NHS
Salisbury
NHS Foundation Trust

Quality Account 2024/25

Glossary of Terms

AMaT	**Audit Management and Tracking System** *A system to manage Clinical Audits, NICE compliance and Mortality reviews through real-time data and action control*
BSW	**Bath and North East Somerset, Swindon, and Wiltshire**
C.diff	**Clostridium Difficile** *A type of bacteria that commonly causes diarrhoea*
CESG	**Clinical Effectiveness Steering Group**
CMB	**Clinical Management Board**
CNST Maternity Incentive Scheme	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. The scheme incentivises ten maternity safety actions*
Care Quality Commission	*The independent regulator of health and adult social care in England*
Datix	*A patient safety and risk management system that integrates safety, risk and governance elements to support the Trust's overall risk management strategy and help reduce risk and improve patient safety*
Deprivation of Liberty Safeguards	*A set of checks under the Mental Capacity Act 2005 which provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm*
EPMA	**Electronic Prescribing and Medicines Administration** *An electric system which helps to facilitate and enhance the communication of a prescription or medicine order*
Friends and Family Test	*A feedback tool that anyone can use to give quick, anonymous feedback to providers of NHS services*
Getting It Right First Time	*A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change*
Health Education England	*A body of the Department of Health and Social Care that supports the delivery of excellent healthcare and health improvement to the patients and public of England*
ICR	***Integrated Care Record*** *A system which interfaces with different digital health and social care records allowing secure access to key information by professionals involved in your care*
Integrated Care Board	*Each Integrated Care System will have an Integrated Care Board. This is a statutory organisation that will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS*
Integrated Care System	*A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area*
LEARN (MLE)	*A web-based system that allows staff to access all their training and development activities.*
Mental Capacity Act	*A law which is designed to help people who cannot make decisions for themselves because they lack the mental capacity to do so*

Medical Examiner	*A senior medical doctor who is trained in the legal and clinical components of the death certification process*
No Criteria to Reside	*Patients who are medically fit for discharge*
NEWS2	**National Early Warning Score 2** *A scoring system to help determine the severity of illness in patients*
NHSE/I	**National Health Service (NHS) England/Improvement**
NICE	**National Institute for Health and Care Excellence** *A body of the Department of Health and Social Care that produces guidelines*
PALS	**Patient Advice and Liaison Service** *Offers confidential advice, support and information on health-related matters and provides a point of contact for patients, their families, and their carers*
PIFU	**Patient Initiated Follow-Up** *A flexible way for patients to arrange appointments based on their needs*
POET	**Patient Observation Electronic Tool** *The Trust's platform for recording: clinical observations with graphical charts, neurological observations, lying and standing blood pressures and patient wellness questions (Martha's rule)*
PROMs	**Patient Reported Outcome Measures** *Assess the quality of care delivered to NHS patients from the patient perspective*
PSIRF	**Patient Safety Incident Response Framework** *Outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted*
Patient Safety Partner	*A voluntary role that ensures patient involvement in organisational safety, supporting and contributing to healthcare governance and to the management of patient safety processes*
Robotic Process Automation	*Software to automate repetitive tasks, enhancing operational efficiency and reducing manual work*
SDEC	**Same Day Emergency Care**
SFT	**Salisbury NHS Foundation Trust**
SHMI	**Summary Hospital-level Mortality Indicator** *The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of the patients being treated*
Structured Judgement Review	*A process for undertaking a review of the care received by patients who have died*
Sharing Outstanding Excellence	*A method of paying a compliment to a team or a member of staff and a way of learning from when things go well*
UKAS	**United Kingdom Accreditation Service** *The National Accreditation Body for the United Kingdom. They are appointed by the government, to assess and accredit organisations that provide services including certification, testing, inspection, calibration, validation and verification.*
VTE	**Venous Thromboembolism** *A blood clot that starts in a vein*

Contents

Introduction

Quality Accounts, which are also known as quality reports, are annual reports for the public that detail information on the quality of services the Trust provides for patients. They are designed to assure patients, families, carers, the public and commissioners that the Trust regularly scrutinises the services it provides and concentrates on those areas that require improvement.

Quality accounts look back on the previous year's performance explaining where the Trust is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement resulting from consultation with patients and the public, our staff, and Governors.

Part 1 – Statement on Quality from the Chief Executive

I am pleased to present our Quality Account for 2024/25 for Salisbury NHS Foundation Trust (SFT), which shows how we have performed against our priorities this year and sets out the main areas of focus for 2025/26. This is the first set of accounts I have had the pleasure of presenting as the jointly appointed Chief Executive of Salisbury NHS Foundation Trust, the Royal United Hospitals Bath and Great Western Hospitals Swindon.

Our continuous improvement methodology known as *Improving Together* has begun to deliver tangible improvements at SFT such as Healthcare Assistants feeling better supported, more confident and more likely to remain in their ward roles and in the Trust because of the Trust's focus on the compliance with Care Certificate initiative. This methodology aligns with similar work our partners at Royal United Hospitals Bath and Great Western Hospitals Swindon are undertaking.

The year has seen significant development of the collaboration between the three hospitals with the creation of the BSW Hospitals Group. The new collaboration means that in the coming years the three hospitals will work together, improve together and learn together to deliver modern effective and quality care to the communities we serve.

Our new Imber Ward within the new Elizabeth Building opened in the summer of 2024 and provides 24 new beds in a modern environment to care for our elderly patients. The ward was held up by national commentators as an example of the best of hospital care for the elderly.

I am proud that the achievements of our new Same Day Emergency Care team that has improved our same day discharge rate and our new Frailty service that has reduced the average length of stay for patients were both finalists for the Health Service Journal Patient Safety Awards.

Despite the flow constraints and an increase in attendances to our Emergency Department (ED) during 2024/25, the Trust has seen improvements across various metrics that are regularly monitored for example, 4-hour performance, ambulance handover times and the number of patients experiencing longer waits. Although we recognise that further improvements are required across some specialities, 75% of suspected cancer patients are now receiving a diagnosis or a ruling out of cancer within 28 days of referral (according to March '25 data).

Our team working with the local military community was also honoured to have been a finalist at the Health Service Journal Awards.

Staff are the organisations most valuable asset, and we continue to invest in their daily experience of work. The annual NHS Staff Survey measures how staff rate their experience of working at the Trust. The 2023 survey saw Salisbury rated as the most improved trust in England. I am delighted that the 2024 survey has shown that overall staff experience has continued to improve. All nine core indicators have shown significant improvement and are now in the top half nationally with seven elements of the People Promise now in the top quartile.

This year SFT was ranked top in the country for staff indicating in the survey that they looked forward to going to work. A huge achievement and testimony to the hard work of everyone across the whole Trust in making the hospital the best place to work.

One of the ways in which the quality of care is recognised is through the Sharing Outstanding Excellence Awards. Patients, family friends or staff can nominate someone.

"Thank you for the exceptional care our mother received and for the way we were all supported during her final hours. The exceptional kindness we were shown throughout the night went a very long way to making it more bearable, and the knowledge that mum's suffering was kept to an absolute minimum, and that her comfort was so closely monitored, was also a great help to us all."

On behalf of the Trust Board, I would like to thank all our staff in all professions who every day work together to deliver compassionate and high-quality care to our patients, regularly going above and beyond. We could not do this without the contribution from each and every one of you.

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

Cara Charles Barks,
Chief Executive Officer

2A - Priorities for Improvement

Salisbury NHS Foundation Trust

In this part of this section of the Quality Report, we outline areas for improvement in the quality of health services that are provided by Salisbury NHS Foundation Trust.

Quality Priorities for 2025/26

Introduction

Our Vision and Goals

Our vision at Salisbury NHS Foundation Trust is to **provide an outstanding experience for our patients, their families and the people who work for and with us.**

To deliver the NHS Long Term Plan and the Trust vision we needed to develop the way in which we all work together and learn. Therefore, in 2020 the Trust undertook a significant conversation with staff. This conversation enabled staff to express in their own words what it felt like to work at the Trust.

In response to this consultation and other available information, such as the annual national NHS staff survey and exit interviews, the Trust Board and colleagues considered how best to build on what was discovered and what was already being done, and how to act to improve our culture, behaviours, and management processes to deliver our vision, strategic priorities, and goals.

The Trust planned to deliver on this re-prioritisation work through the launch of a new strategy in 2022/23, which was driven by a programme of work called *Improving Together*, with priorities being identified under the three strategic themes of **People**, **Population**, and **Partnerships**.

Improving Together

Improving Together is an approach that colleagues in other Trusts locally and across the country have already been engaged in to deliver sustainable long-term improvement. At Salisbury NHS Foundation Trust, this is now the way in which the whole Trust will develop and improve skills, processes, and behaviours and ultimately the mechanism by which we will deliver our new strategy. With the simple goal of delivering an excellent experience for patients, their families, and staff, and being in a position where everyone can proudly say that the Trust is the best place to work.

Bringing together many improvement initiatives already underway, this programme enables our people to improve their skills, help remove things that staff feel block them from delivering outstanding patient experience every time and will enable us all to provide the care we aspire to. At its heart, the programme makes sure that our ongoing priorities and the things we focus our time and energy on will help deliver our vision of an outstanding patient experience, while bringing our values to life and offering new development and training opportunities to staff across the organisation.

Our Improving Together approach to delivering our strategy and continually improving has continued to mature throughout 2024/25. Across the three acute Trusts in Bath and North East Somerset, Swindon, and Wiltshire Partnership (BSW) we have been rolling out Improving Together to align and enable the collective abilities of our workforce to transform and continually improve our services. We are seeking to align our direction, goals, and objectives whilst empowering teams at all levels to maximise their contribution and potential in a focused approach. We are focusing on setting clear expectations and using a coaching leadership style to support problem solving.

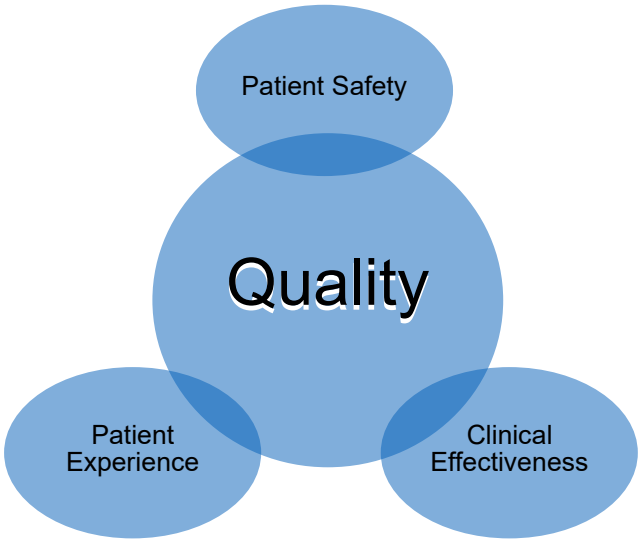
Our Key Priorities

As per the Health and Social Care Act of 2012, the NHS has a duty to continually improve the quality of care being delivered across a range of health services.

In 2025/26 we plan to improve the quality of care primarily through the Trust's Improving Together programme and the work that feeds into the selection of our primary 18-24-month objectives (widely known as our 'Breakthrough Objectives').

Quality is defined as having three dimensions: patient safety, clinical effectiveness, and patient experience, and each of these areas are represented by their own steering groups at the Trust. Specific priorities and objectives which are identified from these steering groups are routinely discussed, and then upwardly reported to our Trust Quality Board.

Through this process, and in addition to the work of Improving Together, our key priorities for 2025/26 have been identified. These are outlined in this section of the report.



Delivering Quality and Patient Care through Improving Together

Improving Together enables us to focus on making improvement part of our daily work, fostering a culture of continuous improvement, and developing leaders as coaches. The operating model integrates improvement into the daily life of teams at three levels.

1. Executives reduce the number of priorities and coach teams to solve problems.
2. Managers work on a set of focused priorities with clear and consistent performance reviews.
3. Frontline teams understand the Trust's strategy and priorities and their role in delivering them. Our goal is for **all** staff to be empowered to make improvements.

Improving Together aligns with NHS Impact and is also used by our BSW Hospital Group partners: Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust.

The Strategic Planning Framework (Appendix A) sets out our areas of focus to achieve our vision and strategy. Nine vision metrics, three under each pillar of the strategy, describe how we measure the delivery of our vision over the next 7-10 years.

The strategic initiatives focus on 'must do, can't fail' programmes of work in pursuit of our vision. These are large programmes of work with a 3–5-year lifespan.

Cascading from our vision are our three strategic domains, known by staff across the organisation as 'the three P's': **People**, **Population**, and **Partnerships**.

'Breakthrough Objectives' are focused at Trust level and targeted for significant improvement (20-30%) within 12 months. Using data to guide our decision making, these have been selected to make the most positive impact on achieving our overall vision. Our Divisions then agree a set of 'driver metrics' with the Executive to align with the breakthrough objectives. This process helps ensure we all can focus on improving the quality of patient care together across the organisation. These are monitored within the individual clinical specialties and are upwardly reported. This is intended to be a seamless process such that every 18-24 months the organisation can focus resources into the areas which will provide the maximum impact for our patients, population, and partnerships. At the same time, improvements in quality and the delivery of patient care will continue to be delivered as part of our core businesses as usual.

Our 18-24 month 'Breakthrough Objectives' for 2025/26 are:

✓ **Managing Patient Deterioration**

After successfully reducing the numbers of patient falls and falls with harm, this breakthrough objective is our next priority for our reducing patient harm vision metric. Our data shows our compliance with NEWS2 observation timings is too low and our incident investigations have shown a trend in delays in the timely response to NEWS2 scores in line with the local and national escalation guidance. Our first step to improving in this area is **to increase the percentage of NEWS2 observations taken on time from 29% in February 2024 to 60%.**

✓ **Reducing time to first outpatient appointment**

After a year in which we successfully halted further deterioration in waiting times to a patient's first outpatient appointment, we will take our learning into 2025/26 and aim **to reduce waiting times by 30%.** We recognise there are some key specialties requiring further support and a dedicated package of improvement coaching has been put in place to deliver in areas where there is the most opportunity for improvement. **We aim to reduce the time to first outpatient appointment from a Trust-wide average of 120 days down to 90 days in 2025/26.**

- ✓ **Creating Value for the Patient: Improving Productivity**
  As the NHS continues to rebound from the pandemic, we are moving our focus to achieving the **same levels of productivity we had in 2019/20**. This supports the quality of our services by improving both our patient experience and clinical effectiveness. In this context 'productivity' is the amount we are paid for the activity the Trust completes against the amount it costs the Trust to deliver the activity. **We aim to improve our productivity from -18% to -8% compared to 2019/20.** Across the Trust our specialities are responding to this aim by working to reduce wasted time and resources and improve the number of patients we can care for each month.

- ✓ **Increasing additional clinical services staff retention**
  After a year of increasing our recruitment and inflows of staff we will now focus on retaining our staff. At a Trust level retention is now the top contributor to our turnover rate. We will work to ensure we retain our workforce, especially in the additional clinical services roles, to support our activity and financial goals – this objective focuses us on having the people we need to realise our plan. **We aim to reduce the turnover for additional clinical services (HCA) from an average of 19% in 2024 to 15% by September 2025.**

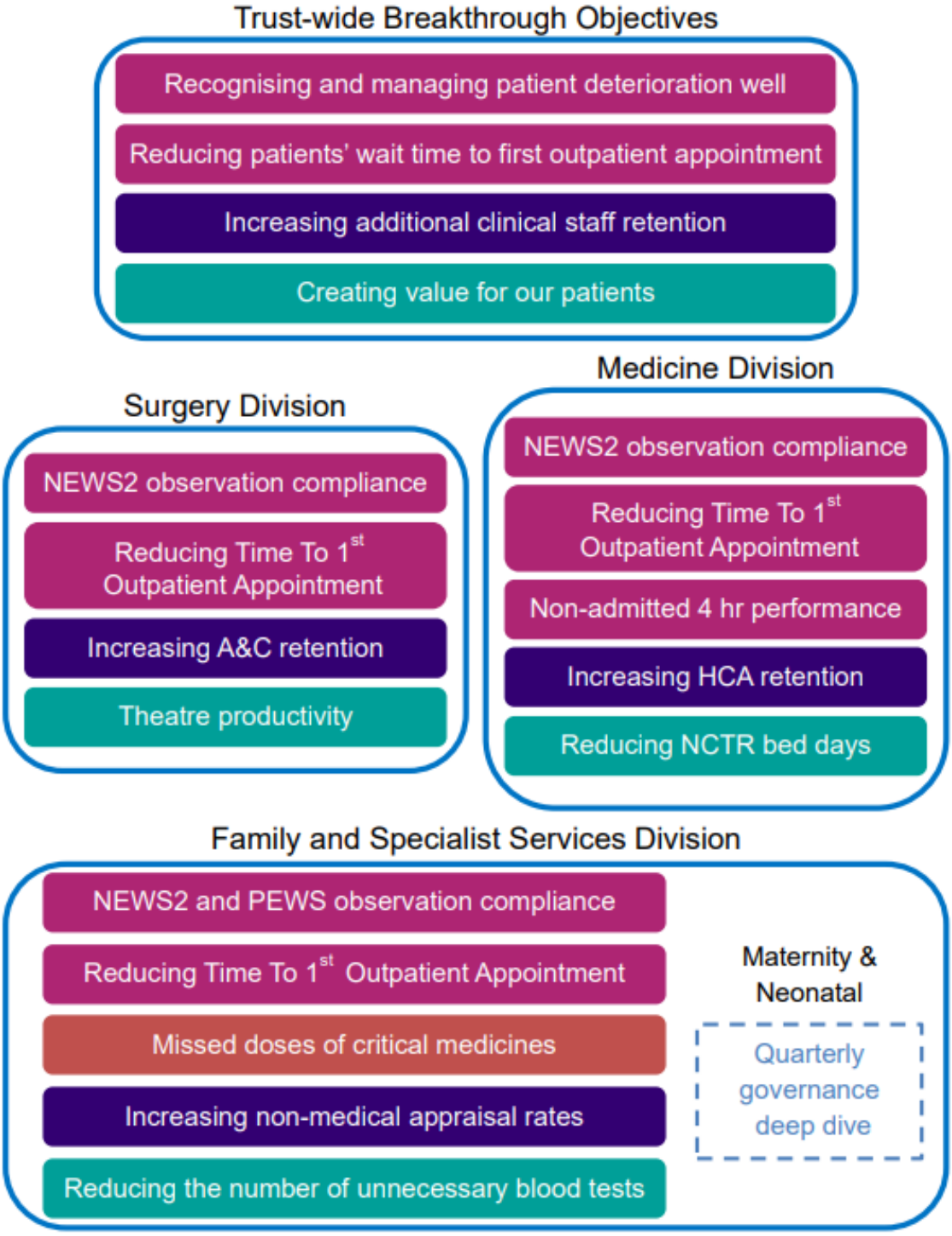
The Trust-wide breakthrough objectives give focus to the top challenges facing the Trust. For example, our vision metric of reducing the total incidents with moderate or high harm show patient deterioration to be the top contributor. Through the Improving Together methodology we first focus on patient deterioration and once we have sustainably improved that, we then move to focused improvement work on the next top contributor at that time. Where a different top contributor is in place on a ward or department we focus on that as the top contributor at a local level.

This enables us to prioritise our work and resources to the biggest areas of potential improvement instead of spreading teams too thinly across multiple priorities at the same time.

Our approach to quality improvement doesn't stop at the four Trust-wide breakthrough objectives. The Improving Together approach feeds into our Divisions, specialities, and teams. The areas of focus, known as driver metrics, for each Division are listed below.

2025/26 Trust-wide breakthrough objectives and Divisional Drivers

From 1st April 2025, there will be three clinical Divisions: Medicine, Surgery and Family and Specialist Services (FaSS) in addition to a Corporate Division. This is to ensure the hospital has a leadership structure that can maintain improvements and support meeting the challenges of the next five years.



The driver metrics are the areas each Division holds in the spotlight and are informed by both the four Trust-wide breakthrough objectives and the Division's review of where their most pressing issues and risks are to succeeding in our vision. Each driver metric is chosen based on a review of the data and evidence to validate a metric's relative impact on the performance, quality, and safety of our services. This approach enables our teams to focus on the most impactful interventions first as we work to continuously improve the quality of our services.

Similarly, at a speciality and team level, driver metrics are chosen. This ensures we can continually work on the most important areas of quality improvement at the Trust, Division, speciality, and team level. Through this system Improving Together aims to give everyone the power to make continuous improvements to their services without the need for detailed top-down direction.

Alongside the driver metrics we keep the rest of the Division, speciality or team's quality measures under review using 'watch metrics'. Watch metrics are measures of our quality and performance which are performing within safe, normal, or acceptable boundaries. They are 'watched' for deterioration or improvement, but our resources are not specifically targeted to that area of work. This enables teams to focus their efforts on our breakthrough objectives and driver metrics while being alerted if a watch metric significantly moves away from their usual performance.

Weekly and monthly reviews are used to keep track of improvements across teams, specialities, and Divisions. With these rolling upwards to the monthly Divisional Performance Review meetings between Divisional Management Teams and the Executive Directors.

Patient Experience

IN 2025/26 WE AIM TO ACHIEVE A MINIMUM RESPONSE RATE OF 18% USING THE FRIENDS AND FAMILY TEST AND MAINTAIN AT LEAST 95% GOOD / VERY GOOD RATING.

