Bundle Trust Board Public 3 July 2025

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
April SOX of the month – Fredrick Kajombo, Temporary Staff, Hospice
April Patient Centred SOX – Katherine Backhouse, Gynaecology
May SOX of the month – UHS Payroll Team and Holly Storey and Anja Richardson, Fit Testing
May Patient Centred SOX – ED Staff
June SOX of the month –
June Patient Centred SOX –

1.2 10:10 - Patient Story
Beryl's Story Introduced by Helen Rynne

1.3 Welcome and Apologies
Apologies received from Cara Charles-Barks

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes attached from meeting held on 1st May 2025
For approval
1.5 Draft Public Board mins 1 May 2025

1.6 10:35 - Matters Arising and Action Log
1.6 July Public Trust Board Action Log

1.7 Register of Attendance
1.7 Register of Attendance - Public Board 2025-26

1.8 10:40 - Chair's Business
Presented by Eiri Jones

1.9 10:45 - Chief Executive Report
Presented by Lisa Thomas
For information
1.9 Chief Executive Report July 2025

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Integrated Performance Report to include exception reports
Presented by Mark Ellis
For assurance
2.1a IPR Cover Sheet - Trust Board 2025-06
2.1b Integrated Performance Report - July 2025

2.2 11:20 - Audit Committee 19th June
Presented by Richard Holmes
For assurance
2.2 Audit Committee Escalation Report

2.3 11:25 - Finance and Performance 3rd June and 24th June 2025
Presented by Debbie Beaven
For assurance
2.3 Finance and Performance Escalation Report June 2025 - Extraordinary meeting
2.3 Finance and Performance Escalation Report 24 June 2025

2.3.1 11:30 - Finance Update
Presented by Mark Ellis
For assurance

2.4 11:35 - Clinical Governance Committee 24th June
Presented by Anne Stebbing
For assurance
2.4 Clinical Governance Committee escalation report 24th June 2025

2.5 11:40 - Trust Management Committee 25th June
Presented by Lisa Thomas
For assurance

2.5 TMC escalation report May meeting
2.5 TMC escalation report June meeting

2.6 11:45 - People and Culture Committee 26th June
Presented b Eiri Jones
For assurance

3 PEOPLE AND CULTURE

3.1 Medical Revalidation and Appraisal Annual Report including Statement of Compliance - deferred to September

3.2 11:50 - Health and Safety Report
Presented by Melanie Whitfield
For assurance

3.2a Public Board H&S Report cover sheet
3.2b EoFY H&S Report FY25

4 GOVERNANCE

4.1 12:00 - Register of Seals
Presented by Fiona McNeight
For information

4.1 Register of Seals

4.2 12:05 - BREAK

5 QUALITY AND RISK

5.1 12:35 - Maternity and Neonatal Quality and Safety Report Q4
Presented by Vicki Marston/Judy Dyos
For assurance

5.1a Front sheet Q and S report Q4 24 25- Trust Board
5.1b Maternity and Neonatal Safety Report Q4 Jan-Mar 25
5.1c APPENDIX 1 - PMRT Report Q4 Jan-Mar 25
5.1d APPENDIX 2 - Training Report Q4 Jan-Mar 25
5.1e APPENDIX 3 - Patient and Staff Experience Report Q4 Jan-Mar 25
5.1f APPENDIX 4 - Saving Babies Lives Report Q4 Jan-March 25
5.1g APPENDIX 5 - Workforce Report Q4 Jan-March 25
5.1h APPENDIX 6 - ATAIN TC Report Q4 Jan-Mar 25

5.2 12:45 - Perinatal Quality Surveillance Report May (April data)
Presented by Vicki Marston/Judy Dyos
For assurance

5.2a Front sheet Tust board perinatal Quality April data
5.2b Perinatal Quality Surveillance May 2025 Slides (April data)

5.3 12:50 - Perinatal Quality Surveillance Report June (May data)
Presented by Vicki Marston/Judy Dyos
For assurance

5.3a Front sheet Perinatal Quality Surveillance Report - June (May data)
5.3b Perinatal Quality Surveillance June 2025 Slides (May data)

5.4 12:55 - Feedback from Ward Champions
Presented by Eiri Jones
For information

5.5 13:05 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance

Trust Board BAF Report July 2025
Board Assurance Framework June 2025
Corporate Risk Register June 2025
CRR tracker v1 Board Committees June 2025

5.6 13:15 - Patient Experience Report Q4
Presented by Judy Dyos
For assurance

5.6 Patient Experience - Patient Feedback Report Q4_Annual Engagement Report 24-25 v2.0

5.7 13:25 - Learning from Deaths Report Q4
Presented by Duncan Murray
For assurance

5.7a Cover Sheet - June 25 LfD

5.7b 20250605 LFD-Q4v1.1

5.8 13:35 - Director of Infection, Prevention and Control Annual Report
Presented by Judy Dyos
For assurance

5.8a Trust board cover sheet - DIPC 24-25

5.8b Annual DIPC Report 2024-25 (Final draft v.1)

5.9 13:45 - Incident Reporting and Risk Report Q4
Presented by Judy Dyos
For assurance

5.9a Q4 risk management report cover sheet

6 CLOSING BUSINESS

6.1 13:55 - Any Other Business

6.2 Agreement of Principal Actions and Items for Escalation

6.3 14:00 - Public Questions

6.4 Date next meeting: 4 September 2025

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 1st May 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director (via Teams)
Mark Ellis (ME)	Interim Chief Finance Officer
Lisa Thomas (LT)	Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Jon Burwell (JB)	Senior Information Officer
Cara Charles Barks (CCB)	Chief Executive
Kirsty Matthews (KM)	Non-Executive Director
Judy Dyos (JD)	Chief Nursing Officer
Duncan Murray (DM)	Chief Medical Officer

In Attendance:

Tony Mears (TM)	Associate Director of Strategy
Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Tapiwa Songore (TS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (items 3.1, 3.2, 3.3, 3.4, 3.5, 3.6 and 3.7)
John O'Keefe (JO'K)	Head of Estates (for agenda item 6.1)
Jonathan Hinchcliffe (JH)	Chief Transformation and Innovation Officer (interim)
Sam Breach (SB)	Clinical Lead for Day Surgery (Item 1.2 only)
Jenny Evans (JE)	Nurse (Item 1.2 only)
Cynthia D'Costa (COD)	Nurse (Item 1.2 only)
Renu Oommen (RO)	Nurse (Item 1.2 only)
Melody Watts (MWa)	Nurse (Item 1.2 only)
Champika Dona (CO)	Matron (Item 1.2 only)

Observers

Jane Podkolinski	Governor
Francis Owen	Governor
Peter Rusell	Governor
Jacques Harte	Governor
Russell Edwards	Public
Luc Bugeja	Public
Jessica Kyte	Public
Ellie Carlisle	Public
Louise Jones	Head of Risk

ACTION

TB1 OPENING BUSINESS

1/5/1 IG welcomed everyone and informed those present that this was a meeting held in public but not a public meeting.

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

IG welcomed JH who was attending his first meeting of the Trust Board.

TB1 1/5/1.2 **Presentation of SOX Certificates**

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

- March SOX of the month – Louise Smith, Clinical Psychology
- March Patient Centred SOX – Courtney Harnett, Acute Medical Unit

IG explained that the nominations were publicly acknowledged at the Board and the Certificates would be presented to the recipients by the members of the Executive Team.

TB1 1/5/1.2 **Staff Story**

MW introduced the Staff Story, and the Board welcomed SB, JE, COD, RO, MWa, and CO from the Day Surgery Unit to the meeting.

The Day Surgery Unit Team narrated how they had managed to build a high functioning team by getting to know and understand each other, and to create a working environment that gave the best experience for patients. The Board noted how the team made sure every team member felt valued and how diversity was celebrated within the team.

LT pointed out that research showed that the greatest socially connected teams led to NHS organisations being rated outstanding by the CQC

The Board thanked the team for the insightful and humbling discussion and for exhibiting the 'Salisbury spirit'

TB1 1/5/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and reported that no apologies had been received.

TB1 1/5/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

TB1 1/5/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 6th March 2025**

IG presented the minutes from the Public Board meeting held on 6th March 2025.

Decision:

The Board **APPROVED** the minutes of the meetings held on 6th March 2025 as a true and correct record, subject to minor amendments suggested at the meeting

TB1 1/5/1.6 **Matters Arising and Action Log**

FMc presented the action log and the Board agreed to close the action TB*1 6/3/4.4 Group Chair Appointment* which had been completed.

The Board received the following update;

TB1 9/1/5.4 Incident Reporting and Risk Report

An update on Duty of Candour responsibility and improvements had been included in the quarterly report. Action closed.

TB1 1/5/1.7 **Public Trust Board Cycle of Business 2025/26**

The Board received the revised Public Trust Board Cycle of Business 2025/26 which had been adjusted to reflect the new meetings cycle. It was noted that the Committee effectiveness review would help refine the reporting from Committees

Decision:
The Board approved the Public Trust Board Cycle of Business 2025/26

TB1 1/5/1.8 **Chair's Business**

IG reported on the following;

- changes taking place within the NHS, NHS England, the Department of Health and Social Care, the Integrated Care Boards (ICBs) and the pressure being placed on systems and acute providers.
- the challenge in the delivery of the Business Plan for 2024/25 and the importance of a clear understanding of the trajectory in order to deliver the cost improvement programme and areas of development.
- The appointment of a new Charity Director who would be staring in June 2025.
- The local government elections which were underway and the importance of responding to the impending changes.

The Board noted the Chair's report.

TB1 1/5/1.9 **Chief Executive's Report**

CCB presented the Chief Executive's Report and highlighted the following key points:

- The level of reform happening nationally especially with the ICBs and the advent of the ten-year health plan. There would be a significant change around the cost and spend affiliated with integrated care systems and the operating costs for ICBs by Q3 and this was linked to the work around headcount reduction.
- the areas of focus for the 10-year plan,

- The impact of the decision made by the UK Supreme Court on 16 April on the definition of a biological woman and the support that was being offered to staff across the trust. The Board noted the importance of making sure everyone was valued and respected,

- The appointment of the Managing Director posts across the three trusts and the announcements would be made In due course.

LT updated the Board on the critical incident declared at the beginning of March which was due to the high number of patients in hospital on the urgent care pathways waiting longer to be admitted to beds. Colleagues across the Trust worked as a team to de-escalate pressures

The Board noted the report.

TB1 1/5/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 1/5/2.1 Integrated Performance Report (IPR) (M12 March)

NP presented the Integrated Performance Report for Month 12 and highlighted the following key points:

- Over the past year the trust had seen significant improvement in its cancer access and was now around the national target.
- The Trust was reporting a financial position of £5.5 million deficit, however productivity increased slightly from -12% to -12.8%
- The SHMI continued to improve further, and maternity had come out of maternity safety programme at the last inspection where the service was rated Good by the CQC.
- Time to 1st outpatient appointment had reached its lowest level since being introduced as a breakthrough objective.
- Staff retention had in slightly increased in month, but it was on a still under the target of 13%.
- Patients with no criteria to reside increased slightly to 94 patients in April., however this had now come down again

Discussion:

The Board noted the challenging conditions and commented the Board for the improved performance, noting the huge amount of work that has gone into making that position sustainable.

The Board observed that the delivery of the 2025/26 plan was predicated on a reduction in bed base and sought clarity on how the trajectory would be managed alongside the continued increasing capacity and activity. It was noted that the plan had three key determinants of length of stay (LOS), admissions and No Criteria to Reside(NCTR). LOS was improving and was now below the peer average. Non elective was also improving and work with the new community partner and other system partners was likely to improve the NCTR. It was noted that the Trust had a greater role in reduction of NCTR, however there was willingness from the system partners to support the work.
The Board sought assurance on stroke performance, and it was noted that the team had introduced a lot of innovation to improve what they could deliver

within the existing resource. The team was also carrying some vacancies, and they had sickness absence.

The Board noted the report

TB1 1/5/2.2 **Audit Committee – 20th March**

RH presented the report from the Audit Committee meeting on 20 March and highlighted the following

- a deep dive into the Vacancy Control Process at Trust and BSW System level had revealed that the BSW Workforce Plan System Meeting (WPSM) established to review recruitment requests across the three Trusts had no non-clinical representation.
- The fieldwork for the final External Audit had commenced and the auditors had picked up the EPR issues as fundamentally affecting their view on value for money. The internal audits had resulted in no outstanding actions and no overdue items
- The Committee had reviewed and recommended the approval of the SFI to the Board.
- The Committee had reviewed the process and management of the BAF and was satisfied with the process in place.

The Board noted the report.

TB1 1/5/2.3 **Finance and Performance Committee – 13th March, 25th March and 29th April**

DB presented the report from the Finance and Performance (F&P) Committee meetings held on 13th March 25th March and 29th April, and highlighted the following;

- The estates funding which would help deliver the reality of the master plan and help address a lot of the maintenance backlog
- The Business Plan for 2025/26 had been approved and the risks were being monitored especially with the CIPs.
- A deep dive had been undertaken in theatre productivity.
- Two contracts were approved with a saving of £300k per annum.

The Board noted the report.

TB1 1/5/2.4 **Clinical Governance Committee – 25th March and 29th April**

AS presented the report from the Clinical Governance Committee meetings held on 25th March and 29th April and highlighted the following;

- The Trust received a CQC IMER inspection improvement notice, and an action plan has been developed.
- the culture within the organisation of ensuring that issues could be escalated was evidenced by the recent clinical audit. A junior doctor highlighted an area where processes could affect patient safety and was picked up quickly through the appropriate channels,

The Board noted the report.

TB1 1/5/2.5 **Trust Management Committee – 26th March and 23rd April**

LT reported on the meeting TMC and reported on the following

- The Children's quality and safety board (CQSB) had raised a concern that the move to the new shared EPR would lose connection for patient medications that come via GP connect – and that this was only an issue for SFT
- The Workforce control process was having an impact on morale and concern of delays impacting delivery of services or improvement plans.
- VTE metric had changed for external reporting from within 24 hours of admission to 14 hours, Clinical management board were considering the change and the impact on reporting.

The Board noted the report.

TB1 1/5/2.6 **People and Culture Committee – 27th March and 24th April**

EJ presented the report and highlighted the following.

- A Deep dive was undertaken on the MLE system and feedback would be provided to both CGC and Audit Committee.
- The BAF discussion confirmed the high-risk areas of digital and workforce and the Workforce risk was out of tolerance
- two gaps in occupational health service that presented an ongoing challenge

Discussion:
The Board queried whether there was a way of collating informal feedback from staff, and it was noted that other mechanisms like Quarterly pulse surveys, freedom to speak up, Board walkabouts, Staff story and Listening events after 100 days were all designed to capture feedback from staff
It was agreed the MW would review the various ways of capturing feedback for the Board

The Board noted the report.

TB1 1/5/3 **STRATEGY AND DEVELOPMENT**

TB1 1/5/3.1 **Improving Together Update Report**

AT presented the Improving Together Quarterly Report highlighting progress in the 2024/25 financial year as well as identifying the focus areas for Q1 and Q2 of the new financial year.

The Board acknowledged the improvements that the program had made in finance and also in the quality of care being provided to patients as evidenced by the reduced of stay to four days less than before the program started.

The Board sought clarity on how the methodology could be used to support the Joint committee in delivery of the corporate project and it was noted that this was now being used in the Joint Committee and was embedding to improve decision making and the development of the Group.

The Board noted the report.

TB1 1/5/3.2 **Triannual Strategy Deployment Update**

The Board welcomed TM to present the report on progress against the Vision Metrics and Strategic Initiatives. Highlights were that

- there was more rigour in the vision, metric and strategic initiative process and clinics were being held to support the owners
- the sustainable workforce metric was now finalised together with the digital strategic initiative metric
- the health inequalities vision metric was slightly revised and together with the organisational sustainability metric
- the new strategic initiative on designing services to meet population needs, was being developed with external partners

Discussion

The Board queried whether there was strategic alignment across the three trusts in the BSW Group and it was noted that the three trusts had the same commitment to workforce, quality of care and interaction with our communities. While different languages were still being used, there were similar underpinning values, commitment and principles.

The Board noted the report.

TB1 1/5/3.3 **Partnerships Stocktake**

TM presented a report outlining SFT's current partnership landscape and developmental areas to enhance collaborative working.

The Board noted that the Trust's ability to deliver outstanding care was fundamentally linked to partnership quality. Success was hinged on meaningful collaboration across the Integrated Care System and beyond, with progress measured through the three partnership vision metrics.

Discussion

The Board discussed the partnership landscape and acknowledged the importance of nuanced mapping as the Group developed. It was important to engage with various stakeholders as a group, but also a sovereign organisation. It was agreed that a Group Stakeholder map would be developed to ensure the balance was right. **CCB**

The Board also noted the importance of including the representative patient voices within the scope of partnership and giving greater priority to the organisations that represented patients and giving equal weight to partnerships as to people and population when making decisions.

The Board noted the report.

TB1 1/5/4 **PEOPLE AND CULTURE**

TB1 1/5/4.1 **National Staff Survey Results**

MW presented the National Staff Survey Results, and the Board noted the overall continued improving trend in the Trust National Staff Survey Results. The Trust was in the upper quartile ranking of trusts for seven out of nine areas, and upper half for the remainder, which far exceeded the ambition to reach at least one upper quartile ranking by 2025.

Discussion

The Board discussed the ambition to achieve the top 25% in at least one of the seven elements of the People Promise and it was noted that the present climate would have an impact on the morale of the teams, however the external environment was universal across NHS organisations.

It was suggested that the Team could also focus on improving the areas showed lower satisfaction and staff that were feeling less engaged

MW pointed out that the in the areas of 'Recognised and rewarded', 'Team' and 'Engagement' the Trust was within 0.03 points of top 25% scores. It was agreed that the Trust could pursue its ambition and also focus on areas that showed lower satisfaction and staff that were feeling less engaged

The Board noted the report.

TB1 1/5/4.2 **Health and Safety Quarterly *Report Eiri chaired this item***

MW presented the report and reported that staff continued to experience violence and aggression, either from confused and struggling patients, but also from patients who were not confused and their families.

Another challenge related to estates was the movement of Tugs

Discussion

The Board sought clarity on the speed restriction and training for Tugs and LT undertook to update the Board **LT**

The Board requested more information on the process in place in the event of a significant health and safety event happening and it was noted that depending on the severity the Managing Director or the Chef Executive event would communicate with the Board in real time.

The Board noted the report.

TB1 1/5/5 QUALITY AND RISK

TB1 1/5/5.1 **Board Assurance Framework and Corporate Risk Register**

FMc presented the BAF highlighting the key risks and risks going into 2025 to 2026.

The Board noted that the risk profile had not changed, and was reflective of the significant risks the Trust was experiencing going into the 2025/26 financial year. The risks related to the financial position, risk to delivery of the

2025/26 Operational Plan given the scale and pace of transformation required, the estate and digital resilience.

One new risk (BAF 11) relating to the scale and pace of the transformation required to deliver the 2025/26 Plan had been added to the BAF.11 BAF risks were out of tolerance, and it was suggested that this warranted a discussion on the risk appetite and whether it was too cautions given the current NHS landscape. It was agreed that this be reviewed in three months.

The Board also noted that BAF 7 would be challenged due to the ongoing changes including EPR deployment and the digital risk was still being assessed

The Board noted the report and review the next three months

TB1 1/5/5.2 **Incident Reporting and Risk Report**

JDy presented the report to provide an overview of risk management activity in Quarter 3. The following was noted.

- SFT harm data was now available to access via the NHSE LFPSE data portal. However, the was a discrepancy between patient safety incident data collected from Datix and those that are on the LFPSE data dashboard. This discrepancy was a consequence of a number of factors, almost exclusively outside of the Trust's control:
- Of the 2700 incidents reported in Q3, 69 (2.55%) of these were reported as moderate or above harm compared with 3.24% of incidents in Q2 and 3.08% in Q1.
- Duty of candour compliance was improving

The Board noted the report.

TB1 1/5/5.3 **Perinatal Quality Surveillance Report March (February data)**

The Board welcomed VM to present the Perinatal Quality Surveillance Report March (February data). Highlights were that.

- There was one stillbirth in February.
- The PPH>1500ml thematic review had noted higher incidences of women from global majority (30%) despite this group representing 12% of maternity service users.
- There was a review of the Trust's claims scorecard used to agree targeted interventions aimed at improving patient safety.
- The Badgernet system had been successful implemented in maternity and was going well.

The Board noted the report.

TB1 1/5/5.4 **Perinatal Quality Surveillance Report April (March data)**

VM presented the report and reported that 14 incidents had been reported as moderate at the end of March, however some of the incidents were likely to be downgraded.

The Board noted the report.

TB1 1/5/5.5 **Bi-Annual Midwifery, Maternity & Neonatal Staffing Report March 2025**

VM presented the Maternity and Neonatal Bi-Annual Staffing report – March 2025 to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from September 2024 to February 2025. This was a requirement of the CNST Maternity Incentive Scheme and relates to Safety Action 5.

The Board noted the report

TB1 1/5/6 **GOVERNANCE**

TB1 1/5/6.1.1 **Annual Review of Directors Interests**

FMc presented the report on the Annual Review of Directors Interests. It was a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests of the Board. Staff on NHS Band 8d and above, procurement staff and Budget Holders Band on 8a and above had been included in the register. No concern had been raised from all the declarations and this formed part of the Counter Fraud functional standard submission. The Board declaration would form part to the FPPT submission

Compliance level was at 99% this year the Board thanked Christina Steel for all the work done in achieving high compliance rate.

The Board noted

TB1 1/5/6.1.2 **2024/25 Annual Review of Gifts and Hospitality**

FMc presented the report on the Annual Review of Gifts and Hospitality. The Board expressed concern at the low number of declarations made and encouraged the team to add rigour in the process.

The Board noted

TB1 1/5/6.2.3 **Fit and Proper Persons Annual Assurance**

FMc presented the report to provide assurance of the Fit and Proper Persons Annual process. The FPPT report would be submitted to the Regional Team as part of the annual submission process.

The Board noted the report.

TB1 1/5/6.2 **Integrated Accountability and Governance Framework to include Review of Board Committee Terms of Reference**

FMc presented the Integrated Accountability and Governance Framework to include Review of Board Committee Terms of Reference.

The IGAF would be further reviewed when the SOF had been published by NHSE. The Committee ToRs had been reviewed by the Committee and recommended for approval

The Board noted the report and approved the Committee ToRs.

TB1 1/5/6.3 **Annual Review of Constitution**

FMc presented the report on the annual review of the Constitution
A number of changes had been approved, and further amendments had been made to following the Council meetings.
Annex 9 had been further reviewed to enable Group working and would be taken back to COG for approval.

The Board thanked the Governors for the diligence in the process and Fiona McNeight for the work.

The Board endorsed the changes to the Constitution

TB1 1/5/6.4 NHSE Self-Certification (CoS7)

FMc presented the report on the NHSE Self-Certification (CoS7) and Training for governors which was a condition for the licence.

The self-certification would be published on the website

The Board approved the NHSE Self-Certification (CoS7) and Training for governors

TB1 1/5/6.5 Joint Committee Terms of Reference and Partnership Agreement

CCB presented the Joint Committee Terms of Reference and Partnership Agreement and informed the Board that the documents had been developed by a working party of Non-Executive and Executive Directors nominated in January 2025 supported by the legal advisors, Browne Jacobson. The group held four workshop sessions and in March invited feedback from colleagues on membership options, quorum and decision-making arrangements. The documents had been localised to ensure they met the needs of the local population.

The working group had recommended the establishment of a special purpose Joint Committee with a clear set of delegated responsibilities from Boards – known as 'Joint Functions'. The Joint Committee would be a committee of the sovereign Boards and fully accountable to each Trust Board. The recommended list of Joint Functions delegated included:

- Group Strategy & Planning
- Transforming our Model of Care - Clinical Services Organisation/ Pathways/ Design for the population we serve
- Financial Recovery & Sustainability - Use of Resources
- Group Mobilisation & Development – including Operating Model, Accountability Framework, Corporate Services model.
- Achieving Digital Maturity – including EPR and Group Digital programme

The initial membership had been proposed as follows:

- Trust lead Non-Executives [Chair, & Vice/Deputy]
- NEDs – 3 per Trust
- Trust lead Executives [CEO, MD x 3]

- All Executive Professional portfolios represented, divided between Trusts [Roles: CNO, CMO, CFO, CPO, CSO, COO, E&F, CITO] NB. Joint Executive Roles x 2, therefore 6 posts from the Trusts.

Work was underway to finalise the membership through the nominations by Trust Chair of the each of the organisations. IG added that the Joint Committee was a joint committee of the three boards, and it did not have a constitutional form of its own outside what had been delegated from the three sovereign bodies. The Boards would be bound by the decisions of the Joint Committee and would therefore be ceding their sovereignty in the five areas. The Joint Committee enabled collaboration, and the expectation was that decisions would be made by consensus.

The Board sought clarity on the information flows and consultation route for the decisions made and it was noted that discussions would be held at a local, level before going to the Joint Committee. It was noted that the governance forward planning and policies for the Trust would been refreshed and aligned to enable quick decision making.

The Board

- Approved the BSW Hospitals Group Partnership Agreement and the five Joint Functions
- Approved the Terms of Reference of the special purpose Joint Committee
- Approved the execution of the Partnership Agreement by 9th May.
- Requested that the Chair and Chief Executive to nominate members of the Joint Committee.
- Agreed to establish the BSW Hospitals Group Joint Committee in May.

