
Closed risks (Service Level)	61	51	57	46
Closed risks (Divisional Level)	4	8	8	7





(data correct as of 23/01/2026)

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Risk Management Training

Risk Management Training

The Risk Management team provide training to staff who are responsible for their area's incidents and risk registers.

- The incident training is no longer part of the Trust induction (work is in progress with the education team to understand why the compliance has reduced)
- The investigation training is a requirement before staff can log into Datix to investigate an incident.
- From October 2025 the investigation training is now delivered via a pre-recorded Microsoft Teams training video (previously it was a twice monthly Microsoft Teams training session delivered by Datix Administrator)
- The risk register training is housed on MLE.
- In addition, the Risk Management team provide ad hoc training alongside this for specific area manager needs.

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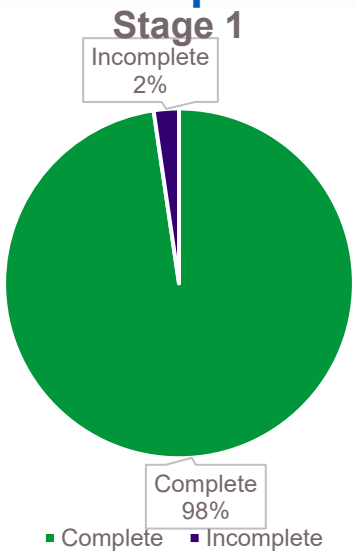
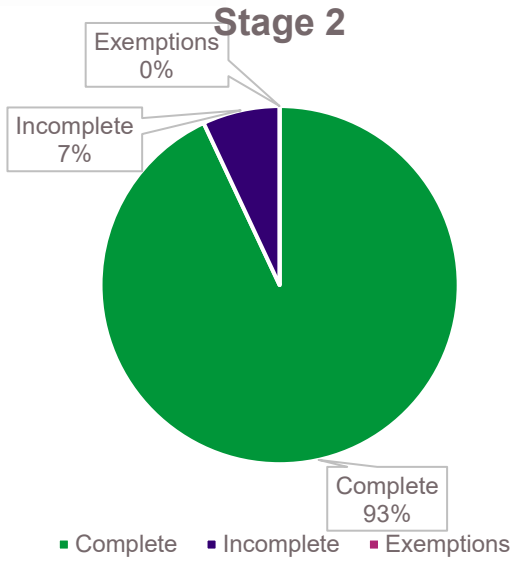
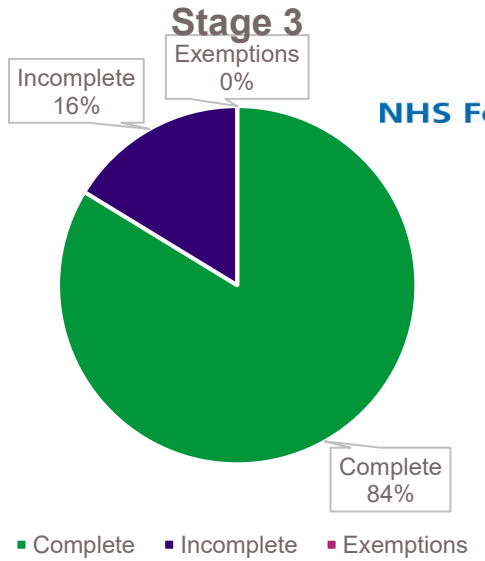
Duty of Candour

Current DoC Compliance for Q3 24/25 Incidents







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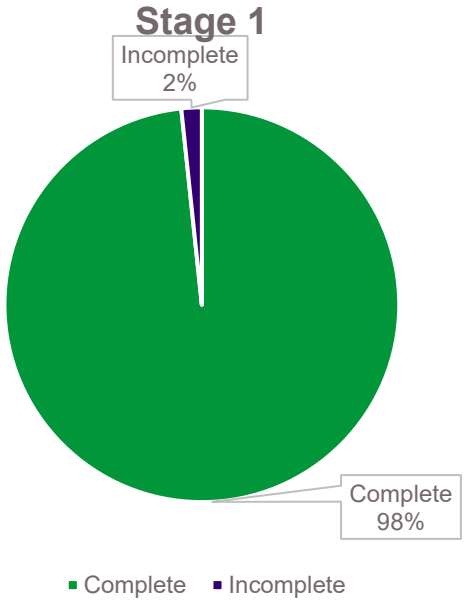
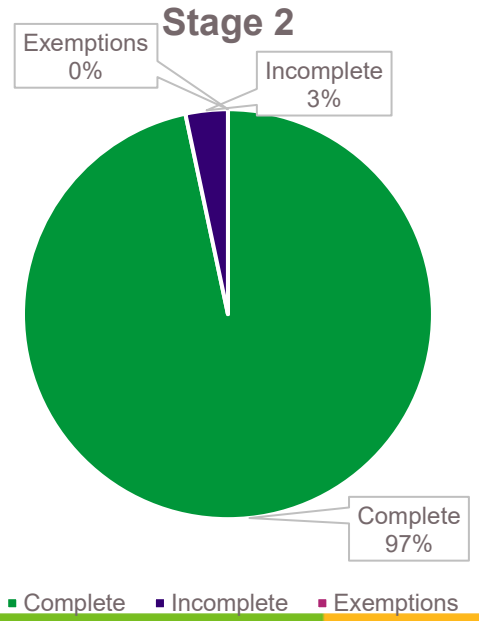
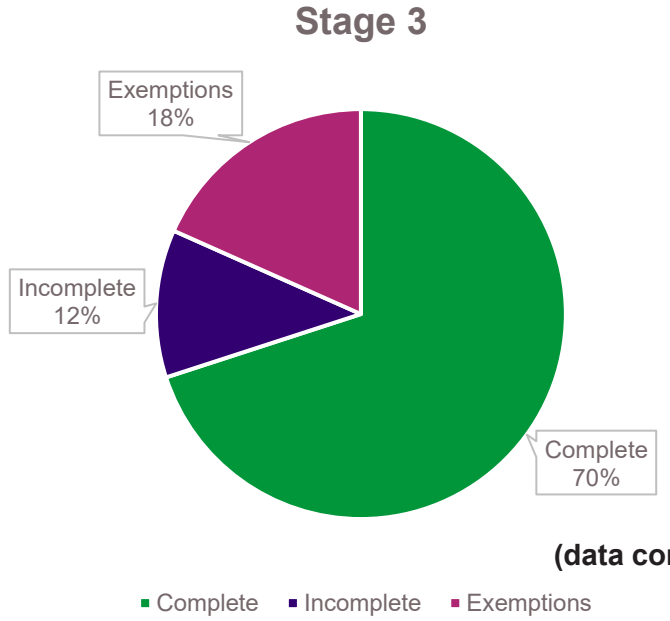
Current DoC Compliance for Q4 24/25 Incidents

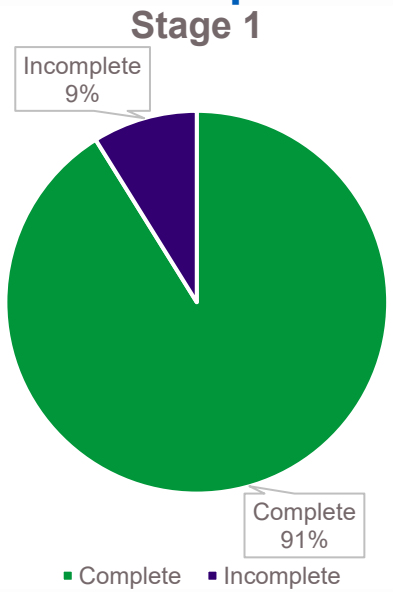


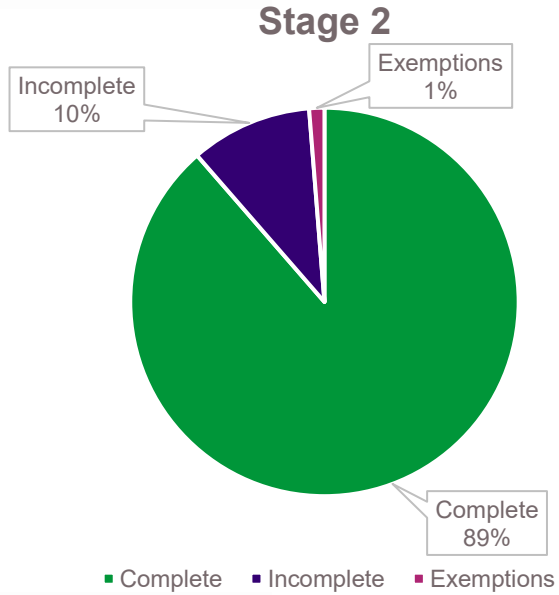


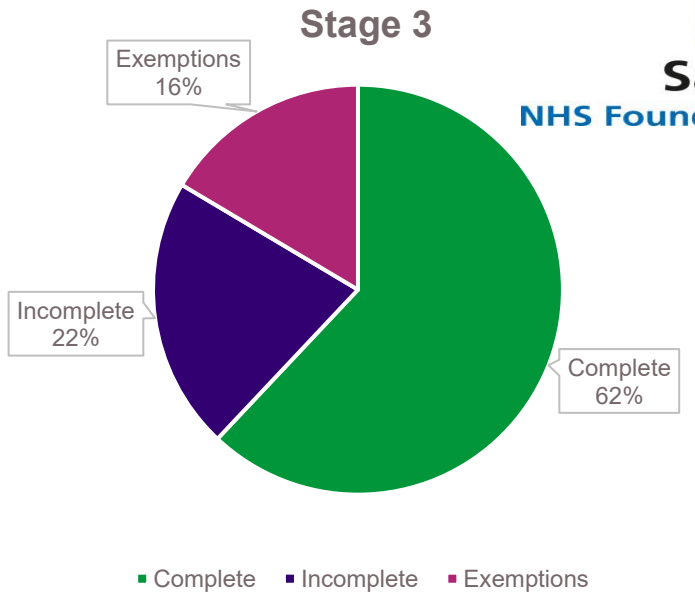


(data correct as of 23/01/26)

Current DoC Compliance for Q1 25/26 Incidents







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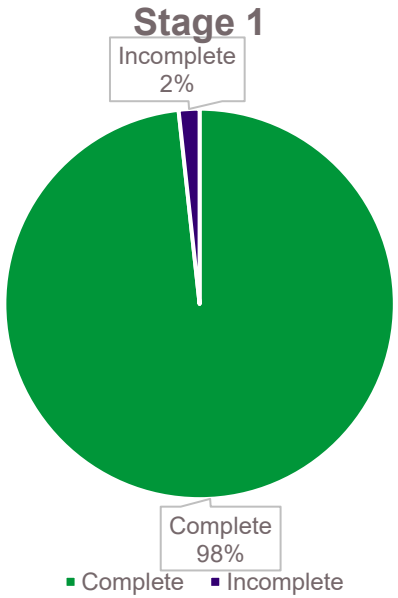
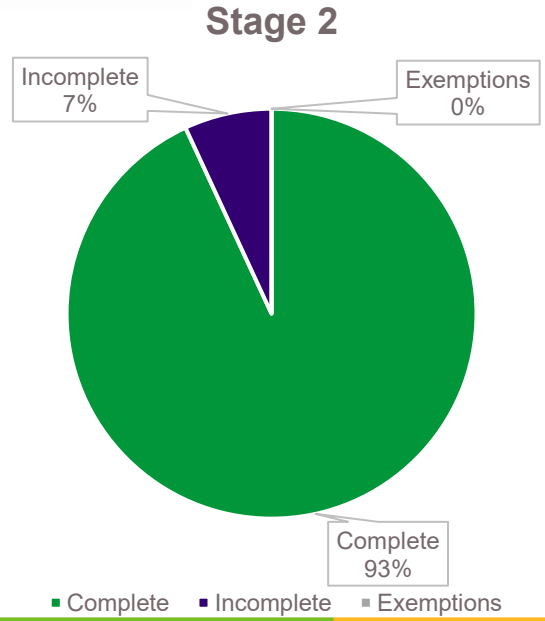
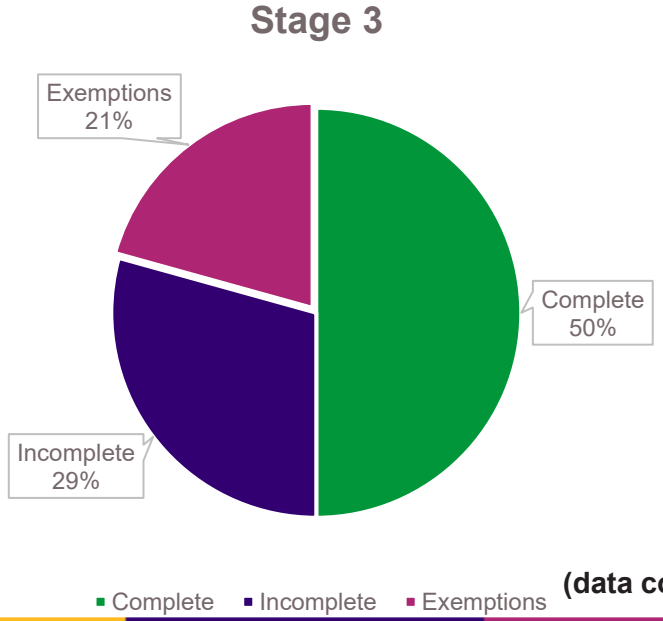
Current DoC Compliance for Q2 25/26 Incidents