Priority 1: Improving accessibility to our Friends and Family Test

The Trust is continuing to invest in the digitalisation and extraction of data insights from our Friends and Family Test surveys, to help inform service improvements. Response rates and overall experience ratings are nationally reported currently, but it is recognised the additional value this data could provide if we were able to robustly theme and analyse feedback received through this mechanism.

We aim to continue to:

- ✓ **Increase overall response rates** to the Friends and Family Test (Improving Together Target of >18% of eligible patients in 2025/26).
- ✓ **Diversify methods for access** (including: online, SMS, over the phone, to make this more accessible to difficult to reach areas of the Trust).
- ✓ **Improve visibility** of feedback mechanisms in both inpatient and outpatient areas.
- ✓ **Increased accessibility and options for inclusivity** (Easy Read, languages, and additional demographic options).
- ✓ **Continue to use data from themes and trends for comparison and benchmarking** with other Trusts within our Integrated Care Board.
- ✓ **Continue to explore and embed triangulation of feedback** of themes with complaints, incidents, compliments, real time feedback and national surveys.

IN 2025/26 WE AIM TO RESPOND TO 85% OF COMPLAINTS WITHIN THEIR AGREED TIMESCALE AND REDUCE RE-OPENED COMPLAINTS TO LESS THAN 5%

Priority 2: Improving our timeliness and quality of response to complaints

Our aim is to provide an accessible, supportive, and robust complaints process, that commits to putting the complainant at its heart. With a clear focus on improving response timescales, changes to the process aim to identify and capitalise on opportunities for early resolution.

We are committed to continually developing appropriate support and training for our staff in order to investigate, respond and embed learning from complaints.

We will measure the quality of these responses through our Complaints Process, surveys and through analysing re-opened complaints.

WE PLEDGE TO INCREASE OUR RESPONSE RATES TO REAL-TIME FEEDBACK BY >15% ON 2024/25 AND MAINTAIN A 90% POSITIVE EXPERIENCE RATING

Priority 3: Putting the lived experience of the patient at the heart of our service improvements

Real-time feedback is a face-to-face survey conducted with the help of our volunteers by the patient's bedside. The aim of the feedback is to give a "real-time" view of a patient's perspective of their care. The survey mirrors the focuses of the National Adult Inpatient Survey and includes questions to measure the patient's perception of the following areas: admission to hospital, the ward environment, their care and treatment, leaving hospital and respect and dignity. This is concluded with an overall experience rating. This feedback continues to develop and is now beginning to be used to triangulate themes being seen though complaints, the Friends and Family Test and National Surveys.

In addition, we plan to continue to develop our pool of service user engagement volunteers, including increasing the number of Patient Safety Partner roles.

We have a highly active readership group, reviewing patient-facing material on a weekly basis and in recognition of the value-added, work will continue to fully embed this review process and material will be carrying an identifiable "patient reviewed" stamp.

We will also continue to explore opportunities for patients to engage with the Trust, offering varied commitments from one-off projects such as those undertaken for Stoma, and Parkinsons. We also plan to continue the development of our Inpatient Spinal Group and Patient Safety Partners.

We are committed to increasing patient involvement in service improvements through the continued development of Patient Panels for Cancer and Spinal Services, with a further addition of a Learning Disabilities and Autism patient group.

Clinical Effectiveness

IN 2025/26 WE WILL CONTINUE TO USE IMPROVING TOGETHER AS THE VEHICLE FOR DRIVING CONTINUOUS IMPROVEMENT ACROSS THE CLINICAL EFFECTIVENESS PORTFOLIO. WE WILL REDUCE THE NUMBER OF MANDATED NATIONAL AUDITS WHICH HAVE PASSED THEIR TARGET DATE FOR COMPLETION. WE WILL UPLOAD OUR MONTHLY PERFORMANCE MONITORING CHARTS TO POWER BI TO INCREASE TRUST-WIDE ACCESSIBILITY TO THIS DATA.

Priority 4: Reducing the number of mandated national audits which have surpassed the target date for completion on our Audit Tracking Software (AMaT)

Local results should be discussed and recorded on AMaT within three months of a relevant national audit report being published. The actions to improve patient safety should also be completed within the time agreed and if these targets are not met then the audit report is determined as overdue. There are instances of the audit having been done but no outcome recorded on AMaT, which is important for providing the oversight and assurance around risks, actions, quality improvement activity, and the wider sharing of areas good practice. An A3 Improvement Tool (example on page 18) has been produced to problem solve these issues by looking at the root causes and to agree countermeasures. An initial six-month target will be set at reducing the number of overdue mandated national audits by 10%, with a target to reduce by a further 10% by year end. This will continue to be discussed during weekly improvement huddles (Trust's Improving Together methodology).

Improvement Huddles. Improvement huddles are where teams come together to work on improvement ideas linked to their goals.

Performance

The monthly performance charts will be uploaded to the Trust's Power BI to allow improved access for Divisions and specialities.

In September 2023, we launched new computer software (AMaT) for managing Clinical Audit. We continue to embed AMaT and build engagement across the Divisions.

There are **456** staff currently using AMaT to record audit activity and to access reporting features, including dashboards.

Support

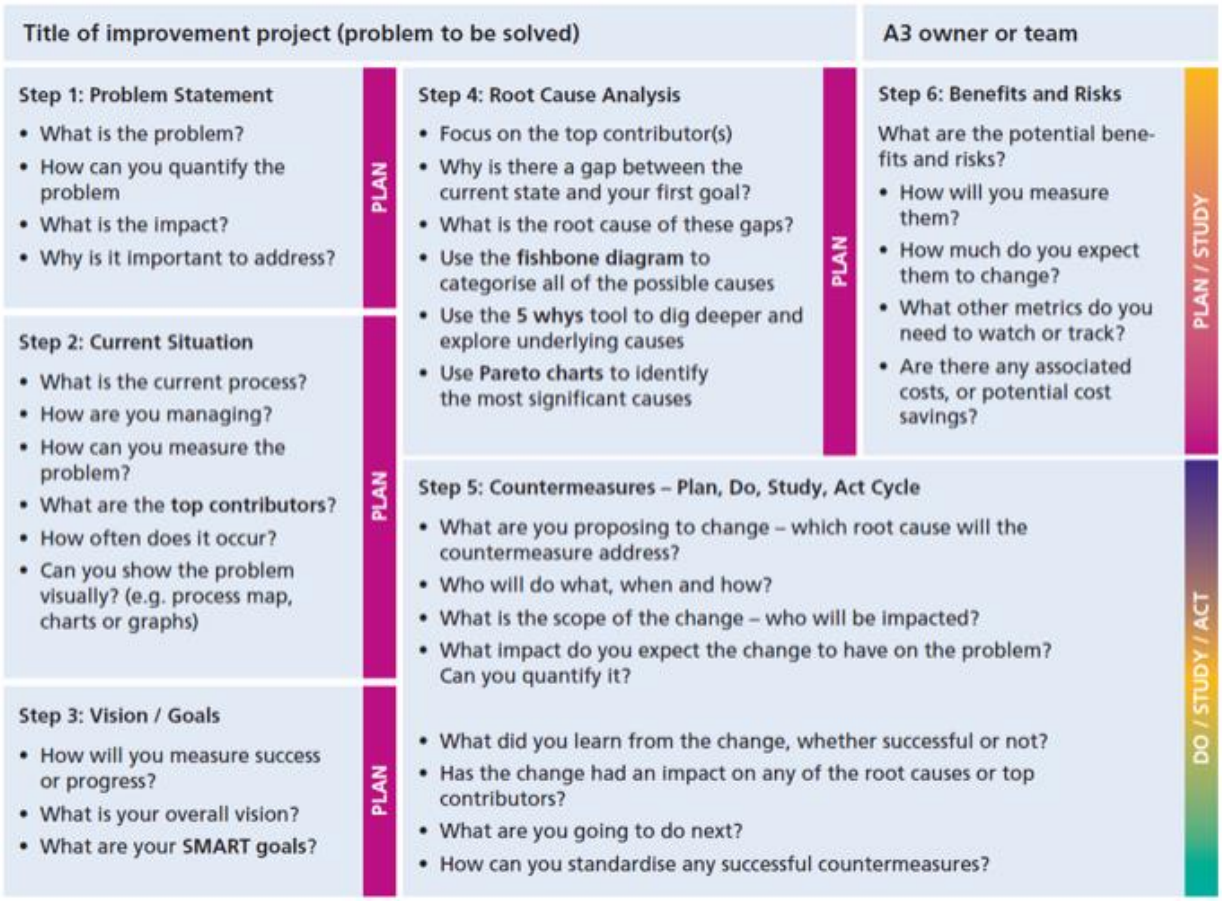
Clinicians will be given further support and training to increase their confidence of using AMaT by way of drop ins, online training, and face-to-face sessions.

Networking

We will continue to network with other Trusts. Lessons will be learned from others and audits, which have been agreed as high priority, will be given increased support.

Using an A3 Improvement Tool

An **A3** Improvement Tool provides a structure for problem solving an issue by looking at the root causes and recording agreed countermeasures.



Patient Safety

IN 2025/26 WE WILL CONTINUE TO EMBED OUR PATIENT SAFETY INCIDENT RESPONSE PLAN AND POLICY, WHICH WILL DETERMINE HOW THE TRUST RESPONDS TO PATIENT SAFETY INCIDENTS USING THE NATIONAL PATIENT SAFETY INCIDENT FRAMEWORK MODEL

Priority 5: Continue to embed the Patient Safety Incident Response Framework

A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients' receiving healthcare.

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

The four aims of the PSIRF are:

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

As part of the transition, SFT developed and implemented the SFT Patient Safety Incident Response Plan and Policy which support the requirements of the PSIRF. They set out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and concerns for the purpose of learning. The policy and plan enable SFT to use a systems-based approach to explore patient safety incidents and where there is identified new learning to support an improvement workstream to enable effective and sustainable change in the most important areas.

As a Trust we are still learning and adapting our processes, as such the Plan and Policy remain active documents and can be reviewed depending on the situation and or within 12-18 months after transition and at regular intervals going forward.

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

This will ensure the focus is on improvements in patient safety rather than producing numerous investigation reports which often do not result in meaningful change.

What happens next?

The Patient Safety Team will continue to work closely alongside the Risk Management Team and the clinical divisional teams to commit to continuous improvement in patient safety through Trust-wide learning.

Looking Back at 2024/25 - What did we say we would do?

Background

Our understanding of the Improving Together methodology has continued to mature over the course of 2024/25. We have seen improvement in all of our breakthrough objectives. Our growing confidence in the approach has enabled us to refresh our breakthrough objectives and use this opportunity with our clinical Divisions to agree their priorities (known as drivers) with the Executive for the 18-24 months ahead.

For 2025/26, this has given the Divisions the opportunity to cascade their drivers to the specialities in each Division who now have their own 'scorecard agreements' that formalise these objectives, this completes the golden thread throughout every strata of the organisation – Executive, Divisions, Specialties, ward and frontline.

Our work on Same Day Emergency Care has continued to bring further improvement across our Medical Division. It is a great example of how success breeds success as our continuous improvement methodology embeds across our teams.

The use of improvement tools such as A3 thinking, improvement huddles, process mapping and data analysis is embedding across our teams. It has been a characteristic of 2024/25 that where problems arise our teams are responding more often in a manner of continuous improvement and using the methodology. We are seeing the results of that in areas such as managing patient deterioration and increasing our productivity the most of any Trust in the region.

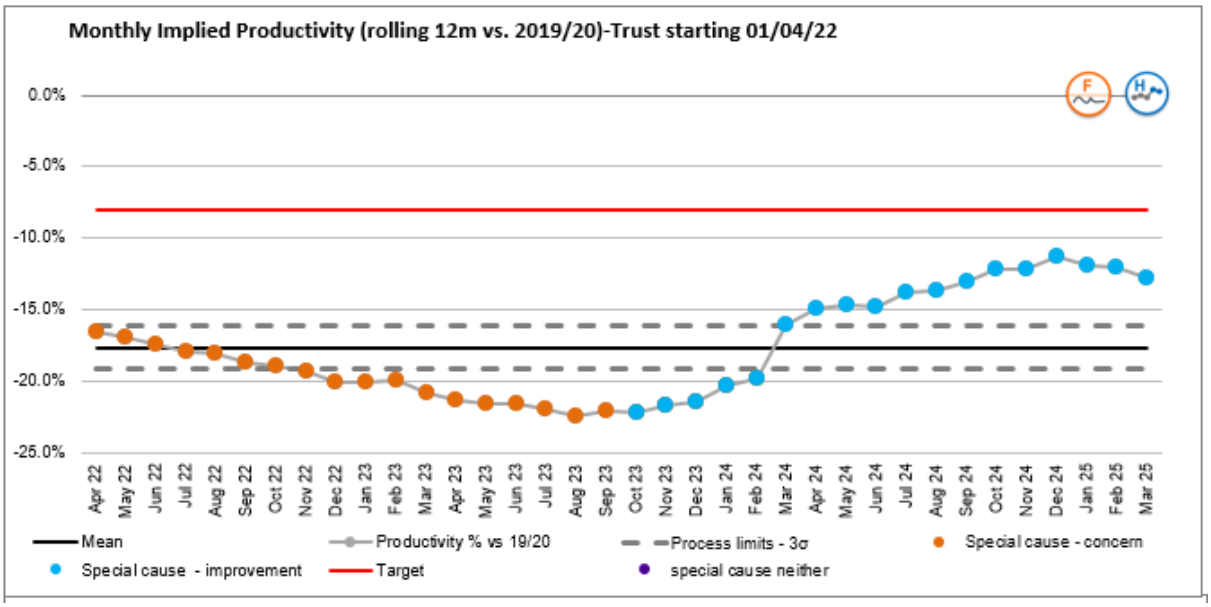
Consultation and Monitoring of our Priorities

Each year the Trust is required to identify and outline its quality priorities. We consulted on our organisational strategy and approach to quality with several stakeholders, and shared our priorities with commissioners, Governors, Healthwatch, and our Trust Executives. The final priorities were approved at Trust Board.

The priorities that we have selected continue to represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience) and have been embedded across our business plans for 2024/25. Our quality priorities were each discussed at their representative steering groups and were also discussed at the Quality Board (CMB).

Progress in the achievement of these priorities will continue to be monitored through regular reporting and discussion at CMB in 2025/26.

Creating Value for our Patients



Our Target for 2024/25

This focuses our efforts on increasing our productivity and in so doing creating better value for our patients. -8% relative to 2019/20 is the recognised 'best possible' by national colleagues and is set as our target.

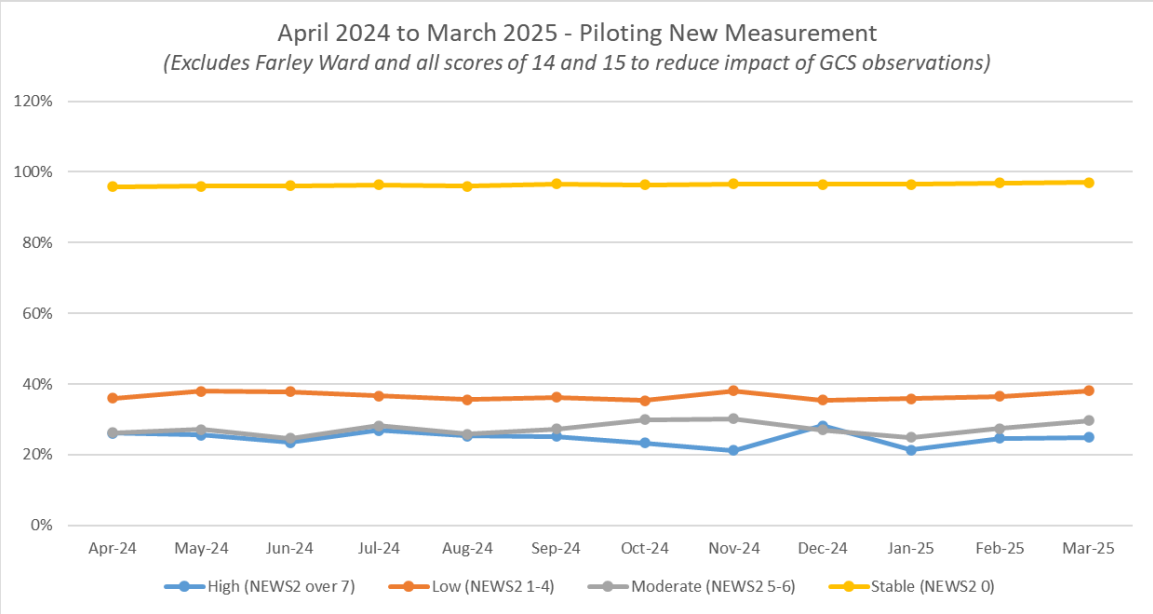
How have we performed?

When selected as a breakthrough objective our productivity was at -21% relative to 2019/20, at the end of 2024/25 it has improved to -11%. The initial position was driven by concerns ranging from increased demand by an ageing population with ever more complex co-morbidity, to shift overlaps and poor rostering.

Actions Included:

- ✓ Controls on temporary staffing.
- ✓ A review and standardisation of outpatient clinic templates.
- ✓ Reductions in length of stay in partnership with system colleagues.
- ✓ Executive attendance in key forums to drive decision making and approach change.

Recognising and Managing Patient Deterioration Well



Our Target for 2024/25

Following our success with reducing falls our stratified data on how harm is occurring in the hospital led us to the next highest contributor – our low rate of timely observations, which in turn were leading to patient deterioration. To do this SFT uses 'NEWS2' within the POET system. The metric is complicated by the fact that if observations are missed by just a few seconds the performance is negatively impacted. Our initial target was set at 50%, but this has been adjusted to 60% to represent what is both achievable and necessary to ensure reduced harm.

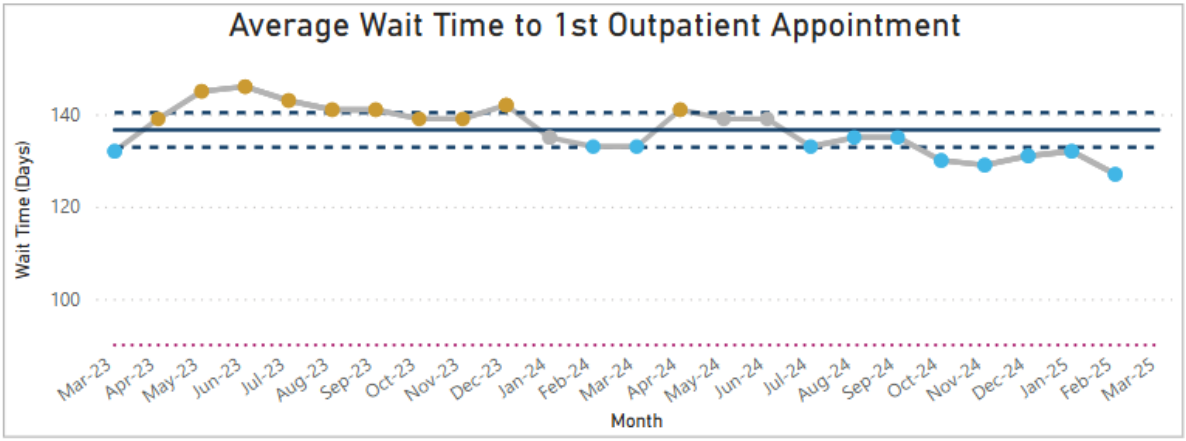
How have we performed?

The Chief Nursing Officer has led work across the organisation to encourage the timely taking and recording of observations. A slow but steady improvement has been seen. In addition to the movement of this headline metric we have seen our balance metric of ICU admissions decrease, suggesting that we are effectively reducing the negative impact of non-timely patient observation.

Actions Include:

- ✓ NEWS2 scores reviewed at handover in the morning and evening.
- ✓ NEWS2 added to the daily morning huddle.
- ✓ CCOT to join weekend medical handover with NEWS2 scores reviewed.
- ✓ NEWS2 training on LEARN (MLE).
- ✓ Ensuring staff have completed POET training).

Reducing time to first outpatient appointment. Aiming to achieve a 30% overall reduction in waiting times and to reduce the time to first outpatient appointment from an average of 126 days down to 90 days.



Our Target for 2024/25

This focuses the Trust on driving down waits for our patients and increasing our elective activity. We are aiming to achieve a 30% overall reduction in waiting times for our patients over the next 12-months. We remain some way from our absolute target of a reduction to an average of 90 days, and this is in part due to complex system factors on which work has begun.

How have we performed?

Unfortunately, we have not achieved the performance targets set by the Trust last year. We recognise that it is a poor patient experience to wait longer than necessary for treatment, and failure against these key performance standards represents a clinical, reputational, financial, and regulatory risk for the Trust.