TB1 1/5/7 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 1/5/7.1 Business Plan 2025/2026

NP presented Business Plan for 2025/2026

The plan was designed to build on the work undertaken during 2024/25, in which the Trust delivered significant improvements and was expected to deliver;

- A route to break even through CIP delivery (£20m needed – identified £17.5m with identified risk) and the plan highlighted the current risk
- The plan also ensured that the Trust delivered the key headline access targets during 2025/26, including delivering further 5% improvement in RTT, delivery of caner targets and getting the 4hr target to 78%.
- The plan would also ensure that the Trust continued to deliver its improvements within Maternity and other safety measures.

The four main levers of the plan were Productivity, Closure of beds, Efficiencies and outpatient transformation programme.

Discussion:

The Board noted the material amount of financial risk in this plan and the challenging set of deliverables that underpinned its delivery. It was agreed

that the Board be cited on the delivery through deep dives in F&P and the risk through the BAF

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The Board Approved the Business Plan 2025/2026

TB1 1/5/7.2 **Review of Standing Financial Instructions and Scheme of Delegation**

ME presented the Standing Financial Instructions and Scheme of Delegation which had been reviewed to reflect the current structure.

The Standing Financial Instructions and Scheme of Delegation had also been reviewed by the Audit Committee and recommended for approval

The Board approved the revised Standing Financial Instructions and Scheme of Delegation

TB1 1/5/7.3 **Estates Technical Service Update**

ME presented report on the work of the Estates Department, consisting of Estates Technical Services (ETS) and Capital Projects teams during the last quarter covering the period January 2025 – March 2025 including current and ongoing risk positions.

One extreme risk (Estates CAFM System) and three high risks remained which had continued beyond target of the end of the 2023/24 financial year due to volume of works. These were now targeted for closure and removal of the high risks by late 2025

The Board noted the report.

TB1 1/5/8 **CLOSING BUSINESS**

TB1 1/5/8.1 **Any Other Business**

None

TB1 1/5/8.2 **Agreement of Principle Actions and Meeting Reflection**

TB1 1/5/8.3 **Public Questions**

There were no public questions.

TB1 1/5/8.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 3rd July 2025.

TB1 1/5/9 **RESOLUTION**

TB1 1/5/9.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Tapiwa Songore	TB1 1/5/3.3Partnerships Stocktake	01/09/2025	Cara Charles Barks	A Group Stakeholder map would be developed to ensure the engagement balance was right	**Due in September**	N	4
Trust Board Public	Tapiwa Songore	TB1 1/5/4.2Health and Safety Quarterly Report	01/06/2025	Lisa Thomas	LT to update the Board on the the speed restriction and training for Tugs	**Completed**	Y	3

Register of Attendance – Public Board 2025/26

	1 May	3 July		4 Sept	6 November		8 January	5 March	attendance rate
Non-Executive Members									
Ian Green (Chair)	✓								1/1
Debbie Beaven	✓								1/1
Richard Holmes	✓								1/1
Kirsty Mathews	✓								1/1
Eiri Jones	✓								1/1
Rakhee Aggarwal	✓								1/1
Paul Cain	✓								1/1
Anne Stebbing	✓								1/1
Executive Director Members									
Mark Ellis	✓								1/1
Lisa Thomas	✓								1/1
Melanie Whitfield	✓								1/1
Judy Dyos	✓								1/1
Duncan Murray	✓								1/1
Niall Prosser	✓								1/1
Cara Charles Barks	✓								1/1
Non-Voting Executive Directors									
Fiona McNeight	✓								1/1
Alex Talbott	✓								1/1
Jonathan Hinchliffe	✓								1/1

Governor Observer								
Jane Podkolinski	✓							
Jayne Sheppard								
Frances Owen	✓							
Peter Russell	✓							

Attended - ✓

Apologies – X

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of meeting:	3rd May 2025		

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

Recommendation:

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

Executive Summary:

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

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

National

Urgent & Emergency Care Plan 2025/26

The Urgent and Emergency Care Plan 2025/26 was published on 6th June 2025 and outlines how patients will receive better, faster and more appropriate emergency care as the Government sets out reforms to shorten waiting times and tackle persistently failing Trusts.

The new package of investment and reforms will improve patients' experiences this year, including caring for more patients in the community, rather than in hospital which is often worse for patients and more expensive for taxpayers.

Backed with a total of nearly £450 million, the Urgent and Emergency Care Plan 2025 to 2026 will deliver:

- around 40 new same day emergency care and urgent treatment centres - which treat and discharge patients in the same day, avoiding unnecessary admissions to hospital;
- up to 15 mental health crisis assessment centres to provide care in the right place for patients and avoid them waiting in A&E for hours for care, which is not the most appropriate setting for people who are experiencing a crisis. These centres will offer people timely access to specialist support and ensure they are directed to the right care;
- almost 500 new ambulances will also be rolled out across the country by March 2026.

The plan's emphasis will be on shifting more patient care into more appropriate care settings as part of the move from hospital to community under the government's Plan for Change to rebuild the NHS, while tackling ambulance handover delays and corridor care.

Further information on the Urgent & Emergency Care Plan 2025/26 can be found via https://www.england.nhs.uk/publication/urgent-and-emergency-care-plan-2025-26/

An overview of the current Urgent and Emergency Care performance across the Trust is outlined below:

Flow around the Trust continues to be challenged as the number of patients with No Criteria to Reside (NCTR) and Bed Occupancy levels remain high, with both increasing slightly to 94 average and 96.7% respectively. Attendances into the Emergency Department (ED) also remain high at 7,392 in month overall, with Type 1 specific attendances of 5,129 being the highest number on record. Despite this, the core metrics of 4-hour Standard performance and Ambulance Handover time both improved slightly to 70.3%, although behind trajectory by 3.6% total and 25 minutes average, against a trajectory of 23 minutes.

National Maternity Investigation Launched to Drive Improvements

On 23 June 2025 the Health and Social Care Secretary announced that there will be a rapid national investigation into NHS maternity and neonatal services. It is believed that the investigation will have two phases, the first will investigate up to 10 maternity and neonatal services, NHS England has yet to confirm which trusts will be involved. The second phase will undertake a system-wide review of maternity and neonatal care, bringing together lessons learned from past inquiries to create one clear plan; the terms of reference for this review are being developed by NHSE.

An overview of the current Maternity and Neonatal services across the Trust is shown below:

The maternity services at Salisbury NHS Foundation Trust were rated “Good” by the Care Quality Commission in October 2024. In 2025, the Trust reported compliance with the 10 Safety Actions for year 6 of the Maternity Incentive Scheme. The Maternity and Neonatal team report monthly to the Board which provides a comprehensive briefing on maternity and neonatal services.

Closure of the Special Care Baby Unit at Yeovil Hospital
On 19 May 2025 Somerset Foundation Trust made the difficult decision to temporarily close their Special Care Baby Unit at Yeovil Hospital, as a result, the Trust is also unable to safely provide care during labour and birth at the Yeovil Maternity Unit for an initial period of six months. Outpatient services continue as usual including antenatal clinics, consultant clinics, scanning and community midwife service, including the homebirth service. There is potential a small number of people will choose to attend Salisbury for their care.

NHS Oversight Framework 2025/26
The new NHS Oversight Framework 2025/26 was published on 26th June 2025 and describes a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

This 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

Further information about the NHS Oversight Framework 2025/26 can be found via:
https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

Group Update

Group Electronic Patient Records (EPR) Programme Senior Responsible Officer (SRO)
The Board is formally asked to note the transfer of the SRO for the Group EPR from the interim Managing Director at the RUH to the interim Chief Transformation & Innovation Officer with effect from 28th May 2025. This change will optimise the programme leadership and governance approach to mitigate the risks associated with the EPR Programme. Thanks go to the RUH interim Managing Director for providing SRO support up to the transfer.

Updates on the EPR Programme will be provided to the Board on a regular basis.

Leadership Team – Confirmation of Managing Director Appointments
In May we confirmed the appointment of three new substantive Managing Directors across BSW Hospitals Group, each bringing a wealth of experience in leadership and a strong track record of delivering high-quality, patient-centred services. As Managing Directors, they will be responsible for the overall operational leadership of our hospitals. They will work closely with each other, their Boards and senior leadership team, and together as part of our Group leadership. The appointments are:

- Great Western Hospitals Swindon - Lisa Thomas. Lisa joins from Salisbury NHS Foundation Trust where she is currently the Interim Managing Director.

- Royal United Hospitals Bath - John Palmer. John joins from Royal Devon University Healthcare NHS Foundation Trust where he is the Chief Operating Officer.

- Salisbury NHS Trust - Nick Johnson. Nick joins from a joint role with Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust where he is Joint Chief Strategy, Transformation and Partnerships Officer and Deputy Chief Executive at Dorset County Hospital.

Interim Chair & Vice Chair Appointments
In May and June, the Trusts also held successful appointment processes for an interim Joint Chair for RUH & GWH (Liam Coleman), an interim Chair in SFT (Eiri Jones) and Vice Chairs in GWH (Faried Chopdat) and RUH (Sumita Hutchison). In coming weeks, the Councils of Governors, company secretaries and governance leads will support the establishment of a joint Nominations Committee to coordinate recruitment of a substantive Joint Chair by April 2026.

Partnership Agreement and Joint Committee Establishment
In May, Trust Boards approved our BSW Hospitals Group Partnership Agreement, including Joint Committee Terms of Reference. The Partnership Agreement was executed on 22nd May, and on 23rd May, Salisbury NHS Foundation Trust hosted the inaugural BSW Hospitals Group Joint Committee meeting. A full committee report to Boards from the Group Joint Committee will be issued with minutes in the 4th week of July.

The next Joint Committee meeting will be held on 16th July in Swindon and will focus on discussion and approval of the proposed Group Operating Model and Leadership Model. A new Group Integrated Performance Report (IPR) will be shared and detailed corporate services model plans will be introduced for priority services – Finance, People, Digital, Estates & Facilities and Capital Planning - plus Corporate Governance and Communications.

Board to Board Development
The 4th of June saw RUH host the latest of our Board-to-Board development days. Discussion generated a series of areas for focused work – including on potential Target Operating Model and development of our Governance and Accountability Framework. A report on proposed next steps is included in July Board papers. Further Board-to-Board sessions are planned in October and next February.

Operating Model/Leadership Structures/Corporate Services
Work to establish our new operating model has continued in May and June, supported by colleagues from Teneo. Corporate services will be an important element of the new operating model. A comprehensive joined-up corporate services programme is now in place. A Project Director funded by NHS England has recently joined, and a Steering Group has been established to oversee the programme.

Group Engine Room
In June, Improving Together Leads confirmed plans with the Managing Directors to establish a Group Engine Room meeting monthly from July, to help us align teams across the Group around our biggest problems and priority programmes.

Mutually Agreed Resignation Scheme (MARS) across GWH, RUH, and SFT
Following agreement in the Joint Committee on 23rd May, BSW Hospitals Group introduced a MARS scheme. MARS enables our Trusts to support staff to leave their organisation on a voluntary basis support Trust corporate service savings. The scheme ran between 2nd and 20th June 2025. An update on the take-up rate and impact of the MARS scheme will be shared in August.

Managing Directors – Local update

The Trust has had another busy few months which is reflected in the integrated performance report. Overall performance remains positive with continued performance maintained across the key metrics. The most challenging element is delivering the financial improvements at pace and alongside increased patient demand. The Trust is subject to additional financial controls, particularly on workforce recruitment, due to the size of the collective deficit across the Bath Swindon and Wiltshire system. The scale of change is significant for the organisation, needing to ensure that we meet the financial challenges through service improvements and implement a new digital system in the replacement electronic patient record (EPR).

Chair

Ian Green finishes his role at the end of June as the Trust Chair, as he has accepted a new appointment as Chair of the NHS Shropshire, Telford and Wrekin Integrated Care Board. During his tenure at Salisbury, he presided over the Trust achieving positive staff survey results and securing a “good” rating for its maternity services from the Care Quality Commission. We thank Ian for his leadership and commitment to compassionate, high-quality patient care.

I am pleased to share that Eiri Jones has been appointed as our Chair on an interim basis for the next nine months whilst a recruitment process is underway for a joint chair for BSW Hospitals Group with GWH and RUH.
Eiri has been a Non-Executive Director at SFT for the last 6 years and brings a wealth of experience in NHS leadership having held a number of senior roles across the NHS. Eiri is a nurse by background and her advocacy for patients is always as the centre of her approach.

The Care Quality Commission (CQC), the independent regulator of health and social care in England, conducted an unannounced inspection in June across our Medical Wards and Endoscopy. They have more follow up conversations to have with some of the Medicine Divisional Management Team and they will ask us to submit more information and data in coming weeks. We won't know the formal inspection outcome for some time yet. However, they did want to share a thank you to all the staff they spoke to. They commented how friendly and welcoming staff were. Some of the verbal feedback included "staff were very friendly, knowledgeable and really good teamwork observed".

Open Day

We had another incredibly successful open day in the hospital on the 7th of June. Thank you to everyone who took part in an incredible Open Day on Saturday which saw well over 1500 guests attend. Judging from the smiles I saw, everyone was having a great time. I have the honour of judging the award for best exhibitor and every department would be worthy of a mention as all staff really did pull out all the stops to showcase what they do.

Staff Awards

The staff awards have been launched for 2025, which culminate in “Thank You” week in September. We have invited colleagues, patients and the public to nominate teams or individuals that reflect the Trusts values. The awards programme provides an opportunity to applaud our hard-working and committed people for their unwavering dedication to our hospital and the efforts they make in providing compassionate care for our patients. I would like to encourage everyone to nominate colleagues and wider teams who have embraced the challenges over the last year, so we can celebrate their contribution to SFT.

Volunteers week

We celebrated volunteers’ week, in 2024 our volunteers gave a staggering 26,605 hours of their time to the hospital. They perform an array of duties, some of which blend in and go unseen. They are hugely appreciated and contribute to the overall patient experience we are able to provide. As a gesture of our thanks, we held a ‘thank you afternoon tea’ for volunteers.

We have had a month of celebrations for a number of areas this month, including armed forces week, learning disability week, national estates and facilities day, world well-being day, Pride, Windrush day. All give us the opportunity to celebrate our colleagues in different ways showcasing everyone who makes a contribution to making patient care outstanding at SFT.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	3rd July 2025		

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

Recommendation:

The Trust Management Committee are asked to note the Trust's operational performance for Month 2 (May 2025).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* remains fairly static at 127 days but continues the improved trend overall, reduced from 147 days.
- *Productivity* remained static at -13.18% against the revised target of -5.33% and now a total of 1.79% improvement against the adoption baseline of -14.97% in April 2024.
- *Managing Patient Deterioration* continued its improvement from 48.5% to 51.3% against the 60% target and new highest point, a total of 5.6% improvement against the baseline of 45.7% in April 2024.
- *Staff Retention* reduced fractionally from 18.3% to 18% against the 15% target and maintains an improved position overall, now 2.4% improvement and against the baseline of 20.4% in April 2024.

Alert

- Flow into the hospital continues to be challenged with *Bed Occupancy* rising from 96.1% to 96.7% average across the month.
- *No Criteria to Reside (NCTR)* also remains high and increased from 92 to 94 against the plan of 66.
- *Income* reported an in-month position of £1.1m deficit against the breakeven plan. The Year to Date (YTD) adverse variance against plan is £3.8m, of which £2.3m is due to the loss of deficit support funding.
- Cancer performance deteriorated in April:
  - *28-day Faster Diagnosis Standard (FDS)* reduced from 75.8% to 73.9% and continues below plan for the fourth month in a row.

- *62-day Standard* reduced sharply from 72.7% to 62.8% and from plan achieving position to one that is far below. Urology remains the top contributor.
- Patients waiting *More than 62 days* for Cancer treatment increased for the first time in months from 55 to 70 and accounts for 6.39% of total waiting list, with Urology the top contributor.

Advise

- Despite high *Attendances* at 7,392 total and Type 1 specific attendances of 5,129 (the highest on record), the Emergency Department (ED) performance generally improved:
  - *4-hour Performance* increased from 69.2% to 70.3%.
  - *Ambulance Handover* time reduced from 27 to 25 minutes average.
  - *Ambulance Handovers >60 minutes* reduced from 92 to 77.
  - *ED 12-hour Breaches (arrival to departure)* increased from 433 to 462.
- Patients in *Corridor Care* increased in both metrics:
  - *ED Attendances placed in Corridor Care* from 238 to 242.
  - *Inpatients placed in Temporary Use of Escalation Beds* from 6 to 13.
- Stroke Care measure of *Motor Minutes per Patient per Day* minutes decreased markedly from 50 to 32 minutes as staff shortages impacted.
- *Total Number of Complaints Received* increased from 18 to 26 total.
- *Total Number of Compliments Received* increased from 9 to 24.

Assure

- Incidents resulting in High Harm reduced for the first time in 5 months from 4.2% to 1.8%.
- Diagnostics *DM01 Standard* reduced marginally from 80.1% to 79.9% with Ultrasound and Endoscopy the top contributors to backlog.
- *Pressure Ulcers* reduced across all categories, with category 2 reducing slightly from 2.4% to 2.2%.
- *Referral to Treatment (RTT)* waiting list metrics continued improvement overall:
  - Patients waiting *>52 weeks* reduced again from 572 to 524.
  - Patients waiting *>65 weeks* increased from 0 to 3 and will be difficult to meet rolling expectation of 0 in the short-term due to capacity constraints in Plastic Surgery.
- *RTT Performance* increased from 64.96% to 66.8% against the March 2026 target of 65%.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

July 2025

(May 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

May saw generally improved performance across key metrics. The national target for waiting lists this year is the *Referral to Treatment (RTT)* performance - the percentage of patients waiting less than 18 weeks from referral to treatment - where the target is 65% by the end of March 2026. The Trust recorded performance of 66.8% in May 2026 and is one of the fast-improving Trust's in the country. Work to reduce long waits for patients continues, as the number waiting *Longer than 52 weeks* reduced again to 524 patients, although the number waiting *Longer than 65 weeks* increased to 3 patients. The access related breakthrough objective of *Wait Time to 1st Appointment* reduced fractionally to 127 days and remains improved overall.

Cancer - reporting a month behind, April data - which deteriorated slightly from the previous month. The *28-day Faster Diagnosis Standard (FDS)* was 73.9% and the *62-day Standard* was 62.8%. Urology remains the top contributor to under performance. Diagnostics *DM01 Standard* performance reduced again marginally to 79.9% with work ongoing in top contributing modalities of Ultrasound and Endoscopy to address. The Stroke Care measure of *Motor Minutes per Patient per Day* reduced sharply to 32 minutes average impacted by staffing shortages.

Flow around the Trust continues to be challenged as the number of patients with *No Criteria to Reside (NCTR)* and *Bed Occupancy* levels remain high, with both increasing slightly to 94 average and 96.7% respectively. *Attendances* into the Emergency Department (ED) also remain high at 7,392 in month overall, with Type 1 specific attendances of 5,129 being the highest number on record. Despite this, the core metrics of *4-hour Standard* performance and *Ambulance Handover* time both improved slightly to 70.3% total and 25 minutes average, with wider ED metrics also reflecting good performance in the face of the challenge: *Ambulance Handovers more than 60 minutes* reduced to 77 and *ED 12-hour breaches* increased slightly to 462 (9% of total attendances). However, the *Temporary Use of Escalation Beds* increased to 13 total and the *ED Corridor Care* also increased to 242 total admissions, reflective of the constraints.

The quality breakthrough objective of *Managing Patient Deterioration* continued improvement to new high point of 51.3% with observations at each risk level remaining stable. Wider quality metrics were contrasting: *Mixed Sex Accommodation breaches* increased to 21 and likely caused by flow challenges, *Incidents resulting in High Harm* reduced notably to 1.8% and *Pressure Ulcers* also reduced across all categories, with category 2 down slightly to 2.22.

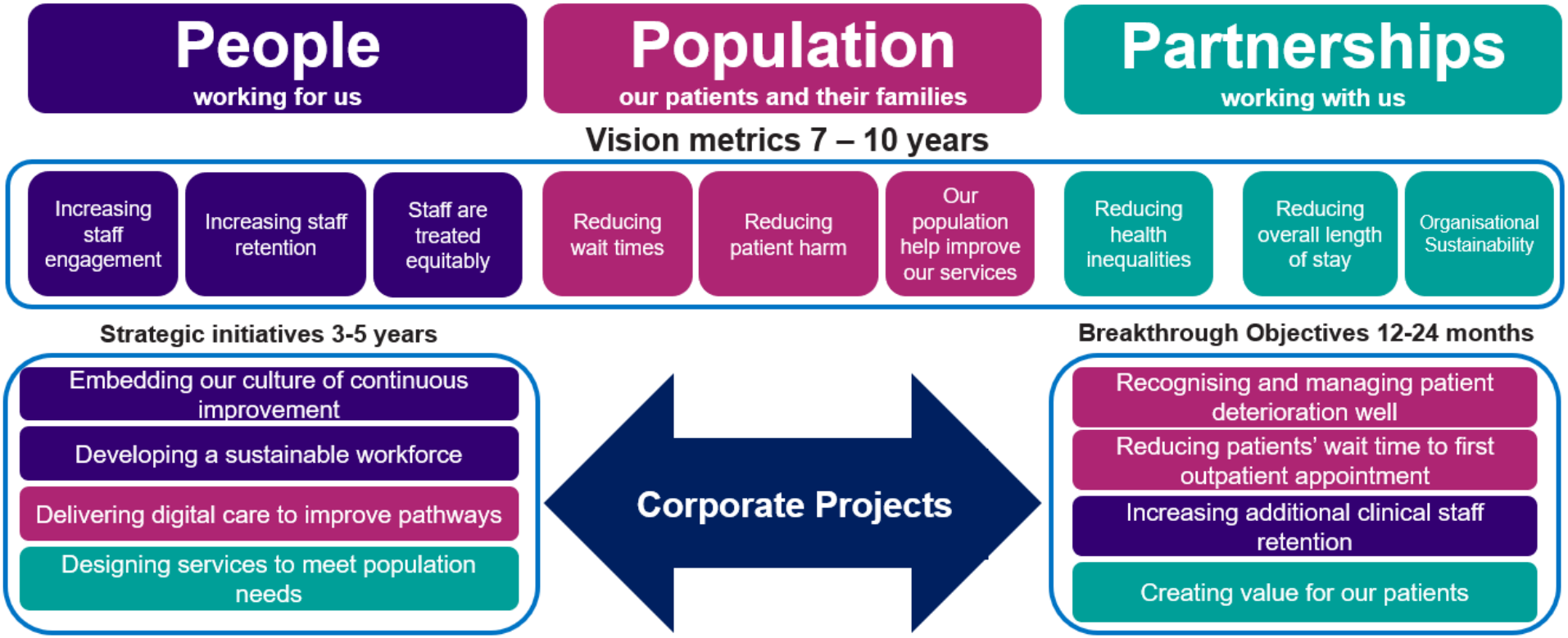
The workforce breakthrough objective of *Staff Retention* reduced to 18% after 2 months of increases and continues the improved trend overall. Other workforce metrics were positive, with *Staff Sickness Absence* reducing to 3.3% and *Staff Vacancies* extending the improvement through a static position of -0.6% and signifying that the Trust is above establishment.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* remained static at -13.18% against the revised target of -5.33%. The Trust reported an in-month position of £1.1m deficit against the breakeven plan. The Year to Date (YTD) adverse variance against plan is £3.8m, of which £2.3m is due to the loss of deficit support funding.

Strategic Priorities

NHS Salisbury NHS Foundation Trust

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



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

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

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

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

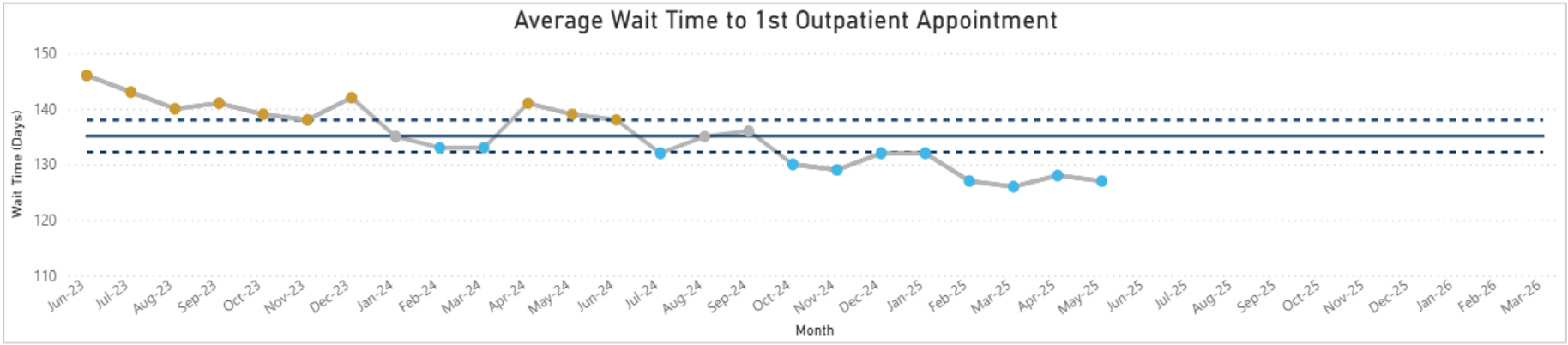
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≤90 days Performance: 127 days Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date
Time to first outpatient appointment (TT1OPA) performance has remained relatively stable between April - May, with performance in both months averaging to 127 days. There was a slight increase in the weekly performance data over the May holiday period, but this has since recovered. High waiting list specialties (>500 patients) with longest average wait times (in days) are: Respiratory (182), Rheumatology (175), and Trauma and Orthopaedics (153). These account for 3 of the 4 Trust focus specialties that are currently being engaged with to consider what additional improvement strategies can be completed to bring down TT1OPA waits.	• To establish the required leadership structure to support the TT1OPA work going into the 2025/26 period. This will include an Outpatient Operational Manager and Clinical Lead. • Develop an Outpatient Programme to support the delivery of the national Elective Reform targets. This will involve agreeing a strategy and programme of work for addressing TT1OPA waits across the Trust. • Investigate how Robotic Process Automation could support efficiency improvements within key outpatient workflows, both at a Booking and Clinical level.	Complete: In post 09/06/2025 30/06/2025 30/06/2025

Risks and Mitigations
• Risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties. Mitigation: The programme strategy includes monitoring and specific focus on top contributing areas. • Risk to project delivery if the required Operational and Clinical Leads, and Transformational resource, is not in place. Mitigation: Recruitment has been completed for the Outpatient Operational and Clinical lead. Transformational resource will be requested as part of the CPPG proposals in July.