(data correct as of 23/01/26)

Current DoC Compliance for Q3 25/26 Incidents

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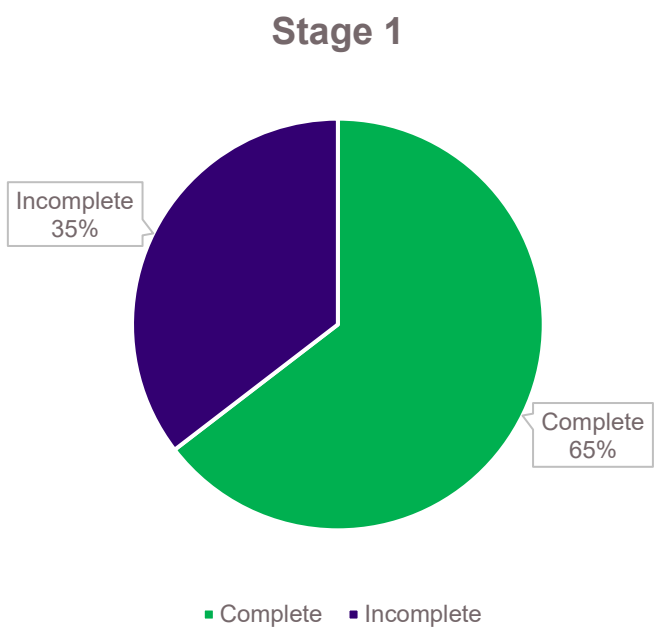
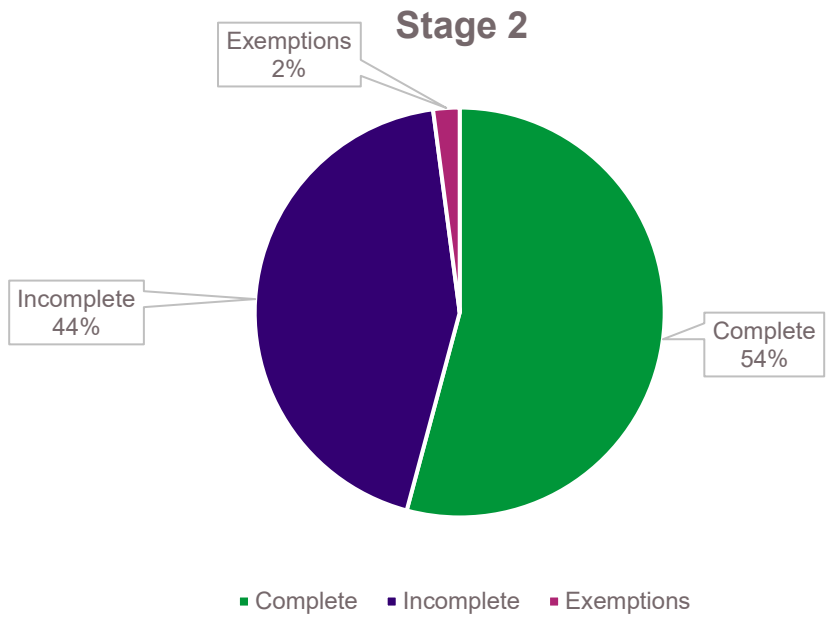
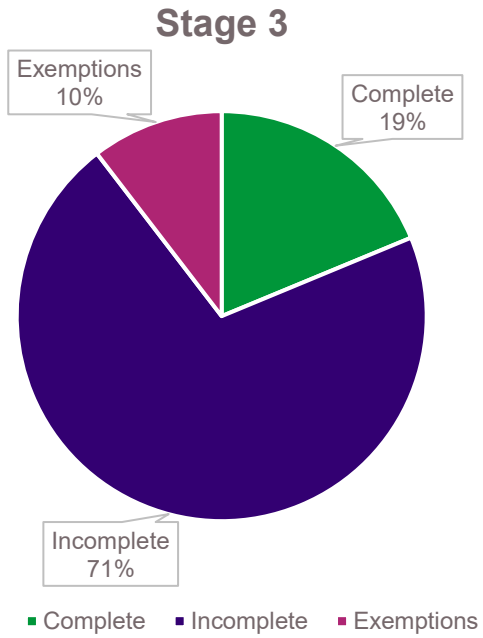
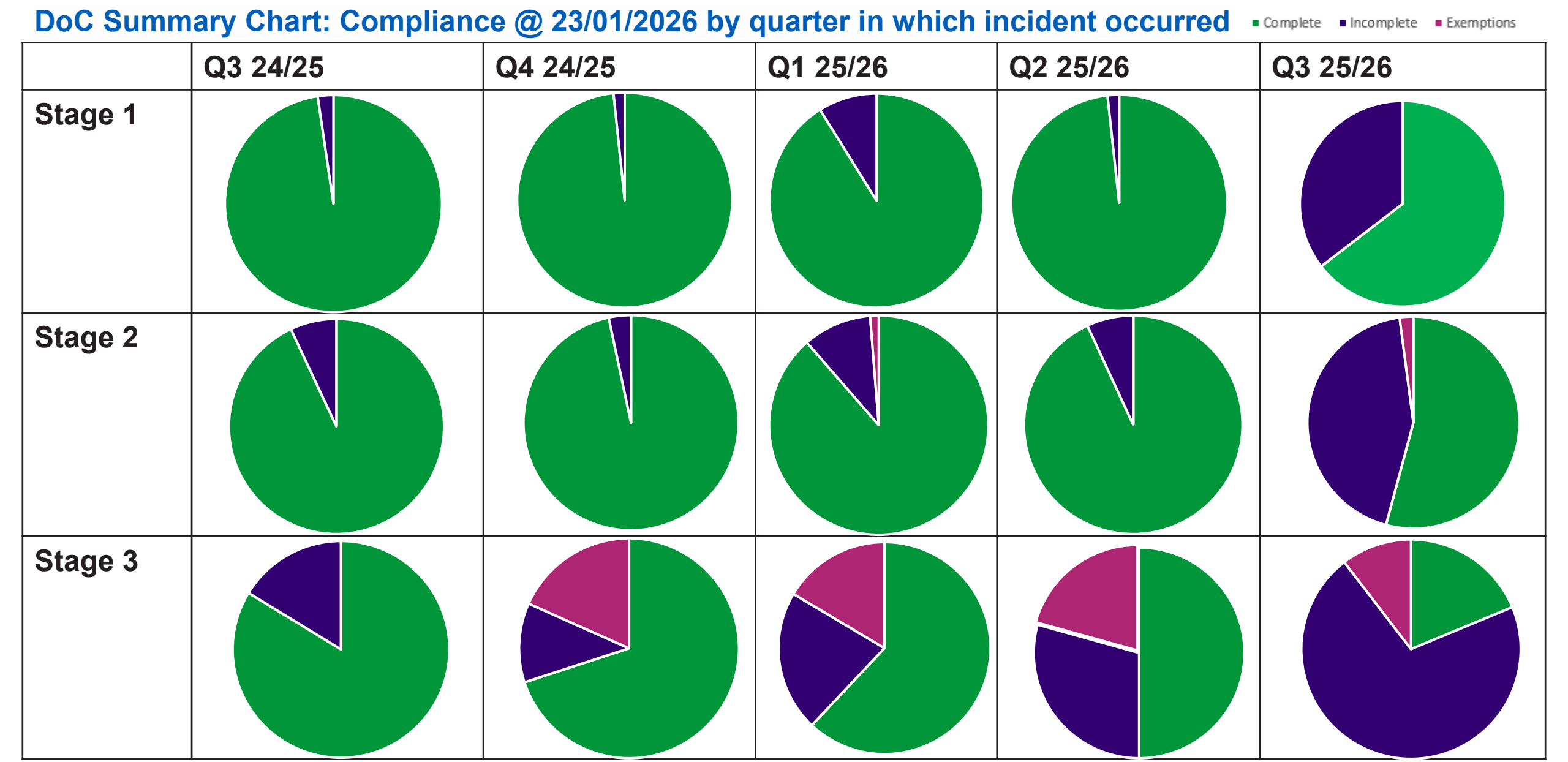






(data correct as of 23/01/2026)

DoC Summary Chart: Compliance @ 23/01/2026 by quarter in which incident occurred



This chart illustrates that Duty of Candour compliance improves with time from incident date. The risk department continues to work with clinical areas to improve timescales for completion of Duty of Candour.

Datix Upgrade and LFPSE

Datix Update

Microsoft is implementing changes to its authentication methods, requiring Datix to be updated to ensure compatibility with the new mandatory two-factor authentication. Without this update, email notifications sent to staff from Datix will cease to function. We previously advised that an upgrade to version 14.6 was required to accommodate this change; however, we have since been informed that the update can be implemented on our current version. Microsoft's original deadline for this change was March 2026, but this has now been extended to December 2026.

Datix Upgrade

The Trust is due to upgrade our current version of Datix in order that we can move over to the V6 Taxonomy of the NHS mandated Learning from Patient Safety Events section of the incident form.

The new version (v14.6) of Datix (with the V6 LFPSE taxonomy) was released on 16th January 26. This upgrade includes a major refresh and modernisation of the look of the DatixWeb system, whilst maintaining the current navigation layout. Screenshots of Datix in all training packages will need to be updated to reflect this new aesthetic, to avoid confusion for users.

There is discussion around the benefits of waiting for v14.6.1 to be released and to upgrade at that time, as this version contains a new functionality (batch updating custom fields) that would be of benefit to the Risk Team. Datix are expecting v14.6.1 to be available in May 2026.

LFPSE Data Validation

- As a result of vacancies in the team, we continue to be unable to undertake the LFPSE data validation required by NHS England (this is currently on the Risk Register).
- External stakeholders may therefore be viewing inaccurate data relating to SFT patient harm on the NHS England LFPSE data dashboard.