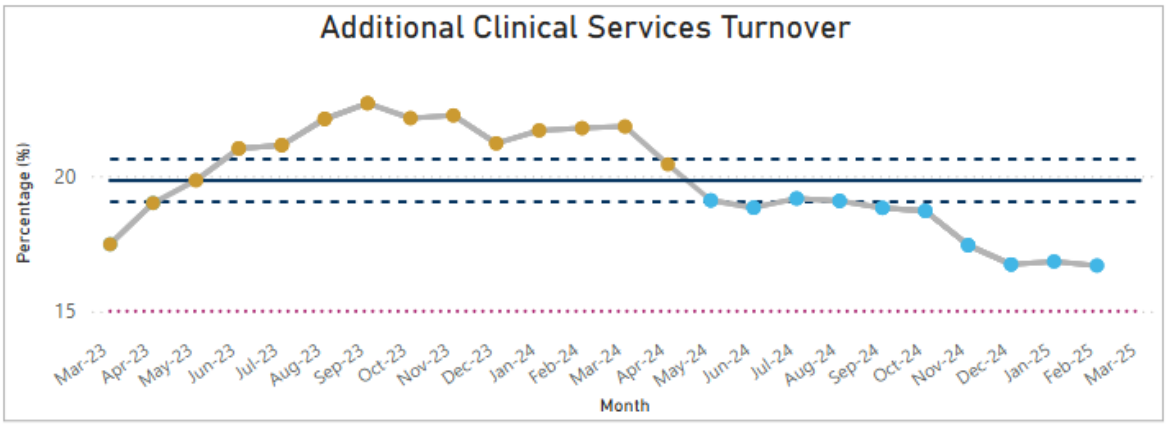
A small cohort of specialties currently account for the majority of the Trust's current backlog of patients awaiting their first outpatient appointment.

In 2024/25, we have continued this priority as one of our four improvement breakthrough objectives (key priorities for all our teams to focus on) in recognition that we did not see the impact we wanted in 2023/24 and will continue again in 2025/26. Using our continuous improvement methodology, we will seek to understand our data and focus on local improvements that collectively contribute to a reduction in overall waiting time. We have seen this approach deliver benefits in some specialty areas and will look to understand, share and expand our successes in the coming 12 months.

Actions included:

- ✓ Establishment of a Planned Care Board.
- ✓ Focusing on a handful of specialties with the biggest opportunity for improvement.
- ✓ Dedicated resource from the Transformation team and the case built for a clinical and operational lead to drive a new programme of work on outpatient transformation.
- ✓ Investigate how Robotic Process Automation can help with Patient Initiated Follow-Up (PIFU) utilisation.

Increasing Additional Clinical Services Staff Retention



Our Target for 2024/25

Flowing from our vision metric to increase staff retention, this breakthrough objective has focused on the top contributor – retention of our additional clinical services staff. Since late 2022 this has averaged 20% and had knock on effects through the patient pathways to which these staff are vital. Our target was to reduce turnover amongst the group to 15%.

How have we performed?

Work has taken place across three broad domains of the roles and development, recruitment, and investigating reasons for staff leaving. These areas of root cause analysis focus have led to the following interventions.

Actions Include:

- ✓ Launch of HCA preceptorship to improve training and induction experience.
- ✓ All new to care HCAs are identified at induction and receive additional support.
- ✓ HCA apprenticeship route established
- ✓ Quarterly HCA learning and celebratory events.

2B - Statements of Assurance from the Board

Salisbury NHS Foundation Trust

In this part of the report, we provide statements of assurance from the Board, as specified by the quality account regulations. We have further expanded on our goals and have provided additional information where possible.

Review of Services

During 2024/25 Salisbury NHS Foundation Trust provided and/or subcontracted 54 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 54 of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2024/25.

The Integrated Governance and Accountability Framework provides one overarching framework which sets out how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of delivering 'an outstanding experience for our patients, their families and the people who work for and with us', by an organisation that is well managed, cost-effective and has a skilled and motivated workforce. In addition, the framework specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focusing across the breadth of quality, operational, finance and workforce performance.

The Clinical Governance Committee is the quality assurance committee of the Trust Board. It is responsible for overseeing the continuous improvement of the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. The committee hears directly from clinical teams where risks to quality are identified to seek assurance that action is being taken to improve. Service deep dives provide assurance to the Committee on the quality-of-service provision and are aligned to corporate risk identified within the Corporate Risk Register and Board Assurance Framework.

The Trust Board has implemented a programme of 'Go and Sees' as part of the Improving Together Programme. The 'Go and See' programme enables the Executive and Non-Executive Directors to visit a team or individual to learn, understand problems, model leadership behaviours and to build a culture of coaching and continuous improvement.

Participation in Clinical Audit

During 2024/25, 63 national clinical audits and 7 confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 56 (89%) national clinical audits, and 7 (100%) confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2024/25, are listed in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1.

Eligible national audits and confidential enquiries the Trust participated in during 2024/25.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
BAUS Data & Audit Programme	BAUS Penile Fracture Audit	✓	0%*
	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	✓	100%
	Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	✓	100%
Breast and Cosmetic Implant Registry	Audit	✓	100%
British Hernia Society Registry	Audit	Not Applicable	Not Applicable
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	✓	100%
Cleft Registry and Audit NEtwork (CRANE) Database	Audit	✓	100%
Emergency Medicine QIPs	Adolescent Mental Health (pilot)	Not Applicable	Not Applicable
	Care of Older People	✓	60%*
	Time Critical Medications	✓	100%

*** Penile Fracture** – there were no cases to submit in 2024/25.
*** Care of Older People** - Previously the data input window was January to December, but it changed to November – October and therefore the window closed before the last records could be added.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Audit	✓	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB	Not Applicable	Not Applicable
	National Audit of Inpatient Falls	✓	100%
	National Hip Fracture Database (NHFD)	✓	100%
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Audit	✓	100%
National Adult Diabetes Audit	National Diabetes Core Audit	✓	100%
	Diabetes Prevention Programme (DPP) Audit	Not Applicable	Not Applicable
	National Diabetes Footcare Audit (NDFA)	✓	100%
	National Diabetes Inpatient Safety Audit (NDISA)	✓	20%
	National Pregnancy in Diabetes Audit (NPID)	✓	100%
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	✓	100%
National Audit of Cardiac Rehabilitation	Audit	✓	100%
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	Audit	Not Applicable	Not Applicable
National Audit of Care at the End of Life (NACEL)	Audit	✓	100%
National Bariatric Surgery Registry	Audit	Not Applicable	Not Applicable

*** National Diabetes Inpatient Safety Audit** – low submission rates due to staffing shortages from vacancies.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	✓	100%
	National Audit of Primary Breast Cancer (NAoPri)	✓	100%
	National Bowel Cancer Audit (NBOCA)	✓	100%
	National Kidney Cancer Audit (NKCA)	✓	100%
	National Lung Cancer Audit (NLCA)	✓	100%
	National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	100%
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	100%
	National Ovarian Cancer Audit (NOCA)	✓	100%
	National Pancreatic Cancer Audit (NPaCA)	✓	100%
	National Prostate Cancer Audit (NPCA)	✓	100%
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit (NACSA)	Not Applicable	Not Applicable
	National Congenital Heart Disease Audit (NCHDA	Not Applicable	Not Applicable
	National Heart Failure Audit (NHFA)	✓	80%*
	National Audit of Cardiac Rhythm Management (CRM)	✓	100%
	Myocardial Ischaemia National Audit Project (MINAP)	✓	100%
	National Audit of Percutaneous Coronary Intervention (NAPCI)	✓	100%
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Not Applicable	Not Applicable
	Left Atrial Appendage Occlusion (LAAO) Registry	Not Applicable	Not Applicable
	Patent Foramen Ovale Closure (PFOC) Registry	Not Applicable	Not Applicable
	Transcatheter Mitral and Tricuspid Valve Registry	Not Applicable	Not Applicable

* **National Heart Failure Audit** – coding delay and staffing shortages due to vacancies & sickness.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Cardiac Arrest Audit (NCAA)	Audit	✓	100%
National Child Mortality Database (NCMD	Audit	✓	100%
National Clinical Audit of Psychosis (NCAP)	Audit	Not Applicable	Not Applicable
National Comparative Audit of Blood Transfusion	National Comparative Audit of NICE Quality Standard QS138	✓	100%
	National Comparative Audit of Bedside Transfusion Practice	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Audit	✓	100%
National Emergency Laparotomy Audit (NELA)	Laparotomy	✓	100%
	No Laparotomy	✓	100%
National Joint Registry	Audit	✓	100%
National Major Trauma Registry (previously knowns as TARN)	Audit	✓	100%
National Maternity and Perinatal Audit (NMPA)	Audit	✓	100%
National Neonatal Audit Programme (NNAP)	Audit	✓	100%
National Obesity Audit (NOA)	Audit	Not Applicable	Not Applicable
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	✓	100%
	Cataract Audit	✓	100%
National Paediatric Diabetes Audit (NPDA)	Audit	✓	100%
National Pulmonary Hypertension Audit	Audit	Not Applicable	Not Applicable

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Respiratory Audit Programme (NRAP):	COPD Secondary Care	✓	100%
	Pulmonary Rehabilitation	✓	100%
	Adult Asthma Secondary Care	✓	100%
	Children and Young People's Asthma Secondary Care	✓	100%
National Vascular Registry (NVR)	Audit	Not Applicable	Not Applicable
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Audit	Not Applicable	Not Applicable
Paediatric Intensive Care Audit Network (PICANet)	Audit	Not Applicable	Not Applicable
Perinatal Mortality Review Tool (PMRT)	Audit	✓	100%
Perioperative Quality Improvement Programme	Audit	✘	0%*
Prescribing Observatory for Mental Health (POMH)	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	Not Applicable	Not Applicable
	The use of melatonin	Not Applicable	Not Applicable
	The use of opioids in mental health services	Not Applicable	Not Applicable
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Oncology & Reconstruction	✘	0%*
	Trauma	✘	0%*
	Orthognathic Surgery	✘	0%*
	Non-melanoma skin cancers	✘	0%*
	Oral and Dentoalveolar Surgery	✘	0%*

*** Perioperative Quality Improvement Programme –** a decision to not participate in this quality improvement programme was taken due to it being deemed research and not audit focused.
* **Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) –** this was previously a pilot and does not appear on the list for 2025/26. The report will be reviewed, once published, for any applicable learning.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
Sentinel Stroke National Audit Programme (SSNAP)	Audit	✓	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Audit	✓	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Audit	✓	100%
UK Cystic Fibrosis Registry	Audit	✓	100%
UK Renal Registry Chronic Kidney Disease Audit	Audit	Not Applicable	Not Applicable
UK Renal Registry National Acute Kidney Injury Audit	Audit	✓	100%

National Confidential Enquiries			
Audit title	**Details**	**Participation**	**% of cases submitted**
Child Health Clinical Outcome Review Programme	Emergency surgery in children and young people	✓	100%
	Juvenile Idiopathic Arthritis	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Audit	✓	100%
Medical and Surgical Clinical Outcome Review Programme	End of Life Care	✓	These audits remain in progress. It is anticipated that we will submit 100%
	Blood Sodium	✓	
	Acute Limb Ischaemia	Not Applicable	
	Managing Acute Illness in People with a Learning Disability	✓	
	Rehabilitation Following Critical Illness	✓	
Mental Health Clinical Outcome Review Programme	Audit	Not Applicable	Not Applicable

The participation in these audits is in line with the Trust's annual clinical audit programme which aims to ensure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all National Institute for Health and Care Excellence guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. Last year the annual audit programme again incorporated around 350 audits, including several audits agreed as part of the contract with our Clinical Commissioning Groups.

The reports of 7 national clinical audits and confidential enquiries that were published in 2024/25 were reviewed by Salisbury NHS Foundation Trust in 2024/25. Of these, none were risk scored as moderate or higher and therefore did not require formal reporting to the Clinical Effectiveness Steering Group by the clinical lead responsible for implementing the changes in practice. Further examples of national clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can be found in Appendix B.

Local clinical audits

The reports of 103 (100%) local clinical audits were reviewed by the Trust in 2024/25. Audit outcomes were discussed at Specialty and / or Divisional meetings and assurance and risk levels agreed. Examples of local clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can also be found in Appendix B.

Research

Research plays a vital role in transforming healthcare, driving innovation and improving patient outcomes. As Lord Darzi has highlighted, research is not just about new discoveries – it's about delivering real, tangible improvements that make a difference in people's lives. The UK has long been a leader in medical research, and it's essential that we continue to strengthen our position on the global stage by fostering a research culture that attracts investment, accelerates breakthroughs, and ultimately benefits our patients.

One of the biggest changes in the UK research landscape this year has been the transition from the 15 National Institute for Health Research (NIHR) Clinical Research Networks (CRNs) to the new NIHR Research Delivery Networks (RDNs). This change, which took effect on the 1st October 2024, was designed to create a more integrated and efficient approach to research delivery across the country. The NIHR RDN is funded by the Department of Health and Social Care (DHSC) and plays an important role in ensuring research is accessible, well- supported, and embedded within the health and care system.

At SFT, our Research Department is guided by both the Trusts strategic objectives, the Integrated Care System and the NIHRs National strategy. This ensures that we not only promote and expand research opportunities but also focus on improving health outcomes and making research more

As we continue to build on this strong foundation, we remain committed to establishing a thriving research environment. By strengthening partnership, increasing participation and driving innovation, we aim to position SFT as a key player in shaping the future of research in the region and nationally.

The funding received from the NIHR is currently not activity-based, as it was in previous years. As such, the service has continued, focusing on creating a stronger, more resilient base to improve the profile of research in the Trust and to work with our partners to improve the health of our community, in future years. This includes:

- Actively collaborating with partners in the BSW region to form a robust alliance. This alliance aims to tackle health inequalities, strengthen research delivery pathways and optimise resource sharing and utilisation for the benefit of the population.

- The establishment of the Research and Innovation Board. We are working along with the Innovation Team to improve the profile of Research and to have engagement with the Executive Team. This Board will have oversight from the Trust Management Committee.

- The development of the Salisbury Research Hub which signifies a strategic initiative aimed at aligning the organisation with leading research partners such as the Wessex Health Partners, generating revenue and most importantly addressing health disparities.

- We are also diligently working on increasing commercial and home-grown research to maximise income both for the department and the Trust.

Patient participation and recruitment continues to thrive:

We recruited 1868 participants over 37 studies, from April 2024 – March 2025.

We have actively conducted the NIHR Patient Research Experience Survey across 10 research studies between April 2024 – March 2025, a total of 62 responses were received. Our engagement underpins our commitment to gathering valuable feedback so we can enhance the patient experience.

A range from 66% - 100% participants felt - Prepared, updated, valued and treated with respect and courtesy and knew how to contact the Research Team. They would consider taking part in Research again!

Commercial Income

We have 5 open commercial studies which is an improvement from the previous year where we opened 2 commercial trials. We are currently setting up 3 additional studies, this will increase the number of commercial studies running in the Trust to 8.

We have seen a slight drop in the non-commercial portfolio, though this is reported across the region. Our aim is to have a balance of commercial and non-commercial portfolio. We have also increased the number of non- commercial non – portfolio studies which is indicative of an improvement in compliance and governance. We now have two academic / student studies and one in the pipeline, as we gradually promote home-grown and National Midwifery and Allied Health Professional (NMAHP)research.

Studies opened in Financial Year (FY)	FY 2023/24	FY 2024/25
Commercial portfolio	2	5
Non-commercial portfolio	37	27
Non-commercial non-portfolio	1	3
Academic/student	0	2

Home Grown Research

There are two nationally funded projects that are open in the Trust.

Short title	Full title
BOWMAN	A Randomised, Sham-Controlled, Proof of Principle Study of Abdominal Functional Electrical Stimulation for Bowel Management in Spinal Cord Injury.
STEPS II	The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial.

We have also had two enquiries to do research within the Trust. This includes enquiries from students, nurses, Doctors and other Allied Health Professionals to be part of research. We are looking at ways to capitalise on this interest in research.

Other successes

- ✓ We have established connections with Primary Care and are set to collaborate on a study with two GP practices. Ongoing discussions about future commercial trials are promising, as they will not only improve patient access to research but also help develop specialities that are not currently active at our site.
- ✓ We have successfully partnered with Southampton on a major NIHR Commercial Research Delivery Centre bid with announcement of acquiring the bid made in December 2024. As a result, we will operate as a spoke hub for the Wessex hubs, playing a key role in delivering cutting edge research.
- ✓ We have expanded our team by appointing two full-time research administrators, a full-time clinical trial Pharmacy technician (part-funded). Additionally, we have recruited a full-time Research Manager, which has allowed us to accelerate the set up and opening of new studies. The Research Department is funding backfill for a senior nurse to create dedicated time for research engagement and to promote NMAHP research within the Trust.
- ✓ We are collaborating with our regional partners to develop a system that incentivises research-active medics (Principal Investigators).

Care Quality Commission Registration

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

Maternity Service assessment

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

Inspectors found:

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

However:

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

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

The full report is available via this link: Salisbury District Hospital HTML report for assessment AP5984 - Care Quality Commission

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

CQC Ionising Radiation (Medical Exposure) Regulations 2017 inspection

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

The CQC issued the Trust with two Improvement Notices under the Health and Safety at Work Act 1974 on 13th March 2025. These notices outlined breaches under IR(ME)R regulations 6(1)(a), 6(2) and 10(5). These breaches related to missing procedures or gaps in detail and the use of non-registered staff in making referrals. The CQC noted that the service displayed many areas of good practice, and inspectors noted clear escalation of IR(ME)R relevant risks within radiology and that there was learning from topics highlighted in the enforcing authority's annual report. The report noted that staff of all grades were engaged and spoke of a good working culture.

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

- The employer must establish recommendations concerning referral guidelines for medical exposures and ensure that these are made available to the referrer. The Trust submitted the action plan to the CQC inspector by the deadline and it has been accepted by the CQC IR(ME)R inspection team

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

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

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

External Well-led Developmental Review

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

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

There have been bi-annual reports to Board on progress against the key improvement themes. There has been significant progress made against all identified areas for improvement. The Trust has aligned the key areas for improvement to existing programmes of work to ensure this has oversight through existing governance arrangements. Some of this work now forms part of a wider BSW corporate governance workstream supporting the move to a Group model.

The ongoing focus into 2025/26 includes:

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

Data Quality

Good quality information (data) underpins the effective delivery of patient care and is essential to drive improvements in the quality of care we deliver. Having high data quality standards gives confidence that decisions that are made using the information are appropriate and ultimately will help to deliver more responsive, high-quality and cost-effective services.

Over 2024/25, the Trust continued work on its Business Intelligence Transformation project which included work to replace our data warehouse and delivering modern tools to support the improvement of data quality and the use of information more widely. The Data Quality Manager continues to lead the Data Quality elements of this project and support implementation.

Our Data Quality Policy is reviewed annually to reflect the progress made in the previous year and includes an improvements plan outlining the actions the Trust intends to take over the next twelve months. This Data Quality Improvement Plan is regularly monitored and updated at the Information Standards Group. We have now published a new internal data quality dashboard on our Power BI platform, so all senior leaders and responsible persons are aware of data quality compliance across the Trust. This includes monitoring the timeliness and accuracy of admission, discharge and transfer data.

Every year, Salisbury NHS Foundation Trust submits records to the Secondary Uses Service for inclusion in the published Hospital Episode Statistics. The percentage of records in the published data which included the patient's valid NHS number and valid General Medical Practice Code is set out in Table 2. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Medical Practice Code and is essential to enable the transfer of clinical information about the patient.

Table 2 - Patient records with a valid NHS number and General Medical Practice Code

Data item	SFT 2023/24	National benchmark 2023/24	SFT 2024/25 (M1-9 only)	National benchmark 2024/25
Valid NHS number				
% for admitted patient care	99.8%	99.7%	99.8%	99.7%
% for outpatient care	99.9%	99.8%	99.8%	99.8%
% for Emergency Department care	99.1%	99.1%	98.1%	98.1%
Valid General Medical Practice Code				
% for admitted patient care	99.9%	99.7%	100%	99.3%
% for outpatient care	100%	99.4%	100%	99.3%
% for Emergency Department care	100%	99.5%	99.2%	99.2%

Data Security and Protection Toolkit Attainment Levels

Information governance is a term used to describe how information is used. It covers system and process management, records management, data quality, data protection and the controls needed to ensure information sharing is secure, confidential, and responsive to Salisbury NHS Foundation Trust and the people it serves.

Good information governance means ensuring the information we hold about our patients and staff is accurate, keeping it safe, and available at the point of care. The Data Security and Protection Toolkit is the way we demonstrate our compliance with national data protection standards. All NHS organisations are required to make an annual submission at the end of June, to assure compliance with data protection and security requirements.

The Trust self-assessment against the 2024/25 Data Security and Protection Toolkit confirmed compliance in all areas, with a status of 'Standards Met'. The self-assessment for 2024/25 is due for submission at the end of June 2025.

Clinical Coding Error Rate

The Trust commissioned an external clinical coding audit from D&A Consultancy (specialist clinical coding auditors) in December 2024 to provide evidence for the Data Security and Protection Toolkit during the reporting period. The error rates reported in the audit for that period for diagnoses and treatment coding (clinical coding) were:

- **Primary Diagnoses Incorrect 3.5%**
- **Secondary Diagnoses Incorrect 4.8%**
- **Primary Procedures Incorrect 3.6%**
- **Secondary Procedures Incorrect 4.5%**

The Data Security and Protection toolkit Standard 1 attainment level was:

Exceeded Level

Clinical Coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Clinical Coding audit methodology is available from NHS Digital.

The clinical coding results should not be extrapolated further than the actual sample of 200 Finished Consultant Episodes (50 Short Stay Emergency Unit, 50 Orthopaedics, 50 Endoscopy, 50 Cardiology).