Recognising and Managing Patient Deterioration

Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≥60% Performance: 51.3% Position: Common Cause

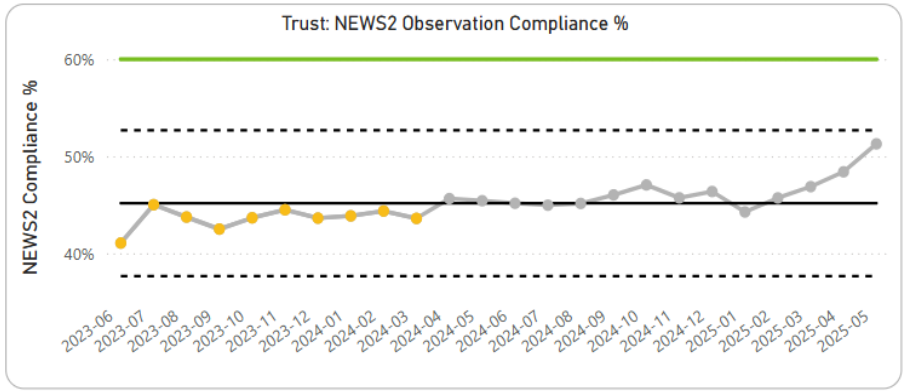


Chart A: NEWS2 scores of 3-6

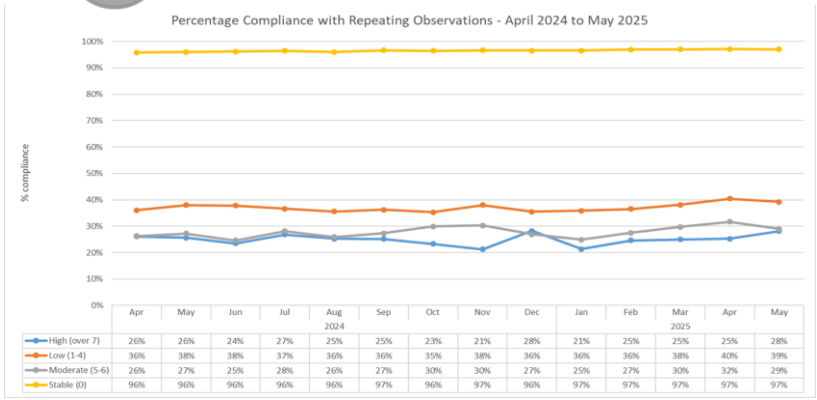


Chart B: NEWS2 scores by risk categories

Understanding the Performance

Improvement continues to 51.3% and collaborative work with ward leaders to improve further is ongoing. The Trust compliance with repeating clinical observations in line with the national standard is:

- Stable (NEWS2 0): 97%
- Low risk (NEWS2 1-4): 39%
- Moderate risk (NEWS2 5-6): 29%
- High risk (NEWS2 7 and above): 28%

The average time for the Registered Nurse (RN) to electronically document decision to escalate (not shown) has remained unchanged.

Chart A includes agreed departments and wards across the Trust with NEWS2 scores of 3-6. Chart B is measuring inpatient wards only, across all NEWS2 scores therefore making the sample size larger. This accounts for the difference in compliance.

Countermeasure Actions	Due Date
RECORD:	
• Ward individual A3's monitored through the divisions.	Ongoing
RECOGNISE:	
• Continue to evaluate patient outcomes for those patients identified at the daily huddle.	Ongoing
RESPOND:	
• Complete A3 following baseline audit.	Ongoing

Risks and Mitigations

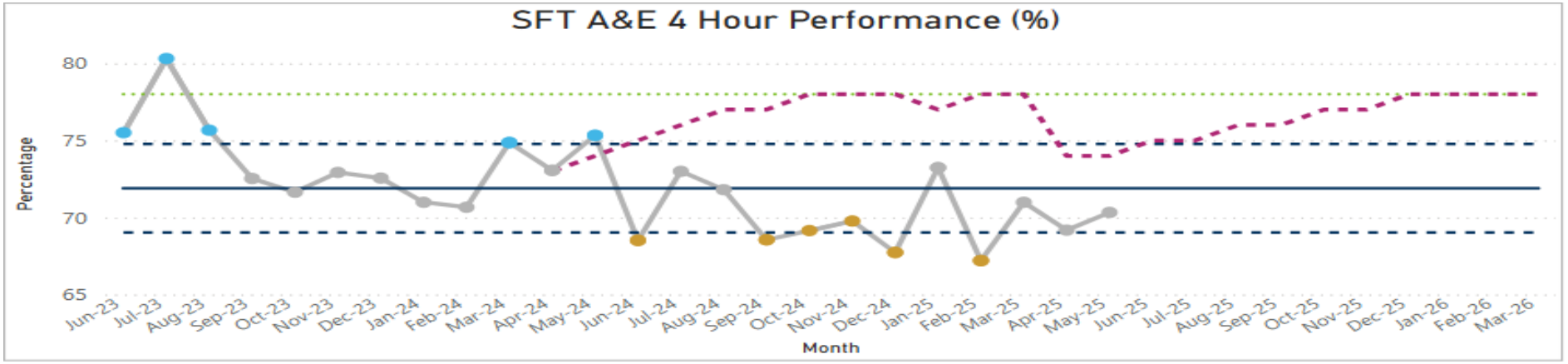
There is still a risk of unrecognised deterioration which may lead to patient harm. However, whilst we continue to learn and improve, other measures allow us to monitor the risk including:

Positive

- Overall mortality rates remain low.
- Cardiac arrest rates remain low.
- Medical emergency team call are increasing.
- Admissions to Radnor Ward increasing.

Emergency Access 4-hour Standard

Target: ≥78% Performance: 70.3% Position: Common Cause



Month	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Proportion of patients spending more than 12 hours in an emergency department	7.5	4.3	4.3	6.4	5.6	8.0	7.1	7.8	10.5	8.7	8.9	9.0

Understanding the Performance

Trust 4-hour performance remains in a static position at 70.3% for May against target of 74%. Attendances remain high at 7,392 in month total and Type 1 specific attendances 8% higher year to date than 24/25, and 3.5% above plan. Absence across the ENP Team has impacted on non-admitted performance. Flow out of the department remains the biggest contributor with average time in department for admitted patients around 11 hours.

No Criteria To Reside (NCTR) was 21.2% against a target of 9% contributing to high bed occupancy. Average Length of Stay (LoS) was 6.73 days and although improved slightly in month is above the mean for average LoS.

The Medical Take was diverted on occasions to avoid the bedding down of Same Day Emergency Care (SDEC) unit, as this has negative impact on the numbers of patients that can be discharged same day from SDEC. Surgical 0-day LoS also seeing a dip in SAU and Surgical SDEC performance.

Countermeasure Actions	Due Date
• AMU / SDEC capacity huddle at 16:00 now in place to increase communication and decrease the chances of a preventable medical take divert.	June 2025
• Review of options to extend SDEC service hours and staffing requirements to allow more streaming options from ED.	June 2025
• Minors and ENP staffing and absence review ongoing as part of workforce development and listening event feedback.	July 2025
• NCTR transformation works continue and number of different actions in place (seen within Slide 10 - Optimising Beds).	Ongoing

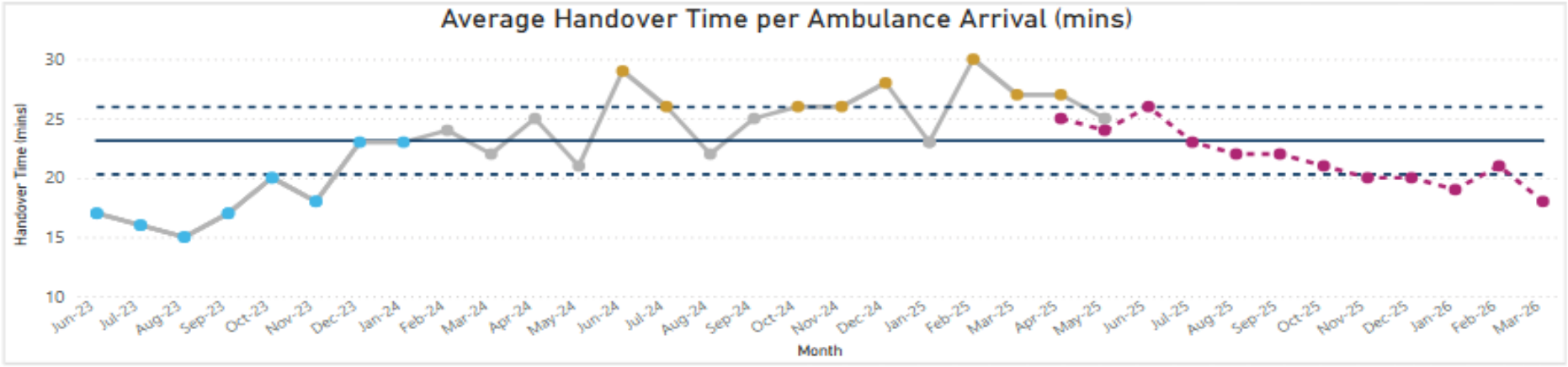
Risks and Mitigations

- Capacity review daily to maintain oversight of any increasing risk of a divert.
- Inability to control the number of patients awaiting external partner discharges. Pathway 1 plans in place to support increased discharge.
- Lack of robust pathways and inability to stream maximum potential patients.
- 'The Big ED Survey' currently recruiting responses from patients, revealing the reasons for attendances at the ED. Survey open till end July 2025.
- System work ongoing with HCRG on admission avoidance. NCTR plan to reduce to 9% of bed base by Mar 2026.

Ambulance Handover Delays

Salisbury NHS Foundation Trust

Target: <u>≤24</u> mins Performance: 25 mins Position: Common Cause



Understanding the Performance
Ambulance Handover average time in May was 25 minutes against the trajectory target set at 24 minutes. This continues to show a more stabilised picture across the previous 8 months, with some variation seen across the winter months as expected. May demonstrated the 3rd consecutive month of improved performance on average. The 60 minutes performance (handovers completed in less than 60 minutes) has seen an average of 94.1% with some variation in performance (between 70.3% - 100%). However, a greater number of days in which 100% was achieved. The days in which performance was poor, was directly associated with an increased Length of Stay (LoS) in the department, alongside an increase in No Criteria to Reside (NCTR), in the 7days preceding. The data evidencing Time to 1st clinician is on a downward trend due to workforce gaps, causing delays in clinical assessment.

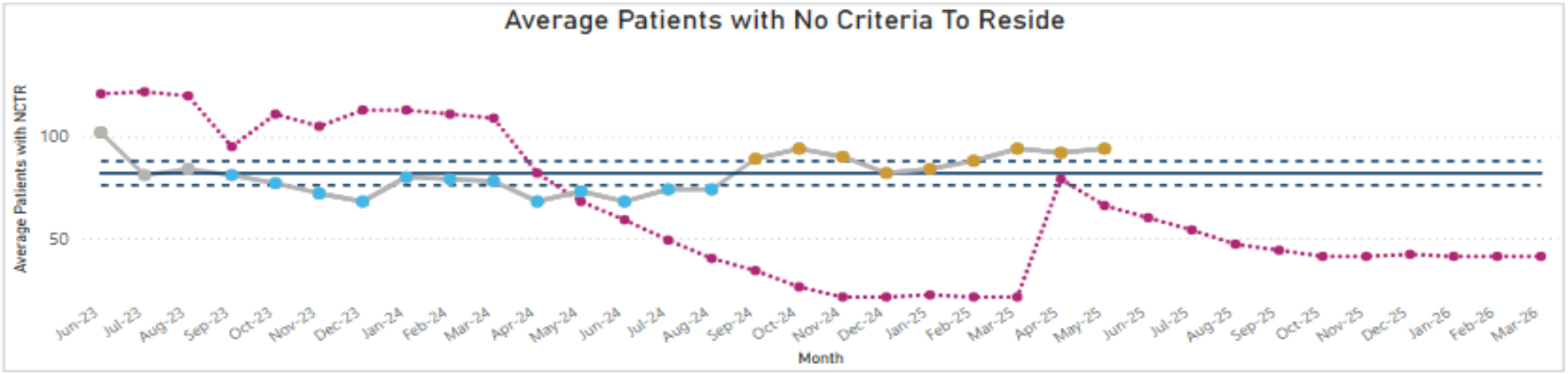
Countermeasure Actions	Due Date
• Focus on time to 1st clinician and recruitment to the consultant team.	Aug 2025
• The revised trajectory target for 2025/26 will continue to readjust focus to see continued improvement.	Ongoing
• NCTR workstreams continue with sustained engagement between SFT and System Partners.	Ongoing
• Increase Non-ED pathways to avoid conveyance – led by System Ambulance handover group.	Ongoing
• Updated escalation plan to prevent the bedding down of SDEC. Approved by execs 20th May, comms plan in place. SOP for Diversion of the Medical Take in progress.	July 2025

Risks and Mitigations
• The 'Direct to Waiting Room' appendix within the SWAST Handover SOP is due for discussion with SWAST 16/06/2025. Concern has been expressed by clinicians should this appendix be enacted. This process is currently mitigated by ensuring Rapid Assessment Treatment and Triage (RATT) is staffed by Nursing and Medical staff who can provide immediate assessment and utilise Amulatory Majors as appropriate. This currently mitigates any risk to performance although there is an opportunity to explore further streaming to the waiting room.
• The successful implementation of the revised escalation plan provides mitigation to the risk of performance dropping during any surge in ambulance arrivals.
• Diversion of the Medical Take is currently mitigated by operational and clinical discussion, however, requires formalising in the form of an SOP.

Optimising Beds

Salisbury NHS Foundation Trust

Target: ≤25 (5%) Performance: 94 Position: Special Cause Concern

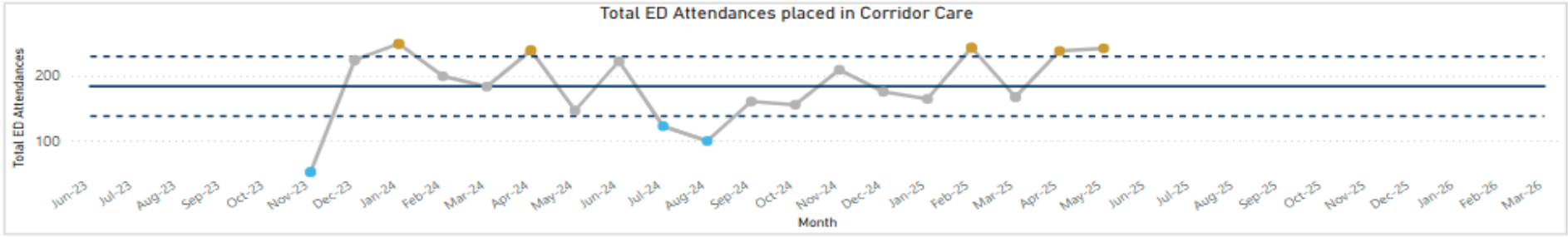


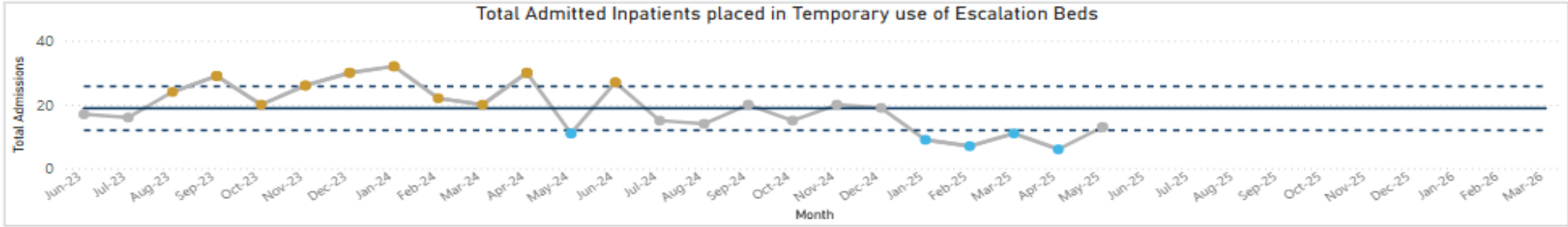
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The average number of patients with No Criteria to Reside (NCTR) for May sits at 21.2% of the core bed base and at sustained high levels for a further month, with 94 patients average against the accepted steady state of 41 and plan target of 66. Also noted is an increase in the number of average delayed bed days from April to May: from 1564 to 1796 days. The top contributor for those patients with NCTR is Interface delays in Pathway 1 (patient, family, carer choice discussions on Package of Care).	• NCTR trajectories set for SFT with help from the ICB. System partners to work daily trajectory for discharges to NCTR to planned steady state (41 patients or 9% as per plan). • Digitalisation of Decision to Admit forms due to go live in August. • (Discharge Assessment and Action) DANA team goes live in June. • ESD team providing therapy capacity to Wiltshire Council • Medicine Division chosen reduction in Deconditioning and NCTR as Divisional Driver to support reductions in Length of Stay. • Care diaries (dependency form) rolled out across inpatient wards. Evaluation and countermeasures to be agreed. • Discharge Roadshow planned for July. Communication out to the teams to attend. External and internal speakers planned.	Mar 26 Aug 25 June 25 July 25 Mar 26 July 25 July 25	• Inability of the system to meet the NCTR trajectories for discharge. • HCRG changes have meant a pause on to the roll out of Hospital at Home (H@H). • External conflicts such as reduction in capacity in local authority social care teams and financial constraints. • Changes to the community model. • Clinical Capacity and demand conflicts. • Clinical Engagement. • Operational Pressures.

Use of Temporary Escalation Beds & ED Corridor Care

NHS Salisbury NHS Foundation Trust

Target: 0 Performance: 242 Position: Common Cause





Understanding the Performance

Use of corridor care continued an upward trajectory at 242 patients affected in May, and matching its highest peaks since data collection started in November 2023.

The bedding of Same Day Emergency Care (SDEC) unit stopped on the 20th May 2025 and has not seen usage as an escalation space since this date. This however is not yet truly reflected in the data above and will require several full months of data to be able to provide a reliable narrative from any impact.

No Criteria to Reside (NCTR) numbers remained static.

Temporary Use of Escalation (TUES) bed numbers remain in line with the previous 5 months of data.

Countermeasure Actions

- Updated escalation plan to prevent the bedding down of SDEC. Approved by execs 20th May, comms plan in place. This includes the use of SDEC when ambulances are held over 2hours, which is so far proven successful.
- NCTR workstreams continue with sustained engagement between SFT and System Partners.

Due Date

Ongoing

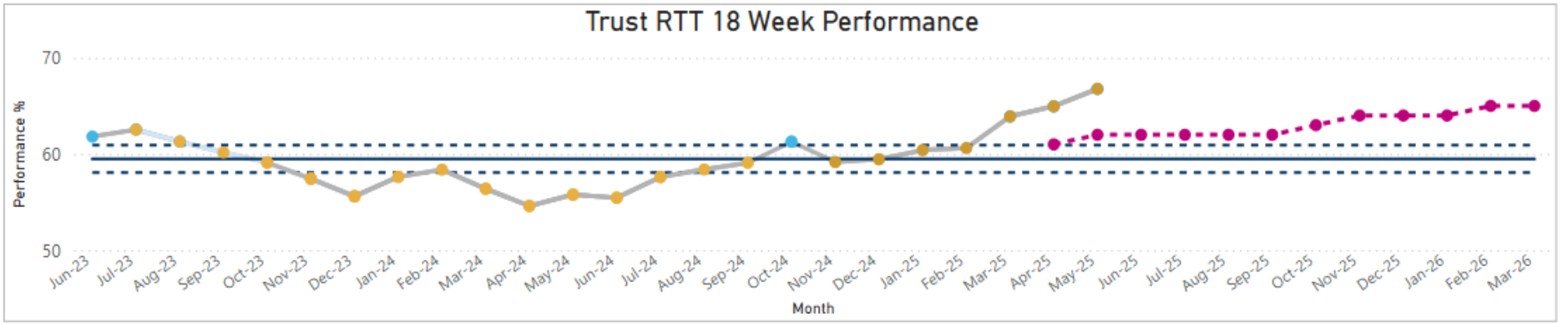
Risks and Mitigations

- Monitoring the number of times that Medicine Divert the Take, remains a priority, alongside agreed criteria for a diversion which will be included within the SOP.
- Continue to monitor the impact of the stop to bedding in SDEC and any potential impact to the Length of Stay (LoS) in ED, any increase in the number of patients placed in TUES beds elsewhere in the Trust.
- Quality of care provision for those patients affected by the placement in escalation beds remains a regular and key point of escalation on daily capacity calls, with the impact of delays documented for patients held in ambulances, in ED corridor care and in TUES beds across the wider Trust.

Elective Referral to Treatment

NHS Salisbury NHS Foundation Trust

Target: ≥61% Performance: 66.8% Position: Special Cause Improvement



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

Understanding the Performance

Referral to Treatment (RTT) performance improved to 66.8% in month and continues ahead of plan.

With total RTT waiting list size of 29,240 in month this means that 19,532 patients have been waiting less that 18 weeks. Highlight performing specialties: Elderly Medicine (88.5%) Urology (80.5%) and ENT (75.6%).

Long wait reductions continue overall, with the number of patients waiting more than 52 weeks reducing again from 572 to 524 which is 1.8% of the waiting list against the March 2026 target of 1%. The number of patients waiting more than 65 weeks increased from 0 to 3 and will be difficult to meet the rolling expectation of 0 in the short-term due to capacity constraints in the high-volume specialty of Plastic Surgery, resulting from consultant sickness.