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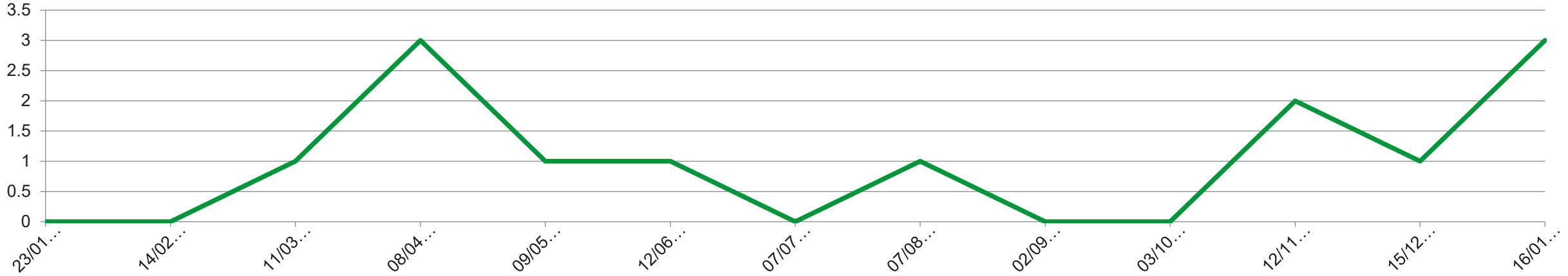
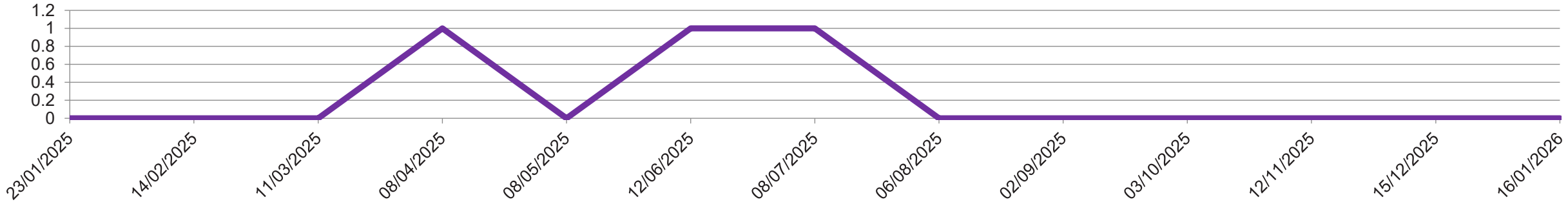
Appendices

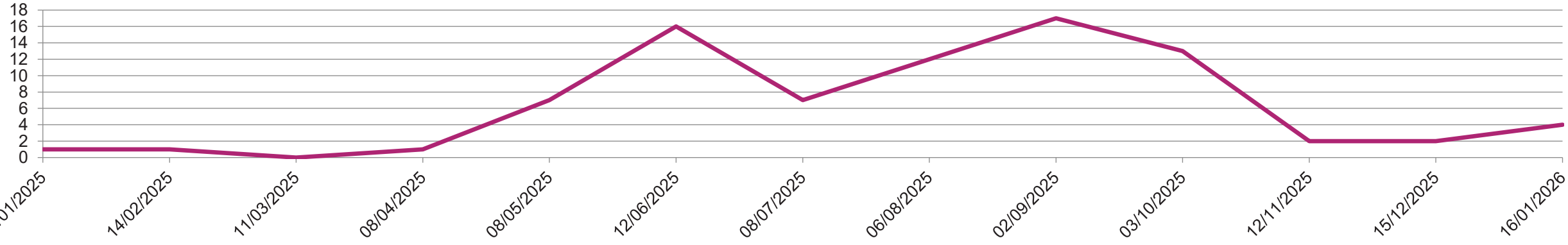
FASS: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



Medicine: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



Surgery: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



Medicine Highest Rated Risks January 2026

The risks highest rated risks in the Medicine Division at 16/01/2026 are:

ID	Title	Location (exact)	Rating (current)	Escalation Status: Departmental or Divisional?
8067	Diabetes foot clinic delays due to staffing shortfalls	Diabetes Centre	16	Divisional Risk Register
7936	Patient experience and care delivery for patients within the ED Escalation space	Emergency Department	16	Divisional Risk Register
5577	Ability of the Emergency Department to accommodate demand 24/7	Emergency Department	15	Divisional Risk Register
5875	Increased incidence of violence and aggression towards staff and patients leading to harm and detrimental impact on wellbeing	Medicine Directorate Management offices	15	Divisional Risk Register
6210	Failure to manage with financial budget	Directorate Wide	15	Divisional Risk Register
6211	Difficulty in providing adequate inpatient bed capacity due to GP/ED attendances and discharge delays	Directorate Wide	15	Divisional Risk Register
7612	Lack of clinical space in Respiratory Dept impacting quality of care and productivity	Respiratory Medicine	15	Divisional Risk Register
8454	Lack of Admin Resource within Medicine Division	Medicine Directorate Management offices	15	Divisional Risk Register
8593	Plastic Outpatient Hand Therapy Capacity	Trustwide	15	Divisional Risk Register
8679	Risk of Harm to patients and staff from reduction of activity in Wessex outpatients to support early adoption of new ESD service	Wessex Rehabilitation Centre	15	Divisional Risk Register
7126	Clinical Space Capacity Plastic Outpatient Hand Therapy	Orthopaedic Therapy Team	15	Department/Service Risk Register
8302	Consultant Cover in Elderly Medicine	Specialty Wide	15	Department/Service Risk Register
8327	Pre and post -intervation surveillance patients falling through due to lack of monitored surveillance database	Vascular Assessment Unit and Diabetes Unit	15	Department/Service Risk Register
8367	Risk that Stroke team are unable to meet the targets for stroke patients under new RCP Stroke guidelines.	Farley Stroke Unit	15	Department/Service Risk Register
8476	Reduction in Rheumatology Consultant workforce	Rheumatology Outpatients	15	Department/Service Risk Register
8523	Lymphoedema service fragility	Vascular Assessment Unit and Diabetes Unit	15	Department/Service Risk Register
8525	Lack of pharmacy service in the Emergency Department	Emergency Department	15	Department/Service Risk Register
8676	Reduction in service due to gaps in Hospice consultant workforce	Hospice	15	Department/Service Risk Register

Surgery Highest Rated Risks January 2026

The highest rated risks in the Surgery Division at 16/01/2026 are:

ID	Title	Location (exact)	Rating (current)	Escalation Status: Departmental or Divisional?
6229	Risk of DSU - Estate Infrastructure failure	Day Surgery Unit	20	Corporate Risk Register
8373	Staffing levels in Colorectal Admin office are desperately low.	General Surgery	20	Department/Service Risk Register
8396	Gap on Plastic Surgery registrar rota due to 2 team members on maternity leave and others leaving sooner than planned	Plastics Department	20	Department/Service Risk Register
7581	Spinal Urology Pathway	Urology	15	Department/Service Risk Register
7917	Fire risk in Main Theatres corridors	Main Theatres	15	Divisional Risk Register
8160	Administration of intravenous morphine without monitoring the patient, not following Trust policy	Acute Pain Team	15	Department/Service Risk Register
8355	Surgical Dental Drills	Oral Surgery Outpatients	15	Department/Service Risk Register
8581	CEP workforce fragility	GI Unit	15	Department/Service Risk Register
8607	Reduced clinical capacity in Ophthalmology	Ophthalmology	15	Divisional Risk Register
8615	Glaucoma capacity	Ophthalmology Outpatients	15	Department/Service Risk Register
8639	Gastro Departmental ability to sign off blood results for patients on passports	GI Unit	15	Department/Service Risk Register

FASS Highest Rated Risks January 2026

The highest rated risks in FASS Division at 16/01/2026 are:

ID	Title	Location (exact)	Rating (current)	Escalation Status: Departmental or Divisional?
8587	Aseptics unit - ability to offer a service	Pharmacy	25	Divisional Risk Register
8596	Unable to recruit impacting on the aseptic compliance process	Pharmacy	20	Divisional Risk Register
8508	Inadequate Antenatal clinic reception cover	Antenatal Clinic	20	Divisional Risk Register
7829	Issues with the blood culture platform in Microbiology	Microbiology	16	Department/Service Risk Register
8334	Mortuary PM Tables and Risk to Staff	Mortuary	16	Department/Service Risk Register
8360	Lack of staffing & resilience in clinical Cancer Pharmacy team impacting ability to deliver the Chemotherapy service at SFT.	Pharmacy	16	Department/Service Risk Register
7727	Nuclear Medicine Gamma Camera beyond end of life	Radiology	15	Department/Service Risk Register
8535	Ward pharmacy working space causing health and safety issues	Pharmacy	15	Department/Service Risk Register
8562	CDC security concerns	Community Diagnostic Centre	15	Department/Service Risk Register
8563	non viable recovery plans for CDC activity	Community Diagnostic Centre	15	Department/Service Risk Register
8592	Medical Equipment replacement	Medical Device Management Centre	15	Department/Service Risk Register
8685	Increase in incidents referred to MNSI for investigation between Aug-Nov 2025	Labour ward	15	Department/Service Risk Register
8694	Viewing Results on Review	Radiology	15	Divisional Risk Register
8710	Training unavailable for head hold and collar care	Spinal Unit	15	Department/Service Risk Register

Medicine Service Level New Risks Q3

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Approval status
8662	Staff and patients tripping and falling due to damaged area on flooring in high flow area	Durrington AFU	9	Open Risks
8609	Critical lack of OT cover on the Stroke Unit	Farley Stroke Unit	10	Open Risks
8676	Reduction in service due to gaps in Hospice consultant workforce	Hospice	15	Open Risks
8642	Front Doors Not closing	Imber Ward	8	Open Risks
8603	Blood results not pulling across to ARIA from Winpath	Oncology Outpatients	10	Open Risks
8591	Specific high risk substance misuse patients could come to harm because of access to hand gels at the ends of the inpatient beds	Redlynch Ward	12	Open Risks
8650	Respiratory nurse ward outcomes not actioned within appropriate timeframe	Respiratory Medicine	8	Open Risks
8695	Long term sickness in Infusion Coordinator team further impacted by planned sickness	Stour Infusion Unit	10	Open Risks
8523	Lymphoedema service fragility	Vascular Assessment Unit and Diabetes Unit	15	Open Risks
8648	Insufficient Physiotherapy Staff at Wessex Rehab to manage caseload from 01/01/2025	Wessex Rehabilitation Centre	8	Open Risks
8590	Insufficient Technical Staff at Wessex Rehab Industrial Workshop	Wessex Rehabilitation Centre	3	Closed risks

Surgery Service Level New Risks Q3

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Approval status
8605	Damage to ENT microscope moving upstairs to Theatre C to accommodate children requiring sedation to stay downstairs.	Day Surgery Unit	6	Open Risks
8687	Endoscopy service disruption due to reduced availability of endoscopy-competent registered nurses	Endoscopy	12	Open Risks
8639	Gastro Departmental ability to sign off blood results for patients on passports	GI Unit	15	Open Risks
8655	Lack of a vascular access team service leading to delays in PICC/Midline insertion	Main Theatres	8	Open Risks
8641	Decreased number of Registered nurses	Ophthalmology	12	Closed risks
8615	Glaucoma capacity	Ophthalmology Outpatients	15	Open Risks
8637	Staffing levels Plastics	Plastic Outpatients	10	Open Risks

FASS Service Level New Risks Q3 – Page 1 of 2

ID	Title	Location (exact)	Rating (current)	Approval status
8684	Non-complaince with Saving babies lives version 3.2 element 3 (Next working day USS with Reduced Fetal movements)	Antenatal Clinic	9	New risks, awaiting DMT review
8670	Risk of unidentified growth restricted babies due to lack of admin resource in antenatal clinical	Antenatal Clinic	9	New risks, awaiting DMT review
8661	Inability to maintain PTL tracking, timely data entry and escalation of breaches as a result of depleted MDTC workforce	Cancer Services	12	Open Risks
8588	Paediatric Demand and Capacity	Childrens Outpatients	9	Open Risks
8680	Risk of harm due to vacant Medical Secretary post in Child Health Outpatients	Childrens Outpatients	6	New risks, reviewed by DMT but further information required
8689	Risk of current CNS workforce leaving for more attractive roles due to current inadequate banding	Fertility Centre	6	New risks, reviewed by DMT but further information required
8647	Current receptionist is leaving and uncertainty on plans to cover this vital role	Gynaecology Outpatients	5	Open Risks
8697	Clinical impact of not having enough histopathologists to meet the demands of the service	Histopathology	12	New risks, reviewed by DMT but further information required
8696	Insufficient histopathologists to meet the demands of the service leading to increased outsourcing	Histopathology	12	New risks, reviewed by DMT but further information required
8685	Increase in incidents referred to MNSI for investigation between Aug-Nov 2025	Labour ward	15	Open Risks
8665	Delay in compliance to NICE guidance in relation to CTG classification	Labour ward	6	Open Risks
8584	Delayed Spinal discharges	Longford Ward	10	Open Risks
8669	Health disparities identified at a local and national level for service users from marginalised groups.	Maternity Administration	6	New risks, awaiting DMT review
8636	Inadequate infrastructure, commissioning and funding for the Maternity & Neonatal Voices partnership	Maternity Administration	6	Open Risks
8626	Accuracy of Pocketalk translation device currently under evaluation	Maternity Administration	3	Open Risks
8592	Medical Equipment replacement	Medical Device Management Centre	15	Open Risks
8616	MDMS Trainer workforce	Medical Device Management Centre	8	Open Risks
8624	Non-renewal of fixed term Administrator contract	Medical Engineering	2	Closed risks
8625	Lack of Microbiology manager from mid-December 2025	Microbiology	12	Open Risks