Seven Day Hospital Services – Implementing the Priority Clinical Standards

There is a recognition and understanding (backed up by emerging data) that variation between weekday and weekend practice has a significant impact on both quality of care and flow through the organisation and therefore is a key area that needs to be tackled. The reasons behind this are multiple and complex but are becoming increasingly understood, in part thanks to the efforts of a specific weekend working group that was established during 2024. A report was reviewed during 2024/25 that highlighted some variation in the provision of seven-day services. Factors which affect this variation include:

- Communication - including digital infrastructure, paper-based processes, and multidisciplinary team handovers.
- Uneven standardisation of workload and process
- Distribution of workload across Divisions, teams, and individuals
- Staffing - including reduced availability of senior decision-makers (SDM)
- High hospital bed occupancy

Weekend working data has been shared and discussed with the Urgent and Emergency Care (UEC) Board throughout 2024 to inform improvement work. Early successes include the redesign of two junior medical workforce models to improve continuity of care over the weekend as well as providing more consistent weekend cover from senior clinical decision makers. Ongoing work includes improving escalation pathways and communication between the multi-disciplinary team, developing process standard work for weekend handover, and streamlining handover between weekday and weekend teams.

- ✓ The group are working to produce a Power Bi report and process standard work for weekend handover.
- ✓ Ongoing work includes splitting our length of stay data by planned and non-elective care pathways.
- ✓ The Head of Site and Flow is bringing together a working group for the implementation of electronic bed management.

The number of patients no longer meeting the criteria to reside status has reduced this year, and this correlates with non-elective length of stay reducing. The overall length of stay for hospital inpatients has also reduced.

As we enter 2025 there are plans to enhance SDM access at the weekend across medicine through additional recruitment and rota redesign, and our understanding is that to deliver better care at the weekend we need to start with the approach that we take during the week. As such, the weekend working group has now joined with other working groups to focus on ‘ward process’ in general and to tackle the high bed occupancy driven by those patients with no criteria to reside.

Freedom to Speak Up (whistleblowing and raising concerns)

The importance of Freedom to Speak Up (FTSU)

Freedom to Speak Up Guardians are often the last opportunity for an organisation to put something right. Recent high-profile cases at other NHS organisations highlight the negative reputational impact which mistreating people for speaking up can have on organisations. And yet these stories persist, that the organisation was more interested in its reputation than in listening to the concerns or acting on them. People come to their guardians for a number of reasons. Just over 50% of cases at SFT involved an element of inappropriate behaviours and attitudes, which follows the national picture. This matters because we know that working environments effect quality and safety; they impact on staffing, on retention, and ways of working. In healthcare, we are in the relationships business: every interaction - whether patient, family member, or colleague - makes a difference to lives and outcomes. Culture is a patient safety issue.

In response to last year's NHS Staff Survey, in relation to the People Promise, the Freedom to Speak Up Guardian (FTSUG) with the wider Organisational Development & People team has worked to improve 'We are Compassionate and Inclusive' and 'We Each have a Voice that Counts' scores. Actions included a clear communications plan promoting the FTSU service, expert data triangulated to create thematic analysis to inform interventions and work alongside staff networks to identify barriers to speaking up. All these aspects have been attended to resulting in significant positive increase in the NHS Staff Survey results for the second year running in these areas.

The FTSUG also delivers training at a variety of events, such as Trust Induction and Resident Doctors Core Training, to influence the creation of psychological safety in order that colleagues can raise concerns with confidence and assurance that they will be listened to and acted upon.

The Trust's Guardian has direct access to all senior leaders including the Chief Executive and all Board members.

Themes and trends are reported quarterly to the Board for assurance and to highlight lessons learned from concerns that have been raised. In 2024-25, 129 concerns have been raised to the Freedom to Speak Up Guardian, a 20% decrease on the previous year. Of these, 35 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

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

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

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

Consolidated Annual Report 2024/25 on Doctors and Dentists in Training Rota Gaps and Improvement Plan

Details of rota gaps are presented four-monthly to the People and Culture Committee as part of the Guardian of Safe Working Report. The annual report presents a consolidated view of the rota gaps.

Below is a summary of rota gaps across all training grades and specialties for 2024/25. There are approximately 224 resident doctors that are expected to be supplied by Health Education England (HEE Wessex).

Where there is a shortfall, the Trust aims to mitigate this by covering the gap with locally employed doctors (LEDs). Ascertaining how many LEDs are in post at any one time is challenging as these posts flux in number according to departmental / specialty demand and training post gaps. There is no defined number of locally employed doctors or total number of doctors for each specialty.

Year 2024/25	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Whole Time Equivalent (WTE) deanery gap	6	6	6	6	8	12	14	14	12	10	8	9
LTFT gap	3.8	3.8	3.8	3.8	5.0	5.4	5.4	5.4	6.3	6.3	6.4	6.4
Net WTE gap	9.8	9.8	9.8	9.8	13	17.4	19.4	19.4	18.3	16.3	14.4	15.4

Despite the fluctuations in fill rate over 2024/25 the numbers of unfilled posts have remained relatively stable. It is noted that there is a disparity between junior (F1- ST2) and senior (ST3+) levels, with a reduced fill rate at senior resident doctor level. It is notable that all 4 dental posts / OMFS are currently unfilled by HEE Wessex.

There has been a gradual increase in the number of resident doctors choosing to work Less Than Full Time (LTFT), with a trend to 0.8 WTE working from earlier in a resident doctor's career. Certain specialties are impacted more by LTFT working, including Anaesthetics and Paediatrics, particularly at the senior resident doctor grades.

Since May 2023 locally employed doctors have been transitioned to the 'junior doctor' 2016 Terms and Conditions to allow parity with their deanery appointed colleagues in terms of working patterns and access to exception reporting.

The numbers of Foundation Programme doctors in the Trust continue to increase following increases in medical school places in recent years. Where possible these posts have replaced junior LED posts.

Plans for Improvement

- ✓ A new electronic rostering system (eRoster) is now in the process of being implemented for medical teams, though this process has been significantly delayed. This may provide a greater opportunity for oversight of potential gaps in rotas. It may make it easier for staff wishing to work extra hours to offer to fill shifts. There are, however, significant restrictions (2016 Terms and Conditions) on working hours of resident doctors, with many of them already working close to the maximum hours allowed in their contracts.
- ✓ There is ongoing work across clinical specialites, Rota Coordinators, the Medical Education team, Guardian of Safe working and Medical HR to improve resident doctors' working patterns and rotas in the Trust.
- ✓ Qualified physician associates are now in post and have been generally well received locally. There is ongoing work to ascertain how these roles will work best to support the existing medical workforce.
- ✓ The Trust continues to work with Health Education England, with a national review of postgraduate doctors training recently announced.

National Core Set of Quality Indicators

Salisbury NHS Foundation Trust

All Trusts are required to report their performance against a statutory core set of quality indicators as part of their quality accounts. The indicators are based on recommendations by the National Quality Board. They are split into five domains. In this section we report:

- ✓ **Our performance against these indicators; presented in a table format, for at least the last two reporting periods**
- ✓ **The national average (where available)**
- ✓ **A supporting commentary, which explains the variation from the national average and the steps taken or planned to improve quality**

Domain 1 – Preventing People from Dying Prematurely

Summary Hospital-level Mortality Indicator (SHMI)

National Quality Priorities						
a. Trust SHMI:	**Dec 2021 – Nov 2022**		**Dec 2022 – Nov 2023**		**Dec 2023 – Nov 2024**	
	SFT	**National Average**	**SFT**	**National Average**	**SFT**	**National Average**
The value of the SHMI for the Trust	1.1179	1.0	1.1186	1.0	0.94	1.0
The banding of the SHMI for the Trust	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
SHMI broken down by Site:						
The value of the SHMI for Salisbury District Hospital	1.0729	1.0	1.0658	1.0	0.94	1.0
The banding of the SHMI for Salisbury District Hospital	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
The value of the SHMI for Salisbury Hospice	2.2734	1.0	2.4281	1.0	No longer published	1.0
The banding of the SHMI for Salisbury Hospice	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected
b. Palliative Care Coding:						
b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust (all sites). The palliative care indicator is a contextual indicator.	49%	40%	49%	42%	40%	44%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Salisbury NHS Foundation Trust recognises the importance of providing good quality care to people with life limiting conditions and to those who are dying. We are proud to include our local Hospice on site. As mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services) the number of expected deaths at Salisbury NHS Foundation Trust may sit above expected levels. When the main hospital site is separated from the hospice, expected deaths fall well within the expected range. The proportion of deaths with a palliative care coding has no specific target but is felt to be a measure of how Trusts recognise those in the last phase of their life and provide services to support them and their loved ones during that time (i.e. a higher figure is better).

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve mortality and harm, and so the quality of its services:

- ✓ The Trust's Mortality Surveillance Group continue to meet every two months for assurance purposes.
- ✓ All actions related to a Board requested mortality insight visit that took place during 2023/24 were completed this year. The SHMI has reduced and there has been an overall reduction in crude mortality rates.
- ✓ A new electronic system for managing mortality reviews and learning from deaths that was launched during 2023/24 is now fully embedded into the Trust's governance processes. Regular IT improvements have been made throughout 2024/25 to improve the system functioning and support the Trust's learning from deaths.

Please refer to Part 3 of this report (Other/Provider content) for further information about how we are learning from deaths

Domain 2 – Enhancing Quality of Life for People with Long-term Conditions

This section is related to mental health services and admission to acute wards where the Crisis Resolution Home Treatment Team were gate keepers. As these are not commissioned at Salisbury NHS Foundation Trust, there are no indicators to report within Domain 2.

Domain 3 – Helping People to Recover from Episodes of Ill Health or Following Injury

Patient Reported Outcome Measures

National Quality Priorities												
Patient reported outcome measures (Average Adjusted Health Gain)	**Apr 22 – Mar 23**				**Apr 23 – Mar 24**				**Apr 24 – Mar 25**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
i) hip replacement surgery	N/A*1	45%	N/A*1	N/A*1	N/A*2	44%	Data not available		Data not yet published.			
ii) knee replacement surgery	N/A*1	33%	N/A*1	N/A*1	N/A*2	31%	Data not available		Data not yet published.			

1 Data not published due to small number of procedures or submission being suspended due to COVID-19

*2 ***Insufficient records***

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

The Patient Reported Outcome Measures have been collected by all providers of NHS-funded care since April 2009. They assess the quality of care delivered to NHS patients from the patient perspective. They currently cover two clinical procedures carried out by Salisbury NHS Foundation Trust (hip and knee replacements) and calculate the health gains after surgical treatment using pre-operative (Q1) and post-operative (Q2) surveys. Patients are under no obligations to complete the questionnaires and can withdraw their consent at any time.

NHSE has reported that response levels may be impacted by a reduction in its resources in recent years. See Patient Reported Outcome Measures (PROMs) in England, Final 2023/24 data for further information.

In 2023/24, the Trust's National PROMs Accredited Supplier (Quality Health Ltd) reported there were 355 primary Total Hip Replacements and Total Knee Replacements combined. 234 Q1 results were captured (66%); and 230 Q2s were sent by Quality Health Ltd (98%), but only 72 Q2 responses were returned (31%). Salisbury NHS Foundation Trust has a minimum participation rate target of 50%. The Trust failed to meet this target in the 2023/24 year.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve patient reported outcome measures, and so the quality of its services:

- ✓ Work with Quality Health Ltd to establish how patients are being chased, given many of our elderly patients are unlikely to respond to email.
- ✓ Investigate the means of chasing and how many reminders are sent by Quality Health Ltd.
- ✓ Work with Quality Health Ltd to increase the response rates going forward.

Patients Readmitted to Hospital Within 30-days of Being Discharged

Note: The updated Quality Account guidance states that the regulations refer to a 28-day readmissions period rather than the 30-day period specified.

National Quality Priorities												
Percentage of patients readmitted within 28 days of discharge from hospital by patient age group	**Apr 2022 – Mar 2023**				**Apr 2023 – Mar 2024**				**Apr 2024 – Mar 2025**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
Age 0 to 15	17.6%	12.8%	302.8%	3.7%	16.4%	13.2%	69.1%	1.6%	Not yet published			
Age 16 or over	12.2%	14.4%	46.8%	2.5%	12.9%	15.1%	99.6%	1.7%	Not yet published			

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce re-admissions, and so the quality of its services:

- ✓ Same Day Emergency Care was rolled out to the Medicine Division during 2023 preventing unnecessary admission / readmissions. Surgical Same Day Emergency Care was expanded in March 2025.
- ✓ Dedicated Acute Frailty Unit has been initiated providing specialist intervention for frail and older people with a focus on rapid assessment and treatment avoiding prolonged stays in hospital wherever possible.
- ✓ SFT will be working with community partners to provide consultant geriatrician oversight to Hospital at Home pathways, to go live Q1 2025/26.
- ✓ Continuation of Power BI data reporting availability and use will enable us to better understand the opportunities to further improve performance in this area.
- ✓ Improved communication with community and partner services and GPs via remodelled discharge services in the community, for people needing care or a bed base (pathways 1-3).
- ✓ Improvement Working group focusing on complex discharge pathways made up of acute, community and social care partners.

Domain 4 – Ensuring People Have a Positive Experience of Care

Responsiveness to the Personal Needs of Patients

National Quality Priorities												
	Apr 22 – Mar 23				Apr 23 – Mar 24				Apr 24 – Mar 25			
	Response Rate	SFT	Highest	Lowest	Response Rate	SFT	Highest	Lowest	Response Rate	SFT	Highest	Lowest
Overall experience score for National Inpatient Survey	51%	8.0	8.5	8.0	51%	8.3	9.3	7.5	Not yet published			

Scoring: For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the Trust is performing.

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Each year the Trust participates in the national adult inpatient survey. The Trust's last published survey was undertaken in November 2023 where a nationally agreed questionnaire was sent to a random sample of 1,250 patients and the results analysed independently by the Patient Survey Co-ordination Centre. 624 surveys were returned, completed.

The national inpatient survey was repeated in November 2024 and is scheduled to complete fieldwork by May 2025. Themes from the national adult inpatient survey, the Friends and Family Test and complaints and concerns are identified by each ward and an improvement plan prepared.

In 2024 the Trust has also taken part in the additional following national surveys:

- The Urgent and Emergency Care Survey.
- The Children and Young Persons survey.
- The Maternity Survey.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve responsiveness to in-patient personal needs, and so the quality of its services:

- **Medication:** New electronic prescribing and medicines administration (EPMA) system implemented Trust-wide: The benefits of EPMA include:
  - ✓ having a full patient medication history, decision support and online resources available to aid prescribing, with allergies and interactions highlighted.
  - ✓ eliminating illegibility issues and the need for transcription.
  - ✓ improving the quality of discharge information.
  - ✓ providing transparency in the prescribing process.

- ✓ making it easier to adhere to safety standards.
- ✓ enabling robust audit information on medicines usage.

- **Discharge process and follow-up:** Committed focus to enhance discharge and follow-up process led by Chief Operating Officer to eliminate inefficiencies and streamline process.

- **Noise and disruption:** A strong focus remains to enhance patient experiences by eliminating noise and disruptions where feasible. Linking with colleagues from across Royal United Hospitals Bath and Great Western Hospitals, Swindon to implement 'Putting the hospital to bed at night' initiative.

- **Communication:**
  - ✓ Promotion and continued development of the Trust's End of Life Communications Course. This course utilises scenarios taken from our patient stories and learning from complaints which are re-enacted by actors to educate staff on the importance of communication in relation to recognising death and deterioration.
  - ✓ Launch of the patient safety initiative "Martha's Rule" empowering patients, families, carers and staff to request an urgent clinical review if they have concerns about a patient's deteriorating condition that they feel is not being adequately addressed.

- **Staffing levels:**
  - ✓ Retention focused activities related to the People Plan, including development of support networks for staff, leadership training and line management support.
  - ✓ Daily staffing reviews continue to ensure safe staffing levels.
  - ✓ Implementation of Flexible work plans and team rostering is encouraged, to enable staff to meet non-work's needs.

- **Catering and facilities improvements:**
  - ✓ Continued increase of housekeeping staff to ensure compliance with new national cleaning standards.
  - ✓ E-menu project to digitise catering orders.
  - ✓ Changes to the parking and ANPR system on the hospital site will mean an increase in the number of patient spaces (including blue badge spaces) and launch of a 24/7 helpdesk support.

To complement the National Inpatient survey, the Trust continues to drive its "Real-Time Feedback" initiative. Real-Time Feedback is a face-to-face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This can be undertaken by staff, volunteers, or Governors.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

- Admission to hospital
- The ward environment
- Doctors and Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Respect and Dignity
- Overall experience

Friends and Family Test – Patient Feedback

National Quality Priorities						
	Apr 22 – Mar 23		Apr 23 – Mar 24		Apr 24 – Mar 25	
	SFT	England Average	SFT	England Average	SFT	England Average
Response rate of patients who completed the Friends and Family test for the ward or Emergency Department						
Emergency Department	0.7%	Not yet published	0.7%	Not yet published	21%	Not yet published
Inpatients	11.7%	Not yet published	21.9%	Not yet published	34%	Not yet published
Score of patients who rated the ward or Emergency Department as Good or Very Good						
Emergency Department	79.5%	Not yet published	91.0%	Not yet published	81.1%	Not yet published
Inpatients	96.5%	Not yet published	97.0%	Not yet published	96.7%	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. In June 2024 the Trust launched its digital SMS Friends and Family Test service and undertook a project to revamp the in-patient card system. These additions have had a significant impact on the Trust's response rates, because of these changes.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the Friends and Family Test – Patient Feedback, and so the quality of its services:

- ✓ Increase overall response rates to the Friends and Family Test (Improving Together Target of >15% of eligible patients in 2024-25).
- ✓ Diversify methods for access (including, online, SMS, over the phone to make this more accessible to difficult to reach areas of the Trust).
- ✓ Improve visibility of feedback mechanisms in both inpatient and outpatient areas.
- ✓ Increased accessibility and options for inclusivity (Easy Read, languages, and additional demographic options).
- ✓ Continue to use data from themes and trends for comparison and benchmarking with other Trusts within our Integrated Care Board.
- ✓ Continue to explore and embed triangulation of feedback of themes with complaints, incidents, compliments, real time feedback and national surveys.

Staff Who Would Recommend the Trust to their Friends or Family

National Quality Priorities											
NHS Staff Survey Results											
Apr 22 – Mar 23				**Apr 23 – Mar 24**				**Apr 24 – Mar 25**			
SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
The percentage of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends											
55.2%	61.8%	86.3%	39.2%	62.8%	63.3%	88.8%	44.3%	64.7%	61.5%	89.6%	39.7%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

At an organisational level, our results show that as a Trust we continue to make significant improvements in many areas. SFT is the most improved Trust for all scores benchmarked against all acute providers and has the highest score for staff looking forward to coming to work.

Our NHS Staff Survey response rate has risen to 59%. This compares to the national median response rate of 48%. It is of note that the spread of responses this year was more evenly balanced between staff groups; this means that the validity of the results is more robust. Our response rate from the Additional Clinical Services staff group that includes Healthcare Assistants (HCAs), Therapy and Maternity Assistants has jumped from 21% to 41%.

All elements of the NHS People Promise have shown statistically significant improvement, and all are now above national average. The broad measure of Staff Engagement has improved and is above the national average.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the percentage of staff who would recommend the Trust to their family or friends, and so the quality of its services:

- ✓ Continuation of “Hearing It” sessions from last year. These sessions are held by the CEO and the Chief People Officer for staff to share what it is like to work here, understand why people stay, what we do well and should keep doing and, importantly, what could be done to make their experiences even better.
- ✓ Divisional information packs will be created to aid staff in planning their response to the survey and action plans to the specific area will be developed to address areas that need improving.

Domain 5 – Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm

Patients Admitted to Hospital who were Risk Assessed for Venous Thromboembolism

A venous thromboembolism is a blood clot which starts in a vein and usually occurs deep inside the body, for instance, in the lower leg.

National Quality Priorities												
Venous Thromboembolism Risk Assessment	Apr 22 – Mar 23				Apr 23 – Mar 24				Apr 24 – Mar 25			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Percentage of patients receiving a Venous Thromboembolism risk assessment	99.8% (internal audit)	Reporting suspended due to COVID-19.			34% (internal audit)	Reporting continues to be suspended.			40%	89%	100%	14%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described, the data is collected from the electronic system Lorenzo and presented in the Power Bi Dashboard. The data is reviewed by a senior nurse before it is then overseen by the Trust's Thrombosis Committee.

Salisbury NHS Foundation Trust continues to hold exemplar status for the prevention and treatment of Venous Thromboembolism (VTE). We continue to monitor the rates of VTE and those attributed to hospital care. All events causing concern are discussed within the divisional learning from incidents events, to ensure feedback and guidance is directed to senior doctors and nurses. The VTE service has seen a total of 882 blood clot events in 2024/25, of which 101 (10.4%) were attributed to hospital care. This compares to a national average of 25%. All blood clot events were reviewed and 93.5% of patients sadly developed their blood clot despite being provided with appropriate treatment (known as thromboprophylaxis).

In 2023, we transitioned from VTE risk assessments being completed on the paper prescription charts, with a monthly data collection, to a digital system. However, the transition to a digital VTE risk assessment system has presented several challenges. The shift from a monthly snapshot audit to a continuous, real-time evaluation has contributed to a decline in the completion percentage figures. This is considered to be an issue with documentation rather than assessments not being completed, and the Trust has observed no associated rise in hospital acquired thromboembolic events as a result of these changes.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for Venous Thromboembolism, and so the quality of its services:

- ✓ Conduct detailed enquiries of patients who developed blood clots in hospital to ensure we learn and improve.
- ✓ Maintain our VTE prophylaxis protocols in line with the most recent NICE guidance on VTE prevention, prophylaxis, and treatment.
- ✓ Increase education on VTE prevention across the Trust introducing VTE champions on all in-patient wards to assist in the cascade of information.