Countermeasure Actions	Due Date
• Validation of waiting list to ensure patients mislabelled as Non-RTT status are corrected to ensure active monitoring and reporting - Analysis and education plan being made to improve this.	Ongoing
• Weekly Access Meeting focus of reducing long waits and driving performance.	Ongoing
• Waiting list validation to ensure accuracy of RTT waiting list and to ensure patients are waiting well, i.e. no change in their health that would alter course of the referral pathway.	Ongoing
• Digital solutions are being explored to automate the validation process.	31/08/2025
• Existing digital software for waiting list management is being enhanced and expanded to improve the process overall.	Ongoing

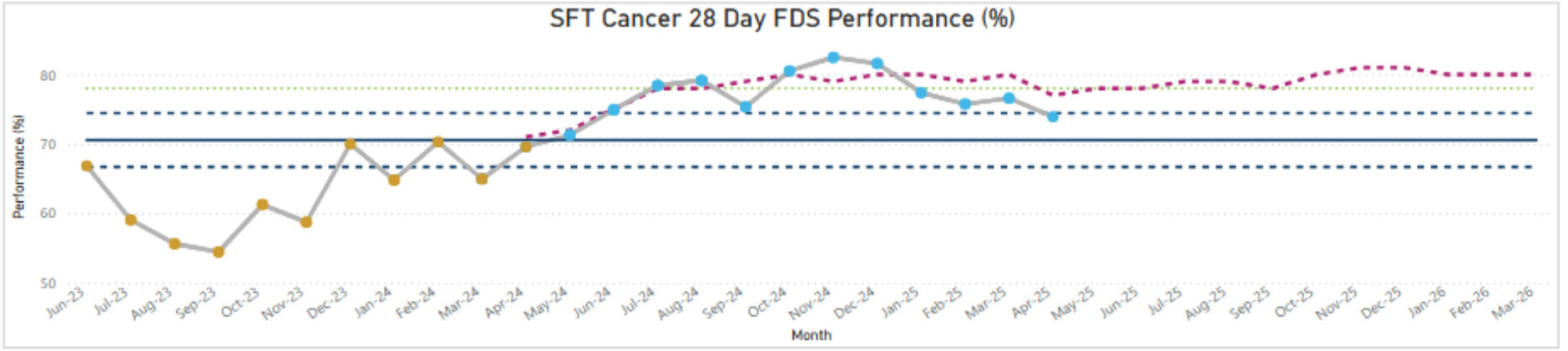
Risks and Mitigations

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

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: ≥78% Performance: 73.9% Position: Special Cause Improvement



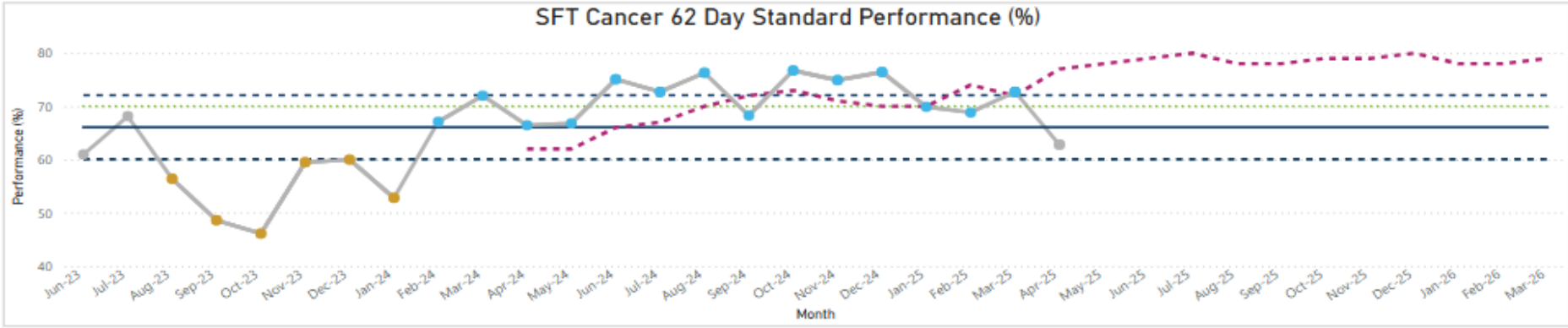
Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
28-day performance standard not achieved in M1, with month-end position of 73.9% and under trajectory of 77%. Specialties which remain most challenges in the delivering the standard include: • Lower GI: 48.4% (deterioration from 52%) • Gynaecology: 60.6% (from 79.4%) • Haematology: 12.5% (from 57.1%) • Lung: 69.1% (from 80%) • Urology: 55.8% (improvement from 46.8%) Breach reasons: insufficient diagnostic capacity (both locally and at tertiary centres), patient choice / engagement, diagnostic reporting, letter typing backlogs and pathway complexity.	• Maintain sufficient breast and skin capacity for first appointments to support overall delivery of FDS. • Demand and capacity modelling of non-site-specific pathway to be undertaken to support improved utilisation and future planning. • Average wait to GA hysteroscopy to be monitored via CIG to support Gynaecology FDS performance.	Weekly via CIG Q2 2025/26 M2 2025/26	• Skin pathways reliant on insourcing or WLIs to maintain average wait to first appointment under 14 days. 'Super clinics' established from Q4 2024/25 to support increased capacity. Involvement in SWAG-driven tele-dermatology roll out across BSW. • Skin cancer awareness in May 2025 is likely to increase demand on the service across Q1 2025/26. • Long-term resource within MDT cancer services teams remains challenging in terms of capacity. Assistant MDT co-ordinators recruited to on a fixed-term basis. Impact of long-term sickness detrimentally affecting capacity to escalate. • Letter typing backlogs identified across multiple tumour sites. Navigators identifying priority letters as needed to support discharge from cancer pathway.

Cancer 62 Day Standard

Salisbury NHS Foundation Trust

Target: ≥70% Performance: 62.8% Position: Common Cause



Patients waiting over 62 days for treatment	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
	91	73	76	65	61	69	78	68	55	84	84	69	66	70

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

Understanding the Performance

Deterioration in 62-day performance in M1 with submitted position of 62.8% below trajectory of 77%. *Data is subject to change upon receipt of post-op histology and confirmed cancer diagnosis treatments recorded after quarterly submission.*

162 patients were treated against the standard in M12, with 54 patients breaching 62 days. Specialties which were unable to meet the standard include:

- Lower GI: 55.6% (4 breaches of 9 patients)
- Haematology: 66.7% (4 of 12)
- Head & Neck: 54.5% (2.5 of 5.5)
- Lung: 56.3% (7 of 16)
- UGI: 64.7% (3 of 8.5)
- Urology: 38.8% (20.5 of 33.5)

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

Countermeasure Actions

	Due Date
• Sustain robust Patient Tracking List (PTL) meetings, with improved resilience and standardisation across all tumour sites.	Ongoing
• Scoping opportunities for roll out of 'Cancer 360' tool across BSW.	Q2 2025/26
• Establishing a urology specific improvement plan / programme to help resolve underlying challenges.	July 25
• Evidence of increase in patient choice breaches throughout pathways; cancer services to audit and outline opportunities.	Q2 2025/26

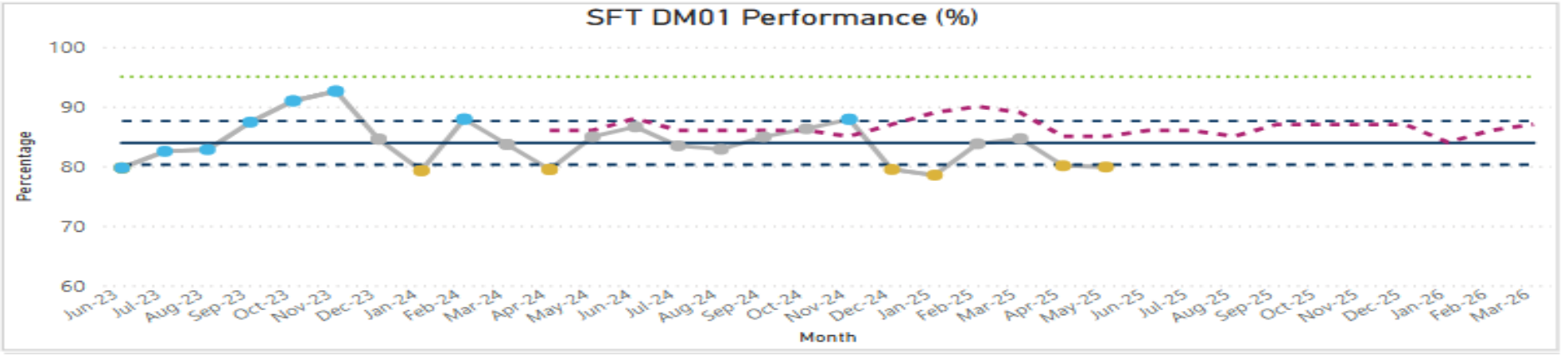
Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62day compliance will be impacted. Aiming for <6% of PTL size for patients >62 days in their pathway.
- Risk to M1/2 2025/26 due to impact of breast screening service and oncoplastic capacity for immediate reconstruction.
- Noted resource within MDT cancer services team remains challenging in terms of long-term capacity.
- Increase in Breast service breaches associated with screening demand and insufficient onco-plastic capacity for immediate reconstruction has impacted the overall denominator.

Diagnostic Waiting Times

Salisbury NHS Foundation Trust

Target: ≥95% Performance: 79.9% Position: Special Cause Concern



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	79.2%	205	Dexa	100%	0	Colonoscopy	53.5%	161	Urodynamics	56.7%	29
CT	93.6%	59	Neurophysiology	100%	0	Gastroscopy	74.6%	59	Cystoscopy	98.1%	1
Ultrasound	80.5%	474	Echo	71.5%	156	Flexi Sigmoid	37.2%	98	Audiology	78.9%	106

Understanding the Performance

Performance against the standard decreased slightly to 79.9%, below both target and plan levels.
Deterioration in the Ultrasound performance is the biggest contributor this month with around 474 patients waiting longer than 6 weeks. The high-volume nature of this modality means that even with many breaches they still achieved 80.5% against the standard. Work continues to review the referral rate, and the service is expecting to have capacity in June above the demand. Ongoing discussions regarding mitigation of outsourcing continues.

Endoscopy remains a contributing area with 318 breaches across the 3 procedures, and performance at around 57%, which is an increase from April. Surgery division preparing improvement recovery trajectory including enhanced trajectory with access capacity in ISTC.

Countermeasure Actions

Countermeasure Actions	Due Date
• Mitigation options being scoped for Ultrasound and completion of demand analysis.	31/07/25
• Recovery Trajectory for Endoscopy being completed with increases in utilisation to provide additional capacity from Q2.	30/06/25
• Continued maximization of Community Diagnostic Centre (CDC) to a) achieve CDC activity plan and b) recover DM01 position.	Ongoing
• Locum support in Audiology continuing to support reduction of pediatric waiting list.	Ongoing

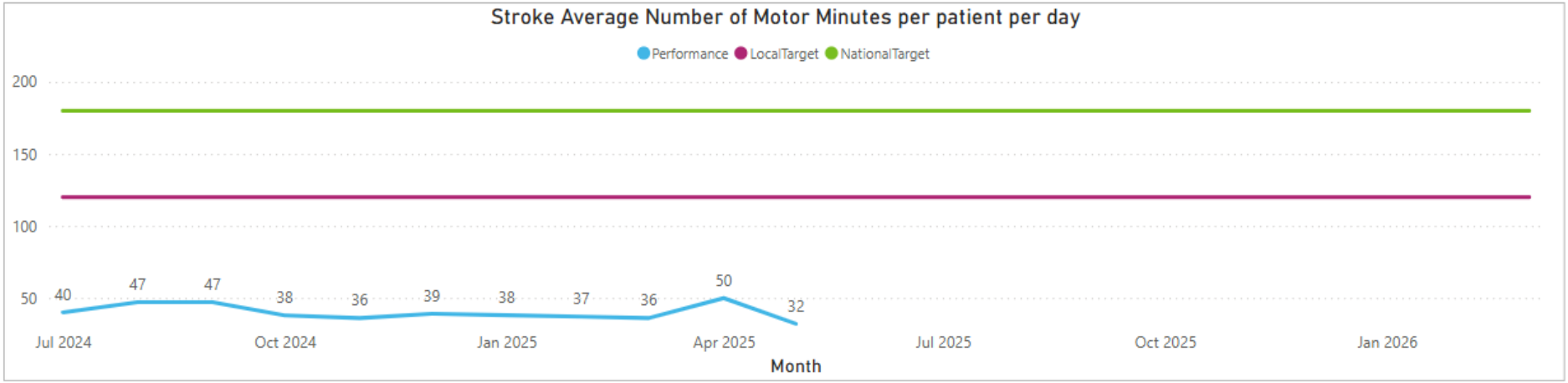
Risks and Mitigations

- Spikes in demand are difficult to respond to when target wait is short, and teams are small. Ongoing work to improve demand and capacity planning and ensure capacity is opened as far out as possible.
- Capacity remains reliant on either insourcing or in house overtime to meet demand.
- Audiology remains difficult to recruit to, with one appointment made whilst another vacancy was created, although as evidenced the backlog is reducing.

Stroke Care

NHS Salisbury NHS Foundation Trust

Target: ≥180 mins Performance: 32 mins Position: N/A



	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2
SSNAP score	C	C	B	A	B	C	C	C

Understanding the Performance

M2 averaged 32 minutes of motor therapy per patient per day, down from 50 minutes last month. This drop is mainly due to two bank holidays, and staffing shortages of 1.0 WTE PT and 1.0 WTE OT. Open gyms ran but lacked consistent volunteer support, and high ward acuity diverted staff skills elsewhere.

Other key points:

- Averages include all patients needing motor input, though up to 30% may be too unstable or lack therapy goals, lowering overall minutes.
- Assessments no longer count toward motor minutes.
- Some motor activity from nursing and outlying patients remains uncaptured.
- No formal benchmarking has been done; however, it is recognised that A GIRFT review would benefit the specialty and this is being considered.

A deep dive of Stroke care was undertaken at a recent CGC.

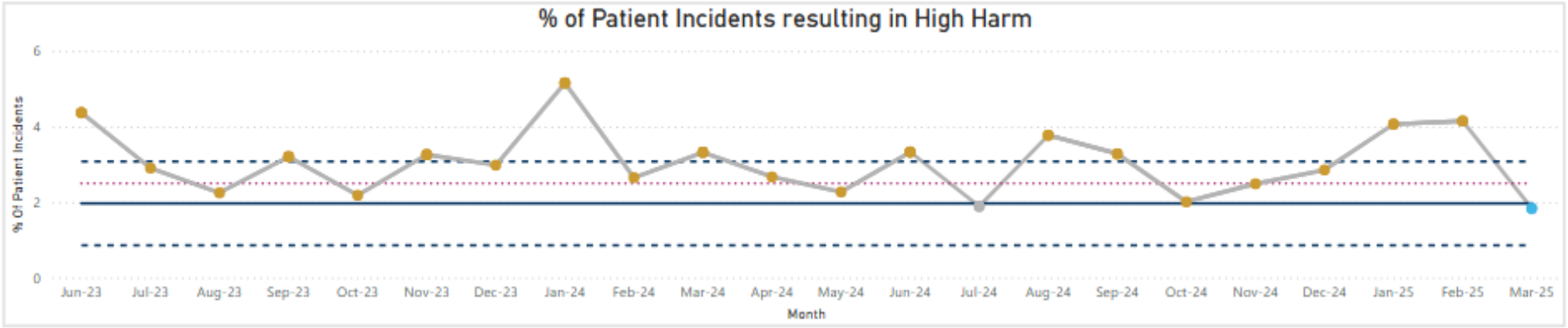
Countermeasure Actions	Due Date
• Further work to optimise uncaptured activity from outlying patients and ward nurses	July 25
• Benchmark performance with local services including methodology for calculating performance.	July 25
• Time in motion and job planning for current team to ensure all available capacity is utilised effectively.	June 25
• Gap analysis between current registered workforce (8.55wte) and new recommendation workforce (13.29) in increased productivity.	June 25
• If optimisation of capacity is achieved, then work up business case for additional staffing.	Aug 25
• Stroke deep dive at CGC in April.	June 25
	Complete

Risks and Mitigations

- Therapy minutes for patients able to participate are higher than reported, as averages include all patients needing motor input.
- A3 will be redesigned to include national benchmarking.
- Current workforce is 10.55 WTE therapists vs. 15.29 WTE recommended.
- Exploration of digital capabilities availabilities to capture motor minutes.
- Go & See's planned with BSW colleagues to share best practice.

Incidents

Target: ≤2.5% Performance: 1.8% Position: Special Cause Improvement



Understanding the Performance
There were 986 total incidents reported in March compared to 886 in February. Of those 986 incidents, 833 were relating to patient safety. Of those 833, 15 were classified as moderate harm (a decrease of 10 from February), no reported major harms occurred and 1 reported catastrophic harm. *There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively.* A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred.

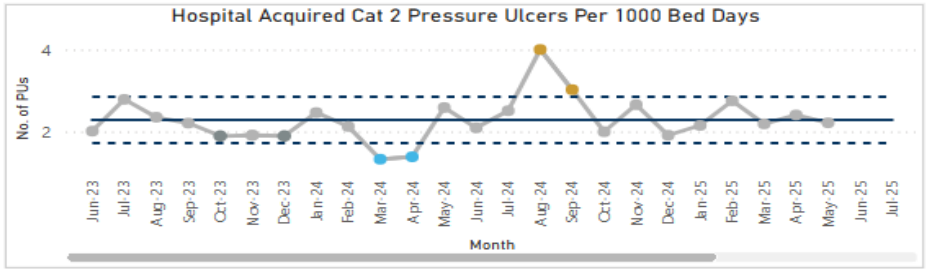
Countermeasure Actions	Due Date
• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required.	Daily
• Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed.	Weekly
• Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients.	Ongoing
• Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated.	Ongoing
• Learning from incidents forum.	Quarterly

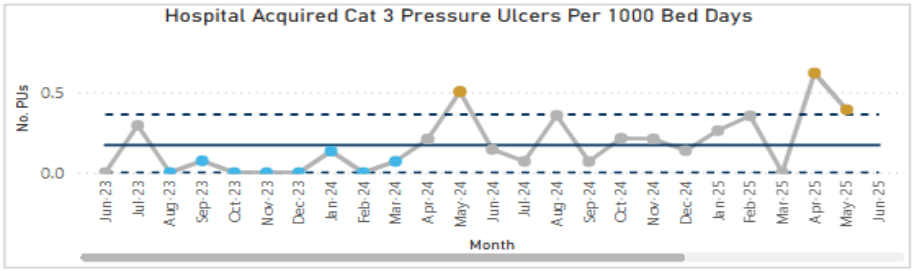
Risks and Mitigations
Learning Identified • Awareness of need for early engagement of interpreters if language barriers identified. • Consider patients past medical history when looking at self-administration of medicines. • Single storage point now being used to store feeding tubes to ensure close monitoring of stock levels and expiry dates. • Mindful practice of checking expiry dates especially when written in American format to reduce human error. • Single use items should be checked for expiry date on inside and out of packaging.

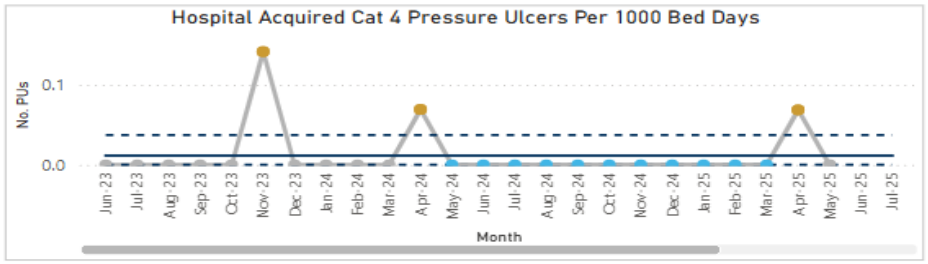
Pressure Ulcers

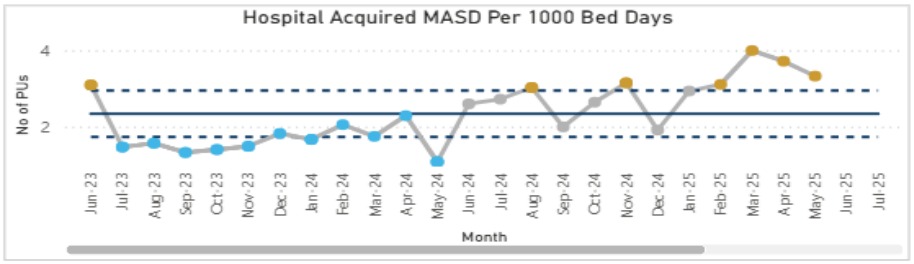
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 2.22 Position: Common Cause









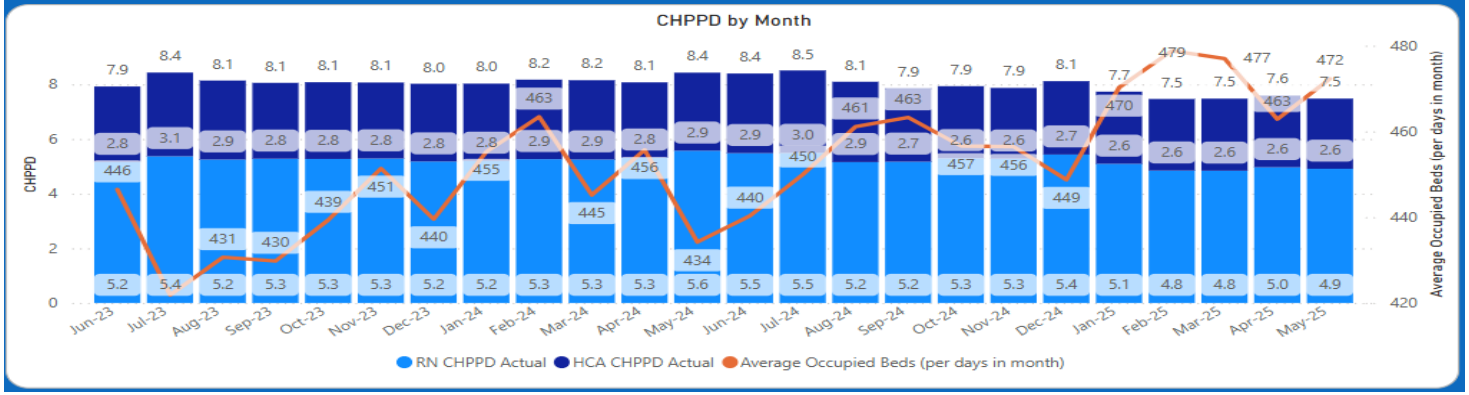
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Compared to April, the number of reported pressure ulcer incidence across the Trust has decreased to 40. Category 2 Pressure Ulcer (PU) incidence numbers continue static to the past two months at 2.22. There has been a decrease of reported category 3 PUs this month and 0 category 4s. A reduction in the number of medical device related pressure ulcers is also seen for May. The total number of pressure ulcers identified on admission was 54. Hospital acquired Moisture Associated Skin Damage (MASD) incidence remains high. However, static compared to April. The number of MASD incidence reported on patient admission was 60.	• Tissue Viability (TV) are part of the new Clinical Service Division, pressure ulcer management and learning monthly meetings. • The bid for the new 30 dynamic air mattress was successful and the new mattresses are now in circulation around the hospital. • TV have organised additional on the ward MASD training for selected medical wards. • TV have continued to offer shadow shift training for students, nurses and doctors this month. • Ward leaders to ensure TV Link Workers attend the TV study days. • Wards to utilise TV link workers to support with wound care management and prevention of skin tissue injury.	May 2025 May 2025 Ongoing Ongoing Ongoing Ongoing	• TV are in the process of organizing a monthly surgical pressure ulcer management and learning meeting with the ward matrons and senior sisters. • Wards to utilise Link workers to support with wound care management and prevention of skin tissue injury. • The new MASD pathway should be discussed at the next Drugs and Therapeutic meeting, before it can be approved and then available to the wards.

Care Hours per Patient per Day (CHPPD)

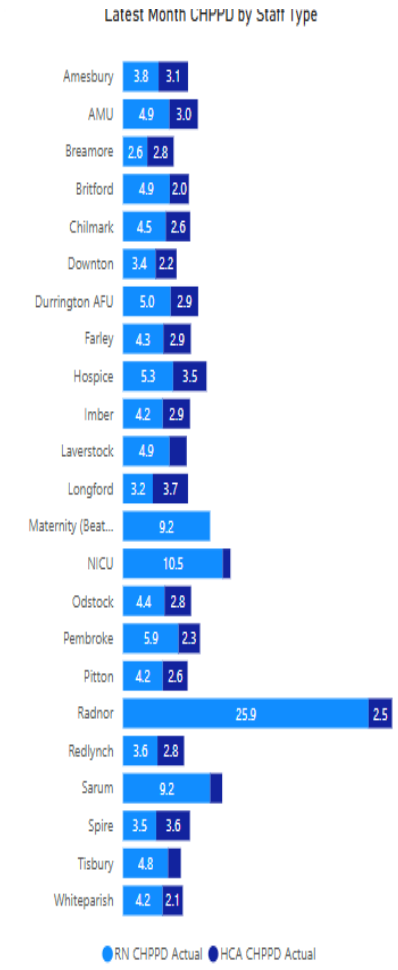
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.5 hours Position: N/A

Latest Month CHPPD	Average CHPPD	Latest Month RN CHPPD	Average RN CHPPD	Latest Month HCA CHPPD	Average HCA CHPPD
7.5	8.0	4.9	5.2	2.6	2.8



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



Understanding the Performance

CHPPD at 7.5 (6.9 when excluding ICU, maternity and NICU) has remained relatively static over the last few months – this is due to the occupied bed days remaining higher than they were in 2024 when CHPPD was above 8. This reflects the ongoing use of escalation beds, boarding of patients in non-bedded areas and wards being full.
Ward sickness did improve in May (5.4% compared to 6.9% in previous month).

Fill rate remains static with Healthcare Assistant (HCA) day shifts remaining under 100% due to factors of pay rates and childcare.
Zero off-framework shifts for May but break-glass rates continue in Pembroke (ending June) and Cardiology.
Temp staff spend in nursing at £816k is up £80k on April, been slight increase in Registered Mental Health Nurse (RMN) requirement.

Countermeasure Actions	Due Date
• Twice daily staffing meetings.	Ongoing
• Trust wide workstreams for agency reduction and sickness cover reporting via AOTP.	Ongoing
• Regional work to align bank rates commenced.	Sep 25
• Further controls being implemented on shifts going out to bank and additional duties.	June 25
• Annual safe staffing establishment reviews commencing in July.	August 25

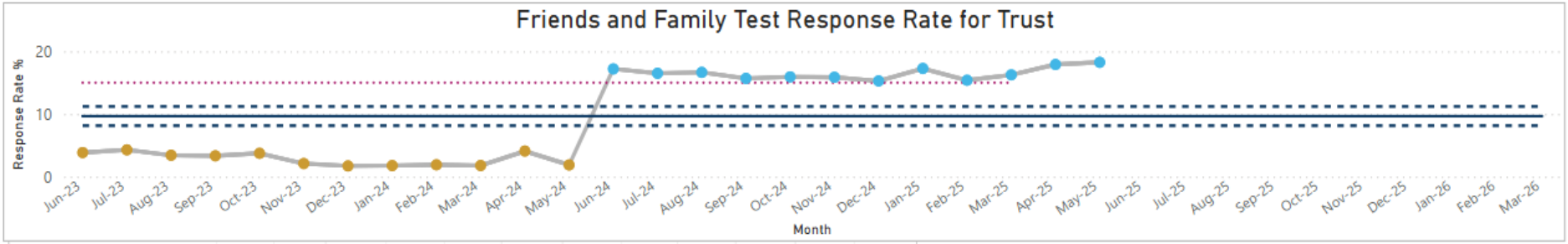
Risks and Mitigations

- Requirement to reduce headcount / temp staffing (risk).
- Ongoing demand for RMNs to support patients at risk (risk).
- Short term ward sickness and absence driving temp staffing considering low vacancies (risk).
- Ongoing use of escalation areas and boarding spaces (risk).
- HCA vacancy and turnover (risk).
- SW collaborative holding agency at capped rates (mitigation).
- Retirement of DCNO / Safe Staffing Fellow for nursing workforce / safe staffing (risk).

Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥18% Performance: 95% Position: Special Cause Improvement



Response Rate by Area	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
FFT Response Rate - A&E	20.6%	20.4%	22.0%	20.7%	21.6%	20.6%	21.7%	21.8%	20.0%	19.5%	21.1%	21.1%
FFT Response Rate - Day Case	3.4%	10.8%	11.2%	6.3%	10.3%	8.7%	10.1%	12.3%	9.6%	23.0%	17.0%	20.5%
FFT Response Rate - Inpatient	10.4%	26.3%	31.8%	21.4%	26.0%	24.8%	27.2%	30.2%	19.9%	34.6%	46.2%	39.3%
FFT Response Rate - Maternity	13.7%	9.7%	10.1%	10.3%	9.5%	10.2%	10.4%	10.3%	8.9%	3.5%	100.0%	100.0%
FFT Response Rate - Outpatient	18.3%	16.4%	16.0%	15.8%	15.6%	15.8%	14.5%	16.8%	15.4%	14.5%	15.5%	16.4%

Understanding the Performance

Our response rate to the Friends and Family Test (FFT) in May reported our highest response to date since the new digital dashboard and SMS message service went live in June 24.

Our response rate was 19% with a satisfaction rate of 94% therefore we met our response rate target but slightly fell short of our satisfaction rate target of 95%.

The top three themes for dissatisfaction are staff attitude, environment and communication.

It is to be noted that due to the BadgerNet upgrade we are not currently surveying Maternity patients until we have the data transferred correctly.

Countermeasure Actions	Due Date
• SMS messages are sent to all eligible patients attending our maternity services, Outpatients and ED. The new online forms have now also gone live, and work is underway to advertise these changes through posters.	Ongoing
• The installation of the new FFT boards in the inpatient areas is taking place, with a second phase rollout planned for outpatient areas. There is a delay in completion of phase 1 due to Estates capacity.	June 2025
• The patient experience team are now working with individual clinics and services to offer alternative data collection methods for informing service Improvements.	Ongoing
• All departments are now offered stickers that can be used by bedsides or treatment areas for patients to leave feedback whilst receiving treatment asking: 'How are we doing?'	Ongoing

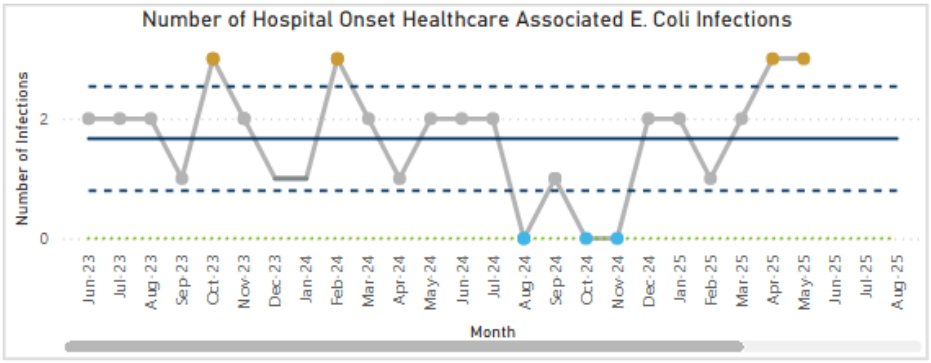
Risks and Mitigations

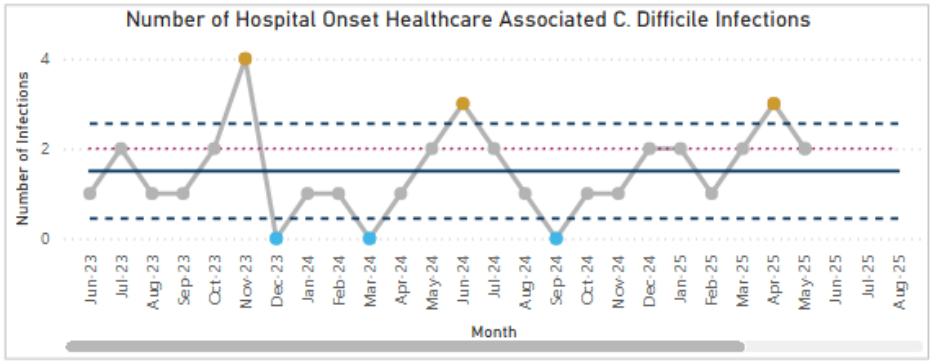
- The Envoy dashboard continues to enable better themes and insight analysis of comments. Going forward we are offering more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 18% improving together response rate target set for 2025/26.

Infection Control

Position: Special Cause Concern

Position: Common Cause





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

Understanding the Performance

There have been three hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, the same as last month.

For HOHA reportable *C.difficile* cases, there have been two cases, compared to three last month. *(The previously reported PIIs of C.difficile for Redlynch, Imber and Spire Wards continues due to ongoing practice concerns).*

The outbreak of COVID-19 was declared for Pitton Ward in April was officially closed on 14th May.
A continued level of diarrhoea activity for inpatient areas necessitating bay closures.
The IPC team involvement supporting staff with the management of suspected Mpox cases presenting via the Emergency Department.

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

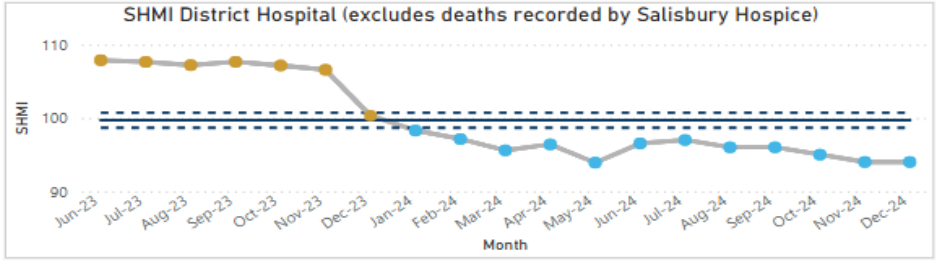
Risks and Mitigations

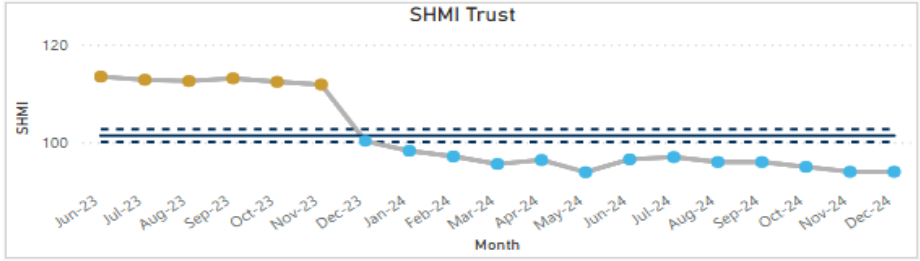
- Demanding and intense clinical workload for IPC nursing team members has resulted in very limited progress with other preventative work.
- Underlying risk continues to be potential increase in reportable HCAI with poor patient outcomes.
- Awaiting formal notification of new NHS standard contract thresholds for 2025/26 in relation to reportable HCAIs for the Trust.

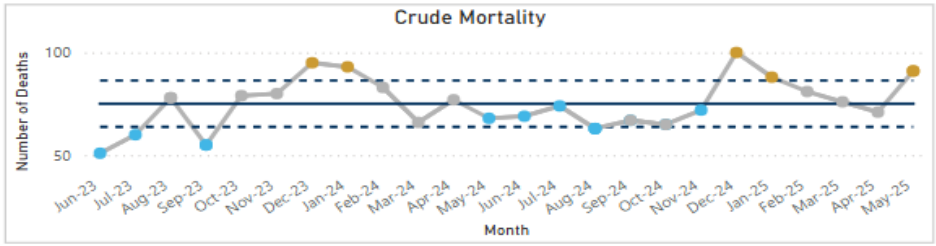
Mortality

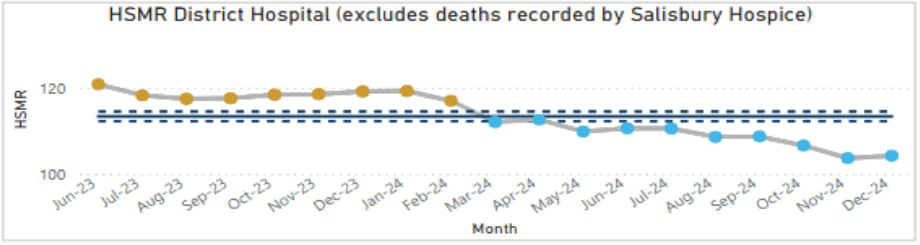
NHS Salisbury NHS Foundation Trust

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









Understanding the Performance

The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in December 2024 is **0.94** and remains statistically within the expected range.

The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in December 2024 for Salisbury District Hospital is **104.2.** This figure has also continued to reduce and is now statistically within the expected range.

A national revision to the methodology for calculating the SHMI came into effect from Dec'23 onwards. We also saw the introduction of the remodelled HSMR (HSMR+). The Trust initially saw an upward shift in the data (applied retrospectively), but the overall trajectory remains a downward one.

Countermeasure Actions	Due Date
• All actions related to the previous NHSE mortality insight visit have now been completed and/or closed. Our mortality metrics used for benchmarking against national figures (HSMR/SHMI) have continued to show improvements.	Ongoing / Bi-Monthly
• The number of primary mortality reviews (SJRs) being undertaken across the Trust is increasing and the Trust's online mortality system is capturing thematic learning and actions. Learning points have been associated with 49 specific actions which include sharing good practice as well as improvements discussed at specialty Morbidity and Mortality Meetings.	Ongoing / Bi-Monthly
• The online mortality system to support learning from deaths was launched in March last year. Activity has been centred on improving reporting outputs from the mortality reviews.	Ongoing / Bi-Monthly

Risks and Mitigations

- The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups.
- Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.
- Benchmarked mortality data are shared via the regional System Mortality Group which included Bath, Salisbury and Swindon Acute Trusts

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	93	92	77		0		Special Cause Concerning - Run Above Mean	X	60
Beds Occupied %	96.9%	96.1%	96.7%	96.0%	92%		Common Cause Variation	X	5
Cancer 31 Day Performance Overall	93.8%	93.1%	93.1%		96%		Special Cause Concerning - Decreasing Run	X	4
Complaints Closed within agreed timescale %	53.0%	55.0%	41.0%	85.0%			Special Cause Improving - Run Above Mean	X	60
ED 12 Hour Breaches (Arrival to Departure)	428	433	462		0		Special Cause Concerning - Above Upper Control Limit	X	60
ED Attendances	7090	7070	7392				Special Cause Concerning - Above Upper Control Limit		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	19.5%	29.1%	23.8%		95%		Special Cause Concerning - Below Lower Control Limit	X	60
Mixed Sex Accommodation Breaches	14	15	21	0	0		Common Cause Variation	X	60
Number of High Harm Falls in Hospital	3	3	3	0	0		Common Cause Variation	X	12
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	6	8	6	0			Special Cause Concerning - Two Out of Three High	X	3
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	0	2	2	0			Special Cause Concerning - Above Upper Control Limit	X	2
RTT Incomplete Pathways: Total 65 week waits	0	0	3	0	0		Special Cause Improving - Below Lower Control Limit	X	1
Total Number of Complaints Received	21	18	26				Special Cause Concerning - Above Upper Control Limit		
Total Number of Compliments Received	75	9	24				Special Cause Concerning - Run Below Mean		

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Flow related metrics continue to feature with Bed occupancy, the number of patients spending more than 12 hours in the Emergency Department ED) and Ambulance waits in ED over 60 minutes all higher than average or target. The number of patients attending ED remains high with Type 1 attendances (Main A&E at SFT) 10% higher year to date than the same period last year. Bed occupancy remains high at 96.7% and an average of 94 beds occupied with patients no longer meeting the criteria to reside (NCTR) but waiting for onward provision to enable discharge.

Mixed sex breaches and High harm falls are in common cause with no statistically significant change to levels.

The percentage of inpatients undergoing Venous Thromboembolism risk assessment within 24 hours of admission continues to remain below control limits. This is believed to be a recording error, with monitoring of the number of VTE's under regular review. This is discussed regularly at the Trusts Clinical Governance Board Committee.

Progress continues against reducing the longest elective waits with just 3 patients waiting longer than 65 weeks, and the number over 52 weeks reducing to 524 which is ahead of the plan of 550.

Cancer 31-day Decision to Treat (DTT) to Treatment metric is alerting due to decreasing performance at 93% against a target of 96%, with the top contributor being delays in the breast pathway due to a higher than average demand. Further details are covered in the Cancer 28-day Faster Diagnosis and Cancer 62 Day Referral to Treatment pages earlier in the report.

Countermeasure Actions

- NCTR trajectories set for SFT with help from the ICB. System partners to work daily trajectory for discharges to NCTR to planned steady state (41 patients or 9% of bed base as per plan).
- Wiltshire Council and SFT to pilot discharge coordinator ward based social work model for 4 months commencing June.
- Close monitoring of breast referrals and theatre capacity to support increased demand following breast screening programme visit to local area.

Risk and Mitigations

- Inability of the system to meet the NCTR trajectories for discharge - HCRG changes have meant a pause on to the roll out of Hospital at Home (H@H). External conflicts such as reduction in capacity in local authority social care teams and financial constraints.
- Performance plans were based on assumptions around growth in ED attendances and Non-elective demand being mitigated to 1.4% and 1.6% respectively. Type 1 ED attendances at M2 year to date are 3% higher than plan (plan included 1.4% growth).

Watch Metrics: Non-Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Diagnostics Activity	8643	8449	8846	8658			Special Cause Improving - Above Upper Control Limit	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	88.9%	73.2%	68.1%				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0				✓	0
RTT % of patients waiting less than 18 weeks for 1st Appointment	43.1%	42.1%	43.0%				Special Cause Improving - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	665	572	524	550	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	67.0%	71.0%	68.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	63	67	63				Common Cause Variation		
Total Patient Falls per 1000 Bed Days	6.23	5.22	6.52	7			Common Cause Variation	✓	0
Trust 30 day Emergency Readmission Rate	12.1%	12.4%	9.9%				Special Cause Improving - Below Lower Control Limit		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

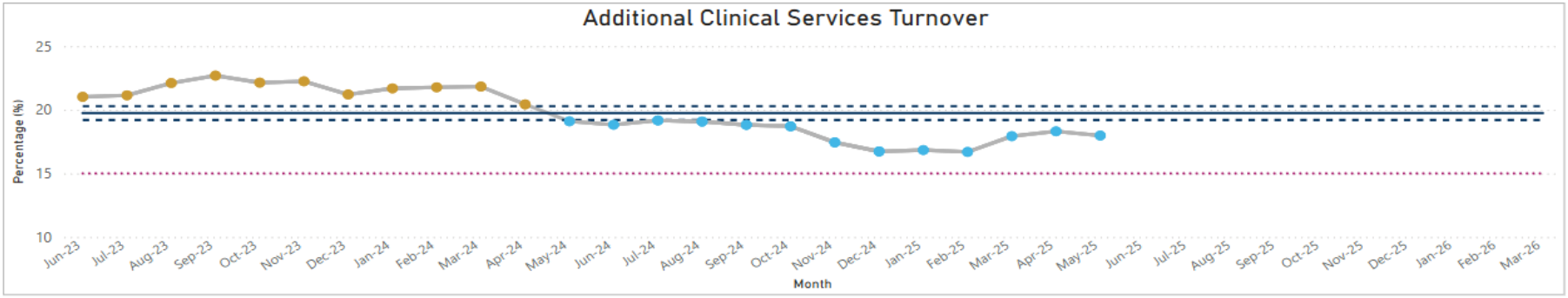
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

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

Target: ≤15% Performance: 18% Position: Special Cause Improvement



Understanding the Performance

ACS Turnover reduced to 17.98% M2 from 18.3% M1, still above the 15% target.

This equates to 4.98 WTE leavers in month.

4.5 WTE had 2 or less years' service.
2.5 WTE were in the 31-40 age range.
1 WTE u-30 and 1.5 WTE 50+.

Leavers reasons given:
- 2.5 WTE Relocation
- 1 WTE Retirement
- 1 WTE Work life Balance
- 0.48 WTE Health

SFT overall turnover increased to 12.34% M2 (12.25% M1) Target is 12%.

Countermeasure Actions	Due Date
• Focus work on Medicine division, and the three wards with highest leavers rates.	Q3 2025/6
• Improved induction/development of ACS staff:	
• Preceptorship. Ongoing – Focus of team to ensure good compliance – target 90% completion at initial, 3, 6, 9 and 12 – Continue to monitor for next year until consistent compliance as above.	Q4 2025/26
• HCAs onboarded directly onto “apprenticeship route”. Second cohort to start programme.	Q2 2025/26
• Introduction of the re-enablement training to the induction.	July 2025
• Review of essential skills.	July 2025

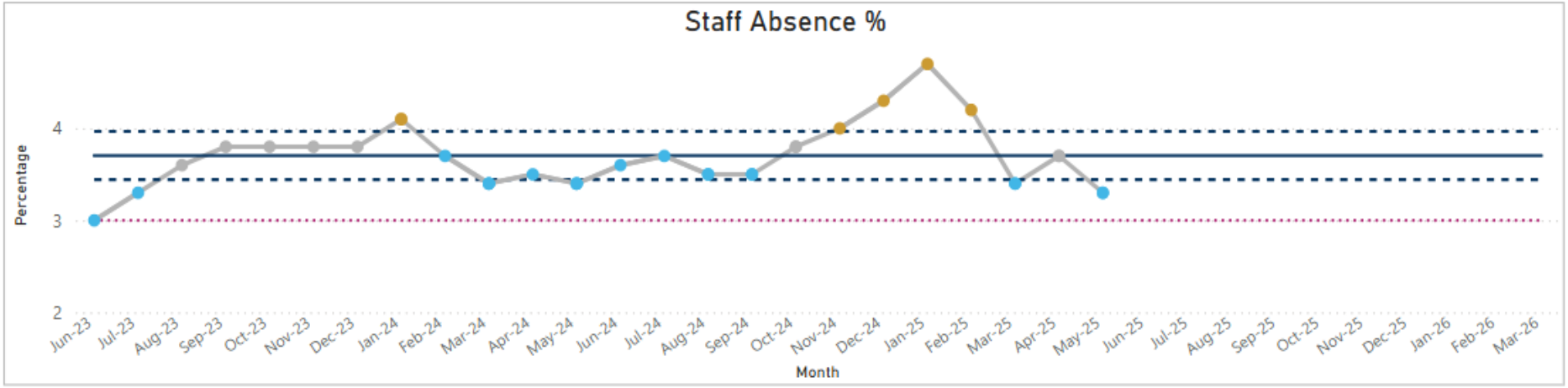
Risks and Mitigations

- Peer support sessions. Need to not only be added to roster but staff to be supported / enabled to attend.
- Shadow and support shifts. B6 role is vacancy and review of role to change skill mix/increase WTE may be held due to SFT workforce reduction requirements, particularly in line with Corporate services review.
- Continued delay in 2025 AFC pay award may put off potential applicants/increase leavers due to cost of living pressures and lack of uplift this financial year.

Sickness Absence

NHS Salisbury NHS Foundation Trust

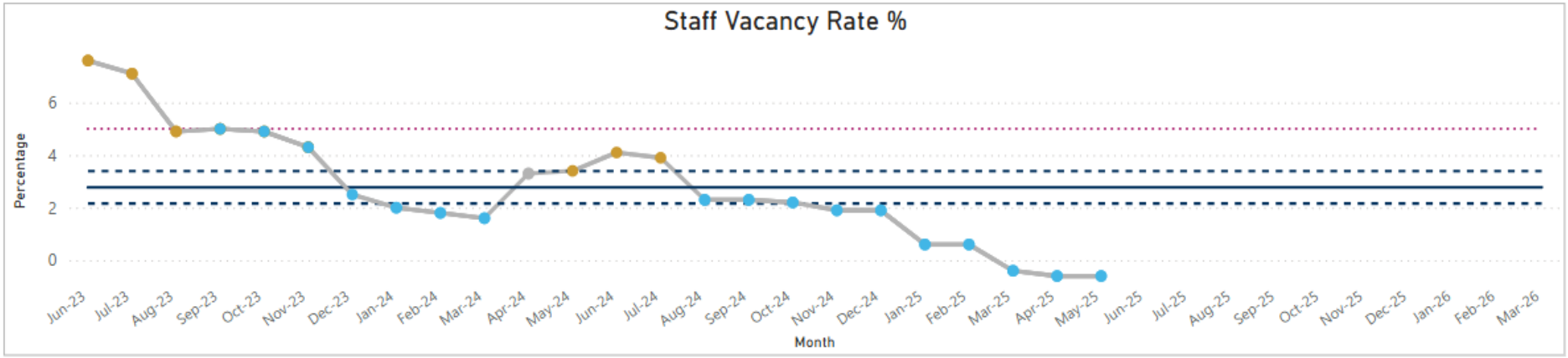
Target: ≤3% Performance: 3.3% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Sickness absence has decreased again slightly to 3.3% in M2. The highest absence rate in month is again Anxiety / Stress / Depression, accounting for c25% of all absence. Colds, Gastrointestinal and MSK make the top 4 absence reasons. • Estates and Surgery remain the highest division at 5.55%. • Medicine (2.51%) & Corporate (2.26%). • Estates & Ancillary are the highest absence staff group at 5.23%. Sickness accounted for 4,234 FTE days lost (4,235 FTE in M1), with a broad 60 / 40 split of short-term vs long-term sickness – highlighting the recent increase in STS has subsided.	• Line Manager (LM) training on Absence Management policy and actions seeking to deliver training opportunities for all by year end. Sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy). • Review of and promotion of support available from Mental Health First Aiders as a resource to support cases of workplace stress and anxiety. • Review of all highest absence staff led by ER Advisor with Ops managers to ensure all appropriate actions are being followed to enable higher attendance.	Ongoing Ongoing Ongoing	• Availability of instructors and advisers to support training interventions and workplace support to LM. • Need to ensure consistent application of policy and processes for supporting attendance at work. This is being developed through Licence to manage workshops. • Availability of LM to attend training. • The ER team will take time/resource to provide support/training to reach all current managers.

Vacancies

Target: ≤5% Performance: -0.6% Position: Special Cause Improvement



Understanding the Performance
M2 vacancies are static at -0.6% (-0.59% in M1), so technically reporting that the overall Trust headcount is above establishment. Note: this is the NET position, so some teams are above and some below funded establishment. The highest contributing staff group is infrastructure staff, where there are a total of 120 WTE vacancies (114 in M1). The highest vacancy rates amongst clinical divisions sit within Medicine (3.83%) 45 WTE. Medicine has 48 teams with <10% vacancy rates. HCA vacancies are 38 WTE (78.12 WTE in M12) with 13 WTE in Elderly Medicine (Breamore, Durrington, Imber, Pitton & Spire). **M12 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 270 WTE M2 (274 WTE M1), a vacancy rate of 5.9%.**

Countermeasure Actions	Due Date
• Targeted support to the identified hard to recruit roles, seeking to support attraction campaigns to fill these post which generate high agency back fill costs.	Ongoing
• Confirmation that vacancies identified as greater than 10% align accurately to team structures to ensure that attraction campaigns are focused on the areas of most need. Further work required to prioritise these areas in line with patient safety / service delivery and to support Trust headcount management.	Ongoing
• Workforce control process being reviewed following new ICB guidance.	June 2025

Risks and Mitigations
• DMT and HRBPs working to design and develop attraction packages for hard to recruit roles. • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through poor publicity around NHS (dissolution of NHS E, reduction in staffing levels due to restriction on budgets etc.).

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	77.9%	75.5%	75.8%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	60
Non-Medical Appraisal Rate %	72.0%	73.6%	74.0%		90%		Common Cause Variation	X	60

Watch Metrics: Alerting Narrative

NHS Salisbury NHS Foundation Trust

People

Understanding the Performance

Mandatory training for M1 is showing below target at 75.8% completion rate across the Trust. The best performing area was Facilities with 93% completion. The lowest contributors are Corporate at 70% and Medicine at 75%. The 90% target has not been met for since January 2023.
The application of significant oversight from management teams remains the most effective action to increase compliance.

Medical appraisals improved "in month" and is 91.5%. However, note the number of "out of date" appraisals has increased from 68 to 78, with the number out of date by >3months decreasing from 35 to 32.

Non-medical appraisals rates have improved to 74% (73.6% M1). This is 4.3% lower than the previous May. This equates to 848 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 58.7% (234 / 567out of date) and Medicine at 73.9% (225 / 861 out of date).

Countermeasure Actions

- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. A working group is established to review and improve the process to enable higher completion rates. A trial of focussed support has been implemented in OD&P directorate in Q4.
- The review/project to overhaul non-medical appraisals is also looking to link to talent management, and CPD required for colleagues across SFT. This is part of the OD&L steering group for monthly review and update.
- A Pilot approach of targeted focus on appraisal compliance within OD&P has seen an improvement from 64% in January 2025 to 88.1% in May 2025.