FASS Service Level New Risks Q3 – Page 2 of 2

ID	Title	Location (exact)	Rating (current)	Approval status
8668	Damp damage to quiet room	Neonatal Unit	10	Open Risks
8621	Risk to meeting KPIs of service due to lack of admin staff	Orthotics	10	Open Risks
8649	Lack of standardisation of Pathology naming conventions in tQuest post WinPath go-live	Pathology SFT	4	Closed risks
8657	risk of medications being completed on EPMA by staff without prescribing rights	Pharmacy	4	New risks, reviewed by DMT but further information required
8638	GE OEC 9900 C-arms for Main Theatre and DSU end of life	Radiology	12	New risks, reviewed by DMT but further information required
8667	Radiology Outsourcing Administrative Burden	Radiology	12	New risks, reviewed by DMT but further information required
8673	Nursing Staffing for Interventional Radiology Service	Radiology	12	Open Risks
8598	Ultrasound Machine interventional Radiology not suitable for imaging patients	Radiology	12	Open Risks
8681	Reception Cover Radiology Insufficient for Weekend and CDC Working	Radiology	10	New risks, reviewed by DMT but further information required
8613	Lack of privacy and dignity for in patients and ED pts in CT/MRI	Radiology	10	Open Risks
8677	Consultant Radiologist Vacancy Staff Wellbeing	Radiology	9	New risks, reviewed by DMT but further information required
8651	Consultant Radiologist- unfilled posts, Consultant shortages	Radiology	9	Open Risks
8652	Consultant Radiologist- unfilled posts, Consultant shortages	Radiology	8	Open Risks
8686	UHD computer not working for remote reporting	Radiology	8	Open Risks
8630	Band 3 RDA 1.5 down	Radiology	6	Open Risks
8614	One QA phantom between 2 CT scanners	Radiology	2	Open Risks
8620	Risk of harm due to bank Receptionist role ending Sexual Health	Sexual Health	6	Open Risks
8629	Possible non-approval of Cleft SaLT Principal role vacancy	Speech Therapy	12	Closed risks
8654	Risk of not recruiting a Spinal booking coordinator owing to vacant post	Spinal Unit	12	New risks, reviewed by DMT but further information required
8643	1 nursing home available in the south west region to take ventilated patients potentially resulting in delayed discharges.	Spinal Unit	6	New risks, reviewed by DMT but further information required
8586	Delays in admitting Spinal patients for rehabilitation	Spinal unit - non ward area	10	Open Risks

CLASSIFICATION: please select

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	4.1
Date of meeting:	Wed 13th May 2026		

Report tile:	Health and Safety Report – Q3			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	ODPMB TMC People and Culture Committee (for info)			
Prepared by:	Troy Ready – Health & Safety Manager			
Executive Sponsor: (presenting)	Ian Crowley – HR Director			

Recommendation:

Trust Board is asked to note the contents of the health and safety report for Q3. Specifically, noting H&S performance is in line, or close to historic trends reported from March 2023 and the correlation between ongoing instances of violence and aggression and staff absence on wards.

Trust Board is asked to review the concerns raised in the report in relation to the impact group design will have on the Trust's ability to maintain current H&S practices, noting that since the report was raised the MD has escalated these specific issues with Corporate Service Review Design Teams and the Group Executive Committee.

Executive Summary:

As the Trust moves towards a BSW group structure, discussions around the management of shared H&S have, to date, been led by individuals outside of the Trust without recognition of the approach adopted at Salisbury. Nor is there evidence that Care Organisations will have a senior, site based, H&S professional. There is a need to ensure senior managers and executives are assured by this proposed approach.

As for Q3 performance, the Trust continues to perform well and improvements show quarter by quarter after a peak in Q1. The outlier to performance is the amount of time lost where staff are exposed to violence and aggression, but do not report time lost as related to such incidents. Instead staff report gastro, headaches and other less serious reasons. But the impact on absence is obvious and there is scope for OD&P, Divisions and Wards to consider how such absences can be prevented and managed.

Where time off is reported because of work related injuries, it is generally due to manual handling. Of the 11 lost time injuries reported in Q3, 6 related to manual handling incidents and 21 of the 33 lost time injuries reported year to date are related to manual handling. It is not clear there is a gap in the Trust management of manual handling. Training, the provision of equipment, occupational health support and alternative duties are all available. Many injuries come from individual decisions to handle patients, without support of other staff, as reported previously.

Violence Prevention and Reduction Group

TMC has also been asked to identify / confirm executive sponsorship for this Group. Traditionally, this was the CPO.

Fire Risk Assessments

In the past 2 years the Fire Safety Team has identified over 1,000 fire risks with documented actions. At the time of reporting there are 651 open risks that remain open. Many risks are within the control of ETS to manage, but rely on capital to successfully mitigate, the Trust continues to tolerate these risks.

There are 57 risks that departments are expected to action that fall into 4 broad categories:

1. Clutter in ward corridors,
2. Fire doors being wedged open,
3. Poor compliance to Face to face training, and a
4. Lack of Fire Wardens.

DMTs have been approached to support work within departments to seek to mitigate these risks to tolerable levels.

Since January 2024, the Trust has mandated 2 yearly face-to-face fire training for all Trust staff. Current compliance is at 41% and only 761 ward-based staff are compliant. National guidance under Health Technical Memoranda 05-01 (HTM 05) states face-to-face training is specifically required for ward, theatre, ICU staff, and those caring for dependent or very high-dependency patients. The Trust requirement to train all is above and beyond the expectations of HTM 05 and is not aligned with national guidance.

TMC has been asked to consider bringing face to face training in line with national guidance with a focus on high risk patient areas and where all other staff would be expected to complete fire e-learning.

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):	

HEALTH AND SAFETY PERFORMANCE REPORT

FY26 – Q3

Salisbury NHS Foundation Trust

1. Performance Measures

Q3 saw a return to historical averages for lost time injuries and time lost.

3 RIDDOR's were reported in Q3.

- A Charge Nurse on Breamore Ward sustained injury after being kicked in the abdomen whilst attempting to deescalate a confused and disorientated patient on the ward.
- A Staff Nurse on Spire Ward sustained a back injury when assisting a patient to mobilise from a seated position, and
- A Volunteer slipped and fractured their wrist after slipping on a wet floor.

Group Structure

As the Trust moves towards a formal BSW group structure, a comment on H&S and the risks of a shared approach across the BSW network is timely. Discussions around the management of shared H&S have, to date, been led by individuals outside of the Trust without recognition of the approach adopted at Salisbury.

Salisbury has adopted an international standard for health and safety management systems (ISO45001). 45001 is used by complex organisations the world over to provide a robust management of the risks to the H&S of staff. But it is not routinely adopted by NHS Trusts, as being unattainable, or historically unnecessary, and it is this thinking that is guiding the BSW H&S model. The approach adopted at Bath and Swindon, as with many other NHS Trusts, is to utilise safety guidelines published by the Health and Safety Executives. Guidance referred to as HSG65. Statements used during the planning of H&S suggests the approach adopted by Salisbury to develop a H&S management system against 45001 is not achievable, impractical and goes beyond the minimum requirement for legal compliance.

Nor is there any evidence H&S has a senior site-based presence. Proposed models suggest a Group Safety role with local H&S Advisors at each site. This model removes senior safety leadership from Salisbury but for 1 day a week and leaves the management of H&S on site to a Band 6 H&S Advisor. H&S is one of the very few corporate disciplines that impose criminal liability on Managing Directors and members of the Executive Team within NHS Trusts. The implications of which are:

1. Fines, penalties and sanctions which remain uninsurable and therefore owed personally, and
2. Individuals are required to declare criminal convictions if found guilty of an offense under the H&S at Work Act, whenever criminal declarations are requested.

The defence to any prosecution is the ability to demonstrate an individual has exercised due diligence in matters relating to H&S. This is a five-step process where each element is distinct and cumulative in nature. It is this concept in which Directors can demonstrate an understanding of, and make informed decisions, relating to ensuring a safe place of work across the Trust.

It would be incredibly difficult for individuals to demonstrate each of the above elements in the way that H&S is being designed. For example:

1. The approach to auditing across Bath and Swindon is to rely upon checklists used by either the H&S Team or departmental H&S representatives. This approach is not an audit, but an annual inspection of a department. Salisbury have annual inspections completed by Departments, and a formal audit program to provide second party assurance against an audit tool developed against ISO45001. The Trust has an annual schedule of activity and

audits are conducted by the H&S team who have completed H&S management system audit training. No such auditing is being considered under the BSW Group H&S model.

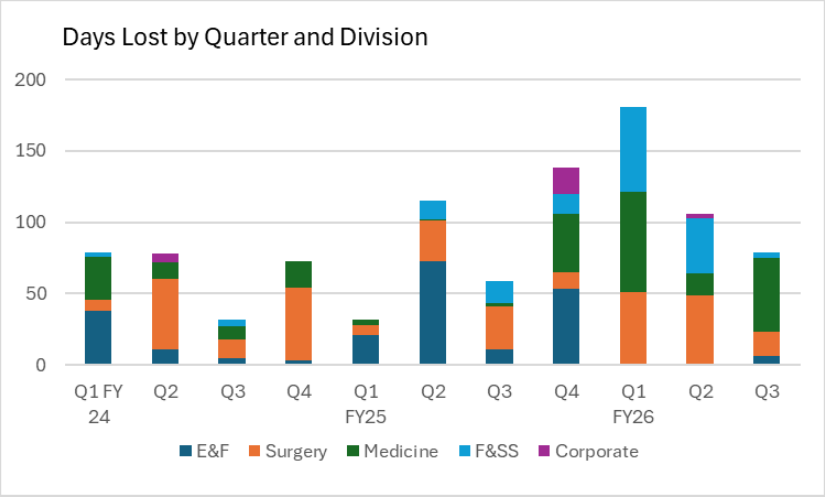
Although the design project is still in relatively early stages, members of the Trust Leadership Team should seek assurances from Group that H&S management is sufficiently robust to protect the Trust and individual liability. The risk is it may not be. Furthermore, answers should be sought on what governance paths exist for the Care Organisation to address local H&S concerns. Again, there is no governance structure to provide such assurances.

1.1 Lost Time Injuries

The rolling average for lost time injuries by quarter since April 2023 (Q1FY24) is 9. Q3 reports are slightly above this rolling average at 11. And as noted in reports for Q1 and Q2, manual handling injuries continue to account for most of the lost time injuries reported.

2.2 Time Lost

The rolling average for lost time per quarter since April 2023 is 88 days. There is a downward trend from a Q1 FY26 year peak, with days lost for Q3 totaling 79 days. 2 lost time injuries were recorded for volunteers, 1 of which was RIDDOR reported for a slip and fractured wrist and whilst included as a lost time injury, the amount of time lost is not included in this 79 days. The table below shows the historical lost time per quarter since April 2023.

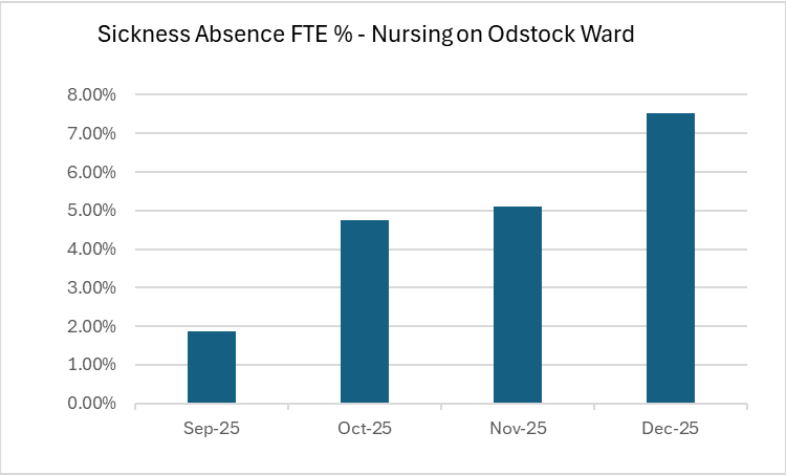


At face value, these results are encouraging, but a further review of broader sickness rates reflects a different picture that suggests the under reporting of work related injuries that result in absence from work.