- ✓ VTE prevention written information is available on all wards and should be provided to all patients on discharge.
- ✓ A QR code has been added to the new electronic discharge summary to signpost patients to Thrombosis UK website to allow them to find further information.
- ✓ Patients receive a SMS message following discharge with a link to access directly to obtain further VTE prevention information.
- ✓ Continued review of the compliance of completing VTE risk assessment, ensuring that we work with our colleagues to ensure that the system in place is the most appropriate to ensure that we can provide effective patient care.
- ✓ Working towards the creation of a new EPR system that will provide a digital VTE risk assessment that will work in conjunction with the EMPA to ensure greater usability and therefore compliance.

Rate of Clostridium difficile (C.diff) infection

C.diff is a type of bacteria that commonly causes diarrhoea.

National Quality Priorities												
Rate per 100,000 bed days of C.diff infection	Apr 22 – Mar 23				Apr 23 – Mar 24				Apr 24 – Mar 25			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Rate per 100,000 bed days of C.diff infection amongst patients aged 2 or over	18.1	38.5	149.9	0	18.2	39.7	119.8	0	Not yet published.			

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust**. The data is reported for Hospital Onset C.difficile cases only.**

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce the number of C.diff cases, and so the quality of its services:

- ✓ Reduce the numbers further by reviewing all reportable cases to identify any learning that can be shared within the Hospital. This work will continue over the next 12 months.
- ✓ Continue to identify learning through our internal incident investigation process.
- ✓ Continue to participate in and contribute to regional improvement projects for the reduction and prevention of C.difficile.

The number of C.difficile cases has been increasing nationally during the last 12 – 24 months and this is also the experience at Salisbury NHS Foundation Trust. Although numbers have increased, we continue to perform well against other Bath & North East Somerset, Swindon and Wiltshire (BSW) acute providers and rank 11 out of 134 Trusts reporting data nationally.

Following the changes to admitting criteria published within the UKHSA HCAI Data Capture Site (DCS) Mandatory Reporting Surveillance Protocol for 2024/25, it was acknowledged that this may lead to an increase in the incidence of reportable hospital onset infections for the Trust. A review of previous C.difficile cases for 2023/24 was undertaken to apply the changed definition to establish the potential impact for reporting, with no change identified using the different case classification.

However, an underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes.

Patient Safety Incidents and the Percentage that Resulted in Severe Harm or Death

National Quality Priorities											
	Apr 22 – Mar 23				Apr 23 – Mar 24				Apr 24 – Mar 25			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Number of patient safety incidents	7,124	*Not published.			7,416	*Not published.			8,527	*Not published.		
Rate of patient safety incidents (per 1,000 bed days)	17.83	*Not published.			15.98	*Not published.			17.39	*Not published.		
Number of patient safety incidents that resulted in severe harm or death	32	*Not published.			36	*Not published.			24	*Not published.		
% of patient safety incidents that resulted in severe harm or death	0.45%	*Not published.			0.49%	*Not published.			0.28%	*Not published.		

*LFPSE data is not published and therefore cannot be used for official statistics. The data reported above comes from the Trust's local risk reporting system, Datix.

Trust statement

In December 2023, the Trust went live with the Learning From Patient Safety Events (LFPSE) system which replaced organisations' requirement to report to the previous National Reporting Learning System (NRLS). The aim of LFPSE is to enable all patient safety incidents to be shared outside of the organisation to aid greater oversight, thus enabling the wider NHS system to understand the nature of patient safety incidents and to share learning and improvement NHS England has released data to reflect the number of patient safety incidents uploaded per month in England, however there is no accurate benchmarking data available at this time to compare with. NHS England has issued a statement that LFPSE data is currently being validated and therefore cannot be used for official statistics

Salisbury NHS Foundation Trust (SFT) has good collaborative working across the organisation, which actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken. SFT's reporting culture has remained positive since the transition to LFPSE. This is evidenced through SFT's high volume reporting of no-harm incidents.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce the number of patient safety incidents and the percentage that resulted in severe harm or death, and so the quality of its services:

- ✓ We continue to educate staff on the positive impact of reporting incidents and near misses.
- ✓ All incidents are discussed at the morning Trust-wide patient safety incident huddle so that immediate support can be provided and actions taken to reduce the risk where possible.
- ✓ All incidents are quality checked by the Risk team. All moderate harm and above incidents are initially reviewed at the weekly Trust Patient Safety Summit. For incidents where a greater understanding and learning are required a further review is undertaken and discussed wider at the Patient Safety Oversight Group.
- ✓ Call for Concern was launched at SFT on 20th February 2025. This is SFT's local adoption of the national Martha's Rule. This will allow a patient, family member or staff member to invoke Martha's Rule, by calling the dedicated Call for Concern phone line, (available 24/7), if they feel their concerns about the patient are not being heard and addressed by the attending team. If the Critical Care Outreach Team determines a prompt review is required, they will make an appropriate referral for another clinician to attend and review the patient.
- ✓ It is crucial to learn from every incident and near miss that happens at SFT and ensure the learning is shared widely from these reviews. Over the past year the Divisions have developed monthly Learning from Incident Forums with a quarterly Trust-wide Learning from Incidents Summit led by the Heads of Nursing and supported by the Patient Safety Team. These are multi-disciplinary, with all members of staff encouraged to attend.
- ✓ The Patient Safety Incident Response Framework (PSIRF) continues to evolve in SFT with enhancing our patient safety reviews by developing a systems-based and multi-disciplinary approach.
- ✓ To support this, the Trust is committed to creating foundations that foster a just and restorative culture that is supportive and compassionate.

Part 3 - Other/Provider Content

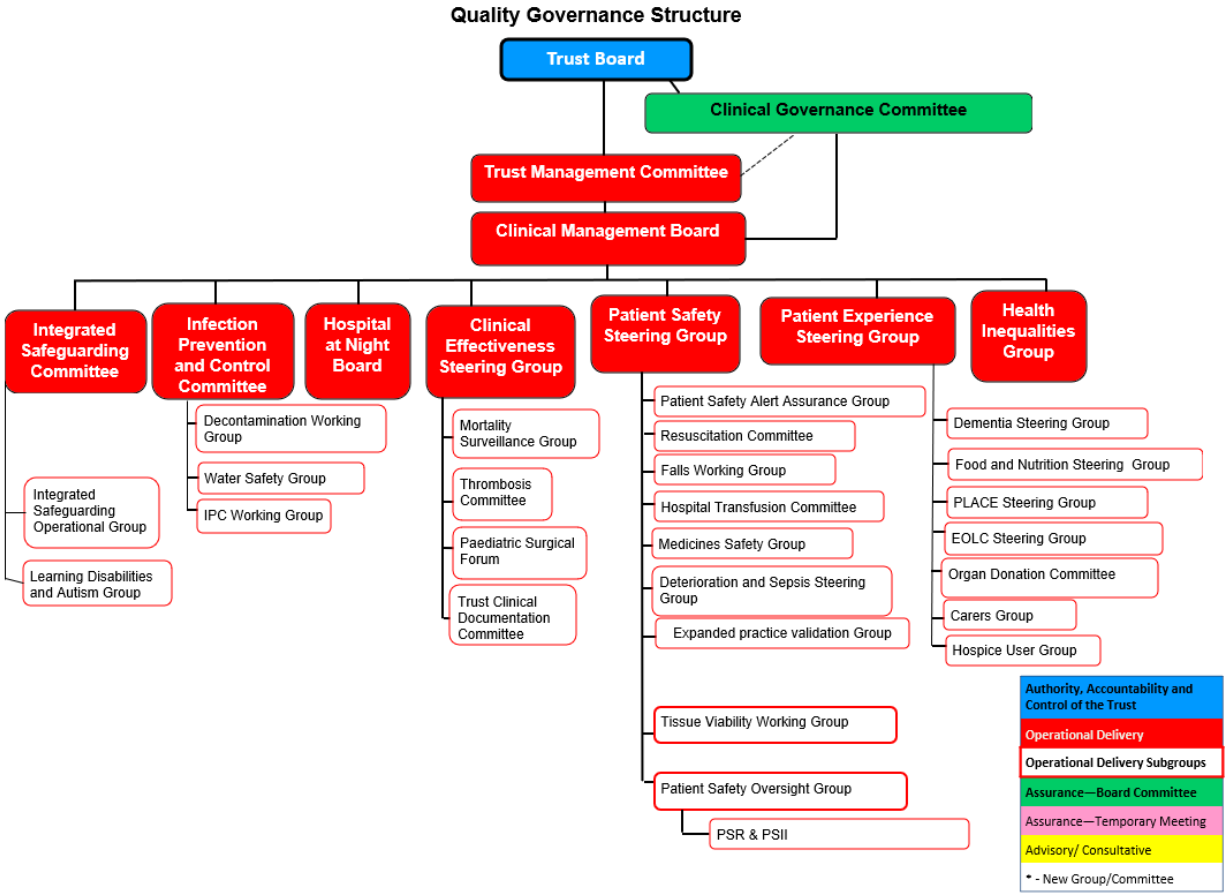
Salisbury NHS Foundation Trust

The quality accounts regulations specify that Part 3 of the quality accounts should be used to present other information relevant to the quality of relevant health services provided or subcontracted by the provider during the reporting period.

Quality Overview

Quality is commonly recognised as having three dimensions: patient safety, clinical effectiveness, and patient experience. At Salisbury NHS Foundation Trust we have three steering groups which each meet monthly, represent each of these arms of quality, and each reports upwards to our Quality Board (CMB). It is here that all aspects of quality are scrutinised and discussed.

In 2024/25, improvement huddles for the Quality department began. Representatives from each team attend the huddle twice a month. As with team huddles, the discussion of improvement projects creates opportunities for shared learning, problem solving and facilitates collaborative working. It also ensures that improvement projects align with the Quality department strategy, which in turn aligns with the Trust's strategy for improvement.



Patient Experience

Overview of Key Priorities 2024/25 (as outlined in part 2A)

Patient Stories

Patient Stories continue to be a highly-valued part of our commitment to ensuring the voices of our service users are heard. So far this year, the stories we have heard included the following themes:

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

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

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

These stories have been through various committees and our Trust Board. Patient stories continue to embed into our learning cultures and have begun trialing in our developing "learning for incidients forums".

Patient engagement

Patient-led service improvement panels

Our patient-led service improvement panel for Spinal Services continues to evolve and develop. They have three active projects, all selected based on the common experience of the group (improving patient information, maximising opportunities for self-rehabilitation and experience of facilities (i.e. noise, toilets). The group has been integral in supporting the instigation of a free trial gait walker for 6 months. The group also provides patient representation for the Regional Oversight Group for Spinal Services.

The Trust also has a well estabished patient-led panel for Cancer Services. The group has been instrumental in developing and improving the cancer information on the Trust's website and improving our Oncology Outpatient area. In addition, they have developed a strong, collaborative relationship with our Cancer Service Leads, resulting in them regularly being asked to support the interviews of patient-facing roles and showcasing the achievements of the group at various forums and committees within the Trust. The group held a community engagement event in March 2025 with the support of the Trust's Coach-House Team. This was the Trust's first opportunity to introduce patients to the Trust's Improving Together methodology. This was a huge success and themes and feedback collated from this is anticpated to inform the future workstreams of this group/service.

Both forums continue to develop their goverance with formal escalation reporting into the Patient Experience Steering Group currently being trialled.

Friends and Family Test

The Trust has invested in the digitilisation and extraction of data insights from our Friends and Family Test (FFT) surveys, to help shape service improvements. Response rates and overall experience ratings are nationally reported currently, but it is recognised the additional value this data provides with its additional ability to theme and analyse feedback received through this mechanism.

Implementation of the new digital solution was launched in June 2024 and since implementation the Trust has been able to consistently exceed its 15% response rate target and has demonstrated additional benefits or more robust analysis of data, aiding triangulation with other patient experience measures.

Real-time feedback

Real-time feedback was re-launched in February 2023 and continues to go from strength to strength. This year, over 330 surveys have been conducted by the patient's bedside. The aim of the feedback is to give a "real-time" view of a patient's perspective of their care.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas; admission to hospital, ward environment, doctors and nurses, care, treatment, operations and procedures, leaving hospital and respect and dignity. It is summarised with an overall experience rating.

This feedback continues to develop and is being used to triangulate themes being seen though complaints and the Friends and Family Test.

Hard of Hearing Project

We continued to develop a pool of service-user engagement volunteers, who work across various workstreams, supporting and advising on projects such as the Trust's Hard of Hearing Project which launched in May 2024.

This project was launched following a patient story and has continued to gain traction with the introduction of hard of hearing support boxes in all inpatient and most outpatient areas. In addition, adoption of an on demand BSL service available in our Emergency Department, Maternity and from PALS and communication cards for patients have also been developed.

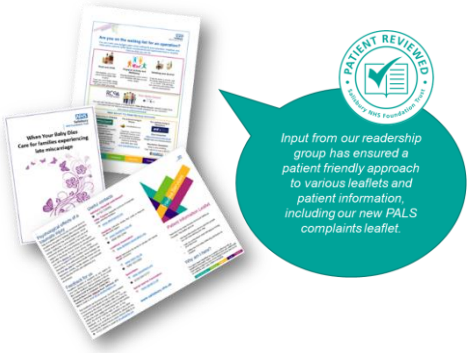
Patient Safety Partners

The patient safety partner (PSP) role is continuing to embed within the Trust, with two PSPs having been in post since January 2024. They are regular attendees at various forums representing the patient voice and patient safety agenda. This includes Patient Safety and Patient Experience Steering Groups and Learning from Incidents Forums. The Trust is currently recruiting two further PSPs with a view to further embedding these roles within each of clinical Divisions.

Readership group

We continue to develop this group and are actively encouraging all new patient literature to be reviewed by the readership group, before coming to the Patient Experience Steering Group for approval.

All literature that has been through this process will be indicated with the new patient reviewed logo.



Working with our communities

Veterans

The Trust is proud to have achieved its Gold accreditation for veteran awareness from the Armed Forces Covenant and now has over 230 registered Armed Forces Champions, and this continues to grow.

In January, the Trust expanded its support for Veterans with the introduction of its new Help for Heroes Nurse-led service.

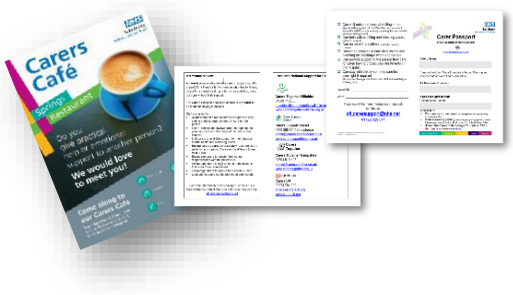
Learning Disabilities & Autism

In support of the development of our Learning Disability and Autism strategy the Trust has begun fostering engagement with those who have used our services and will subsequently be holding our first Learning Disability (LD) focus group in March.

The Trust purchased Widgit Software licences and the patient experience team has undertaken Easy Read training in a bid to produce more Easy Read patient information. These methods were used recently to construct the invitations for the LD focus group.

Carers

The Trust launched a new Carers Passport aimed at better informing staff about the importance of carer involvement and continue to hold our drop-in support and information sessions at our Carers Café on a weekly basis.



This is run by our passionate and experienced volunteers, offering one-to-one support and information for those with unpaid caring responsibilities. On the back of this we are working hard to educate our staff on the important role of carers during their loved one's hospital journey, reaffirming our pledge to John's Campaign and relaunching our "new look" carers passport and new support and information inbox (sft.carersupport@nhs.net).

Listening to our patients in partnership with our hospital charity

Stars Appeal funded – Recliner chairs

High-end recliner/sleeper chairs were identified as a patient and visitor need, these were to provide more comfort for a patient's family/carer during an inpatient stay and would enhance not only their experience but that of the patient by having this support by their bedside, especially for those with cognitive impairments or those at end of life.

The hospital charity has supported the bid for two recliner/sleeper chairs in each inpatient ward. These have been phased in roll-out over the past 12 months, with the project scheduled for completed in March 2025.

Stars Appeal funded - Aromatherapist

In November 2022 the Trust appointed an International Federation of Professional Aromatherapists accredited Aromatherapist, funded by our hospital charity. This service is a branch of herbalism aimed at providing alternative therapies to those undergoing treatment.

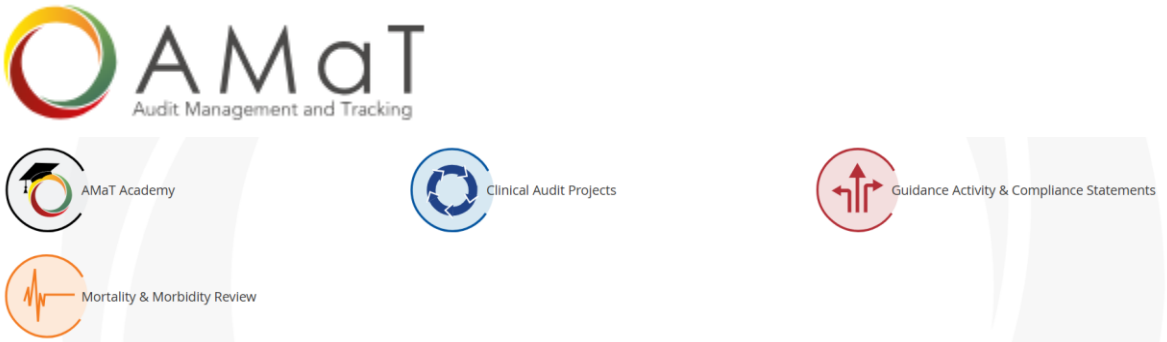
This continues to be a highly-valued service amongst our patients and is currently offered to parents of babies on our Neonatal Intensive Care Unit, and patients undergoing burns and cancer treatments.

Over the last 12 months the service has seen over 800 patients across these three areas of the hospital.

Clinical Effectiveness

Overview

2024/25 has seen the new audit system, AMaT, being used to record and report on audit activity. The new processes saw 17 audit reports, with a risk score of moderate or above, discussed at CESG. Engagement with staff continues with a video shown to new starters during induction, which signposts them to further information on the Trust intranet. Improving Together is the vehicle for improvement for the team, who attend weekly huddles to discuss performance and improvement ideas. Networking has increased with teams from Bath and Swindon, along with other Trusts from the South West and nationally.



456 staff are using AMaT to record audit activity and access reporting features, including dashboards.

Other areas of improvement:

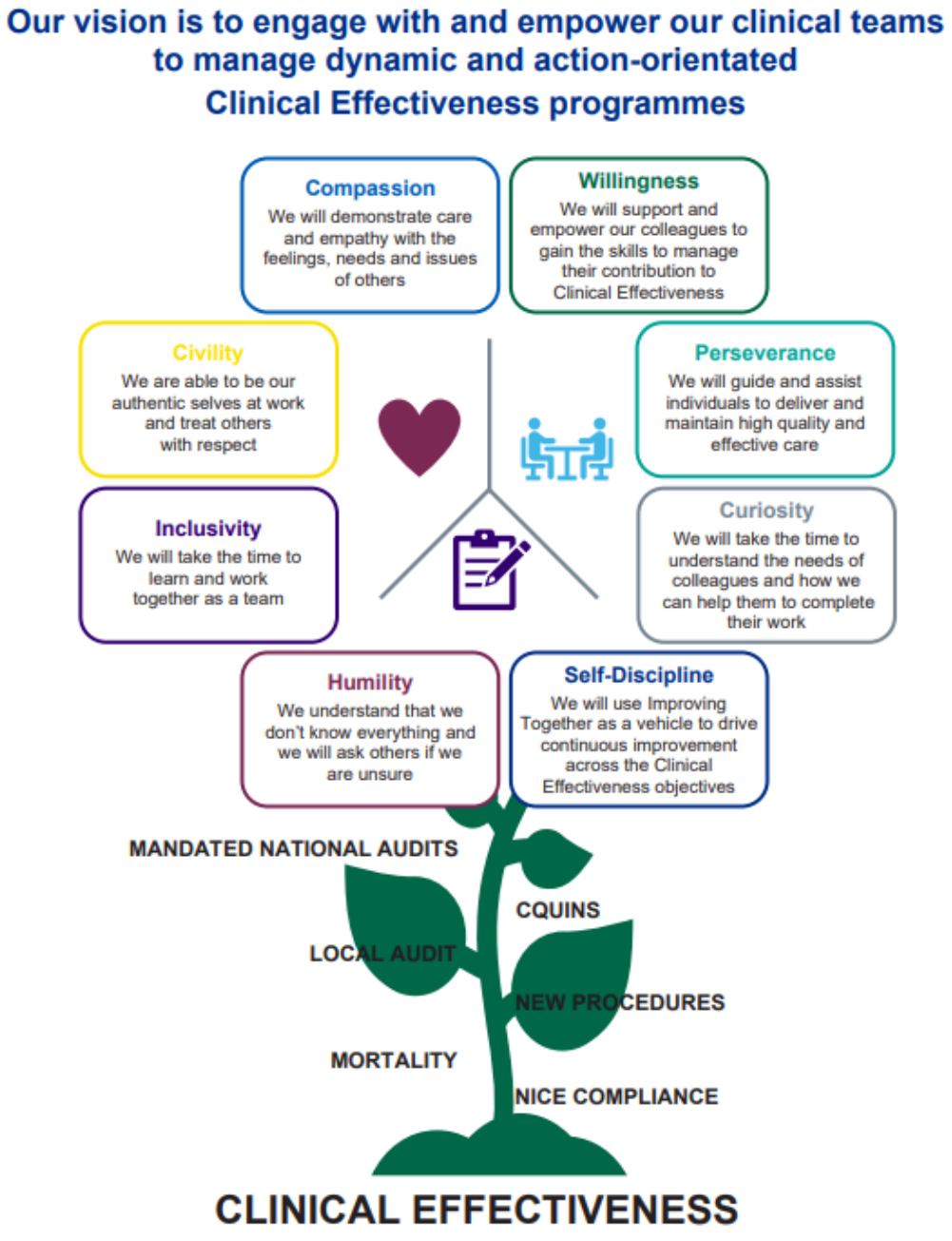
- The Clinical Audit and Effectiveness team has been providing support to clinical specialities through **attendance at department / divisional governance meetings** and has been identifying new forums and opportunities for engagement. New staff are signposted to clinical audit information during their Trust induction.
- 17 audit reports, with a **risk score** of moderate or above, were discussed at CESG. This change in processes occurred in 2023/24 to ensure that actions and audit outcomes are linked to patient safety concerns, and that these risks are discussed at Trust governance meetings. This supports our drive to have more focused discussions centred around making improvements for the delivery of patient care and clinical pathways, rather than discussing numbers. It also facilitates shared learning and support for improvement across the Divisions.
- The Clinical Audit and Effectiveness team has continued to use **Improving Together** as their method for prioritising improvement. Weekly huddles help the team focus on priorities, agree improvements, and celebrate successes. Driver metrics prioritised reducing the number of **National Institute for Health and Care Excellence guidance (NICE),** and **mandated national audits**, which had passed their target date for completion. Performance is recorded each month to highlight areas for improvement.
- Networking has increased with teams from **Bath** and **Swindon**, along with other Trusts from the South West and nationally.