Risk and Mitigations

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

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	90.0%	90.8%	91.5%	90.0%			Special Cause Improving - Above Upper Control Limit	✓	0
Staff Turnover (Trust overall)	12.3%	12.3%	12.3%	13.0%			Special Cause Improving - Below Lower Control Limit	✓	0
Staffing Availability	3.8%	3.9%	3.5%	3.7%			Special Cause Improving - Run Below Mean	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

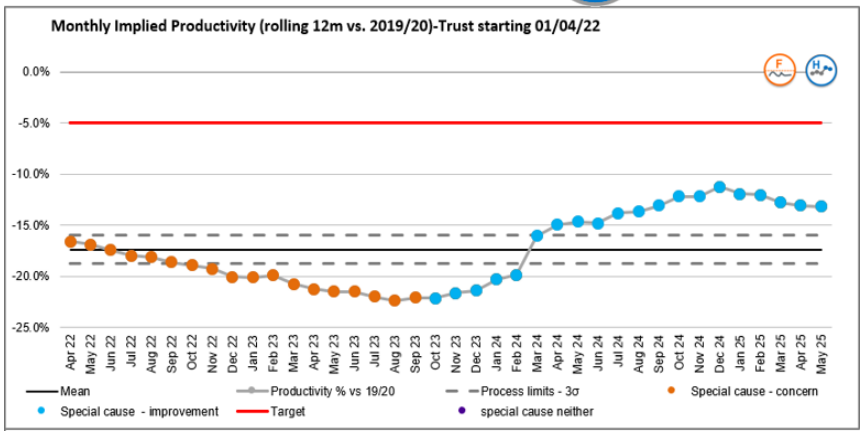
Creating Value for Our Patients

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≤-5.33% Performance: -13.18% Position: Special Cause Improvement



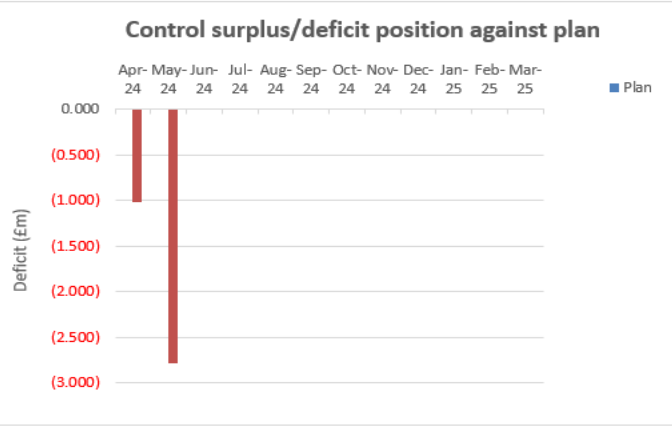
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
In Month 2 higher pay and non-pay costs from the increased bed base, backfill and medical agency requirements plus drugs and clinical supplies have only been partially mitigated by increased elective and non-elective activity, with a 0.1% deterioration in the rolling 12-month delivery (updated for month 1 activity validation). There is an improvement of 1.8% from April 24 due to cost increases being mitigated by activity improvements with the main increase in Non-Elective +1 day delivery. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20. The inflation rate has been adjusted for 2.8% pay award assumption for 25/26.	• Modernisation and consistency of administrative processes programme oversight meeting to be set up. • Corporate transformation and redesign programme. • Content oversight forums to be convened to drive the pace and feedback on programmatic workstreams.	June 2025 Ongoing June 2025	• The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

NHS Salisbury NHS Foundation Trust

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

	May '25 In Month			May '25 YTD			25-26 Plan
Operating Income							
NHS Clinical income	28,621	28,473	(148)	56,951	56,625	(326)	331,367
Other Clinical Income	1,016	1,250	234	2,426	2,312	(114)	18,506
Other Income (excl Donations)	3,594	3,352	(242)	7,180	7,098	(82)	42,470
Total income	**33,231**	**33,074**	**(157)**	**66,557**	**66,035**	**(522)**	**392,343**
Operating Expenditure							
Pay	(22,015)	(22,506)	(491)	(44,133)	(44,881)	(748)	(260,645)
Non Pay	(11,001)	(11,018)	(17)	(21,991)	(22,635)	(644)	(129,119)
Total Expenditure	**(33,016)**	**(33,524)**	**(508)**	**(66,124)**	**(67,515)**	**(1,391)**	**(389,764)**
EBITDA	**215**	**(449)**	**(664)**	**433**	**(1,481)**	**(1,914)**	**2,579**
Financing Costs (incl Depreciation)	(1,882)	(1,705)	177	(3,766)	(3,364)	402	(22,579)
NHSI Control Total	**(1,667)**	**(2,154)**	**(487)**	**(3,333)**	**(4,844)**	**(1,511)**	**(20,000)**
Deficit Support Funding - local	515	515	-	1,030	1,030	-	6,182
Deficit Support Funding - national	1,152	(1,152)	(2,304)	2,303	-	(2,303)	13,818
Reported Position	**-**	**(2,791)**	**(2,791)**	**-**	**(3,814)**	**(3,814)**	**-**



Understanding the Performance

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

The in-month position was a deficit of £2.8m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan Year to Date (YTD) the Trust is not able to access deficit support funding. The YTD adverse variance against plan is £3.8m, of which £2.3m is due to the loss of deficit support funding and is driven by pay and non-pay pressures largely driven by non-elective activity volumes and pathways resulting in an increased bed base, additional backfill requirements and medical agency costs plus drugs and clinical supplies costs.

Countermeasure Actions

- Financial recovery group (FRG) was established in April 2023, as a sub-committee of the Finance and Performance committee, to provide monthly scrutiny and support to the savings programme. The workforce FRG was established in July 24 to provide additional scrutiny on the deployed workforce, which has now been restructured into the Trust WCP process.

Due Date

Ongoing

Risks and Mitigations

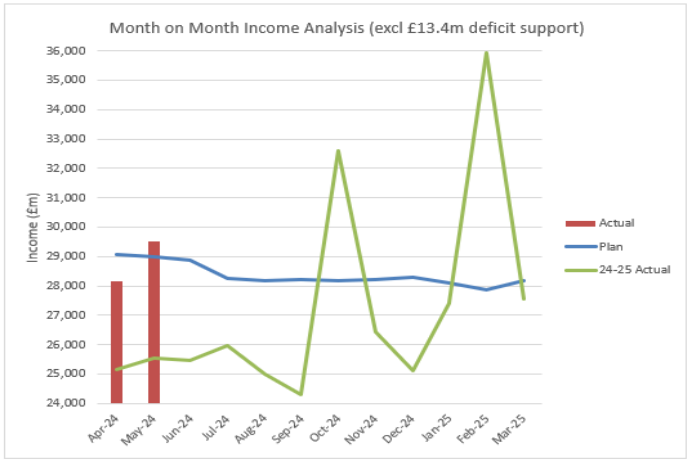
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases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

Income and Activity Delivered by Point of Delivery

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

Income by Point of Delivery (PoD) for all commissioners	May Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	2,652	2,707	55
Day Case	4,326	4,459	133
Elective inpatients	2,915	2,813	(102)
Excluded Drugs & Devices (inc Lucentis)	5,037	4,930	(107)
Non Elective inpatients	15,417	15,735	318
Other	19,481	19,167	(314)
Outpatients	8,153	7,844	(309)
TOTAL	57,981	57,655	(326)

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	36,369	36,104	(265)
Dorset ICB	5,127	4,978	(149)
Hampshire, Southampton & IOW ICB	4,622	4,506	(116)
Specialist Services	7,712	7,985	273
Other	4,151	4,082	(69)
TOTAL	57,981	57,655	(326)



	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	13,353	13,788	45	13,380	370
Day case	4,304	4,626	158	4,882	(241)
Elective	632	620	(25)	607	(4)
Non Elective	5,153	5,386	179	5,341	86
Outpatients	52,648	50,187	(534)	48,788	1,214

Understanding the Performance

The Trust level performance is driven by lower Elective Inpatients, Outpatient First attendances and Procedures impacting on the ERF income. There is underperformance across all the main commissioners except for Specialised commissioning due to overperformance on high-cost drugs and devices.

BSW depreciation pass through funding and CDC are underperforming but this is partially offset by overperformance on Cross border, Channel Islands, Provider to Provider contracts and Local authorities.

Activity across the main points of delivery was higher in May than in April.

Countermeasure Actions

- 2025/26 contracts must be signed by the end of May 25.

Due Date

May 2025

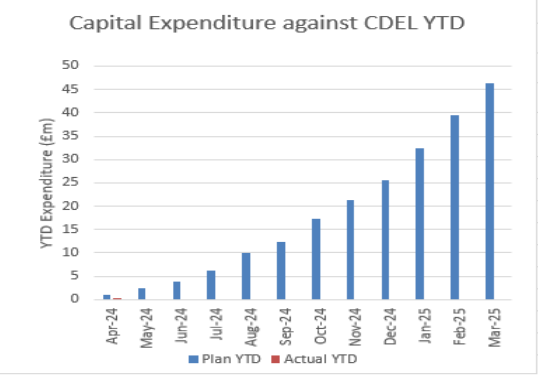
Risks and Mitigations

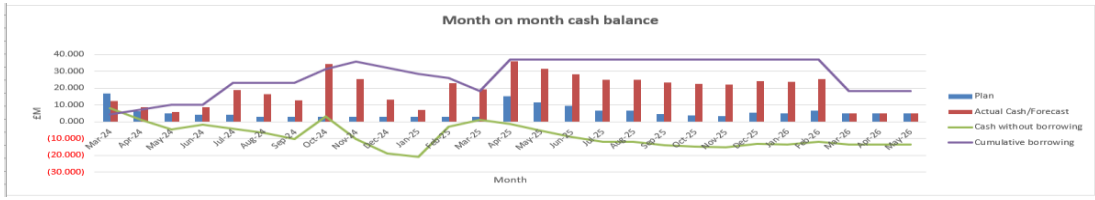
- The second 25/26 NHS England Standard contract consultation closed on 28th April with changes to the contract activity management provisions and requirement for agreement of robust Indicative activity plans now required.
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

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

	Closing Balance March 2025 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,520	7,573	53
Debtors	19,291	24,483	5,192
Cash	22,530	31,631	9,101
TOTAL CURRENT ASSETS	**49,341**	**63,687**	**14,346**
Creditors	(49,082)	(47,594)	1,488
Borrowings	(1,391)	(19,773)	(18,382)
Provisions	(590)	(589)	1
TOTAL CURRENT LIABILITIES	**(51,063)**	**(67,956)**	**(16,893)**
TOTAL WORKING CAPITAL	**(1,722)**	**(4,269)**	**(2,547)**





Schemes	Annual Plan £000s	May '25 YTD Plan £000s	May '25 YTD Actual £000s	May '25 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,915	194	273	79
Building projects	1,392	92	195	103
Fire schemes	608	40		(40)
IM&T	5,370	200	398	198
Medical Equipment	3,000	200	13	(187)
Leases	750	100		(100)
Total CDEL schemes	**14,035**	**826**	**879**	**53**
National Funding				
Shared EPR - Nationally funded element	3,199	783	572	(211)
Estates Safety Funding	5,254			
25/26 Community Diagnostic Centre	12,160			
25/26 Seed Funding for Elective Care Centre	5,400	650	49	(601)
25/26 Procedure room	300			
25/26 Urgent Treatment Centre	7,000	100	7	(93)
Total National Funding	**33,313**	**1,533**	**628**	**(905)**
GRAND TOTAL	**47,348**	**2,359**	**1,507**	**-852**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £1.5m at Month 2. This is mainly driven by EPR and building projects. Nationally funded schemes are dependent on the successful submission of business cases, apart from Shared EPR and the Estates Safety Funding which have already received approval. However, due to the challenged revenue position across BSW, CDEL schemes which are not yet in progress are being paused to preserve cash to support the revenue position.

The cash balance at month 2 continues to be above plan due to the payment of an additional month's contractual payment by BSW commissioners of £20m in month 1. This will be repaid in M12.

Countermeasure Actions

Countermeasure Actions	Due Date
• BSW ICB has paid two months contract payments in April to mitigate any requirements for PDC support in 25/26. The payments include 2 months of the £20m deficit support for 25/26.	Complete
• Given the YTD deficit at M2, and the subsequent loss of deficit support funding, CDEL capital schemes which have not yet started are being paused to preserve cash. The same constraint does not apply to nationally funded schemes, which are cash backed.	June 2025

Risks and Mitigations

- The aging estate, medical equipment and digital modernisation means that the Trust's capital requirements are more than resources. The Trust seeks to mitigate the constraint of available system capital by proactively bidding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.
- Deficit support funding in 25/26 is contingent on the system financial plan delivery which was not achieved in Month 2. However, the funding will be achieved if the system can recover the position in 25/26. Therefore, immediate financial recovery is of paramount importance.

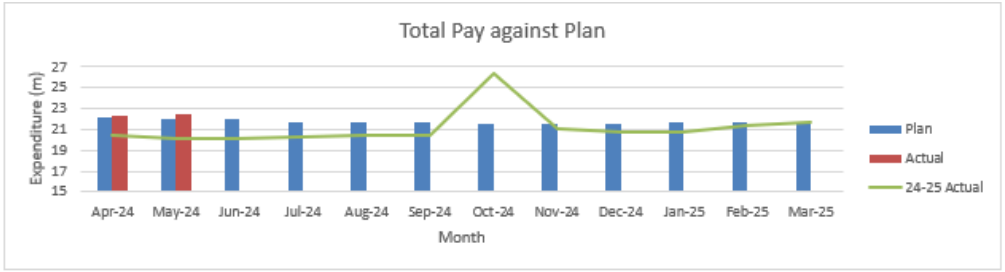
Workforce and Agency Spend

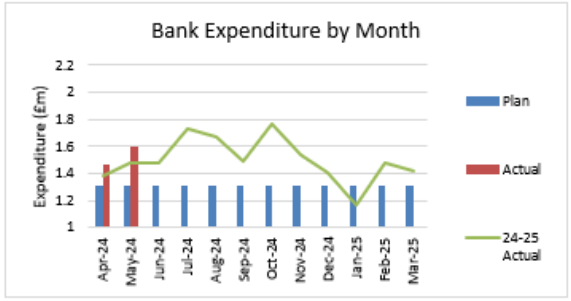
Salisbury NHS Foundation Trust

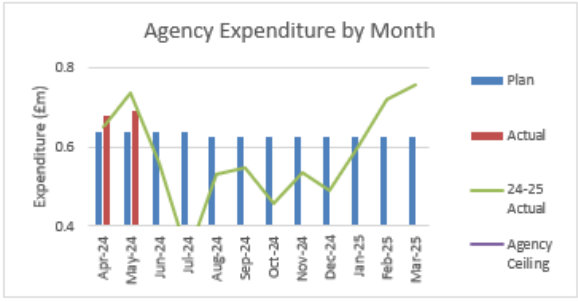
Target: N/A Performance: N/A Position: N/A

	May '25 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	40,796	40,279	517
Pay - Bank	2,576	3,060	(484)
Pay - Agency	619	1,367	(748)
Other (eg apprenticeship levy	142	175	(33)
TOTAL	44,133	44,881	(748)
Medical Staff	11,312	12,526	(1,214)
Nursing	12,215	12,026	189
Support to Nursing	3,425	3,518	(93)
Other Clinical Staff	6,401	5,946	455
Infrastructure staff	10,638	10,689	(51)
Other (eg apprenticeship levy	142	175	(33)
TOTAL	44,133	44,881	(748)

	May '25 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	564.9	567.61	2.7
Nursing	1,228.2	1,323.26	95.1
Support to Nursing	553.8	564.15	10.3
Other Clinical Staff	636.3	658.67	22.4
Infrastructure staff	1,492.0	1,436.93	(55.1)
TOTAL	4,475.2	4,550.6	75.4







Understanding the Performance

The pay expenditure run-rate has deteriorated by £0.1m from month 1. YTD Pay spend is adverse to plan by £0.7m. This is driven largely by medical staffing agency spend, and higher than planned costs in the NHS Infrastructure Support cohort. Unmet pay savings targets also contribute £0.5m to the YTD adverse variance.

The pay savings target in month was £0.5m, with delivery at £0.3m and largely non-recurrent vacancy savings across various areas. The pay savings target of £11.3m for 2025/26 has a phased profile, therefore the programmes of work (largely Corporate redesign, administration modernisation, and sickness management) will need to enter the delivery phase by Q2 and deliver recurrent financial benefits to meet the plan.
At month 2 there is an over establishment of 75 WTE, with a further 107 WTE staff in the recruitment pipeline.

Countermeasure Actions	Due Date
• Trust wide and Divisional workforce control panels in place since November 23.	Ongoing
• Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients) as well as content oversight forums for transformational programmatic workstream driving improvements in workforce efficiency and expenditure.	Ongoing
• Further workforce controls and non-pay expenditure restrictions in place (such as elimination of discretionary expenditure).	June 2025

Risks and Mitigations

- Staff availability initiatives are in train to mitigate workforce gaps as well as agency premiums, however due to operational pressures it is likely the Trust will continue with agency premiums within medical and nursing staffing cohorts in the short term.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

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

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

Appendix

Reading a Statistical Process Control (SPC) Chart

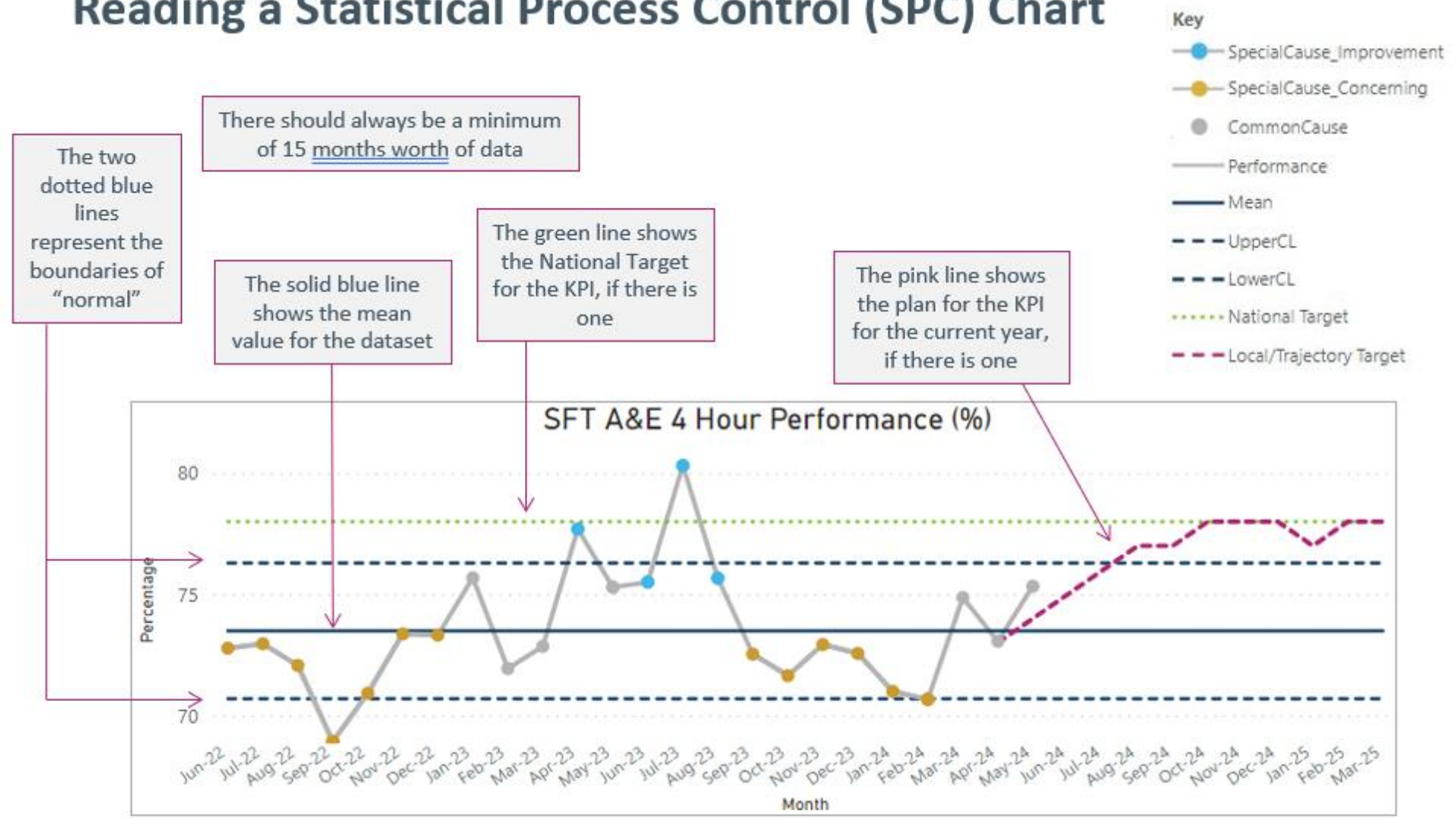
There should always be a minimum of 15 months worth of data

The two dotted blue lines represent the boundaries of "normal"

The solid blue line shows the mean value for the dataset

The green line shows the National Target for the KPI, if there is one

The pink line shows the plan for the KPI for the current year, if there is one



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	3 July 2025		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	19 June 2025
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

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

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

- The Committee received an Internal Audit covering EPR Programme Governance and Change. This is a joint report, the scope of which covers each of the three Group Trusts, and it was completed in February 2025.
- The Internal Auditors provided a rating of 'significant assurance with minor improvement opportunities'.
- Given the significant deterioration in the EPR Programme's own assessment of its status to Red at the end of March, after the Internal Audit, and the separate Programme Assurance work undertaken in April/May on behalf of the programme by Berkley Assurance which highlighted a number of substantive issues to be resolved, the Audit Committee was concerned that the rating of the Internal Audit report, if it were to be carried out now, might not allow it to be significantly assured.
- The Committee also noted the imminent completion dates of a number of actions committed to by Management back in February, and challenged management to provide a written update to the Audit Committee to assure it that given the current status of the Programme either:
    - The Action is still appropriate and the action will be completed before the completion date, or
    - The Action is still appropriate but the completion date will need to be reconsidered, and reasons, or
    - The Action is no longer relevant given the changing circumstances of the Programme, or
    - That new Actions need to be implemented, and reasons.
- The Committee referred this Internal Audit report to the EPR Joint Committee.
- The Internal Auditors noted the similarity of the findings in the KPMG report and the Berkley report.

- Together, the Audit Committee and the Internal Auditors reflected on and reminded themselves that Assurances provided in any Audit Report can only be fully relied on at the time of the publication of the report. The Internal Auditors have committed to give some thought as to how to include some subjective view in Audit Reports in the future as to an indication of the length of time an opinion can be relied on.

NHS Salisbury NHS Foundation Trust

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

- The Committee received an advisory Internal Audit on elements of the Workforce Controls process highlighting some medium/low rated recommendations. The Committee referred this to the People and Culture Committee for review.
- The Committee received a Counter Fraud Audit on Counter Fraud Reporting Culture which highlighted a few medium/low rated recommendations. Again, the Committee referred this to the People and Culture Committee for review.

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

- The Committee received the Annual Report and Head of Audit Opinion from KPMG, which "for the period 1 April 2024 to 31 March 2025 is that 'Significant assurance with minor improvement opportunities' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'
- Similarly, the Committee received the Local Counter Fraud Annual Report from KPMG. The Trust is required to undertake a self-assessment for each of twelve components of the NHS Counter Fraud Authority requirements; 11 out of the 12 are assessed at Green with the remaining component rated as Amber. This is an improvement over last year that saw 9 Green and three Amber rated components. The regulatory submission has been signed off by the CFO and Chair of the Audit Committee and was submitted in advance of the regulatory submission date.
- The Committee noted the imminent submission of the 2025 National Cost Collection data; it also noted that the common Group costing function that is being proposed would streamline and facilitate subsequent annual submissions.

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

- The Committee received the External Auditor's Report to the Audit Committee following their annual audit of the 2024/2025 year. The audit was reported as being substantially complete, but with a small number of matters to close out, none of which were considered material. No substantive matters of concern were raised, and the Auditors will not be qualifying their opinion as included in the consolidated financial statements. The Auditors will however again be reporting a significant weakness in the Trust's arrangements to secure financial sustainability into the future.
- The Committee received and approved the Annual Governance Statement, which will be included in the Annual Report.
- On this basis, the Audit Committee recommended that the Accounts and Annual Report be approved by the Board, and the usual Letter of Representation be signed, pending final closure of the minor outstanding matters. Submission date for filing Annual Report and Accounts to appropriate regulatory bodies is June 30th

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
	3rd July 2025		

Report from (Committee Name):	Finance & Performance Committee – Extraordinary		Committee Meeting Date:	3 June 2025
Status:	Information	Discussion	Assurance	Approval
	x		x	x
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- SFT was £1m off plan in Month 1 and the wider BSW Hospital Group significantly off plan, which the region and system have reacted to by seeking additional controls on costs and assurance for delivery of the overall plan. The main contributor to the adverse deviation is the continuing pressure on flow/demand and the stubborn high levels of NCTR (presently in the high 80s).
- With many different conversations taking place in different forums, different audiences and "commanders" there is an increased risk of creating gaps in leadership messages, priorities and areas of focus and it is becoming harder for MD and Executive to bring consistency and focus to the areas within their control. There is no doubt that external pressures will continue to be significant and we will need to act with rigor and pace, balancing the financial imperatives with patient safety and quality.