This example is best illustrated on Odstock Ward where the absence rates for nursing staff rose from 1.87% in September to 7.52% in December. In discussions with staff and ward leaders, this is due to the behaviour of 1 patient who was admitted during Q3 as an out of area patient under the regional plastic surgery service. Patient behaviour displayed during this time included physical abuse, racial vilification, verbal abuse, throwing infected wound dressings at staff and smoking cigarettes in the room. Between November and December twenty-five (25) datix reports were submitted by numerous staff and by December staff had simply had enough, yet not one staff member reported lost time because of these events.

The H&S Team were regularly on the ward speaking with staff, the Trust engaged with the local police to warn the patient, cigarettes were confiscated and deliveries checked, legal advice was sought on discharge planning, Clinical Psychology checked in with staff, debriefing sessions were coordinated and there was engagement with the Consultant Surgeon, Chief and Deputy Chief Operating Officers to manage admission and discharge.

During this time, no staff member reported a lost time injury because of the stressors faced. Instead, data shows absences were reported as cold and flu or gastrointestinal problems. Such reasons escape the implications that come from a work related injury days off in this manner help ease the burden staff carry from abuse despite efforts to manage the patient. But it is beyond doubt the increase in FTE absence was due to this patient.



Per the Violence Prevention and Reduction Policy, the Trust can, and does, take a significant number of actions to manage risks from such patients, we set expectations around behaviours, warn patients of consequences, report crimes to the police and discharge patients. Staff accept patients may not be able to be discharged, but there is a prevailing mindset reported by staff during this time, that patient safety takes primacy over their safety and simply take a few days off work in such a way as not to attract attention.

2.3 Injury and Frequency Rates

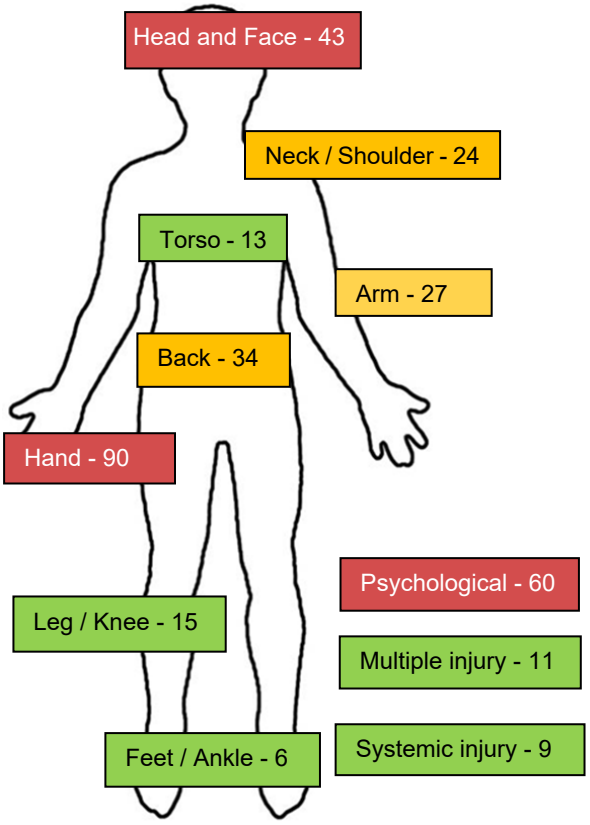
Injury and Frequency Rates by Division										
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	RIDDOR	YTD
Estates & Facilities	6	7	2	3	10	5.1	2.3	0.9		-
Surgery	17	116	-	10	-	4.4	1.7	3.8		4
Medicine	52	137	8	15	10	6.3	4.9	4.3	2	5
F&SS	4	103	1	5	1.6	2.6	0.5	4.0		1
Corporate	-	3	-	1	-	0.7	-	0.2		-
Public, Patient & Volunteers	-	-	2	3	-	-	-	-	1	2
Total	**79**	**366**	**11**	**33**	**3.8**	**3.8**	**2.1**	**3.2**	**3**	**12**

Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

3. Injury Statistics

A breakdown of the type of incidents reported and the injury location are listed in the table below:

Type of Incident	Number of Reports		
	Q1	Q2	Q3
Near miss	24	18	20
Slip Trip	21	14	15
Violence - Confusion	19	30	25
Sharps Injury	14	19	20
Manual Handling	13	13	15
Violence - Mental Health	10	14	10
Antisocial Behaviour	10	20	23
Struck an Object	9	7	6
Racial Vilification	8	5	10
Estates Related Damage	6	9	10
Display Screen Equipment	5	1	2
Sexual Abuse	4	4	5
Lacerations	3	2	5
Radiation	3	1	1
Chemical	2	3	1
Struck by Moving Object	2	3	-
Biological and Waste	1	8	8
Other	1	2	1
Total	155	173	181



4. Incident Trends

Violence and aggression, sharps injuries and manual handling injuries continue to be the most reported type of incident or injury in Q3, with the increasing trend of sharps injuries.

4.1 Sharps Injuries

As noted in Q1, there is a robust response mechanism to sharps injuries when reported, and the numbers of sharps injuries are reported at the Infection Prevention Committee (IPC). Initial discussions on investigating, presenting and learning from incidents is less established and there is no one to date that has taken a lead on the prevention of sharps injuries across the Trust.

During Q2, the H&S Manager attended IPC to understand the mechanism to identify trends, learn from clinical practices and develop actions. The Trust Matron for Quality and Safety has been tasked with undertaking a thematic review on needlestick injuries and will meet with the H&S Manager once this is completed.

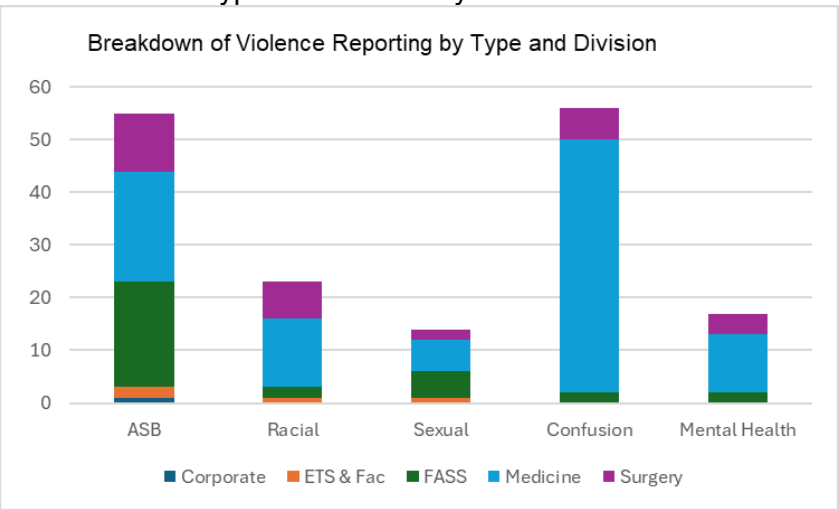
4.2 Violence and Aggression

181 incidents were reported in Q3 (up from 155 in Q1 and from 173 in Q2). 73 reports related to violence and aggression. More specifically:

- 25 related to confused patients,
- 23 related to antisocial behaviour,
- 10 related to racial abuse, and
- 5 related to sexual harassment.

The Trust through the Violence Prevention and Reduction Working Group has facilitated strategies to manage each of these types of violence but the Trust is not in a position to

eliminate this behaviour. The focus for future work is, as noted above, is to consider how we can improve the support staff to when exposed to such events.
A breakdown of types of violence by Division is seen below:



4.2.1 Executive Sponsorship of Violence and Aggression

The Violence Prevention and Reduction Working Group had an executive sponsor in the Trust Chief People Officer. It is not clear if there is executive led oversight of violence and aggression at the Trust as we continue efforts towards consolidating a group model across BSW.

4.3 Manual Handling

Manual handling injuries continue to result in the greatest number of lost time injuries. Of the 11 lost time injuries reported in Q3, 6 related to manual handling incidents and 21 of the 33 lost time injuries are related to manual handling.

The response to manual handling related injuries includes a review by the Manual Handling Lead, a referral to Occupational Health, investigation by the H&S Team and the provision of alternative duties for a period of time. Reviewing the relatively innocuous mechanisms of injury, and recognising the numerous actions taken to manage the risks of manual handling, it is not clear there are further reasonably practicable actions the Trust can take to further reduce the numbers of manual handling related injuries.

5. Risk Activity and Hazard Management

5.1 Reducing the Internal Movement of Tugs

The location of the Nunton waste store will pose an increased risk to the safety of staff, patients and visitors, especially with the development of the Urgent Treatment Centre (UTC) and the expected increased footfall in this area. The Q1 report stated H&S, Estates Capital and Facilities would review this area to scope the potential for an external waste area to eliminate the use of tugs within this entrance. A proposed area and design is being put to the planning team with a view to determine the viability of this outcome within the UTC budget. This would eliminate the need for tugs to routinely travel from Nunton towards the carousel that passes Springs and the Carpark 8 entrance, both of which are high pedestrian areas.

The Internal Movement of Tugs Policy (the Draft Policy) although completed in DRAFT will agree routes of travel, medical assessments of tugs drivers and tighter training and competency assessments. A collective grievance regarding the proposed changes has been submitted and is currently being investigated before Draft Policy is approved.

5.2 Fire Risk Assessments

In the past 2 years the Fire Safety Team has identified over 1,000 fire risks with documented actions. At the time of reporting there are 651 open risks that remain unactioned. Many risks are within the control of ETS to manage but there are 57 risks that departments are expected to action. 4 broad actions relate to:

1. Clutter in ward corridors,

2. Fire doors being wedged open,
3. Poor compliance to Face to face training, and a
4. Lack of Fire Wardens.

5.2.1 Fire Training

As noted above, fire training is a risk. Since January 2024, the Trust has mandated 2 yearly face-to-face fire training for all Trust staff. Current compliance is at 41% and only 761 ward-based staff are compliant. National guidance under Health Technical Memoranda 05-01 (HTM 05) states face-to-face training is specifically required for ward, theatre, ICU staff, and those caring for dependent or very high-dependency patients. The Trust requirement to train all is above and beyond the expectations of HTM 05 and the current "all staff" requirement for face-to-face is not proportionate to the risk and is not aligned with national guidance.

Proposed Amendment to Face to Face Training
The Fire Safety Team propose to reduce the need for all staff to complete face to face training. Face to face training is retained for high-risk clinical staff and those with specific fire safety roles. All other staff would be expected to complete fire e-learning and other appropriate fire training only. Doing so would bring the Trust in line with national guidance and allow a greater emphasis on high risk patient areas.

5.3 Fit Testing

Overall fit testing compliance by ward and department continues to improve each quarter. As noted in previous reports, NHSE removed the preferred masks from circulation and compliance rates were significantly affected. The Fit Test Team continues to undertake more than 350 staff each quarter. A comparison of compliance in January 2025 and December 2025 shows the improvements made:

- Housekeeping went from 3% to 59%,
- Maternity from 24% to 63%,
- Spire from 26% to 71%,
- Farley from 16% to 70%

In January overall Trust compliance was at 35%. In December compliance sits at 65%. 2 areas are affecting overall compliance. They are the medical teams in Emergency (26%) and Anaesthetics (19%).

Report written by
Troy Ready
Health and Safety Manager
January 2026

Report to:	Trust Board	Agenda item:	5.1
Date of meeting:	13th May 2026		

Report title:	NHSE Licence Self-Certification – CoS7 (2026/27)			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Tapiwa Songore, Interim Head of Corporate Governance			
Executive Sponsor: (presenting)	Cara Charles-Barks, Chief Executive			
Appendices	Appendix 1: Self certification Condition CoS7- Commissioner Requested Services (CRS) Requirements			
BAF Risk link	All			

Recommendation:

The Committee is asked to recommend the Board to approve the Trust's CoS7 self-certification for publication on the Trust website and to authorise the Chair and Chief Executive to sign the NHS England template (Appendix 1) on the Trust's behalf.

In doing so, the Board confirms declaration B within Condition CoS7 as 'Confirmed', based on the evidence and narrative set out within the template.