Please refer to **Section 2B** and **Appendix B** of this report to see an overview of the audit activity which has taken place across the Trust during the last financial year.

Clinical Effectiveness Behaviour Charter

This charter allows the Clinical Effectiveness team to share the behaviours that are important to them, with the colleagues they encounter. Agreeing a behaviour charter promotes a working environment where every member of the team feels valued, supported, and included. It also supports the team's shared objectives which align with the Trust's values.

The behaviours framework can also help individual members of the team to thrive in their role. It can be useful if improvement is required, and also at times of challenge. Individual team members can use the charter to be reminded of what we value and be encouraged to be the best version of themselves.



Learning from Deaths

Most deaths that occur at Salisbury NHS Foundation Trust are reviewed (scrutinised) by a Medical Examiner shortly after death. There are few exceptions to this. An internal review (for instance a structured judgement review (SJR)) may be recommended should there be potential learning identified following the death of a patient. This could be identified through a review of the medical records, or following consultation with the clinical team or relatives/carers of the bereaved.

In addition to the SJRs, clinical teams are encouraged to complete any other mortality reviews using the new online platform. These abbreviated reviews use some of the same fields as the SJRs, including those related to learning points and capture any actions arising from them. This allows areas of good practice and areas for improvement to be documented and shared in a consistent way. Further reviews may be commissioned in response to alerts generated by national benchmarking systems to which the Trust subscribes or receives as a statutory requirement.

The total number of deaths and the total number of Structured Judgement Reviews completed during each quarter of 2024/25 are shown in the table below.

The number of Structured Judgement Reviews undertaken relating to deaths during 2024/25 was 382, and this represents approximately 42% of all deaths. This is in addition to almost 100% of inpatient deaths being scrutinised by the Medical Examiner prior to a Structured Judgement Review being requested.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
Inpatient Deaths (inclusive of Emergency Department and Hospice)	215	204	237	245	901
1st Scrutinised by the Medical Examiner	210	200	232	243	885
Structured Judgement Reviews undertaken related to deaths during 2024/2025 *	110	89	104	79	382
Structured Judgement Reviews undertaken related to deaths during 2023/24 *	59	37	36	51	183
Patient deaths judged more likely than not to have been due to problems in the care provided to the patient (Hogan Score)	<5	<5	<5	<5	<5

**The figures in the table are inclusive of those reviews undertaken using the Trust's abbreviated checklist and which are completed within the new mortality review platform alongside the SJRs.*

The Trust's Mortality Surveillance Group continues to meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health U.K. (Dr Foster) is invited to attend to help us interpret and analyse our mortality data and identify any variations in specific disease groups. Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Other Learning from Deaths Developments

- Following the launch of our new internal electronic mortality system in March 2024, we have improved our processes for identifying positive learning, including areas of good practice and opportunities for improvement. The system is enabling us to better coordinate learning across clinical specialties and is helping to standardise how learning is captured.

- The Trust was previously a statistical outlier for some of the data used to benchmark our performance nationally. Following a mortality insight review requested by the Trust, a number of actions were instigated and completed, and the Trust is no longer an outlier. The latest SHMI (summary hospital-level mortality indicator) published in this report is 0.94, compared against the national average of 1.0. This is below the mean and statistically sits within the expected range.

.

- Close to 100% of our inpatient deaths are now subject to a mortality review, which are initially undertaken by Medical Examiners employed by the Trust. Where indicated, additional reviews are completed by appropriate specialists and their teams (often known as structured judgement reviews), and the number of these reviews being undertaken during 2024/25 has increased and remains consistently high.

- Following the launch of the Patient Safety Incident Response Framework (PSIRF) – See link (NHS England » Patient Safety Incident Response Framework) there has been a review of the Trust's mortality processes to ensure that these are closely aligned to patient safety systems. The Trust has a positive culture of sharing learning from deaths

Health Inequalities

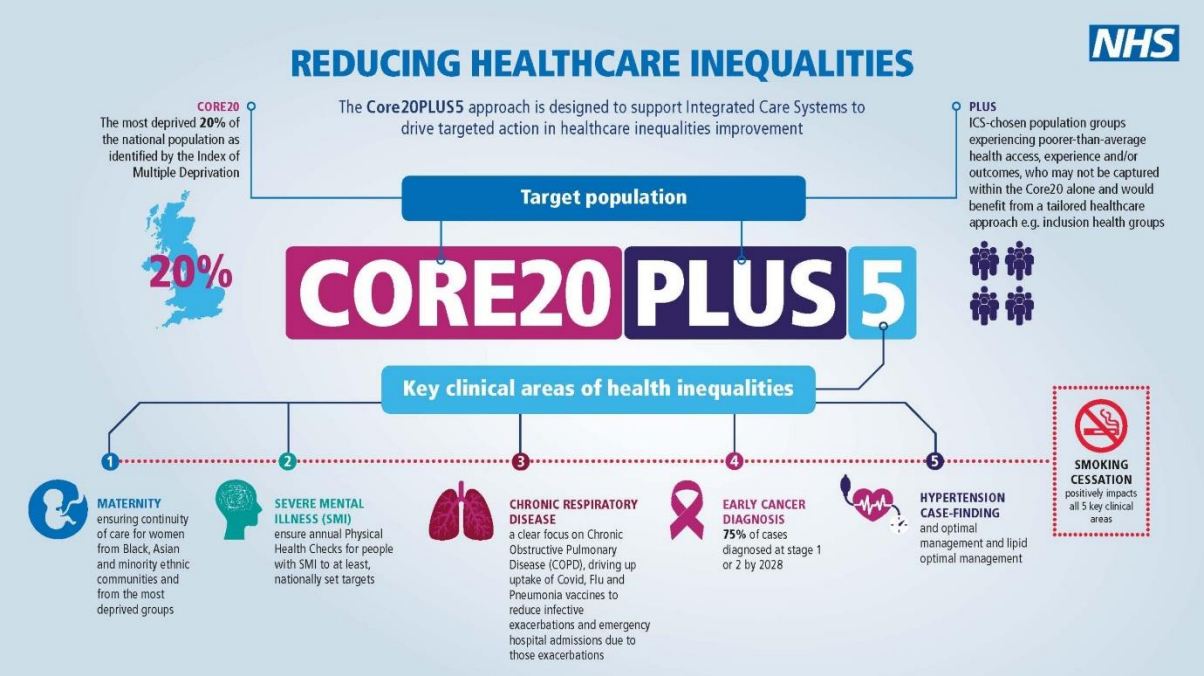
Health inequalities are unfair, avoidable, and systemic differences in health outcomes for different groups of people.

The **CORE20PLUS5** approach guides our work on health inequalities. The 'Core' references the 20% most deprived communities in England. In Wiltshire we have eight geographical areas in the poorest 20% nationally, and three of these are in Salisbury.

The '**PLUS**' represents defined groups that experience disparities in health outcomes within our local geography. In the case of BSW this is the Gypsy, Roma, Traveller, and Boater communities, as well as routine and manual workers. Military populations are considered here too. For children there is a focus on mental health, and the children of Gypsy, Roma, Traveller, and Boater families.

The '**5**' represents the key clinical areas of focus – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. Smoking cessation is a theme through all five.

Core20PLUS5 (adults)



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

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

This year, a further £863,195 was allocated to Wiltshire to help fund projects that will reduce health inequalities. A series of workshops were held with key stakeholders across Wiltshire to determine how funds should be spent to address health inequalities in 2025. The specific priorities agreed are outlined below and funded projects will be required to focus on these specific areas.

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

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

- A new operations group was established in 2024/25 with specific focus on health inequalities. Our policies were reviewed, and as a result of some process changes, we have seen a significant reduction in the average wait time to first outpatient appointment for people with LD and autism. Further work is underway to establish where there may be further opportunities for improvement.

- New staff have continued to be recruited to roles that will help support our work in reducing health inequalities. Two Equality, Diversity and Inclusion Cancer Leads were recruited to work with communities to improve early diagnosis and awareness of presenting signs and symptoms of cancer, and secondly to improve staff education around cultural awareness and reasonable adjustments. There will be a focus on manual workers and the boating community.

- SFT staff have been attending a local Farmers Market and providing education around skin cancer awareness.

- The smokefree group are working in close collaboration with Wiltshire Council to provide written resources to our hospital inpatients. There is a visible TTD (treating tobacco dependency) service with good input from Pharmacy ward-based teams and Pre-operative Assessment teams, with an average of 120 referrals/month.

- We have continued a virtual diagnostic partnership with a company to support Children and Young People (CYP) with asthma and have established *Asthma Friendly Schools* in collaboration with Wiltshire, BANES and Swindon local authorities. We are making every contact count within clinic consultations (using Smokerlyzer CO monitors on smoking/vaping parents and giving brief advice about cessation).

Getting It Right First Time

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients. The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Over the past year they have moved towards more systems reviews within BSW, the South West region or the Wessex region

GIRFT launched the further faster forward programme in November 2023 to look at outpatient transformation to reduce variation between hospitals. There are seventeen areas which are relevant within this hospital with departments analysing how improvement can be made. Regular meetings within the South West region have taken placed during this year to reduce variation in outpatient departments including booking, referral pathways and discharge.

In the year 2024/25, GIRFT system visits occurred in Diabetes, Gynaecology, Anaesthesia, Endocrinology, Pancreatic Cancer, Surgery and Paediatric Rheumatology.

Summary of Getting It Right First Time Activity:

Anaesthesia perioperative pathways	**Good practice included:** • Booking and scheduling • Preoperative assessment • Day-case one-stop-service hand/ wrist elective colorectal pathway **Areas to work on included:** • Understaffing in booking and scheduling • Therapy and social care challenges • Escalation into day-case beds due to high number of patients awaiting social care
Diabetes	**Actions:** • How to move to a 7-day service • How to develop Diabetes' perioperative service • Transition to closed loop pumps for Type 1 patients • Issues with coding as higher than average length of stay for Diabetes ketoacidosis
Gynaecology	**This visit highlighted several areas of potential improvement:** • Capacity vs demand • Long-waiting patients – elective recovery • Resilience for cross cover across specialist areas • Job planning model for electronic triage and Advice & Guidance • Increase in obstetric demand impacting job plans

High Volume Low Complexity (HVLC) Programme

GIRFT launched this programme to support elective recovery from COVID-19, with the aim to reduce the backlog of patients waiting for planned operations by increasing productivity.

The national team outlined key metrics at the first visit in March 2023 and the most recent visit, which this data relates to, was in December 2024.

Focus themes such as day-case activity rates have improved across the system to average 86.7% (from 75%), with SFT at 86% against a benchmark 85%. Theatre utilisation for the system was 79.1% at the time of the visit, with SFT at 74.5%. However, improvement has been seen since, driven through a weekly Theatre Productivity Group, and SFT now averages 80%.

A Gap Analysis pack of HVLC operating performance against benchmarks has been finalised to inform potential of dedicated operating lists considering consultant, location and constraints. This has been shared with specialties to drive best practice and improve overall performance aligned with national targets.

Notable SFT performance in the last year against the defined key metrics included achieving national targets for: General Surgery day-case rate for Cholecystectomy (3 days) and Length of Stay (LoS) less than 2 days for Appendicectomy (48.2%), Urology day-case rate for Trans Urethral Resection of Bladder Tumour (46.7%) and ENT day-case rate for child Tonsillectomy (70.4%). Improvements were also seen against the following metrics: Orthopaedics Fractured Neck of Femur (FNOF) LoS at 16 days (from 19), Urology day-case rate for Ureteroscopy at 55% (from 54%) and ENT day-case rate for adult Tonsillectomy at 82% (from 80%). And Orthopaedics sustained their performance against LoS for Hip and Knee replacements at 4 and 2.8 days respectively.

System Review Table:

BSW ICB
HVLC Speciality specific metrics summary

Specialty	Metric	GIRFT Benchmark	ICB performance	vs previous period
Daycase	BADS day case (DC) performance	85%	86.7%	↑
Theatres	Capped theatre Utilisation	85%	79.1%	↓
T&O	Total Hip LoS	2.7 days	2.6 days	=
T&O	Total Knee LoS	2.7 days	2.4 days	↓
T&O	FNOF Arthroplasty LoS	14 days	14.7 days	↓
ENT	DC rates adult Tonsillectomy	90%	87.3%	↑
Urology	DC rates TURBT	44%	51.7%	↑
Urology	DC rates Ureteroscopy	75.1%	73.9%	↓
General Surgery	DC rates for elective Cholecystectomy	71.4%	65.2%	↑
Gynaecology	% LoS less than 2 days for vaginal Hysterectomy	70.4%	71.7%	↑
Gynaecology	Minimal access rate for patients (less than 50 years) receiving Hysterectomy	77.7%	56.6%	↓

GIRFT
GETTING IT RIGHT FIRST TIME

Patient Safety

Call For Concern (A Martha's Rule initiative)

Martha's Rule aims to ensure a consistent and effective approach to managing concerns, promoting patient safety, improving communication between patients, families and healthcare professionals, and building trust between the NHS and the patients it serves.

In early 2025, the Trust launched Call for Concern – a part of Martha's Rule, this patient safety initiative empowers patients, families, carers and staff to request an urgent clinical review if they have concerns about a patient's deteriorating condition that they feel this is not being adequately addressed. This initiative was introduced in response to tragic cases like that of Martha Mills, a 13-year-old who died from sepsis after her family's concerns were not addressed promptly.

There are 3 components to this initiative:

1. All staff in NHS Trusts must have 24/7 access to a rapid review from a critical care outreach team, which staff can then contact should they have concerns about a patient.
2. All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via the contact number, advertised around the Trust and more widely, if they are worried about the patient's condition.
3. The NHS must implement a structured wellbeing question to obtain information relating to a patient's condition directly from patients and their families or carers at least daily.

Actions the Trust has taken to implement this project:

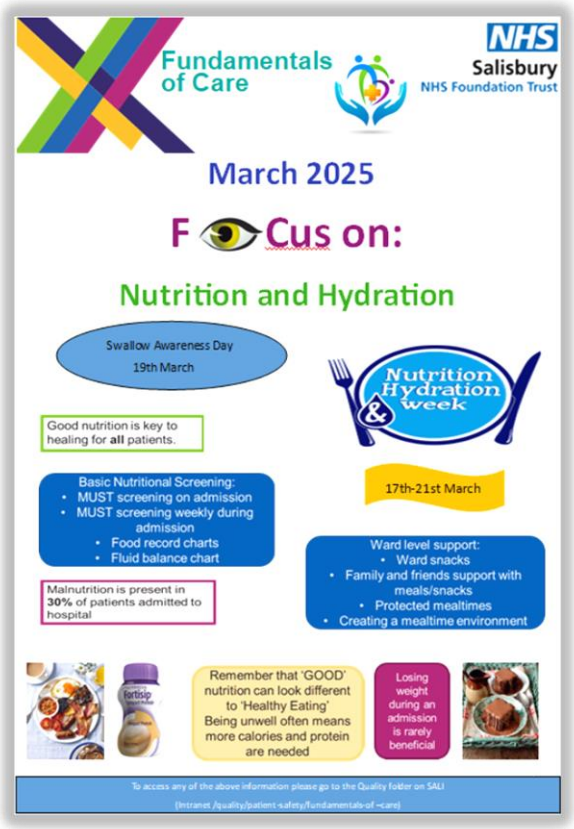
- ✓ A Standard Operating Procedure has been approved and ratified at CMB.
- ✓ Information leaflets have been produced and distributed.
- ✓ A communications plan has been rolled out, including the Trust's staff bulletin email and electronic screens.
- ✓ Trolley dashes to inform staff about this project have taken place.
- ✓ Patient Wellness Questions (component 3) have been developed and built into the POET system.
- ✓ A pilot of component 3 was launched in 5 areas in March 2025, with wider rollout planned across the Trust in April 2025.

SFT is the only Trust in the Wessex Health Innovation region to have fully electronic reporting and recording.

Fundamentals of Care

The Fundamentals of Care focus programme was rolled out across the Trust in September 2024, to run over 8 months. Each month focused on a different area of essential care that every patient requires to optimise their physical and psychosocial wellbeing. The aim was to encourage continual focus and engagement from all staff, celebrate and share good practice, as well as optimising patient care, and empower patients by information sharing. Areas covered included mouth care, nutrition and hydration, pain management and communication.

The topic for the month was led by subject matter experts and supported by the Patient Safety Team. A monthly information poster was given to each ward, alongside a library literature review with interesting, related articles and books. Dissemination of information was by a variety of methods including trolley dashes, ward teaching opportunities, demonstrations and small group discussions, alongside signposting to additional resources.



A pre and post monthly audit was undertaken to assess compliance with a set group of questions, giving the ability to indicate whether knowledge sharing had improved patient care within the ward setting at the end of each month.

It is planned to have a 'celebration stand' during International Nurses Day in May 2025 where resources will be shared as well as the results of the audits. It is hoped that there can be some sharing of good practice that wards may be able to adopt from each other.

Ongoing work includes analysis of the audit data to inform next steps, and a particular focus already underway employing Improving Together methodology is the 'What Matters to You' form. This is an information gathering template ideally at every patient's bedside to inform the care team on what is important to each individual patient, such as their preferred name, communication needs, support required and important people in their life.

Safeguarding Adults (Mental Capacity Act and Deprivation of Liberty Safeguards, Domestic Abuse and Learning Disabilities)

Safeguarding Adults is about **protecting a person's right to live in safety, free from abuse and neglect**. According to the Care Act 2014 the aims of safeguarding adults are:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives "Making Safeguarding Personal".
- To promote an outcomes approach to safeguarding that works for people resulting in the best experience possible.
- To raise public awareness so that professionals, other staff, and communities as a whole play their part in preventing, identifying, and responding to abuse and neglect.

Mental Capacity Act and Deprivation of Liberty Safeguards, Domestic Abuse and Learning Disabilities also sit under the umbrella of Adult Safeguarding.

What have we done to improve adult safeguarding in 2024/25?

- ✓ We have continued to provide Adult Safeguarding, Mental Capacity Act & Deprivation of Liberty Safeguards and Domestic Abuse training, advice, and support across the Trust.
- ✓ The number of s42 Safeguarding referrals completed by SFT has increased by 15%.
- ✓ The number of Urgent DoLS authorisations completed SFT has increased by 27%.
- ✓ Continued developing the Ward and Department Safeguarding and Learning Disability Champions, providing bi-monthly workshops.
- ✓ We continue to provide bespoke training to individual wards, departments, and teams.
- ✓ We continue to attend the Wiltshire Multi-Agency Risk Assessment Case Conference (Domestic Abuse) weekly.
- ✓ We continue to train staff with the Learning Disability Oliver McGowan training. SFT has trained the largest number of staff in the Acute Alliance.
- ✓ We submitted to the 2023/24 NHSE Learning Disability Standards for Acute Trusts in 2024.
- ✓ The Adult Safeguarding Team was nominated in the Trust's Staff Awards 2024.
- ✓ We continue to introduce Adult Safeguarding Supervision across the Trust and provide monthly group Adult Supervision sessions.
- ✓ We continue to support the Divisions in investigating and learning from any Safeguarding concerns within the Trust.
- ✓ We continue to support the Multi Agency aspect of Safeguarding across our 3 local authorities.
- ✓ The Team presented 'Safeguarding Stars' to 22 staff across the organisation who had demonstrated excellent Safeguarding practice.
- ✓ The Team successfully recruited into the Administrator post.
- ✓ A Health Independent Domestic Violence Advocate (IDVA) post has been funded for 12 months by FearFree and commenced in July 2024. They will support both patient and staff victims of Domestic Abuse. At the point of writing, it is unclear if this funding will continue beyond July 2025.
- ✓ The Team has completed audits on the Mental Health Act Administration and Restrictive practice.
- ✓ The Team has been involved in the Safeguarding, Mental Capacity, Cognition & Restrictive Practice EPR workstreams.