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

- **Risks to plan**
  - The M1 BSW deficit support has been withheld and there is a risk that this will be withheld if we don't get back to plan, which will have serious consequences for cash flow.
  - Silo thinking could result in gaps when we bring all the plans together and there is a need to see the full landscape of what can't be done as teams are cut and to evaluate the impact on existing resources of passing responsibilities onto others who already have significant workloads and responsibilities.
  - The recommendation on the timing of the closure of beds with Tisbury ward was deferred to F&P on June 23rd following a discussion around the impacts of closure if we are not at a "safe" level of NCTR, with the risk of patients being in escalation spaces, corridors etc. We will have another deep dive to understand what we can reasonably expect to happen in the next month or two to get to a safe level. There is some concern that this is delaying cost reduction action with no definitive date of closure, but we were guided by the leadership team on the safety impact of premature closure.

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

- **Plan approved by Board –** The Executive remain behind the 25/26 plan with the Committee and Board members agreeing that we shouldn't deviate from plan. There is a reasonable degree of confidence that the actions within it will deliver the necessary improvements, but as highlighted in the plan submission, it is not without risk and requires whole system collaboration and improvement, particularly in reducing NCTR and Community services, where we seek more assurance.
- **Region expectations**
  - Leadership – Board and NED oversight – assured that we have that oversight.
  - Workforce Controls – assurance that the process is being aligned across the Group. With concerns raised about the impact on safety and quality and the potential for cumulative risk impact we were assured that quality impacts assessments are taking place and cases put forward with the CEO/Accountable Office (Cara) taking the appropriate safety based decisions. For additional assurance there will be a desktop review of the controls.
  - Temporary staffing controls are considered doable.
  - Workforce planning is needed with some improvement possible, but the biggest difference coming with digital capacity, which is a tension with the EPR.
  - Non pay spend – sensible proposals are being considered to ensure messages, and optics are aligned with the financial imperative, whilst finding ways to manage any impact on morale.

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

- **Programmes of work –** F&P recommended and agreed with Chair's action in the meeting the following capital programmes. None have a negative revenue impact and funding has been allocated nationally.
  - Seed funding for elective care centre (£5.4m)
  - Works funding for an additional procedure room in DSU (£0.3m)
  - Works for funding for developing an urgent treatment centre (£7m)

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
	3rd July 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	24 June 2025
Status:	Information	Discussion	Assurance	Approval
	x		x	x
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- **SFT's financial position** deteriorated again, with the main driver being the withdrawal of deficit support funding of £2.3m, taking us to a deficit of £3.8m in M2. Although M2 was another "underlying deficit" month, the run rate improved, which gives some hope for an improving position moving forward. However, unless the whole of BSW gives assurance on the delivery of the plan under a new term called RONDA (Risk of Non Delivery Assurance), we will not receive any deficit support, which will result in some serious cash flow issues later in the year, the consequence of which may be BSW being put into a failure regime (what that means is not yet clear).
- **The resources required** to meet the many demands (BAU, CIPs, redesign of Corp services with a 50% reduction target, transformation, financial data and evaluations) all teams are extremely stretched, finance being the example shared with us. Despite the urgent deadlines there needs to be some prioritisation to allow these demands to be met and to avoid significant levels of stress, burnout and attrition.

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

- **NCTR** – remains stubbornly high, currently around 94. There is an action plan and engagement across partners, but movement is slow and without a significant reduction in NCTR over the summer our financial and operational plans will be further jeopardised. HCRG are evaluating the hospital @ home model, but we have not yet seen the outcome and have no timeline for when we can expect it. We need to be able to sustain a max level of <60 NCTR to enable us to close Tisbury and keep it closed for the rest of the year. In the meantime, there is a rolling programme to try and close beds ahead of the work to refurbish Tisbury.
- **Flow** and bed occupancy – are both higher than plan, which is impacting our ability to reduce workforce costs in line with plan. The flow volume is affecting ambulance handover times and challenging ED staff resilience and capacity to cover sickness and keep appropriate staffing levels, however, there continue to be small improvements in metrics for these.
- **Secretarial and Admin Resources** will be the focus of more engagement and positive events as they go through the transformation to build a more sustainable model and flexibility to move where the pressure points are.

- **Connecting the workforce plans with Finances** is needed to enable the Committees to take proper assurance that we are doing what is needed to deliver the planned operational and financial objectives and that they properly align.

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

- **IPR –** Small improvement continues across a number of performance metrics, e.g. Time To First OP Appointment and Referral To Treatment. The outpatient team is recruited. At the moment SFT are within the top 12 nationally for RTT improvements. Cancer performance dipped in April, but with a new leadership team and an internal improvement plan for Urology (not benchmarking well with peers), there is an expectation of an improved picture in the next month or two. DM01 is recovering after earlier slippage and expects to get back to 80% and with regional support, which may include capital support in 26/27, there are hopes of getting to 90% by Christmas for Endoscopy.
- **Estates**
  - The £5.8m critical infrastructure funding will be used to deal with the £14m of risk, including demolishing one chimney, theatre electrics (although there is an impact on utilisation with each theatre out of action for a month for works to be done – requiring some careful risk planning given the impact on financial performance.
  - The new CAFM system is 3-4 months away and will enable the team to see accurate data and give us the assurances that we need and that are absent currently because of spurious data!
  - Commercial terms are being drafted for the Geothermal energy supply, which will support the whole site, with some additional potential capacity from a nearby solar farm.
  - Elective Care Centre - design is progressing well and there have been positive noises from national levels about the approach to the business case which the Trust is progressing.
- Items taken offline for comment: principles for winter plan, digital and Cyber.

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

- **Southern Counties Pathology Model –** A proposal for a new governance structure was put forward, but the Committee felt it needed to understand the operating model before concluding what the appropriate governance structure was.
- **Clinical Insourcing Managed Service Gastroenterology** – A contract to run to 31/3/26 was approved for this essential service.
- **25/26 Diagnostic Capital** – approval was given for 3 small projects – Audiology, Neurophysiology equipment and Physiological science equipment. A recommendation to Board to approve the CDC expansion was also given.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	3rd July 2025		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	24th June 2025
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing, Chair of CGC			
Appendices (if necessary)				

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

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

- CGC were informed about a failure in electronic discharge summary transmission due to to an IT issue which has now been resolved. This had affected about 4500 patients since November 2024. GPs have now received copies of the summaries and have been asked to report any harm they have identified. A sample audit has identified low risk of harm. This is being reiewed through the patient safety incident review process.
- An incident in histopathology had resulted in a number of specimens being inappropriately processed. A small number of patients (<20), may need repeat biopsy. Duty of candour is being followed and patient safety incident review process is underway.

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

- CGC noted the Trust had received an unannounced visit from the CQC to review Medical Wards and Endoscopy the previous week. No significant immediate concerns had been identified, and several positive findings had received initial comments. Less evidence of hand washing than expected had been noted, which does not reflect our own audit data. Additional local audits are taking place to provide further assurance. Our data will be shared along within many other pieces of information requested by the CQC to help with their report. CNO informed CGC that additional support had been identified to help with the information collation, given the reduction in staffing in compliance noted previously.
- There are continuing concerns around the accuracy of key training data compliance, (especially safeguarding, which is noted to be more complicated to manage, given the various levels of training required for different staff). CGC received an update of the work being done to improve MLE and noted also that the system will come up for replacement or renewal at end of March 2026. CGC asked for further assurance from People and Culture as to the date by when we should be able to rely on the data. CGC noted this is on the Trust risk register and an internal audit is planned for later this year.
- BAF 2 risk score has increased due to concerns about the oral and maxillo-facial services, which currently have reduced staffing. Attempts to improve this by use of temporary staffing and working with partners are underway, but the limited capacity of the system to offer mutual aid raises the risk. CGC agreed the increase in BAF 10 was appropriate given the national NHS changes and uncertainty

generated. CGC questioned whether BAF 7 should increase given the current restrictions on recruitment, and the likely impact on staff morale and well-being. This will be raised by the MD at People and Culture.

- CGC noted the continued improvement in NEWS2 scoring and agreed that considerable improvement in this area has been achieved. Concerns about pressure ulcers were noted and CGC agreed this may be more appropriate as a reducing harm breakthrough objective metric in the near future.
- There are continued concerns regarding the motor minutes metric in stroke care, which have not sustained the improvement expected from the information provided to CGC in a deep dive last meeting. CMO and CMO agreed to report further at next CGC.
- CGC noted that the non-elective activity had continued to be very high, resulting in more corridor care and an increase challenge to safe, high quality care. CGC noted however the number of high harm incidents has reduced in month.
- CGC received the perinatal surveillance reports covering April and May data, and the 2024/2025 Q4 Maternity and Neonatal Safety report. Increased vacancies in midwifery have resulted in an increased midwife to birth ratio, but new starters are expected in the next few months. Key standards have been maintained. Continued progress with Savings Babies Lives was noted. The National Maternity Review recently announced was noted, and further information is awaited.

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

- CGC received the following **annual reports** and agreed they provided considerable assurance in their respective areas.
- **Director of Infection Prevention and control.** This report detailed all the arrangements in place to look after our patients and staff and reduce the risks of harm from infection. It reported on the number of health acquired infections in 2024 /2025. The hospital has seen more patients with clostridium difficile infections than previously, and CGC were informed that increased numbers have also been seen in our surrounding community.
- **Clinical Audit report 2024/2025 and plan for 2025/2026** demonstrated levels of audit completeness and improving levels of review of audit findings and identifying actions for improved quality and performance standards.
- **Annual NICE report** evidenced process of reviewing NICE guidance and identifying level of compliance with guidance relevant to SFT
- **Annual patient engagement review** demonstrated numerous examples of improved engagement with patients including more vulnerable and harder to reach patients. CGC also noted the increased requirement for translation services.
- **Medicine Safety annual report** highlighted how vacancies within the central and wider pharmacy team haave necessitated senior staff covering many roles with vital patient facing responsibilities. Recent recruitments have improved the situation.
- CGC noted the final version of the **Quality Account 2024/2025** which had been approved by Trust Board earlier this month.
- Learning from deaths quarterly report provided significance assurance regarding review of patient deaths to ensure learning is identified. Discussion with other trusts in BSW group has identified further insights that can be gained from the mortality data provided by our third party providers. CGC recommended the summary of this report provides assurance for the Board.
- CGC acknowledged the assurance provided by the Medicine Division governance report, and noted the significant improvement in response time to complaints, as a result of the passion / mission of key members of staff.
- CGC received the 6 monthly Quality Impact Assessment Assurance report, and noted the importance of this during this time of service change and recruitment restrictions.
- CGC received the escalation reports from Clinical Management Board for April and May and noted the good work being done by the Wiltshire Health Inequalities Group.

•

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	3rd July 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	28th May
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

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

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

- NCTR position remains very challenging contributing to high overall bed occupancy
- Non Elective demand remains above the 1.6% expected in the plan.
- Hospital at home service roll out plan has been put on hold by HCRG leading to concern about implications for discharge and flow plans at SFT.

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

- Elective Care centre ECC, design update was presented agreeing the best location for the centre.
- The climate adaptation and climate risk assessment was presented to the committee to inform wider stakeholders on the expectations ahead.
- Digital steering group gave an update on Badgernet challenges with CTG integration and scoping work was underway to understand what was needed to change CTG's.

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

- The committee received an update from estates showing progress against the key risks.
- Some improvements in pharmacy recruitment to key posts reducing the risk rating on risk register.
- 65 week wait performance continues to be ahead of plan.

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

- Fraud, bribery and corruption policy was approved.
-

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	3rd July 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	25th June
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

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

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

- Finance position was discussed noting the significant challenges and risks to the plan, agreed escalation meetings were outlined and the clear implications for cash were outlined to the committee.
- NCTR remains significantly off plan at 20% of beds rather than the planned 9% leading to higher staffing costs through escalation beds.
- There are some challenges in cancer pathways particularly urology and breast pathways. Action plans are in place to deliver pathway improvements.
- Digital steering group escalated continued challenges with LIMS implementation. Theatreman upgrade is also delayed from July to August due to supplier challenges.
- Badgernet upgrade phase two is working through the integration of CTG machines which has identified a risk. Mitigation plans are being developed with a detailed plan presented for 26th June.

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

- The Committee noted the west of England imaging network terms of reference and business plan. Given the small interface we have with west of England a recommendation that other trusts in the group represent BSW Hospitals.

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

- The new outpatients teams (Clinical lead, operational manager) are now in place this is having a positive impact on the outpatient transformation programme.
- UEC bed plan has now been implemented – the bed plan has been adjusted to remove SDEC as a escalation area.
- H&S report noted continued low level of injury trends and incidents.
- Estates update noted reducing risks due to implementation of new estates digital system . The Trust has been successful in being awarded £5.2m for estates work.

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

- CDC expansion business case was approved but subject to understanding of the resourcing plan to accommodate additional reporting in the context of hard to recruit consultant radiologists.
- Neonatal staffing was approved to comply with BAPM – further work is required to mitigate the cost pressure. The expectation this would reduce the need for high cost agency spend currently used for rota gaps.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of meeting:	Thursday 3 July 2025		

Report tile:	Health and Safety Report			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Health and Safety Committee OD&P Management Board Trust Management Committee People and Culture Committee			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

Trust Board is asked to note the contents of the Annual H&S Report.

Executive Summary:

A requirement of the Trust H&S management system is to produce an annual H&S report looking at injury trends, actions taken to manage risks, ongoing opportunities to improve the management of H&S and to create objectives for the next year.

The annual report for FY25 shows, despite quarter on quarter variations, continued improvements in H&S performance year on year. Whilst the number of lost time injuries fell, there was an increase in the number of days lost on FY25. An increase due to the injuries of 4 staff who have all returned to work. If these 4 injuries were removed from calculations, the average number of days lost per lost time injury is 3 days.

Injury rates are therefore small with no obvious common causes of injury. But there are some common trends in incident reporting. These are highlighted below:

- Reports of violence and aggression rose from 133 in FY24 to 208 in FY25. As in previous years antisocial behaviour, mental health and behavioural disorders and cognitive impairment in elderly patients remains relatively equally reported.
- near miss reports increased significantly, and

sharps injuries saw a significant increase that will be explored in FY26 with the infection prevention group and occupational health.

During the year work the H&S team completed scheduled H&S activities that included 8 internal audits, 23 ward and department inspections and 17 department task analysis / risk assessments. Activity will continue during FY26 on a scheduled basis that covers areas not included in either FY24 or FY25. As noted in a previous quarterly report, the Trust H&S Team is engaged through a commercial relationship with the BSW ICB to provide technical advice and audit activity across each of the 4 locations. This will continue into FY26.

The Trust estate continues to present ongoing challenges to H&S. A number of risks are under a review and consultation to ensure risks are being mitigated and plans in place to reduce the risk to staff. These risks include:
storage and power in Theatres,
structural integrity of the energy centre chimney,
aging electrical circuitry in the accommodation block
maintaining negative pressure in microbiology department.

To ensure the ongoing success of the H&S management system the Trust will measure a number of negative and positive performance measures during FY26 that will include the following:

The number of lost time injuries,
The amount of time lost in days,
The frequency of injuries and time lost against time worked,
Develop and implement a monthly activity schedule,
Record the number of staff completing the violence prevention and breakaway training, and
Record the number of closed and open action plans from audits, investigations and risk activity.

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

HEALTH AND SAFETY PERFORMANCE REPORT
FY25 – ANNUAL REPORT – Q4

Salisbury NHS Foundation Trust

1. Performance Measures

Overall performance, shows relatively consistent results when viewed against the 23/24FY and a marked improvement on the 22/23FY.

1.1 Lost Time Injuries

On average there were 2.5 lost time injuries and 1.1 RIDDOR's reported each month.

Financial Year	Number of Lost Time Injuries	Days Lost
22/23	143	1,296
23/24	39	270
24/25	30	344

As seen in the table above, there was a reduction in the number of lost time injuries reported from FY24, a trend that continues from the reduction on FY23. There were no new injury trends not already identified, or assessed, by the H&S team from previous years. For example, violence and aggression accounts for much of the incident reporting and manual handling injuries account for much of the time lost across the Trust.

1.2 Time Lost

Days lost vary widely by quarter with an average of 28 days lost per month. This is a 27% increase on FY25. But while it is up on last year, it is encouraging to note 60% of all days lost can be attributed to the following 4 injuries (all reported as RIDDOR's to the health and Safety Executive):

- The exacerbation of an underlying medical condition that required surgery for a member of the Facilities Team,
- The amputation, and surgical repair, of the tip of a finger of an Estates employee handing a telescopic pole,
- A back injury within theatres as a result of lifting a surgical tray from storage racking, and
- A fractured finger from a confused patient grabbing a staff member's hand.

All 4 workers made a return to work on pre injury duties.

Almost 50% of all lost time injuries resulted in less than 3 days off work. A lost time injury within the Corporate Division, who slipped in an outdoor area of the Trust whilst walking from the top of the hospital campus to the main hospital, will see lost time extend into Q1 FY26.

1.3 Injury and Frequency Rates

Injury and Frequency Rates by Division										
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	RIDDOR	YTD
Estates & Facilities	53	158	-	4	-	5.2	20	15	-	2
Surgery	12	77	4	12	5.2	2.6	1.2	1.9	-	3
Medicine	41	48	3	8	4.8	2.1	4.9	1.3	2	2
W&N	14	14	1	1	6.5	1.7	6.8	1.7	1	1

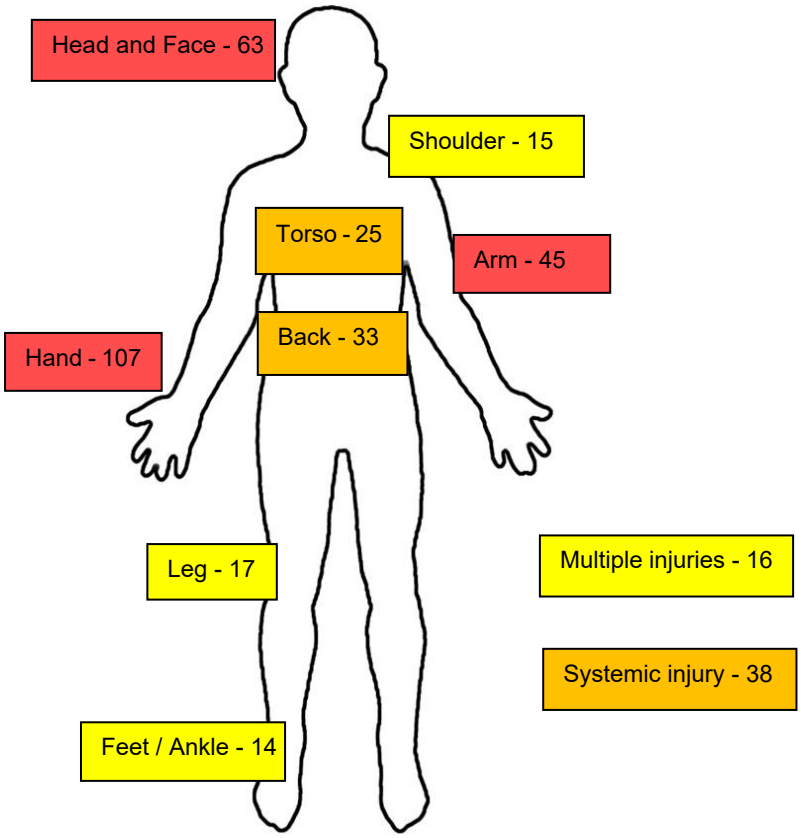
CSFS	-	29	-	4	-	2.7	-	0.9	-	4
Corporate	18	18	1	1	2.3	0.6	3.1	08	1	1
Total	**138**	**344**	**9**	**30**	**3.2**	**1.9**	**3.7**	**2.3**	**4**	**13**

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

2. Injury Statistics

Incident reporting rose 68% on FY24 (from 387 to 608). The increase in reporting in is encouraging and we can expect to see increases in reporting next year as the H&S team continue to respond to each report. When the H&S team formalised the response to Datix reports, it was not uncommon to be told how staff did not think anyone read the reports and did not expect a response. As staff see the value in reporting and have come to expect a response, an increase in reporting is not unexpected.

2.1. Injuries by Body Location



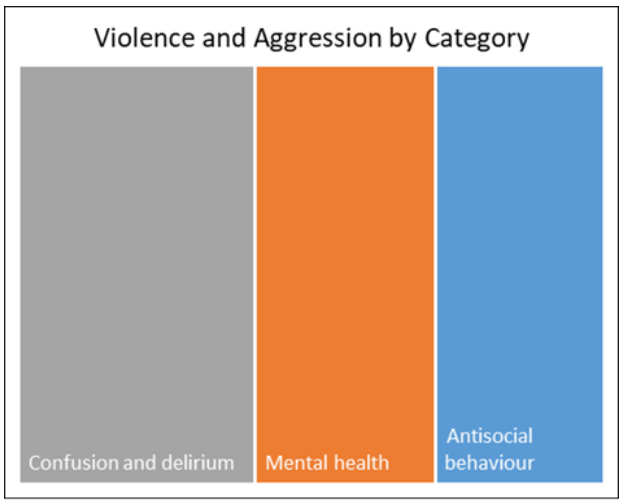
Though it does need to be mentioned that of the 608 incidents reported, near misses, damage to equipment and infrastructure do not result in injury and not all exposure to violence and aggression results in an injury either. Psychological injuries are recorded under systemic injury.

2.2 Incidents by Classification

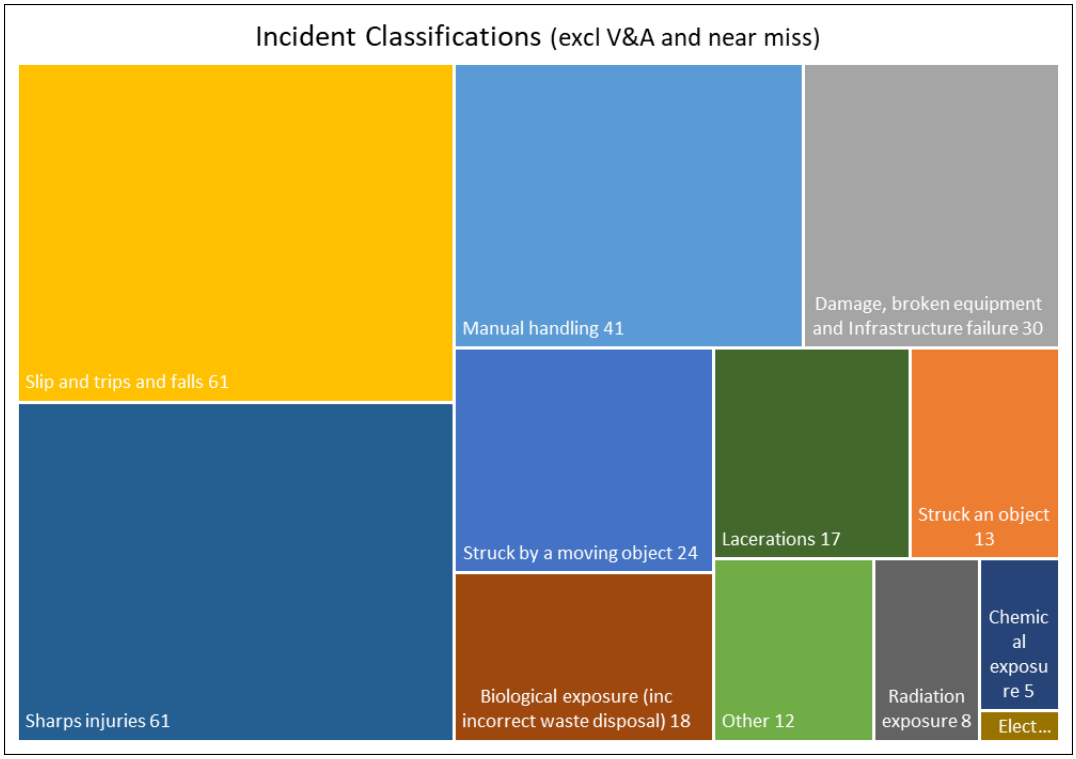
There are 2 areas of significantly increased reporting in FY25:

- Violence and aggression saw a 58% increase on FY24 (from 133 to 208), and is supported in the staff survey results that noted over 75% of staff report exposure to violence and aggression, and
- near miss reporting (from 5 to 103).

As noted throughout the year, violence and aggression generally falls into 3 categories and as previous years violence and aggression related to confused and delirious patients remains the most reported type of incident. The diagram below shows how mental health and antisocial behaviour are reported with equal frequency.



Away from violence and aggression and near miss reporting, incident reporting is broadly in line with expected incident and injury trends with slips and trips, manual handling and needlestick injuries forming the most frequently reported injuries and incidents.



Two thirds of lost time injuries can be attributed to manual handling. On investigation many of the injuries reported have been the result of undertaking care of patients without assistance from colleagues who were unable to help or unavailable at that immediate time. There are significant actions taken to reduce the risk of manual handling that includes but is not limited to manual handling training, lifting and handling equipment, Moving & Handling Advisors and patient risk assessments. The decision to undertake care personal care for a patient when

assistance is not available, and more so where staff have an underlying medical condition or preexisting injury, remains the key factor in many lifting and handling related injuries.

Sharps injuries saw an increase from FY24 (from 33 to 61).

Action
The nature of sharps injuries will be investigated as part of a wider program of work that will involve the H&S Manager, Head of Occupational Health and Infection Prevention Team. The H&S Manager will report on progress in the Q1 report for FY26.