Executive Summary:

The Trust operates under an NHS Provider Licence and is required to self-certify on an annual basis whether or not it is compliant with the conditions of the NHS Provider Licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However, the Trust is still required to self-assess against CoS7 (Commissioner Requested Services).

CoS7(3) requires NHS Foundation Trusts providing Commissioner Requested Services (CRS) to certify that they have a reasonable expectation that the required resources will be available to deliver designated services.

NHS England provides a standard template for this purpose (Appendix 1). Once approved, the template will be completed and signed by the Chair and Chief Executive and published in the Key Publications section of the Trust website.

This report invites the Board to approve the Trust's CoS7 self-certification for 2026/27. In completing the NHS England template, the Board is asked to note the following factors (as reflected in the 'factors to draw attention to' section of the template):

- The 2025/26 annual accounts are prepared on a going concern basis.
- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.
- The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.
- The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).
- The financial plan for 2026/27 is challenging with an efficiency and productivity target of £32.5m, (7.4% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

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):	

Worksheet CoS7

Financial Year to which self-certification relates 2026_27

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

• The 2025/26 annual accounts are prepared on a going concern basis.

• Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.

• The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.

• The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).

• The financial plan for 2026/27 is challenging with an efficiency and productivity target of £32.5m (7.4% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Cara Charles-Barks	**Name**	Paul von der Heyde
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

NHS Salisbury NHS Foundation Trust

	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	13 May 2025		

Report tile:	Fit and Proper Persons Annual Assurance			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Kylie Sanders, Head of Corporate Governance			
Executive Sponsor: (presenting)	Nick Johnson, Managing Director			
Appendices				

Recommendation:
The Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2025-26 and that all Board members satisfy the requirements.

Executive Summary:
The purpose of this paper is to provide annual assurance that all Board Directors remain fit and proper for their roles, and meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

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):	

1.0 Introduction

In accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test' (FPPT).

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations from the Kark Review, NHS England developed the FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023, and the Trust Board approved its Fit and Persons Policy in May 2025.

The policy requires a full FPPT to be completed;

a) on appointment, and
b) annually for existing directors.

The annual self-declaration process is undertaken at the start of each new financial year and the results of the annual self-declaration are recorded on the Electronic Staff Record (ESR). The scope for the policy is specified as '*All executive and non-executive directors of the Board, including permanent, interim, and associate positions, irrespective of their voting rights'*

2.0 Fit and Proper Person: New Appointment and Annual Assurance Checks

All current directors have been subject to the following checks.

a) DBS checks;
b) Search of insolvency and bankruptcy register,
c) Search of Companies House register to ensure that no board member is disqualified as a Director,
d) Search of the Charity Commission's Register of Removed Trustees,
e) Web/social media search,
f) Satisfactory completion of the self-declaration.

3.0 Outcome of the Annual Fit and Proper Persons Checks

All Directors of the Trust Board satisfy the requirements and the outcome of the FPPT checks has been saved on each personal file and uploaded onto ESR. All Directors completed the Fit and Proper Persons Test Self Declaration Form and these will be reviewed by the Trust Chair in preparation for the regional submission.

Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues to the attention of the Director of Integrated Governance or the Trust Chair.

4.0 Conclusion

All Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

5.0 Recommendations

The Board is asked to note that the FPPT has been conducted for the period 2025-26 and that all Board members satisfy the requirements.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	5.3
Date of meeting:	13th May 2026		

Report tile:	2025/26 Annual Review of Directors Interests			
Status:	Information	Discussion	Assurance	Approval
	✓			✓
Approval Process: (where has this paper been reviewed and approved):	Trust Management Committee 22.04.2026			
Prepared by:	Christina Steele, EA to Managing Director and Chair			
Executive Sponsor: (presenting)	Kylie Sanders, Head of Corporate Governance			
Appendices (list if applicable):	Annual Register of Interests (Board members and Band 8d+ or equivalent Staff)			

Recommendation:

To review, note and approve the annual Register of Interests as of April 2026.

Executive Summary:

There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. In 2020 it was agreed that the annual requirement would extend to all decision-making staff at band 8d and above or equivalent. In 2024, following recommendations in the Counter Fraud: Conflicts of Interest report, it was agreed to expand the scope of the annual requirement to band 8a budget holders and in 2025, this was expanded to include all budget holders, regardless of banding.

In 2021/22, improvements made on the previous process resulted in an improved compliance rate of 60%.
In 2022/23 the Trust achieved 53% compliance.
In 2023/24 the Trust achieved 71.5% compliance.
In 2024/25 the Trust achieved 99% compliance
This year the return rate (as of 13/04/2026) is **94.97%**.

Compliance with this process is reported as part of the Counter Fraud Annual Risk Assessment submission. An update on the actions set by our Local Counter Fraud Specialist will report to the Audit Committee.

In December 2025 Finance/OD&P provided the names of 563 staff required to complete the yearly declaration of interest. A total of 26 staff were excluded from the figures as they had either left the Trust, could not be found on the system, were on maternity leave, were on long term absence during this process or they did not identify as a budget holder. This includes six 8d+ staff, one Procurement staff member, one Governor and eighteen budget holders. Following exclusion of these staff members, the total corrected figure of declarations of interest were 537.

The Corporate Governance team had a return of 94.9% (510 of 537) declaration of interest forms. 32% (162) made a positive return, of which 85% (137) were reviewed and countersigned by their line manager or

appropriate senior person, stating no conflict. The further 15% were reviewed by the Corporate Governance Team and no concerns were noted. In addition, a further 163 declaration forms were submitted by staff across a range of specialities and job roles, which did not fall within the annual return criteria. 53% (86) made a positive return, of which 99% were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

95% (240) of Band 8d+ submitted their declarations of interest form, 49% declared a possible conflict of interest with 84% reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

100% (111) of Procurement staff submitted their declarations of interest form. In addition, a further 10 declarations were made as staff joined the team, bringing the total returns to 121, however they have not been calculated within the figures. 4.5% of procurement staff declared a possible conflict of interest, all of which were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict. Any member of staff within procurement, who has declared an interest, would be excluded from any procurement process where a conflict of interest has been acknowledged.

94% (17) of the Board submitted their declarations of interest form, 67% declared a possible conflict of interest, all of which were reviewed by their line manager or appropriate senior person, stating no conflict. The Board declarations will be reviewed by the Senior Independent Director (SID) and any concerns will be raised. In addition to the annual declaration, all Board members declare any conflict of interest at the beginning of all Board and Board Committee meetings, for any relevant agenda item. The Board declarations will be published on the Trust website.

100% (15) of Governors submitted their declarations of interest form and five Governors declared a possible conflict of interest of which all but one were reviewed and countersigned by the Chair or appropriate senior Corporate Governance member, stating no conflict.

91% (139) of Budget Holders submitted their declarations of interest form, 16% declared a possible conflict of interest, of which all but one were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

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):	

Board

First Name	Last Name	Job Title	Company	Position	Action/Notes
Rakhee	Aggarwal	Non Executive Director			
Paul	Cain	Non Executive Director	Avant Health Ltd	Director and shareholder	Signed by Chair
Cara	Charles-Barks	Chief Executive Officer	Chatham Row Management Company Ltd	Director	Signed by Chair for RUH and GWH
Judy	Dyos	Chief Nursing Officer		No declarations	
Mark	Ellis	Senior Risk Officer	STL - Wholly owned subsidiary of SFT	Director	Signed by Managing Director
			SSL - JV between SFT & Steris	Director	
Jude	Gray	Chief People Officer	ICP Support	Trustee	GWH's DOI Form
			Gympanzees	Trustee	
			Deloitte	Son is Senior Manager	
Jonathan	Hinchliffe	Interim Chief Transformation and Innovation Officer	St Vincents Consultant	Delivery Director	Signed by CEO
Andrew	Hollowood	Group Strategic Clinical Transformation officer		No declarations	
Richard	Holmes	Non Executive Director		No declarations	
Nick	Johnson	Managing Director		No declarations	
Margaret	Jones	Non Executive Director	Stars Appeal Charity	Corporate Trustee	Signed by Head of Corporate Governance
			Dorset Health Care NHS Trust/ Dorset County Hospital	Joint NED & Deputy Chair	
Ali	Layne-Smith	Interim Chief People Officer	LydianHR Ltd. - HR consultancy providing HR and employee relations consultancy to organisations including NHS Trusts	Owner	Reviewed by Head of Corporate Governance
			Cambridge University Hospitals FT	Non-Executive Director	
Duncan	Murray	Chief Medical Officer	DM Clinical and Professional Services Ltd	Director, Owner and shareholder. Wife is also director.	Signed by Managing Director
Niall	Prosser	Chief Operating Officer		On secondment from RUH	Signed by Managing Director
Margaret	Stebbing	Non Executive Director	Hampshire Hospitals NHS FT	Consultant Surgeon	Signed by Chair
Alexander	Talbott	Director of Improvement		No declarations	
Simon	Wade	Chief Finance Officer		No declarations	GWH's DOI Form
Peter	Knell	NED	Tricuro Limited	Executive Finance Director	Signed by Chair
			Harukai Limited	Director, Owner,	
Richard	Samuel	NED	RO5 Consulting Ltd	Director, shareholder - Provides advisory services to NHS organisations, commercial organisations and pharma companies	Signed by Chair
			Dorset Hospitals NHS Foundation Trust	Wife is Deputy Director of Finance	

Senior Staff - 8d (or equivalent) and above

First Name	Last Name	Job Title	Company	Position	Action/Notes
Lynne-Marie	Abbott	Associate Director of Finance	Odstock Medical Limited	Director	Signed by Line Manager
			Chewvate Limited	Owner	
Yasser	Abdelhalim Shahata			No declarations	
Anna	Aertssen	Consultant		No declarations	
Hayder	Agha	Consultant	Hampshire Clinic, Basingstoke	Consultant	Signed by Line Manager
Andrew	Agombar	Consultant		No declarations	
Robin	Alcock	Consultant		Spouse is Purchasing Assistant in Procurement	No change from last year which was signed by Line Manager
			Salisbury NHS Foundation Trust	Consultant Radiologist - Private Practice	
Layth	Alsaffar	Consultant	Biofix LTD	Director, 50% Owner and shareholder	Signed by Line Manager
			Summerset Owners Ltd	25% owner and shareholder	
			Isle of Wight Trust	Ad Hoc Locum Work	
Christopher	Anderson	Consultant	Downton Baptist Church	Safeguarding Lead	
Angela	Ansell			No declarations	
Laurence	Arnold	Programme Director	Sterile Supplies Ltd	On Board	Signed by Line Manager
				Partner runs own business providing services to pharmaceutical organisations.	
Jonathan	Arnott	Consultant	New Hall Hospital	Self Employed Private Practice	Signed by Line Manager
Rashi	Arora	Consultant		Speaker fees/Consultant fees from Roche for participation in ARVO and SWOS Conference	Signed by Line Manager
Sarah	Assheton			No declarations	
Charlotte	Atkinson	Consultant		No declarations	
Nwe	Aung			No declarations	
Katharine	Backhouse	Consultant		No declarations	
Danielle	Bagg	Consultant & Deputy Divisional Medical Director		Married to Dr William Knibbs - AMU Consultant	Signed by Line Manager
James	Baird	Consultant		No declarations	
Philippa	Baker	Consultant		No declarations	
Surendra	Bandi	Consultant	Limited Company	Adhoc Medical Reports, Director, part owner, share holder, wife Is also director, owner and shareholder.	Signed by Line Manager
			British Association of Spinal Cord Injuries Specialists	President	
				Wife is GP	
Guy	Barham	Consultant	Wessex Medical & Surgical Services	Director, self employed + wife is also director	Signed by Line Manager
			Orthpaedic Plastic and Spinal Services LLP	Owner	
Juliet	Barker			No declarations	
James	Barr				
Anna	Barton	Consultant		No declarations	
Laura	Beddard		Orthopaedics Plastics and Spinal Specialists LLP Member	Director	Signed by Line Manager
Nicola	Bell		SUHT	Consultant	
			Self Employed	Consultant	
Basant	Bhattarai	Consultant	Nirban Limited	Director	Signed by Line Manager
			New Hall Hospital	Consultat Anaesthetist	