Safeguarding Children

Salisbury NHS Foundation Trust is committed to safeguarding children and promoting the welfare of children and young people. In accordance with the Children's Act 2004 all individuals who work in health organisations must be trained and competent to recognise when a child or young person may need safeguards put in place and know what to do in response to their concerns. Section 11 of the Children's Act places a statutory duty on NHS organisations including NHS England, Integrated Care Boards and NHS Foundation Trusts to ensure that their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of the child.

Safeguarding children and promoting welfare of children is defined in 'Working Together to Safeguard Children and Young People' (HM Government 2023) as:

- Children's Welfare is paramount.
- Providing help and support to meet the needs of children as soon as problems emerge.
- Protecting children from maltreatment, whether that is within or outside of the home, including online.
- Preventing impairment of children's mental and physical heath or development.
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care.

What have we done to improve safeguarding children in 2024/25?

- ✓ Two Safeguarding Children Audits were completed in 2024/25: A Multi-Agency Safeguarding Hub Referral audit and a Staff Knowledge Awareness audit. All audits were disseminated, and action plans were implemented where improvements were identified.
- ✓ Level 3 Safeguarding Children training has continued to be face-to-face and there were 11 sessions facilitated in 2024/25. The training was updated to include more information on Children Looked After and 'Closed Culture / Settings' which is where an organisation has a responsibility to respond to organisational abuse.
- ✓ A Safeguarding Learning Event was facilitated for staff at the Trust. There were guest speakers from National Referral Mechanism Panel, BSW Integrated Care Board, Integrated Front Door and other agencies.
- ✓ In the Maternity CQC inspection September 2024 Maternity Safeguarding was given a rating of good and it stated that staff understood 'how to describe how to protect women from abuse', and a protocol is in place to enable practitioners to work together with families, health agencies and children's social care to safeguard unborn babies.
- ✓ The Named Nurse received training and became a member of the National Referral Mechanism Panel (NRM) for children and young people (CYP). The NRM panel is the process for identifying CYP who may be the victims of modern slavery and human trafficking.

Our Workforce

People Promise

The NHS People Promise is our promise to each other to work together to improve the experience of working in the NHS for everyone (NHS England » Our People Promise). In 2022 Salisbury NHS Foundation Trust became a People Promise Exemplar site, sponsored by NHSE. We incorporated the seven elements of the People Promise into our Salisbury NHS Foundation Trust Long Term People Plan and we continue to implement that plan year on year, setting new ambitions and projects to support our staff. Staff satisfaction has significantly improved, taking us from below average in all but one area of the People Promise in 2022 to average or above average in 3 areas by 2023 and to above average in all areas by the 2024 NHS Staff Survey. The projects we undertake are driven by the data which tells us what our colleagues would like to improve. There is at least one project under each of the People Promise areas. One of our main focuses for 2025 will be to improve the quality of and access to appraisals including improved professional and personal development plans to support us as a Learning Organisation.

Staff Availability

Our breakthrough objective has been to improve our retention of staff, specifically our Additional Clinical Services. We have seen a 2% improvement and will continue this focused work until we reach our Trust target of 15%.

- ✓ **We are compassionate and inclusive:** We will continue to implement an improved set of recruitment practices to fill our vacancies appropriately and efficiently.
- ✓ **We each have a voice that counts:** Civility saves lives. We will launch a civility and respect compact as it will help to improve our everyday interactions and the care delivered to our patients.
- ✓ **We are safe and healthy:** We will continue to actively manage absences, paying positive, proactive attention to our staff wellbeing. We will aim to maintain the reduced vacancy rates. We will work towards achieving accreditation for our Occupational Health Service.
- ✓ **We are always learning:** We will increase our apprenticeship offer and trial new roles to encourage staff to grow their careers at the Trust.
- ✓ **We work flexibly:** We will support departments to use team-based rostering to give individuals greater control over when they work. We will encourage the uptake of the homeworking support fund.
- ✓ **We are a team:** We will provide people management skills training for ward leaders to give them the skills and information they need to deal with absence, sickness, and other issues appropriately and in a timely way.

Staff Engagement

Our vision metric includes the aspiration to increase staff engagement to the upper quartile for NHS acute providers in the NHS Staff Survey by 2027. We aspire for people to recommend Salisbury NHS Foundation Trust both as a place to work and somewhere to receive care. To support this the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** We will continue to roll out our Leadership Behaviours Framework and to expand our leadership and coaching training offers. We will continue to develop policies and practices to support the implementation of a Restorative Just and Learning Culture.
- ✓ **We are recognised and rewarded:** We will develop a recognition framework that celebrates the successes of our people through the Trust's annual Staff Awards, Sharing Outstanding Excellence Awards and recognition events. We will further develop all areas of our Employee Value Proposition to continually improve the offer.

  We each have a voice that counts: We introduced a Staff Council in 2024, explore promotion of professional networks, and continue our feedback and listening events. We will continue to improve our processes and practices that foster speaking up and enabling psychological safety for our people.
- ✓ **We are safe and healthy:** We will continue to offer tailored wellbeing interventions. We will continue to improve our health and wellbeing data collection to ensure our offer meets our people's needs. By more effective triangulation of our data, we will be able to ensure support is being directed effectively to those that need it.
- ✓ **We are always learning:** We will continue to improve our appraisal compliance and the quality of the appraisals completed. We will signpost people better to resources, information, and training to support them at all stages of their careers.
- ✓ **We work flexibly:** We will continue to roll out our communications plan to encourage an equitable and open approach to flexible working in all areas of the Trust. We will begin to develop and gather some evidence to better describe the cost benefits and impact of flexible working on staff engagement and motivation.
- ✓ **We are a team:** We will review our induction processes including for international medical graduates. We will run our new My first 90 days programme and evaluate the effectiveness of it so that we can continue to improve the first 90-day experience of staff joining the Trust.

Staff Turnover

Our vision metric also includes our aspiration to increase retention encouraging people to stay and develop their careers within our workforce. By April 2027 we aspire to regularly maintain turnover in line with the Trust target of 10% and an increasing stability index. To support this the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** We aim to improve the feeling of belonging for our people, including offering cultural awareness workshops and by creating an advocates programme and other programmes that support people to thrive at work.
- ✓ **We are recognised and rewarded:** We will continue to deliver our retire and return offer, keeping our people in the Trust for longer. We will engage with the BSW legacy mentor offer to ensure that expertise is not lost and that our new people benefit from the experience of others.
- ✓ **We each have a voice that counts:** We will continue to further develop our Freedom to Speak Up offer to continually improve experiences and outcomes for our people. We will work together to ensure that those who have spoken up do not suffer detriment.
- ✓ **We are safe and healthy:** We will improve our exit interview and data collection on leavers so that we can begin to address any common themes. We will continue to revamp our staff rooms so that our people have improved environments in which to rest and relax. We will continue so support the psychological wellbeing of our people.
- ✓ **We are always learning:** We will develop a talent management approach that enables a more proactive approach to developing people's careers at the Trust.
- ✓ **We work flexibly:** We will continue to train managers to embrace and fully understand flexible working. We will support teams to develop positive approaches to flexible working that support all members.
- ✓ **We are a team:** We will collaborate with our teams to develop conflict resolution skills and to access manager training that gives them the skills to better manage their teams so that people are more likely to stay.

An inclusive employer

Our final metric in our people vision is to create an environment where our people recognise and experience the Trust as an inclusive employer. We aspire for a more positive trend against all of the seven Workforce Disability Equality Standards and four Workforce Race Equality Standards indicators in the staff survey. By April 2027 we aspire to achieve the median for our benchmark group across the workforce standards at Salisbury NHS Foundation Trust. To support this the following People Promise interventions are planned.

- ✓ **We are compassionate and inclusive:** As well as improving our own in-house Equality, Diversity and Inclusion offers we will be working towards the six high-impact actions related to recruitment and promotion. This will help us to recruit a range of different people to join the Trust and to ensure there are equitable career opportunities for all. We have adopted the South West leading for inclusion strategy which includes a commitment for all leaders to demonstrate a personal objective in support of equality.
- ✓ **We each have a voice that counts:** We will continue to expand our networks and to encourage a range of meetings and events to support our people.
- ✓ **We are safe and healthy:** We will continue to develop our wellbeing offer for Black, Asian and Minority Ethnic colleagues, to ensure that we are more closely meeting the wellbeing needs of that group.
- ✓ **We are always learning:** We will continue to roll out our Equality, Diversity and Inclusion training across the Trust, making cultural awareness training available to all new starters.
- ✓ **We are a team:** We will deliver cascade briefings that help all of our people to feel informed. We will continue our listening events to ensure our people continue to feel listened to and see the actions taken.

Highlights from our Clinical Divisions

Medicine Division

Key achievements for 2024/25

- **Catalysis leadership training** the first cohort has completed their training with a second cohort planned.
- **Divisional structure investment** supporting operational functions and performance across the Division. The Operations team won a national award for its work.
- **Established Governance Structure** with regular well represented forums. External KPMG audit completed with reliable results achieved.
- **NHS Staff Survey:** The Division has improved upon the results from previous year.
- **Awards**: The Acute Frailty Unit and Acute Medicine Unit were regional finalists in the Health Service Journal awards for improving care in older people and urgent and emergency care on SDEC.
- **Staff Awards 2024:**
  Chair's Award - Imber Project Team.
  Continuous Improvement, Education and Research Award - Cardiology Team.
  Contribution from an Overseas Colleague Award - Staff Nurse, Tisbury Ward.

Improvements made in 2024/25

- **Established Breamore ward as the no criteria to reside unit.** This is a national term used for patients who are medically fit for discharge from hospital. The focus of Breamore unit is to enable these patients to leave hospital, with support if needed.
- **Stour Unit,** our Rheumatology and Nunton Infusion Units have merged to provide a single new patient infusion unit. The purpose-built space has 15 chairs and a new treatment room to provide better care for the patient.

Objectives and plans for 2025/26

- **Management of deteriorating patients,** to continue improvement in the treatment and escalation of deteriorating patients.
- **Time to first outpatient appointment,** to continue to improve on reducing the time that a patient waits for their first outpatient appointment from their referral.
- **4 hour waiting times in ED**, to improve the Trust's performance on waiting times.
- **Retention of our Healthcare Assistant colleagues,** to continue to work on actions to develop and retain our Healthcare Assistants.
- **Reduce further reliance on temporary staffing / RMN** (Registered Mental Health Nurse) and additional duties to support Divisional financial recovery.

Surgery Division

Key achievements for 2024/25

- **Surgical SDEC,** launched March 2025. This new unit is a pilot for an initial three-month period while the effectiveness and realisation of benefits are reviewed. This change has been undertaken to minimise and remove delays in the surgical emergency patient pathway. There is also improved patient flow from the Emergency Department (ED), as the new unit creates additional Surgical SDEC space.
- **Embedded an operational structure:** The Operations team won the Proud2bOps award with colleagues in the Medicine Division.
- **Improved NHS Staff Survey response rate:** The responses from the survey will support the Division in its plans for improving staff development and retention.
- **Doctor Will Garrett awarded the Evelyn Baker Medal by the Association of Anaesthetists:** This medal is awarded to anaesthetists who exhibit exceptional competence across all aspects of anaesthetic practice, including clinical excellence, teaching and training, and colleague support. It honours the 'unsung heroes' within anaesthetic departments.
- **Mr Harshad Dabke awarded a 2024 International Award of Excellence & British Healthcare award for outstanding contributions in Spinal Surgery (Best Spine Surgeon), setting new standards in healthcare excellence:** This is a leading award for healthcare excellence, celebrating diverse achievements across the medical field.

Improvements made in 2024/25

- **Sustained reduction in Nursing Agency spend,** helping with the Division's financial position.
- **Learning from Incidents forum,** has commenced and established Governance processes.
- **Thames Valley & Wessex Operational Delivery Network,** positive feedback received regarding excellent Multi-Disciplinary Team working.
- **Theatre Productivity Group,** supporting improvements in Theatres utilisation.
- **Review and development of the Preoperative Assessment service.**
- **Time to First Outpatient Appointment Improvements,** in our top contributing specialties.
- **Gastroenterology service,** positive progress has been made in supporting the Gastro service on recruitment of staff, development of pathways and structure.
- **Call for Concern,** our ICU team has been heavily involved with supporting this initiative.

Objectives and plans for 2025/26

- **Time to First Outpatient performance,** to continue to focus on reducing Time to First Outpatient Appointment performance.
- **Financial Position and Delivery of Cost Improvement Programme (CIP),** work with all teams to support and improve the current financial position and delivery of the Division's CIP**.**
- **Continued focus on Non-Medical Appraisals.**
- **Staff Retention,** to continue to focus on how the Division can support and improve staff retention.
- **Complaints and Concerns,** improve the process to robustly respond to complaints and concerns.

Women & Newborn Division

Key Achievements for 2024/25

- **Compliance with CNST Maternity Incentive Scheme,** 10/10 compliance achieved for 2024, evidencing areas considered by the national teams to demonstrate safe practice.
- **CQC inspection report showing GOOD,** for all areas in maternity.
- **Maternity Safety Support programme,** exited the programme due to evidence of continued commitment to quality and safety in our service.
- **Neonatal Unit achieved UNICEF Baby Friendly level 3.**

Improvements made in 2024/25

- **National MEWS tool implemented** in November 2024, compliance consistently above 90%. Noted by the region to be the first Trust in Wessex to implement and recognised and presented at Wessex Intrapartum Network regional meeting and sharing event.
- **Reduction in vacancy rates,** nearly fully recruited clinical midwife line reflected in improved staff morale.
- **Improved volume of patient feedback in gynaecology,** allowing responsiveness to women's needs. Gathering momentum in engaging the patients in service development.
- **Ongoing reduction in general wait for a first gynaecology outpatient appointment,** using Improving Together Methodology.
- **Significant improvement in 28-day faster diagnosis target,** for patients referred on a cancer pathway**.** Improved quality demonstrated for our women who are waiting less time to be told they do not have cancer.
- **Retinopathy Of Prematurity screening**, significantly improved compliance.

Objectives and plans for 2025/26

- **Use of AMAT** and focus on guidelines across the Division to ensure clinical effectiveness and quality in our services.
- **Increase productivity,** in theatres for gynaecology and fertility to maximise value for our population.
- **Increasing appraisal rates and effectiveness,** to improve staff wellbeing.
- **Development and succession planning,** across the maternity and neonatal teams
- **Increased focus on reducing separation times,** between mothers and babies where babies are being cared for in Neonatal Unit.
- **Focus on compliance with Maternity and Neonatal Three-Year Delivery Plan.**
- **Continued focus on reducing time to first outpatient appointment,** focussing on patient pathways, follow-up reduction and exploring community pathways for physiotherapy and coil fitting.

Clinical Support & Family Services (CSFS) Division

Key Achievements for 2024/25

- **Reduced the average time each patient waits for first outpatient appointment,** from 124 days in March 2023 to 92 days in February 2025.
- **Restored compliance with 28-day Faster Cancer Diagnosis Standard,** in December 2024, SFT performance was the best in the South west.
- **Maintained diagnostic scanning performance:** CT, MRI, and Ultrasound scans available to patients in a timely way.
- **Veterans Covenant Healthcare Alliance certificate of recognition** was presented to Wessex Rehabilitation service.
- **UKAS accreditation,** maintained in Laboratory Medicine and achieved for Microbiology.
- **Pressure Ulcers:** Halved the number of pressure ulcers reported for patients in the Spinal Unit in last 6 months, from an average of 6 per month to an average of 3 per month in January 2025.
- **Maintained Blood Transfusion compliance** with Blood Safety & Quality Regulations.
- **Staff Awards 2024:**
  Rising Star of the Year Award – Paediatric Matron
  Lifetime Contribution Award – Hospice staff
  Patient Experience Award – Speech & Language Therapy Assistant
  Sharing Outstanding Excellence (SOX) of the Year – Spinal Unit Team
  Leadership Award – Team Lead, Early Supported Discharge Team

Improvements made in 2024/25

- **Patient complaints:** Responded within agreed timescale over the last 12 months.
- **Pathology Laboratory tours:** Introduced tours to improve knowledge and awareness for service users.
- **Increased Aseptic Unit capacity,** for the highly skilled sterile preparation of injectable medicines e.g. chemotherapy
- **Pharmacy Pilot:** Carried out trial on wards to reduce missed or delayed medication doses.
- **Patient Deterioration:** Focused on ward teams' recognition of and response to patient deterioration, aiming to identify and remove barriers, and share good practice.

Objectives and plans for 2025/26

- **Appraisal rates:** Improve (non-medical staff) and maintain medical appraisal rates, promoting a culture of continuous professional development.
- **Reducing Outpatient waiting times:** Expand work to include appropriate follow-up and patient initiated follow up.
- **Improving Together:** Continue to embed Improving Together at service level.
- **Delayed / missed medication doses:** Expand work on this, sharing learning from one ward to another.
- **Testing turnaround times:** Improve in Laboratory Medicine for University Hospital Southampton referrals.
- **Blood Transfusion:** Implement additional automated testing to increase efficiency and effectiveness.

Other 2024/25 Highlights

First New Arrival Registered on BadgerNet

In February 2025, a new digital system called BadgerNet was launched to replace paper records for maternity care. The very first baby was officially registered into the system at 11:23 AM on February 26, 2025.

Switching to digital records makes it easier for healthcare staff to track, report, and access important information. It will also save time,

allowing staff to focus more on patient care. Plus, the new system helps hospitals nearby who also use BadgerNet (like in Southampton, Portsmouth, Swindon and others) share patient information easily, improving care for patients who move between care locations. Newly registered patients won't need to carry paper records anymore, as their health information will be available digitally through the handheld patient app, Badger Notes, making things more convenient for everyone.

Implementation of Digital Respect

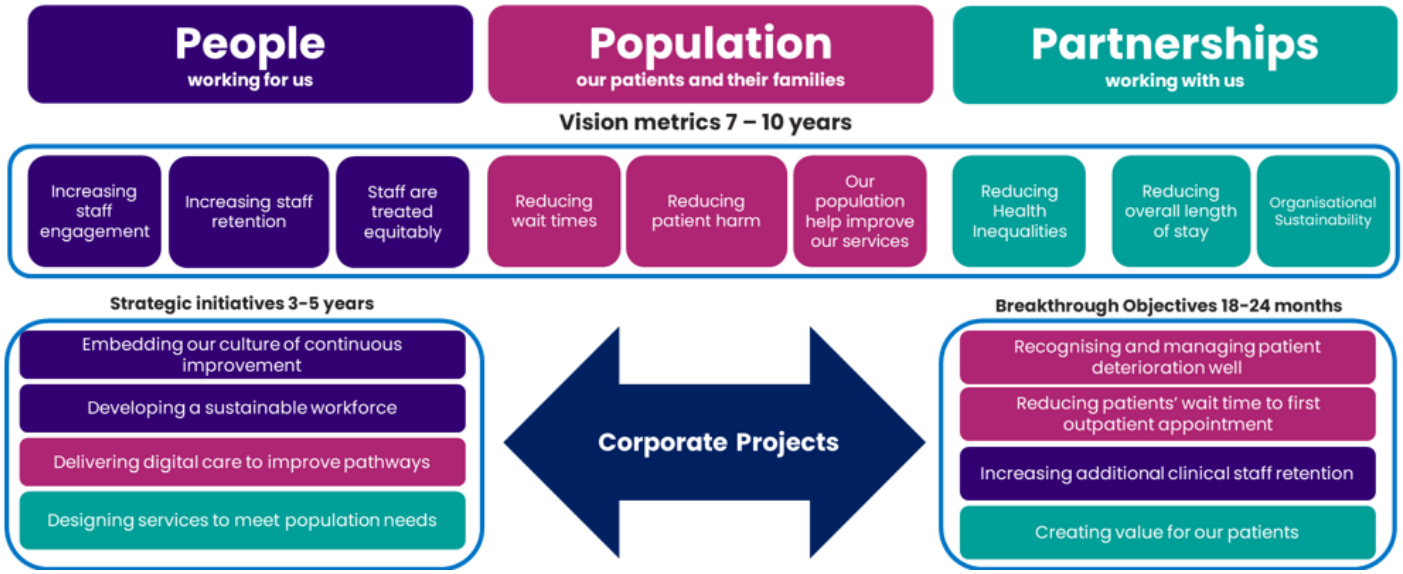
The Digital ReSPECT project was a BSW initiative to replace the ReSPECT paper plans used within SFT with a digital plan. The digital plans are created in the Integrated Care Record (ICR) which is used throughout Wiltshire and can be accessed by Royal United Hospitals Bath and Great Western Hospitals, GP practices, Avon and Wiltshire Mental Health partnership and community health providers. Many of these organisations were already using the ICR to create Digital ReSPECT plans.

The project aimed to deliver high-quality training for staff, digital learning resources and an overall awareness of the importance of the ReSPECT conversation for patients and families. The engagement and uptake of this digital process by clinicians has been a success, and we are pleased to see that our numbers are steadily growing.