Toby	Black	Consultant		No declarations	
Amanda	Bond	Consultant	Salisbury Gallbladder Surgery Ltd	Director, Family invovled & Private Practice	
			Salisbury Hospitals Foundation Charity	Board/Member	
Richard	Booth	Consultant	Croydon University Hospital	Honorary Consultant	
Julia	Bowditch	Consultant	Bowditch Medical LTd	Director	Signed by Line Manager
			Ramsay Health	Consultant	
Hannah	Boyd				
Robert	Boyd	Consultant	Robert Boyd Limited	Director and wife also director	Only sent 2 pages
			New Hall Hospital	Consultant	
			Hampshire Foot and Ankle	Consultant	
Graham	Branagan	Consultant	G&PB Ltd	Director, Owner, Shareholder. Wife is co-director and works in Ophthalmology	Signed by Line Manager
			BWS Grammer School	Chair of Governors	
			G&PB Ltd	Consultant Surgeon	
James	Brewin	Consultant	Sarum Urology Ltd	Director, Part Owner and Marjoity Shareholder.	Signed by Line Manager
Carl	Broadbridge		New Hall Hospital, Ramsay Health	Consultant Anaesthetist	Signed by Line Manager
Victoria	Brown	Consultant		No declarations	
Sally	Bugg			No declarations	
Timothy	Burge	Consultant	Self Employed	Medico - Legal Consultant	Signed by Line Manager
Jonathan	Burwell			No declarations	
Harriet	Bush			No declarations	
Lucy	Bushby			No declarations	
Mary	Bussell	Consultant		No declarations	
Colin	Campbell		UHS	Honorary Consultant	Signed by Line Manager
			RALP Campbell Ltd	Director	
Carmen	Carroll	Consultant		No declarations	
Phillippa	Caygill			No declarations	
Simon	Claridge				
Zoe	Cole	Consultant		No declarations	
Ian	Cook	Consultant	Ramsay Health	Consultant	Signed by Line Manager
Martin	Cook	Consultant	KPMC Medical Ltd	Director - Wife also Director	No change from last year which was signed by Line Manager. Approved by Line Manager again 2026
			Salisbury Cathedral	Photographer	
			New Hall Hospital	Consultant Anaesthetist	
Sarah	Cook	Consultant		No declarations	
Belinda	Cornforth	Consultant	Property LLP	Joint Director	Signed by Line Manager
			Limited Company Property Investments	Joint Director	
			Hartley Orthopaedics	Joint Director	
Peta	Coulson-Smith	Consultant	UHS	Teaching Fellow	Signed by Line Manager
Suzanne	Coulter				
Christopher	Couzens		CAS Medical Services Limited	Director	Signed by Line Manager
			Salisbury Anaesthetic Group - NHH Hospital	Consultant	
Aisling	Coy	Consultant	Purple Medical Ltd	Director/Owner	Signed by Line Manager
				Pharma sponsorship to attend BSR Conference	
			Consultant Connect	Consultant	

Natasha	Craig	Consultant	Residents Property Management Company	Director	Signed by Line Manager
Alexandra	Crick	Consultant		No declarations	
Ian	Crowley	HR Director		No declarations	
Ross	Cruickshank				
Harshad	Dabke	Consultant	OPSS LLP	Director	
			New Hall Hospital	Consultant	
Stephen	Davies	Consultant		No declarations	
Melissa	Davies	Consultant	Wessex Urology	Director	Signed by Line Manager
Simon	Dennis	Consultant	Simon Dennis ENT Ltd	Director	Signed by Line Manager
			New Hall Hospital	Self Employed Consultant	
Ajit	Dhillon	Consultant		No declarations	
Jane	Dickinson	Programme Director		No declarations	
Philip	Donnison	Consultant	PDAnaesthetics ltd	Director	
Chloe	Downes (Billingham)	Consultant	Intensive Medical Events Ltd	Director	Signed by Line Manager
			Billingham Anaesthetic Services Ltd	Director, Employee + Husband also director	
Ian	Downie	Consultant	Salisbury Hospice	Trustee	Signed by Line Manager
			Falkland Islands Government	Consultant Oral & Max Fax Surgeon	
			Self Employed	OMFS Consultant	
Jonathan	Drayson	Consultant		No declarations	
Harriet	Edgar	Consultant		No declarations	
Peter	Ellis	Consultant		No declarations	
Ahmed	Elmorsy	Consultant	Orthopaedics Plastics and Spinal Specialists LLP	Director	Signed by Line Manager
			New Hall Hospital	Consultant	
Mohammed	Elsaghir	Consultant	New Hall Hospital	Consultant - Admission priviledges	
Sian	Evans			No declarations	
Nicholas	Evans		Nick Evans Spinal Surgery Limited	Director, Majority Shareholder, Wife is shareholder	Signed by Line Manager
				Additional work via OPSS LLP at SDH	
			Ramsay Healthcare	Spinal Surgeon (NHS Only)	
Rebecca	Exton	Consultant & CD		No declarations	
Yazmin	Faiza	Consultant		No declarations	
Nefer	Fallico				On a one year career break
Tracey	Farnon	Consultant		No declarations	
Lynn	Fenner	Consultant		No declarations	
Roanne	Fiddes	Consultant		No declarations	
Laura	Findlay	Consultant		No declarations	
Nicola	Finneran				
Matthew	Flynn	Consultant	Flynn - Lees Consultant Ltd	Director. Partner also Director	Signed by Line Manager
			HM Coroner	Autopsy Pathologist	
			New Hall, Salisbury Histopathology, Dental Clinics	Private Practice	
Emily	Foard (King)			No declarations	
Elinor	Fraser	Consultant		Husband is a GP Partner at Abbeywell Surgery	Signed by Line Manager
Louise	Gamble			No declarations	
Temitayo	Gandon			No declarations	
William	Garrett		Self Employed	Consultant	Signed by Line Manager
Neil	Garrett	Consultant & ED Clinical Lead		No declarations	
Abdus	Ghauri			No declarations	

Konstantina	Giannopoulou	Consultant		No declarations	
Fredrick	Gleadowe			No declarations	
Effie	Grand	Consultant	Cancer Research UK	President of local fundraising group	Signed by Line Manager
Sebastian	Gray	Consultant	Re-Palm Health	Joint Director (with wife)	Signed by Line Manager
			BSW ICB	Clinical Advisor	
Lee	Gray			No declarations	
Lee	Grimes	Consultant	Jersey General Hospital	Locum Haematologist	Signed by Line Manager
Emma	Halliwell	Consultant		No declarations	
Robert	Ham	DDO - Medicine		No declarations	
Naeem	Haq	Consultant	Sarum Eye Clinic	Director, co-owner, share holder, Consultant & wife is co-owner	Signed by Line Manager
			MWNH Ltd	Director, co-owner, share holder, Consultant	
			New Hall Hospital	Sits on the MAC	
Helen	Hardy	Consultant		No declarations	
Annabel	Harris		NHS England South West Commissioning Group	Appraiser	Signed by Line Manager
			Wessex Appraisal Company	Appraiser	
James	Haslam	Consultant	Critical Care Medicine Ltd	Director	Signed by Line Manager
			New Hall Hospital, Ramsay Health	Consultant Anaesthetist	
Heba	Hassan	Consultant		No declarations	
Ann	Hawkins	Consultant			Second page missing but third page with Line Managers signature received
Helen	Hayward	Consultant		No declarations	
Julian	Hemming	Consultant		No declarations	
Stuart	Henderson	Consultant and Deputy CMO	Keith Henderson Accounting	Director	Signed by Line Manager
			Churchill Accounting	Director	
Mary	Hennebry	Consultant	Captiosus Consulting Ltd	Director (since 2022)	No change since 2022 form
Ryan	Higgin	Consultant	RH Orthopaedics Ltd	Director, shareholder, private work + spouse is a shareholder	
			OPSS	Director	
			Welbeck Hampshire Orthopaedic LLP	Director	
Jeremy	Hill	Consultant		No declarations	
Alexandra	Hogan	Consultant	University Hospital Southampton	Visiting Professor (adjunct), Health Sciences	Signed by Line Manager
Bryony	Hogg (Jones)	Consultant		No declarations	Maternity Leave
Xantha	Holmwood			No declarations	
Nigel	Horlock		Private Practice Partnership	Director - Wife is partner	
Christopher	Horne	Consultant	Ramsay Health	Consultant Endocrinologist	Signed by Line Manager
Michael	Hughes	Consultant	University Hospital Southampton	Consultant Radiologist	Signed by Line Manager
			New Hall Hospital	Consultant Radiologist	
Adam	Hughes	Consultant		No declarations	
Roger	Humphry			No declarations	
Simon	Hunter			No declarations	
Miranthi	Huwae	Consultant		No declarations	
Helen	Iveson	Consultant		No declarations	
Thomas	Jackson				On sabbatical
Neal	Jacobs		Salisbury Medical Solutions Ltd	Director, Owner, Shareholder, Private Practice, and wife is director	
			Orthopaedic Plastic and Spinal Specialist LLP	Member	
Maqbool	Jaffer		Maqbool Jaffer Ltd	Director	Signed by Line Manager

Ian	Jenkins			No declarations	
Maxmillian	Johnston	Consultant		Director and part owner of Ltd Private Companies. Wife is also director and part owner of one company.	Signed by Line Manager
			New Hall Hospital	Consultant	
Stephen	Jukes		Ramsay New Hall Hospital - Contracted	Consultant	Signed by Line Manager
Claire	Jury	Consultant		No declarations	
Graeme	Kerr			No declarations	
Abigail	Kingston		Salisbury Gynaecology Ltd	Ongoing PP Work	Signed by Line Manager
			New Hall	Private Practice Consultant	
Heena	Kithany	Consultant		No declarations	
Katarzyna	Konieczny			No declarations	
James	Lawrence	Consultant		No declarations	
Samuel	Leach	Consultant	New Hall Hospital	Consultant	Signed by Line Manager
Carl	Lewin			No declarations	
Susan	Lewis	Consultant	New Hall Hospital	Private Consultant	Signed by Line Manager
Karinya	Lewis	Consultant	Stars Appeal	Ambassador	Signed by Line Manager
			Global Health Protection UKHSA	Husband is Director	
			IHG	Ophthalmology Consultant	
Jonathan	Linton				
Nola	Lloyd	Consultant	Limited Company - Nola Skin Care Clinic	Director and owner & employee	Signed by Line Manager
			Working Hands Charity	Trustee	
Graham	Lloyd-Jones	Consultant	Radiology Masterclass Ltd	Director, part owner, shareholder and soupe is also part owner/shareholder	Signed by Line Manager
			Self Employed	Consultant Radiologist	
Gavin	Lockhart	Head of Clinical Psychology	Self Employed Private Practice	Consultant Clinical Psychologist	Signed by Line Manager
Thomas	Mankelow	Consultant		No declarations	
Konstantinos	Marinakis	Consultant	Lymington Hospital	ENT Consultant	
			KVM ENT Services	ENT Consultant	
Victoria	Marston	Director of Midwifery and Neonatal		No declarations	
Aram	Mashoof Fard	Consultant		Private Medical Reports	Signed by Line Manager
Shahid	Masood	Consultant	Ramsay, New Hall	Plastic Surgeon	Signed by Line Manager
Damian	Mayo	Consultant		No declarations	
Gavin	McCoubrey	Consultant	Southampton Spire	Consultant - Private Practice on job plan	Signed by Line Manager
			Sarum Rd Winchester	Consultant - Private Practice on job plan	
			Bournemouth Nuffield	Consultant - Private Practice on job plan	
Caroline	McGuiness	Consultant	Orthoplastic LLP	Director	
			Caroline McGuiness Private Practice Ltd	Private Practice	
Annalise	McNair		Inspire Orthodontics Ltd	Director, Owner and Orthodontist	Signed by Line Manager
Tony	Mears	Deputy Director, Strategy & Operational Planning	Self -Employed	Published writer	Signed by Line Manager
Rohan	Mehta				
Serap	Mellor			No declarations	
Russell	Mellor	Consultant		No declarations	
Nicola	Meston	Consultant	NHS England	Training Programme Director	Signed by Line Manager

James	Milnthorpe	Consultant		No declarations	
Sophie	Moloney-Geany				On Maternity Leave until Q3 2026
Clare	Morden				
Georgina	Morris		Dermatology Special Interest Group with British Association for Sexual Health and HIV	Chair	Signed by Line Manager
			Wessex Profressional Support and Wellbeing Service	Case Manager	
Alistair	Morton	Consultant		No declarations	
Scott	Murgatroyd	Consultant	Semur Limitied	Director & Spouse is Co-Director	Signed by Line Manager
			Salisbury Anaesthetic Group - NHH Hospital	Anaesthetists	
Sergio	Nabais De Araujo	Consultant	TMLEP	Medico-legal expert	Signed by Line Manager (In 2024, no changes)
			Self Employed Private Practice	Consultant Cardiologist	
Kashif	Naeem	Consultant	Salisbury District Hospital	Private Practice	Signed by Line Manager
Andrew	Nash	Consultant	ANA Medical Services Ltd	Director	No change from last year which was signed by Line Manager
			New Hall Hospital	Consultant	
Sarah	Needle			No declarations	
Gail	Ng	Consultant	The HALO Trust	Volunteer Doctor	Signed by Line Manager
Marios	Nicolaou				Unable to find
Rachel	Oaten	Consultant	East Midlands Ambulance	Strategic Medical Advisor	Signed by Line Manager
			North Bristol NHS Trust Major Trauma Centre	Bank Consultant Trauma Team Leader	Signed by Line Manager
John	O'Keeffe	Head of Estates		No declarations	
Julie	Onslow			No declarations	
Dirandiran	Padiachy				On sabbatical
Robert	Padwick	Consultant	CARTA Services Ltd	Director, Owner and Wife is also Director	Signed by Line Manager
			Ramsay Healthcare Ltd	Consultant	
Claire	Page	Consultant		No declarations	
Christopher	Pandya	Consultant		No declarations	
Angshuman	Panigrahi	Consultant	HM Coroners	Pathologist	Signed by Line Manager
			Ramsay Healthcare	Reporting of private cases	
Tracey	Parker-Foo	Consultant		No declarations	
Amit	Patel	Consultant		No declarations	
Katherine	Peace	Consultant	KPMC Medical Limited	Director, Share holder and husband equal shareholder	Signed by Line Manager
			New Hall Hospital	Consultant Radiologist	
			Salisbury Radiology Department	Adhoc PP work	
Amy	Pearce	Consultant		No declarations	
Gregory	Pearson	Consultant	Wessex Gynaecology & Wellbeing Ltd	Director. Wife, mother and daughter have shared.	Signed by Line Manager
			Circle Sarum Road Winchester and Practice Plus Devizes via Wessex Gynaecology and Wellbeing	Private and NHS work - Consultant Gynaecologist	
Mary	Pedley	Consultant		No declarations	
Philip	Pettit				Retired from Trust
Katrina	Pettit	Consultant		No declarations	
Ginette	Phippen	Divisional Medical Director		No declarations	
Elisa	Porretta	Consultant		No declarations	
Jonathan	Quayle	Consultant	Orthopaedics Plastics and Spinal Specialists LLP	Directorship	Signed by Line Manager
			New Hall Hospital	Consultant	

Holly	Racey	Associate Director of Finance		No declarations	
Clare	Raubusch	Consultant		No declarations	
Alastair	Raynes	Chief Pharmacist		No declarations	
Hannah	Rickard	Consultant	Hannah Rickard Medical Ltd	Director	Signed by Line Manager
			Nw Hall Hospital	Consultant	
Philippa	Ridley	Consultant		No declarations	
Robert	Ritchie	Consultant	UHS	Consultant	Split site role.
Ian	Robinson	Head of Facilities		No declarations	
Raina	Rodrigues		Aesthetic Virtue Limited (Malta)	Director, Owner, Shareholder, + Consultant & Medical Director	
			Aesthetic Holdings Limited (Malta)	Director, Owner, Shareholder, + Consultant & Medical Director	
			The Academy of Aesthetic Excellence Limited (UK)	Director, Owner, Shareholder + Consultant & Medical Director. Husband is 50% shareholder	
Natalia	Roszkowski	Consultant		Spouse is Surgical Consultant doing Private Practice in London and has a Ltd company.	Signed by Line Manager
Paul	Russell	Consultant	Army Volunteer Reserve	Commissioned Officer Volunteer Reserve	
Ahmed	Salem	Consultant		No declarations	
Jessica	Savage	Consultant		No declarations	
Bhavisha	Shah			No declarations	
Khalid	Shamel	Consultant		No declarations	
Margaret	Sheekey	Consultant		No declarations	
Jayne	Sheppard	Deputy CNO		No declarations	
Gurdip	Shergill	Consultant	Shergill Orthopaedics Ltd	Director	Signed by Line Manager
			New Hall Hospital	Consultant	
Ben	Siggers	Consultant	Siggers Medical Ltd	Director & Private Practice	Signed by Line Manager
			Hampshire and Isle of Wight Air Ambulance	Consultant - Under service level agreement between SFT and UHS	
			South Central Ambulance Service Trust	Medical Incident Advisor	
			New Hall Hospital	Self Employed Consultant	
Gemma	Simons	Consultant	Hampshire Isle of Wight Healthcare NHS Foundation Trust	Consultant	Signed by Line Manager
Manas	Sinha	Consultant	Olima Medical Ltd	Consultant	
			Private Practice	Nuffield Health & Salisbury Hospital	Signed by Line Manager
Diana	Slade-Sharman	Consultant	Slade-Sharman Ltd	Owner	
			New Hall Hospital	Consultant	
Simon	Sleight	Consultant		No declarations	
Martin	Smith	Consultant	Salisbury Endocrinology Medical Partnership Ltd (SEMP)	Director, Owner and Consultant	Signed by Line Manager
			New Hall Hospital	Consultant	
George (Richard)	Smith	Consultant	Dr G R Smith Ltd	Director, wife co-director and son paid employee	Signed by Line Manager
			Dairy House Farm Ltd	Owner	
			STARS Appear	Ambassador	
			BSR Heberden's Committee	Charity	
			Eli Lilly, UCB, Medac, J&J, Gedeonrichter	Conference/ Meeting Speaker	
			Eli Lilly	Stood on single advisory board	
			Tasc Committee	Sit on	

			KEMPH, Falkland Islands, Weekend Locums	Consultant	
			Private Practice	2 clinics per week, one at Salisbury, one at SIMP - Consultant	
Victoria	Smith	Consultant		No declarations	
Alistair	Smith				
Claire	Solly	Consultant	New Hall Hospital	Consultant Anaesthetist	Signed by Line Manager
Rowena	Staples			Husband is Director of Ltd company - Powis Hughes a Chartered Surveying Company	Signed by Line Manager
Jessica	Steele	Consultant			Did operation in cyprus for Ministry of Health but no other declarations
Paul	Stephens	Consultant		No declarations	
Mark	Szymankiewicz	Consultant	SWIFTSS	Trustee	Signed by Line Manager
			The Ruth Grace Foundation	Trustee	
			Hereford Muheza Salisbury Link	Trustee	
Stephen	Taylor	Consultant		No declarations	
Robert	Templer	Consultant		No declarations	
Uma	Thakur	Consultant	Ophthotech Ltd	Director	Signed by Line Manager
			New Hall Hospital	Consultant	
Catherine	Thompson	Consultant		No declarations	
Kate	Thompson	Consultant		No declarations	
Eunan	Tiernan	Consultant	New Hall/ Sarum Road	Consultant	Signed by Line Manager
Aarti	Umranikar	Consultant	Medical Limited Company	Co-Director	Signed by Line Manager
			TFP Southampton	Consultant	
Leonidas	Vachtsevanos				
Alison	Vandyken			No declarations	
Ivor	Vanhegan	Consultant	Expert Witness (Medicolegal)	Self Employed	
			Ramsay New Hall Hospital	Self Employed	
Stephen	Veitch		SW Veitch Orthopaedics Ltd	Director, 40% shareholding, Private Medical Practice	Signed by Line Manager
			Orthopaedic Plastic Spine Surgery New Hall Hospital	LLP Member	
				Consultant	
Alice	Veitch	Consultant	SW Veitch Orthopaedics Ltd	Shareholder	Signed by Line Manager
				Spouse owns SW Veitch Orthopaedics Ltd	
				Son works for Siemens Mobility	
			Odstock Radiology Group	Consultant Radiologist	
Stuart	Verdin	Consultant	New Hall Hospital	Consultant	Signed by Line Manager
Matthew	Wakefield	Consultant	Matthew Wakefield Eye Surgery Limited	Director & Shareholder. Wife is also Director	
			MWNH Limited	Director & Shareholder. Line Manager/Colleague is also director	
			Independent Health Group (IHG)	Practising privileges	
			Medcentres Plus	Practising privileges	
James	Ward	Consultant		Product consultation with Guardian Usability	Signed by Line Manager
James	Ward	Doctor	Buckinghamshire Healthcare NHS Trust	ARCC TVW Consultant	Signed by Line Manager
				Wife is Director of Bright Star Psychology Ltd	
Shree-eesh	Waydia	Consultant		No declarations	

Robert	Webb	Director of Procurement & Commercial Services	Siemens Financial Services	Sister in Law (Penny Pinnock) works as financial manager for leasing services to the NHS	Signed by Line Manager
Timothy	Wells				
Susan	Wheatley				
Neil	Wickham	Consultant	NWPS Holding Limited	Director, Owner, Shareholder and spouse is shareholder	Signed by Line Manager
			NHS Professionals	Locum Consultant	
James	Wigley		New Hall Hospital	Consultant	Signed by Line Manager
Simon	Williams	Consultant	SPW Medical Ltd	Director	Signed by Line Manager
Mark	Wills	Consultant	New Hall Hospital	Consultant Radiologist	Signed by Line Manager
			Private work through SDH Radiology	Consultant Radiologist	
Duncan	Wood	Consultant & Head of Department	Odstock Medical Ltd	Shareholder	Signed by Line Manager
Hazel	Woodland			No declarations	
Ian	Wright	Consultant		No declarations	

2025/26 Register of Gifts

Date	Name	Post	Declaration	Accepted/ Declined	Amount/ Value (£)
30/09/2025	Jon Burwell	Chief Information Officer	S6 Pathology and SWASH Imaging Network requested attendance on a visit to Northern Ireland to see Sectra PACS being used for Pathology and Radiology. Sectra a paying for flights, food and accommodation for the Trust. Trip is 6th – 7th November 2025.	Approved - signed by Jonathan Hinchliffe	£500
30/09/2025	Jon Burwell	Chief Information Officer	Opportunity to attend the annual Tech UK healthcare networking dinner on 13th November with Tanium offering a seat.	Approved - signed by Jonathan Hinchliffe	£150
02/06/2025	Fertility Staff	All Bands	£100 M&S Voucher received via post. Refreshments for the team will be bought using the voucher.	Approved - Signed by Kerry Randall, Gynaecology Matron	£100
09/04/2025	Greg Pearson	Consultant	Sponsored dinner and education event from Hologic	Approved - Signed by Katharine Backhouse	£100 - £200
10/06/2025	Greg Pearson	Consultant	An informal dinner paid for by Ocean Med	Approved - Signed by Katharine Backhouse	£100 - £200

Report to:	Trust Board	Agenda item:	5.4
Date of meeting:	13th May 2026		

Report tile:	2025/26 Annual Review of Gifts and Hospitality			
Status:	Information	Discussion	Assurance	Approval
	✓			✓
Approval Process: (where has this paper been reviewed and approved):	Trust Management Committee 22.04.2026			
Prepared by:	Christina Steele, EA to Managing Director and Chair			
Executive Sponsor: (presenting)	Kylie Sanders, Head of Corporate Governance			
Appendices (list if applicable):	Annual Register of Gifts and Hospitality			

Recommendation:

To review and note the annual Register of Gifts and Hospitality 2025/26.

Executive Summary:

In line with the Trust Conflicts of Interest Policy, staff should not accept gifts or hospitality that may affect, or be seen to affect, their professional judgement. Gifts valued at over £50 should be declared and discussed with a line manager. Meals or refreshments valued between £25 and £75 may be accepted but must be declared.

During 2025/26, a total of five declarations were submitted to the Corporate Governance Team, with an estimated combined value of approximately £1,150. Each declaration was reviewed in consultation with the respective employee's line manager, and no issues or concerns were identified.

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):	