Appendix A – Strategic Planning Framework 2025-26

Vision

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



Appendix B – Audit Examples and Actions

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group in 2024/25		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
National Respiratory Audit Programme (NRAP), Paediatric Asthma – clinical audit (data 2021/22), organisational audit (data 2021) and Drawing Breath report (data 2021/2) Presented: July 2024	This project, which started in June 2019, collects information about children and young people admitted to hospital with an asthma attack. The information will be used to help improve asthma care for children and young people (CYP). **Successes:** • Access to diagnostic tools: spirometry and FeNO (fractional exhaled nitric oxide) text. • Designated clinical lead for CYP with asthma. • Availability of smoking cessation service to which CYP and parents/carers can be signposted. • Transition service for CYP to adult services. • Inhaler technique checked. **Concerns:** • Have a respiratory nurse specialist trained in the care of children and young people with asthma. • Poor compliance with steroid administration within 1 hour. • Poor compliance with addressing tobacco dependency in parents/carers. • Poor compliance in issuing/reviewing personalised asthma action plans as part of discharge planning.	1. Business case development for asthma services to include an asthma specialist nurse. 2. Work ongoing to look at triaging current access plan and ensuring failsafe in place for when patients not being seen by the guaranteed activity date. 3. Patients who have missed a follow-up date by more than 12 weeks to be checked.
Saving Babies Lives V3 Presented: September 2024	Audit of the completion of "hourly review in labour" proforma. **Successes:** • V3 elements 4.3b, 4.3c & 4.3d have all achieved compliance. • In 2022, a fetal surveillance lead (FSL) midwife was appointed in a permanent role following a 2-year fixed term employment, and FSL obstetrician has been appointed since 2020. In 2024, the Midwifery Lead role was split, so there are now co-leads in this position, working together to continue to implement the standards outlined in SBLv3. **Concerns**: • Poor compliance with hourly "fresh eyes".	1. Improve "fresh eyes" compliance by promoting through staff communication, newsletters, walk abouts, education. 2. Improve visibility and process with white boards on doors for information sharing on due times. 3. Widening responsibilities by changing to allowing preceptees to contribute to the reviews due for colleagues once 6 months post qualified.

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group in 2024/25		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
National Audit of Dementia – Care in General Hospitals 2022-2023 Round 5 (data: 2022-23) Presented: September 2024	A clinical audit programme looking at quality of care received by people with dementia in general hospitals. **Successes:** • Good compliance with initial assessments for delirium and pain in patients with cognitive impairment • Excellent feedback from the carers questionnaire about the help of the dementia nurse. **Concerns:** • Ongoing assessments of delirium and pain once patients are on the wards is less good. • Over reliance on the dementia nurse to interact and help confused patients and their carers. This suggests a certain lack of confidence and training from existing nurses into managing these patients themselves. • Lack of engagement for existing training resources and time to empower existing ward nurses to manage these patients. Resource to boost the ability to increase engagement and champion training would be welcome.	1. Ongoing education and training for all staff in managing patients with delirium and dementia. 2. Continue work with our volunteers to help with meaningful engagement with delirious patients (alongside appropriate training) to help with nutritional needs, companionship, interaction, meaningful activities. 3. Aim to develop on the existing resources regarding the delirium/dementia team which is currently under resourced. 4. Increase awareness of new delirium guidance through clear communication/training with clinical teams to signpost.
National Audit of Percutaneous Coronary Intervention (NAPCI) 2023 (data 2021-22) NICOR/NCAP Presented: Nov. 2024	This audit is part of the National Cardiac Audit Programme (NCAP) and focuses on several specific quality improvement metrics for the delivery of PCI services. These are derived from national and/or international standards and guidelines. **Successes:** High use of intracoronary imaging in LMS PCI* and percentage of elective cases done as day cases. **Concerns:** Below average DTB (door to balloon) times – likely due to delays for STEMI patients accepted through the ED department. *LMS PCI – left main stem percutaneous coronary intervention .	1. Deep dive of specific cases from this audit period to identify reasons behind the delay in achieving good DTB times.

Examples of National Clinical Audits that were presented to the Clinical Effectiveness Steering Group in 2024/25		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Improving Quality in Crohn's and Colitis (IQICC) 2024 (data: 2023) Presented: January 2025	To identify how Inflammatory Bowel Disease (IBD) services are performing against 2019 standards. Patients with Crohn's and Colitis are asked to rate the quality of their care over the last 2 months. **Successes:** • Team expansion, upskilling, and networking. • Pathway navigators. • Better patient access to services (advice line, new clinics, new pathways for advanced therapy initiation and follow-up). • Education program for patients and staff. • Working with Crohn's & Colitis UK and military service to address the issue of provision of care to military personnel. **Concerns:** • No allocated substantive IBD consultant. • Emergency outpatient flexible sigmoidoscopy and surveillance colonoscopy • Patient involvement in service development plans. • Workload and resilience.	1. Increase number of advice line hours/day. 2. Modify the GP referral pathway. 3. Hot slots for flexible sigmoidoscopy and recapture surveillance colonoscopy for UC patients. 4. Introduction of 10-year PIFU and revalidation. 5. Introduction of patient education evening, flare card, and PROMs.

Examples of Local Audits in 2024/25 that were presented to the Clinical Effectiveness Steering Group		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Safe Medicine Management – Theatres and DSU Presented: May 2024	To determine compliance with safe medicine management, following a pharmacy audit. **Successes:** • Controlled drug cupboards are now double locked. • Fluid cabinets with Salto locks introduced to theatres. **Concerns:** • Failure to securely store IV fluids in the anaesthetic rooms, especially when the rooms are not in use.	1. Update training provided for all staff on safe medicine management. 2. Remind scrub staff that fluid warmer cabinets should be checked daily, and all fluids must be dated to ensure storage guidance can be followed. 3. Engage band 7 team leads to assist with supporting staff on compliance with warming cabinets.
Transient Elastography (fibroscan) Presented: July 2024	**New procedure audit** Following procurement of a fibroscanner, which was approved in 2021, this audit provides assurance of its benefit. A fibroscan measures “stiffness” of the liver, and any scarring (fibrosis). It provides information about fatty change (steatosis) and is simple and, painless and give immediate results. **Successes:** • 11 staff completed training and competencies. **Concerns:** • There are no potential complications or risks with this non-invasive procedure.	No specific actions required.
Follow-up echocardiograms post MI (myocardial infarction) Presented: July 2024	To determine if patients with poor cardiac function post-MI are being offered follow-up echocardiograms with the recommended time period of 6 – 12 weeks. **Successes:** • There were no key successes. **Concerns:** • Only 33% of patients post-MI with *LVEF≤ 40% had a follow-up echocardiogram within the appropriate time frame. • The primary reason for patients not being followed up is that follow-up was not requested on their discharge summary. *LVEF – left ventricular ejection fraction.	1. Infographic produced to clarify target standard, and to prompt clinicians to act on it. 2. Discussion with key stakeholders in CIU (cardiac investigation unit) who are responsible for arranging follow-up appointments. 3. Review the 33% of patients to check if there was a reason they did not have a follow-up echocardiogram.

Examples of Local Audits in 2024/25 that were presented to the Clinical Effectiveness Steering Group		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Paediatric Early Warning Score (PEWS) Audit (data: December 2023 to May 2024) Presented: July 2024	To improve the quality of observations taken on children and young people on the paediatric ward with the aim of detecting deteriorating clinical condition and escalating in a timely manner. **Successes:** • "If PEWS was escalated, was the review undertaken in the required timeframe" completed each month. • "Is PEWS correct" completed most months. **Concerns:** • "How is your child different since I last saw them" not consistently answered.	1. "How is your child different since I last saw them" – question discussed regularly at departmental governance meeting, and daily check being completed with families. 2. Audit results displayed on performance board in staff corridor. 3. Successes shared in Team education newsletter.
Are we falling behind – Time to CT Head following an inpatient fall Presented: August 2024	To determine if CT head requests are being performed within the triaged time according to NICE guidelines. **Successes:** • Most CT head requests, post inpatient falls, are undertaken within 1-hour (including those meeting 8-hour criteria). • Red Flag features are documented in 100% of requests. • Majority of doctors are aware of the inpatient falls proforma and where to find it. **Concerns:** • CT head requests, post inpatient falls, which are not undertaken within 1-hour tend to involve out of hours requests. • Not all doctors used the fall proforma, although they were aware of it. • Radiography not always alerted of CT head requests.	1. Add CT Radiographer extension number and bleep to proforma. 2. Ensure up to date forms distributed on wards and placed in easily identifiable places. 3. Add a pop up, similar to MRI requests prompting to fill in GCS, Anti-coagulants or tick box for other red flag features, a tick box or comment box for indication of CT Head and prompt to call radiographers once request submitted with the correct extension/bleep to use at which time. 4. Create Induction Infographic to disseminate to new doctors around process of CT head requests. 5. Share audit results with CESG and CMB.

Examples of Local Audits in 2024/25 that were presented to the Clinical Effectiveness Steering Group		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Navigating the way to excellent HCC (hepatocellular carcinoma) Surveillance Presented: August 2024	Quantitative evaluation of the impact of a band 4 hepatology pathway navigator (HPN) on HCC surveillance invitation and uptake. **Successes:** • Meeting the national standards since the HPN started in post. • Improved equality – all eligible patients are invited to screening. • Tests are appropriate (excessive testing avoided). **Concerns:** • Before the HPN started in post only 12.6% of patients received an ultrasound scan.	No specific actions required.
BSOTS audit (Birmingham Symptom Specific Obstetric Triage System) Presented: September 2024	This audit looked at five key areas within the use of BSOTs TAC cards. The areas enable us to better understand whether the tool is being effectively used to triage women in a safe and effective way, highlighting risks to forward plan the care provided and the time frame in which their care is received. **Successes:** • Good compliance in key areas. **Concerns:** • Lack of understanding in the use of RAG score for some staff. • 37% of patients not reviewed in the correct time frame.	1. Remind and educate all staff of the importance of triage within 15 minutes. 2. Re-launch of BSOTs pathway. 3. Further review of the data to better understand the reasons for non-compliance.
Pregnancy status in the paediatric surgery population Presented: October 2024	To assess compliance with RCPCH and RCOA guidance on pre-procedure pregnancy risk assessments in patients with childbearing potential under the age of 16. **Concerns:** • There is currently no trust policy on this subject.	1. New Trust policy to be created and implemented.

Examples of Local Audits in 2024/25 that were presented to the Clinical Effectiveness Steering Group		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Reducing fracture risk by optimising bone health management following inpatient falls 2023 (data 2022) Presented: January 2025	NICE guidelines suggest that fragility fracture risk assessments should be considered in females aged ≥65 years and males aged ≥75 years, as well as females <65 years and males <75 years with risk factors such as history of falls or previous fragility fractures. **Concerns:** • Bone health assessments are not being performed when required.	1. Create an assessment proforma for doctors and senior nurses to use, to assess bone health. 2. Liaise with falls nurse specialist to discuss adding this assessment prompt to the existing form.
Local Anaesthetic Safety in Orthopaedic Procedures Presented: March 2025	Evaluation of local anaesthetic safety checks during orthopaedic procedures. **Successes:** • 81% showed compliance with mandatory formal local anaesthetic discussion. **Concerns:** • Surgeons double-checked local infiltration of anaesthetic (LIA) in 50% of responses.	1. "INSPECT before you INJECT!" reminder should be added to the team brief discussions. 2. Scrub nurses to prompt surgeons to double-check.
Improving the recognition and care of patients with uncertain recovery. Presented: March 2025	To improve the recognition of inpatients with uncertain survival, life limiting conditions, or at risk of dying soon after admission. (NICE Guideline 142 recommendation 1.1.1 – People managing and delivering services should develop systems to identify adults who are likely to be approaching the end of their life". To improve care of patients at the end of their lives and to improve communication with patients and relatives. **Successes:** • Most patients were recognised as dying. • High percentage of patients referred to palliative/end of life care teams. **Concerns:** • High number of patient moves from ward to ward. • Management plan of patients after that recognition was is not always clear.	1. Discuss the number of ward moves and agree if escalation is needed at the End of Life Strategy Steering Group. 2. Undertake a real-time audit in March 2025

Examples of Local Audits that were presented to the Clinical Effectiveness Steering Group in 2024 / 25		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Improving the awareness of vascular occlusion from dermal fillers in aesthetics procedures in acute healthcare Presented: March 2025	Establish the current level of awareness about the serious complications of dermal filler injections. **Successes**: • Excellent participation and engagement with this audit from resident doctors and consultants. **Concerns:** • 37% were aware of vascular occlusions (VO) caused by HA dermal fillers. • 52% were unsure how to treat VOs. • 41% were not aware of hyaluronidase (which is used to manage VO). • 87% reported not knowing where to find guidance on managing VO caused by dermal fillers.	1. Treatment protocol to be created on how to manage vascular occlusion. 2. Include in teaching for resident doctors, hospital at night, emergency department, and acute care.

Appendix C – Letters of Assurance

The following were all invited to comment and provide assurances on the content of the Salisbury NHS Foundation Trust Quality Account 2024/25.

- **Wiltshire Council Health Select Committee**
- **Salisbury NHS Foundation Trust Governors**
- **Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board**
- **Healthwatch Wiltshire**

Copies of the responses received have been attached in this Appendix, along with a Directors' Responsibilities Statement which has been signed by the Chair of the Trust Board and the Chief Executive.

Wiltshire Council Health Select Committee were invited to provide a statement but were unable to due to time constraints resulting from the Wiltshire Council election in May.

Statement from the Governors – June 2025

The Quality Account for 2024/25 shows how the Trust has performed against its priorities this year and sets out the main areas of focus for 2025/26.

The report is shaped utilising the Trust's Improving Together methodology to focus upon the three strategic themes of People, Population, and Partnerships to deliver effective and sustainable change.

The governors have been given an opportunity to provide feedback on the Quality Account in draft. We endorse the priorities or 'breakthrough objectives' provided for 2024/25 which; recognising and managing patient deterioration well, reducing patients wait time to first outpatient appointment, creating value for our patients, increasing additional clinical staff retention.

As with majority of NHS trusts, the governors recognise Salisbury has faced another extremely busy and at times challenging year with significant changes as we've moved into a group model. However, we acknowledge the quality of work completed and the role improving together has played in implementing positive change .

The governors welcome the introduction of Martha's Rule alongside other measures to improve the identification of patient deterioration. A major patient safety initiative which has enabled patients and families to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to.

The opening of the new inpatient ward, Imber in the new Elizabeth Building is a very good news story providing a promising opportunity to implement outstanding care for elderly patients within a dedicated space.

Whilst the electronic patient record story is not near completion, we recognise the dedicated work and complexities faced from all involved to keep the project on track.

The governors would like to thank our staff for the outstanding work they have done and continue to do, to deliver compassionate and high-quality care to all our communities .

Peter Russell, Lead Governor
Jayne Sheppard, Deputy Lead Governor

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

Statement from Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board on Salisbury NHS Foundation Trust 2024/25 Quality Account.

NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB) welcome the opportunity to review and comment on Salisbury NHS Foundation Trust's Quality Account for 2024/ 2025. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and quality visits and aligns to NHSE Quality Account requirements.

BSW ICB notes the comprehensive overview of the Trust's achievements, challenges, and future priorities, aimed at providing continued delivery of high-quality care.

It is the view of the ICB that the Quality Account reflects Salisbury NHS Foundation Trust's ongoing commitment to continuous improvement in patient care and safety, and recognises the trusts' key achievements in the following areas:

- Managing Patient Deterioration- there has been a slow but steady achievement in the timely taking and recording of NEWS 2 observations and ICU admissions decreasing, suggesting that SFT are effectively reducing the negative impact of non-timely patient observation. Multiple actions have been implemented, including NEWS2 scores reviewed at handover in the morning and evening, Critical Care Outreach Team (CCOT) joining medical handover with NWES2 scores reviewed, NEWS2 learning on LEARN and ensuring staff complete POET training, and there is infrastructure in place for further gains to be achieved in 25/26.
- Improving Clinical Effectiveness by Improved productivity achieving an improvement of -21% to -11% against 19/20 baseline, this has been achieved by the review and standardisation of outpatient clinic templates, controls of temporary staffing, reductions in length of stay in partnership with system colleagues, executive attendance in key forums to drive decision-making and approach change. in decision-making forums.
- Improving Retention of additional clinical services staff through reducing the turnover in Healthcare Assistants (HCAs) from 20% to 15%. There has been considerable progress with initiatives likely to yield longer-term retention benefits. This has been achieved through comprehensive staff support initiatives, including the launch of HCA preceptorship and apprenticeship pathways and tailored induction and quarterly learning/celebration events.

- Whilst the target to reduce time to first outpatient appointment from 120 days to 90 days has not been achieved, it is recognised this is due to a small cohort of specialties currently accounting for the majority of the trust's current backlog of patients awaiting their first outpatient appointment. However, the trust has successfully halted further deterioration in waiting times to a patient's first outpatient appointment. By further understanding the trusts' data and focusing on local improvements that have collectively contributed to a reduction in overall waiting times, the trust is expected to improve understanding, sharing, and expanding on the successes in the coming 12 months. Several improvements have already been initiated including, focusing on a handful of specialities with the biggest opportunity for improvement, dedicated resource from the transformation team and the case built for a clinical and operational lead to drive a new programme of work on out-patient transformation, and investigate how Robotic Process Automation can help with the Patient Initiated Follow-Up (PIFU) utilisation.

The ICB recognises the trusts 2025/26 plan to improve the quality of care primarily through the Trust's Improving Together programme and the agreed breakthrough objectives. Specific areas identified for further development during 2025/26 are:

- Improving the management of patient deterioration by increasing the percentage of NEWS2 observations taken on time from 29% in February 2024 to 60%.
- Reducing time to first outpatient appointment from a Trust-wide average of 120 days down to 90 days in 2025/26.
- Creating Value for the Patient by further improving productivity aiming to improve productivity from -18% to -8% compared to 2019/20.
- Increasing additional clinical services staff retention by reducing the turnover of additional clinical services (HCA) from an average of 19% in 2024 to 15% by September 2025.

We look forward to seeing progress with the quality priorities identified in this Quality Account, in conjunction with the continued maturity of PSIRF and the Trust's contribution to system wide learning and improvement through programmes such as Martha's rule and the further implementation of the PIER framework.

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with the Salisbury NHS Foundation Trust and together with our wider stakeholders will continue to work collaboratively to achieve our shared priorities as an Integrated Care System in 2025/26.

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

Yours sincerely

Gill May

Chief Nurse Officer

BSW ICB

Healthwatch Wiltshire Response to Salisbury NHS Foundation Trust Quality Account 2024/25

Healthwatch Wiltshire welcomes the opportunity to comment on Salisbury NHS Foundation Trust's (SFT) Quality Account for 2024/25. We appreciate the Trust's continued commitment to transparency, improvement, and patient-centred care, and we commend the comprehensive nature of this year's report.

Progress in 2024/25

We recognise the significant strides made by the Trust over the past year, particularly in embedding the Improving Together methodology across all levels of the organisation. This approach has clearly begun to yield tangible benefits, including:

- Improved staff experience, as evidenced by the Trust being the most improved in the 2024 NHS Staff Survey and achieving top national rankings in several People Promise indicators
- Enhanced patient safety, with a notable reduction in incidents resulting in severe harm or death, and the successful implementation of the Patient Safety Incident Response Framework (PSIRF)
- Increased productivity, with a marked improvement from -21% to -11% compared to 2019/20 levels
- Recognition and management of patient deterioration, with improvements in NEWS2 compliance and a reduction in ICU admissions
- Expansion of patient engagement, including the development of patient-led panels in cancer and spinal services, and the introduction of the Call for Concern initiative under Martha's Rule.

We also commend the Trust's efforts to address health inequalities, particularly through targeted outreach to underserved communities and the development of inclusive patient feedback mechanisms.

Priorities for 2025/26

We support the Trust's identified breakthrough objectives for the coming year, which align well with the feedback we receive from local people. In particular, we welcome:

- The continued focus on reducing outpatient waiting times, especially in key specialties where delays have been most pronounced
- The emphasis on retaining additional clinical services staff, which is vital for continuity of care and patient experience
- The commitment to improving patient experience, including increasing Friends and Family Test response rates and enhancing the quality of complaint responses
- The drive to improve clinical effectiveness, particularly through better audit completion and data accessibility via Power BI.

We encourage the Trust to maintain momentum in these areas and to ensure that improvements are felt equitably across all patient groups.

Areas for Continued Focus

While we are encouraged by the progress made, we would like to highlight a few areas where continued attention would be beneficial:

- Outpatient transformation: We urge the Trust to ensure that patient voices are central to the redesign of outpatient services, particularly in specialties with persistent backlogs
- Accessibility of feedback mechanisms: Continued efforts are needed to ensure that all patients, including those with communication needs or from minority backgrounds, can easily provide feedback
- Learning from complaints and incidents: We support the Trust's move towards a more compassionate and systems-based approach to learning, and we encourage transparency in how this learning is shared with patients and the public.

Conclusion

Healthwatch Wiltshire appreciates the Trust's openness and the clear evidence of a learning culture that values both staff and patient voices. We look forward to continuing our collaborative relationship with Salisbury NHS Foundation Trust and supporting its efforts to deliver safe, effective, and compassionate care for all.

Healthwatch Wiltshire
June 2025

NHS
Salisbury
NHS Foundation Trust

Statements of Directors' Responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2024/25.
- The content of the quality report is not inconsistent with internal and external sources of information.
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the quality report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the quality report is robust and reliable and conforms to the specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- There is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the quality account for 2024/25. Therefore, no limited assurance report is available on the quality account report in 2024/25.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board.

Ian Green OBE	**Cara Charles Barks**	**Lisa Thomas**
Chairman	**Chief Executive Officer**	**Managing Director**
Date: 19th June 2025	**Date: 19th June 2025**	**Date: 19th June 2025**

Salisbury NHS Foundation Trust
Salisbury District Hospital
Odstock Road
Salisbury, Wiltshire,
SP2 8BJ

This document is available in large print, audio tape or another language on request.

SFT557_05/25