5 slip/ trip incidents are reported a month across the Trust. Slips and trips on external roads, paths and parking areas are perhaps the most commonly noted cause, although slipping off a chair and falling to the floor whilst sitting down has seen an increase in reporting.

3. Risk Actitvity

3.1 Managing Violence and Aggression

As noted in Q3, there was been a significant number of actions during FY25 to reduce the risk of violence and aggression, at least by way of reducing the consequence of harm through training and awareness and improving the response to staff who are exposed to such behaviours, if not the frequency of reports of violence and aggression.

During FY25 the Violence Prevention and Reduction Working Group assessed the Trust initiatives against the revised Violence Prevention and Reduction Standard released by NHSE during the year. The Trust is compliant to almost all criteria, but for categorising reports of incidence by age, race and gender. This criteria will be picked up in future reporting though it is not clear what impact this will have on the management of violence and aggression. Evidence of racial abuse is almost always linked to patients with cognitive impairment where treatment of the underlying cause remains paramount. Staff exposed to such actions continue to be supported by the H&S team as such incidents are reported.

Much of the reports of racial discrimination and verbal abuse are recorded against patients with confusion, delirium and lack capacity. Managing the underlying causes of delirium and confusion remains the only way to reduce the verbal abuse towards staff within this cohort of patients. In this regard supporting staff remains an important element of managing violence and aggression.

During FY25 195 staff members completed violence prevention and breakaway training. Almost all staff who attend this course have been ward based staff providing hands on care to patients and therefore directly exposed to violence and aggression from patients. The course remains well attended. The feedback from staff who have attended the course is that it provides hands on, practical knowledge and skills that are helpful in understanding violence and aggression, especially within mental health, confusion and delirium and how to change communication styles to accommodate confusion and mental health. Courses will continue during FY26.

3.2 Reducing the Internal Movement of Tugs

As noted throughout the year work continues on a project to reduce the use of tugs where appropriate to do so, and to reduce the volume of tugs using internal corridors. There is broad support for the need to change, an understanding that using tugs in the current manner cannot continue and that suitable alternatives are available. Consultation with all departments that use tugs has been completed and each department have expressed broad support of this initiative but are mindful of the need to provide replacement equipment to reduce the risk of manual handling injuries and have raised other concerns that include:

- Additional time to undertake tasks,
- The state of roads in some key areas of travel,
- Costs associated with some changes, and

- Noise and increased vehicle travel in receipts and deliveries area.

Some of the concerns raised were reasonable and required some changes to be made, such as assessing the suitability of alternatives to move goods and repairs to roads to be made. Road repairs have been made and there has been encouraging engagement to seek modified ways of working that reduce tug use.

Work continues to engage with departments, assess remedial works and navigate those small areas of resistance to changes being made. and identifying opportunities to further reduce internal tug travel. It was initially reported that changes would come into force towards the end of March but is likely to be around late Q1 / early Q2 of FY26.

A further challenge is the cost of pedestrian operated equipment to tow trolleys. The equipment identified is more expensive than initially identified because of the gradient on maternity hill. More powerful batteries are required to tow weights up gradients of over 7% and this comes with greater costs. It should be noted the gradient on maternity hill is the reason tugs are set at a speed greater than walking pace. A slower speed would not allow tugs to go up maternity hill.

Another encouraging solution is potentially available in the Nunton entrance. The current waste store is adjacent to the entrance where it is difficult to turn tugs around and staff drive past the car park 8 entrance at Springs. With the refurbishment of the Walk in Centre at Nunton, there is scope to move the waste store into an undercover external area near the secure bike storage. This would eliminate the need for tugs to enter the Nunton entrance and eliminate the operation of tugs in an increasingly busy part of the hospital campus.

The H&S Manager will consult with Facilities and Estates in preparation of construction works later in the year.

Action
Departments have been asked to submit requests for the purchase of pedestrian tugs to replace ride on tugs. For decision makers, it is important to note under H&S legal obligations it is considered a breach of H&S laws to prioritise financial costs where the costs to reduce that risk is proportionate to the risk and the actions recommended are reasonable and practical.

3.3 Liquid Nitrogen

The Trust has a bulk liquid nitrogen store for use within clinics within the Trust and delivered to GP's by the Trust Courier Service. In response to an action from the Medical Gases Group the H&S Manager was asked to assess the risk of storing, decanting and transporting liquid nitrogen, to review any safe operating procedures and develop a Liquid Nitrogen Policy. A draft policy, operating procedures and risk assessment has been developed and will be finalised by August.

Action
The H&S Manager will present a Safe Decanting and Handling of Liquid Nitrogen Policy to the June H&S Committee for approval and consult with departments on safe working procedures.

4. Auditing, Ward Inspections and Risk Assessments

During the 25FY the H&S team developed a schedule of planned activity to be implemented each month. This included:

1. An external audit of the Bath Swindon and Wiltshire Integrated Care Board (BSW ICB).
2. Internal audits for the following departments / wards:
    a. Odstock Health and Fitness Centre
    b. Medical Engineering
    c. Medical Devices
    d. Amesbury Ward
    e. Odstock Ward
    f. Wessex Rehabilitation Industrial Workshop, and

g. Sarum Ward

3. Departmental Task Analysis for the following areas:
    a. Waste and Gardens Team
    b. Housekeeping
    c. Porters
    d. Kitchen
    e. Couriers and Transport, and
    f. Cellular Pathology
4. Facilitating ward risk assessments for 10 clinical departments
5. Facilitating annual inspections across 23 departments

Action plans are developed as a result of each of the above listed activities but there is a need to review these actions plans with wards and departments in a more structured way.

The audit program has been implemented for more than 10 months now. There were initial Trustwide themes identified in the first few months and actions implemented to address these themes. For example the lack of inspections, investigations and risk assessments. Many of the actions of the H&S Team (restarting department inspections, risk assessment workshops and investigation training) are all implemented in response to these findings.

Many of the findings from recent audits now reflect local issues and challenges. For example; specific machine guarding in medical engineering, the induction of patients within the Wessex Rehab workshop or ensuring the assessment of a dysregulated patient includes an assessment of staff risks on Sarum ward.

5. H&S Committee & Sub Committee Activity

5.1 Estates Risks

There has been a number of risks the H&S and Estates Teams review on a scheduled basis. These risks are listed in the table below and scheduled meetings will continue through FY26.

Risk	Score	Description of risk	Controls and Actions Taken to Mitigate Risks
7931	16	Theatres electrical power is reliant upon extension leads that are not supported by UPS	Extension leads are being used for surgical equipment due to insufficient sockets and are not protected by IPS/UPS sockets. ETS and Medical Devices Team have developed an electrical capacity table for each theatre and the power requirements for theatre equipment to ensure schedule theatre lists do not exceed power capacity or require the use of extension leads. There is a project currently being scoped for the refurbishment of selected theatres. A fortnightly inspection continues to be carried out by the estates, medical devices and theatres teams whilst the UPS/IPS protected socket project is being explored.
7932	16	Wyle house earthing failure poses a risk if frayed electrical equipment is used.	The cabling installed during construction is breaking down. A Project Manager has been nominated to manage a replacement project, metal items such as faceplates and light fixtures with plastic ones have been replaced with plastic and a contractor has been nominated to undertake schedule of works.
7917	15	Fire risk in main theatres due to the volume of goods stored in theatre corridors	Simple but effective actions have been taken to reduce the risk such as practice evacuations, clearer evacuation plans and practice evacuations and removal of racking adjacent to isolation valves, but the volume of equipment continues to expand. Storage space has been created with the security team being moved out of the Level 1 CCTV room which has been allocated to theatres for additional storage.

7490	15	Structural integrity of the Energy Centre main chimneys	Structural engineers have assessed the risk of collapse and a project is currently underway to measure and record the movement of chimneys with a view to remove 1 chimney in FY26 and reduce the height of the second chimney by half the current height.
7309		Containment Level 3 room at risk if negative pressure fails	The current exhaust fans are operative and effective but there is no backup exhaust system. Should the current fan fail the Trust will lose capacity to compete Level 3 pathology testing. Initial assessment of work requires replace exhaust hosing and duct work. ETS are currently scoping works and seeking costings.

5.2 Sub Committees

There are 12 sub committees that report to the H&S Committee. Each Committee have terms of reference (updated every 2 years), provides quarterly assurance, alert and advice reports and an annual review. Some examples of sub group activities are listed below:

- Aviation Safety Group ensure continued accreditation to Civil Aviation Publication (CAP) 1264 Standard for Helicopter Landing Areas at Hospitals,
- Violence Prevention Group oversaw the development of No Excuse for Abuse Campaign,
- Medical Gas Group oversaw the management of a nitrous oxide leak across the Trust,
- Fire Safety Group oversaw the implementation of a fire risk action plan within theatres,
- Radiation Protection Group continue to oversee actions to mitigate the acute shortage of Radiation Physicists at the Trust and engage with University Hospital Southampton and Royal United Hospital, Bath to provide further longer term engagement.
- The Water, Electrical and Ventilation Safety Groups continue to oversee the ongoing maintenance requirements across the Trust whilst the Estates Team source suitable Computer-Aided Facility Management (CAFM) software to improving asset management and maintenance.

6. Fit Testing

During FY25, the fit test team offered over 3,270 appointments and fit tested 1,915 staff, at an average of 280 appointments each month. In addition, the team conducted 9 weekend days to ensure staff who only work weekends were fit tested, and completed more than 30 days of testing within departments where there were high levels of non compliance to fit testing.

Until mid year, the coordination of fit testing appointments was a manual exercise managed by the fit testing team who would book in appointments as new staff commenced or as people rebooked a fit test. Bookings moved to MLE (Learn) in mid-2024. This not only streamlined the booking process, it enabled the team to draw compliance reports by wards to identify the overall level of compliance. Quarterly reports are now distributed to wards and divisional managers to understand and improve compliance as required and has driven improvements in overall compliance, and as noted above, has resulted in a number of ward based testing days.
MLE reports have enables a targeted approach to testing and has seen significant improvements in fit testing in almost all clinical areas. This work will continue into FY26.

938 people did not attend a scheduled appointment and gave no notification they would not be attending. This is in part due to the use of MLE to book fit test appointments and the benefits of using MLE outweigh the number of non attendees.

The Fit Test Team is scheduled to move into new area in May / June 2025.

7. FY26 Goals, Objectives and Challenges

To ensure the continued improvement of H&S performance across the Trust and to ensure the systematic approach to managing safety, the Trust will measure the following performance indicators. Some of which will report on the consequences of injuries (negative performance indicators) and those actions which would be expected to prevent injuries (positive performance indicators).

Negative performance indicators for FY26 will include:

- Lost time injuries
- Amount of time lost in days
- Frequency of time lost and number of injuries against time worked

Positive Performance Indicators for FY26 will include:

- Develop and implement a monthly activity schedule to promote H&S activities that includes auditing, inspections, task analysis and risk assessments.
- Records the number of staff completing the violence prevention and breakaway training
- Record the number of closed action plans from audits, investigation and risk activity.

Each performance measure will be reported in quarterly H&S reports presented to the H&SC, TMC, P&CC and Board.

Report written by
Troy Ready
Health and Safety Manager

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	3rd July 2025		

Report title:	Register of Seals			
Status:	Information	Discussion	Assurance	Approval
	✓			
Approval Process: (where has this paper been reviewed and approved):	Approved by Lisa Thomas, Chief Executive			
Prepared by:	Sasha Godfrey, EA and Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

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

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

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

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
384	27 March 2025	Deed of Variation of restrictive covenants relating to land adjoining SDH executed by the Trust	Laurence Arnold	Duncan Murray	Lisa Thomas
385	27 March 2025	Deed of Variation of restrictive covenants relating to land adjoining SDH executed by the Charity	Laurence Arnold	Judy Dyos	Melanie Whitfield

386	10 June 2025	Deed of Surrender and Variation room 11 and 12 Block 26 SDH	Laurence Arnold	Mark Ellis	Lisa Thomas

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	3rd July 2025		

Report tile:	Maternity & Neonatal Quality and Safety Report for Quarter 4 2024/25.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	DMT approval 13.06.25 Maternity and Neonatal Assurance Committee -19.06.25 Clinical Governance Committee - 24th June 2025			
Prepared by:	Vicki Marston- Director of Midwifery and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the report for Q4 2025, and for its content to be minuted as per CNST requirements ensuring that quarterly oversight of the Quality and Safety Agenda is maintained in addition to the monthly Perinatal Quality Surveillance Model that is reported monthly.

CNST requirement for minutes to note the following:

1. PMRT review to be noted in board minutes.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%
3. Feedback from ward to board and board to ward evidenced by Safety Champion meetings and attendance by Executive and Non-executive safety champions.
4. Consideration and discussion of the triangulation between feedback, incidents and the litigation scorecard to learn and improve care for women and babies.

Executive Summary:

The Maternity and Neonatal Quality and Safety Report for Q4 demonstrates current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Trust Board of present and emerging safety concerns within Maternity and Neonatal Services.

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 and 2022 recommendations and work towards the 2023 publication of the Three-Year Delivery plan. It will also demonstrate patient experience and feedback and learning.

This report reflects data from **Quarter 4 24/25** with detail highlighted below:

- Midwifery and Neonatal staffing-
  - Non-complaint for BAPM (British Association for Perinatal Medicine) for Neonatal Nurses action plan in progress to write business case.
  - Non-Compliant for BAPM for Medical cover– action plan in progress to write business case.

- 1 Stillbirth (Excluding Medical Termination of Pregnancy)
  - Overall stillbirth rate for last 12 months for SFT is 2.1 per 1000. (National rate 3.9/1000 National ambition 2.5 per 1000).

- 0 reportable Neonatal Deaths.
  - This makes a total of 0 NND > 24 week in the last 12 months which equates to 0. per 1000 live births. The national neonatal death rate is 1.65 per 1000 live births.

- 1 reportable case referred to Maternity and Newborn Safety Investigations **(**MNSI) but was rejected by MNSI as MNSI triaged and felt it did not meet criteria.

- 0 new Maternity PSII commissioned in Q4.

- Executive and non-executive safety champion attendance at safety champions meetings and regular walkabouts in progress. You said/We did boards visible to staff to ensure ward to board and board to ward cascade of information and oversight.

- Progress with compliance to Saving Babies Lives Vs 3 remains challenging, however expected trajectory being met as agreed by LMNS.

- Gradual increase to 73% as of March 2025.

- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q4.

- Feedback received via safety champions, FFT, MNVP. Complaints and concerns actioned and fed back to staff and service users.

- Avoidable Admission into the Neonatal Unit (ATAIN) – SFT continues to have ATAIN rates under the national and local ambition, however the small numbers of admissions and the unit size do mean broad fluctuations month to month.

- Triangulation meetings continue with focus on considering complaints, incidents, feedback and litigation in collaboration to ensure focussed and collective improvements.
  Litigation scorecard also demonstrates use and interrogation of claims against historic and current incidents to support learning and improved processes, systems and outcomes.

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

Maternity and Neonatal Services Quality and Safety Report Q4 2024/25

MATERNITY DATA MEASURES: PERINATAL QUALITY SURVEILLANCE TOOL

Trust: **Salisbury NHS Foundation Trust Hospital**

CQC Maternity Inspection Ratings 2024	MATERNITY	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE
	Select Rating:	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*
	Good	**Good**	**Good**	**Good**	**Good**	**Good**

NHSE Maternity Safety Support Programme	No	SFT successfully exited the MSSP during Q3 2024/25

	2024/25											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓									
2. Findings of review of all cases eligible for referral to MNSI	✓	✓	✓									
Report on: 2a. Number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓									
2b. Training compliance for all staff groups in maternity related to the core competency framework (CCF) and wider job essential training	Compliant with MIS Year 6 targets (inc. CCF)	Compliant with MIS Year 6 targets (inc. CCF)	Compliant with MIS Year 6 targets (inc. CCF)									
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓									
3.Service User Voice Feedback	✓	✓	✓									
4.Staff feedback from frontline champion and walk-abouts	✓	✓	✓									
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓									
6.Coroner Reg 28 made directly to Trust	n/a	n/a	n/a									
7.Progress in achievement of CNST 10	✓	✓	✓									

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours	Reported annually

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1. Report Overview

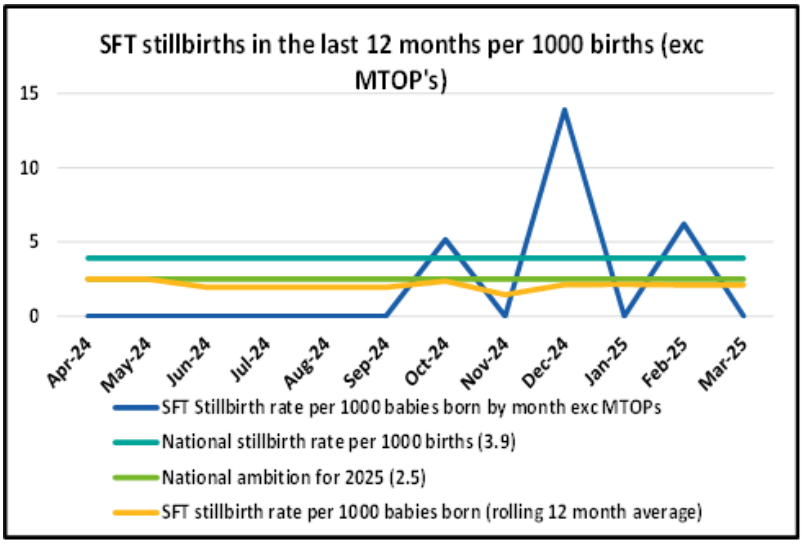
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Trust Board and LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level. Monthly reports will also be shared with Trust Board and LMNS Board via the Perinatal Quality Surveillance Monthly slide set.

2. Perinatal Mortality Rate

The full report is contained in the appendices. The following is a summary of key highlights.

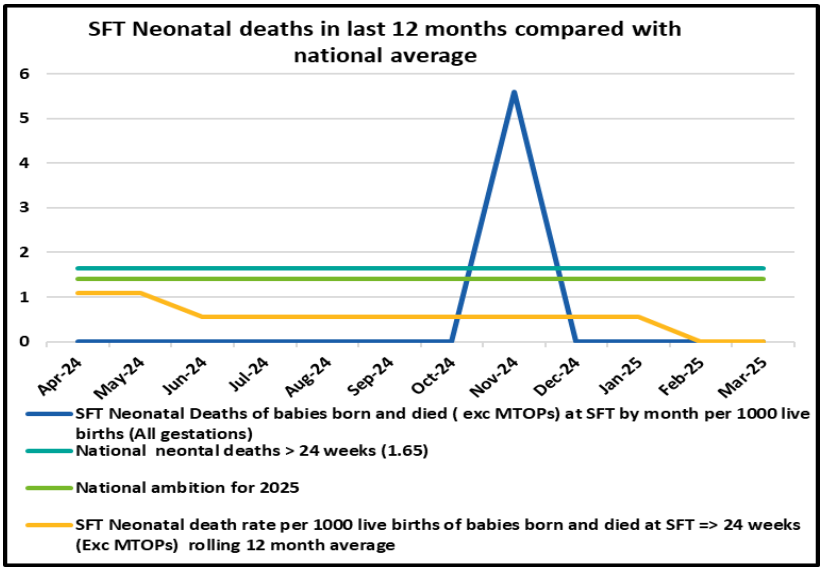
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

Figure 1. Monthly Stillbirth rate (per 1000 births excluding MTOP's) for SFT over the last 12 months, compared with national rate and ambition.



In the last completed quarter (Q4), SFT had 1 stillbirth (Excluding MTOP's). This is a total of 4 in the last 12 months, which equates to 2.1 per 1000 births in the last 12 months and is below the national rate which is 3.9 per 1000 births and national ambition of 2.5 per 1000 births.

Figure 2. Monthly neonatal death rate per 1000 live births > 24 weeks for SFT compared with national rate.



In the last quarter (Q4), SFT had 0 neonatal deaths >24 weeks. This is a total of 0 neonatal death >24 weeks in the last 12 months which equates to 0 per 1000 live births and is below the national neonatal death rate of 1.65 per 1000 live births.

There are currently three historic PMRT cases with outstanding actions and these are detailed in the full report in the appendices. Two actions relate to guideline development and updating. One action relates to arrangements for ongoing Aspirin prescribing in pregnancy. These have been discussed at Safety Champions meetings with the Executive and Non-Executive Safety champions and work is ongoing to progress these actions to close.

2.1 Perinatal Mortality Summary for the Quarter (Q4 Jan – March 2025)

Figure 3. Perinatal Mortality summary

PMRT ID	Cause of Death	Issues/ Actions / learning
95895	Severe growth restriction	**Issue:** This mother had a history of severe pre-eclampsia/HELLP syndrome/eclampsia but she did not receive appropriate pre-conceptional. Management. **Action:** Look into any current pathways to share learning with GP's and link in with these to share learning. **Issue:** This mother's progress in labour was not monitored on a partogram. **Action:** BadgerNet electronic records now in use, will produce partogram. **Issue:** Although indicated, this mother was not offered further postnatal investigations for herself and/or her baby. **Action:** Blood tests taken 7/1/25 to follow up.
96493	Sacrococcygeal teratoma	**Issue:** There is no evidence in the notes that this mother was asked about domestic abuse at booking. **Action:** To discuss with teams around asking question to everyone and to ask this mother postnatally.

		Issue: This mother has a psychological/mental health disorder, this was identified in a previous pregnancy, but she did not receive specialist pre-conceptional counselling/management. **Action:** Not within our service, if not on medication may not be required. **Issue:** This mother has a psychological/mental health disorder and her antenatal care was not appropriate given this history. **Action:** BadgerNet will cover and hold evidence of questions asked in future bookings. **Issue:** This mother's progress in labour was not monitored on a partogram. **Action:** BadgerNet will have partogram built in.

2.2 PMRT real time data monitoring tool

At Salisbury NHS Foundation Trust, authorised PMRT users generate reports that summarise the results from completed reviews over a period, within the PMRT for user-defined time periods. Reports are accessed directly from the national PMRT reporting portal. They are used as the basis for Trust Board reports and are discussed with Trust Maternity Safety Champions.

A report generated from the PMRT tool shows 2 cases reviewed in Q4 from Q3.
One case from Q3 is waiting MNSI final report before PMRT review.
Once case from Q4 will be reviewed in Q1 25/26 on 2nd May 2025.

PMRT_BoardReport_Salisbury NHS Four

2.3 Learning from PMRT reviews

There were 2 cases reviewed under PMRT in Q4. Learning and progress against previous actions are detailed in the full report in the appendices.

3. Maternity and Newborn Safety Investigations (MNSI) and Maternity Patient Safety Incident Investigation (PSII's)

3.1 Background

The National Maternity Safety Ambition, launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB (now MNSI) to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan.

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischemic encephalopathy (HIE), or,
- Was therapeutically cooled (active cooling only), or,
- Had decreased central tone and was comatose and had seizures of any kind.

To meet the requirements against the 15 Immediate and Essential Actions (IEAs) in the Ockenden 2022 report, all SI's concerning maternity services adhere to the Trusts Patient Safety Incident Response (PSIRF) Policy and Plan.

3.2 CNST Maternity Incentive Scheme (MIS) year 6 compliance - Safety Action 10

As part of the CNST MIS standards, Trusts are required to ensure that there is a robust process for referring eligible cases to MNSI and for notification to the NHS Resolution Early Notification Scheme (ENS). Information must be provided to families about MNSI and ENS and duty of candour compliance maintained. Maternity services are required to report quarterly to Trust Boards for oversight of evidence for Safety Action 10.

During Q4, one case was referred to MNSI. Following their triage process, it was rejected by MNSI (see figure 5 below).

Figure 4. Summary of MNSI and ENS cases for safety action 10 compliance in Q4.

Cases referred to MNSI	Case accepted as eligible for investigation by MNSI	Families have received DOC 2 letter containing information explaining the role of MNSI and ENS	Duty of Candour (DoC) compliance	Case referred to ENS	Claims reporting wizard completed (families informed of NHSR involvement)
MI-039791	Rejected	N/A	N/A	N/A	N/A

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 6 (safety action 10).

3.3 Investigation progress update (MNSI and PSII cases) for the last Quarter (Q4)

On 8th January 2024, SFT transitioned to the national Patient Safety Incident Response Framework (PSIRF). The Trust Patient Safety Incident Response Plan (PSIRP) identifies local and nationally mandated PSII responses. Maternity Serious Incidents include both commissioned Patient Safety Incident Investigations (PSII's) and MNSI cases that have been accepted.

Figure 5. Investigation progress update

Investigation Type and Ref	MNSI Ref	Summary of Incident	Date Investigation Commissioned	External Notifications and Other Investigations	Current Investigation Progress
PSII-001	**N/A**	**Cooled baby - preterm**	**6.2.24**		**Awaiting final report.**

3.4 Coroner Reg 28 made directly to Trust

There have been no coroner regulation 28's and actions being taken in the last quarter.

3.5 Maternity Patient Safety Incident Investigation (PSII) during Q4

During the last quarter, there were 0 new maternity PSII's commissioned. These are normally highlighted below for the last quarter.

Figure 6. Commissioned Maternity PSII's

DATIX	Incident Summary	Immediate learning identified
N/A	**Nil PSII's commissioned or MNSI cases in Q4.**	

All patient safety incidents, resulting in moderate harm or above, follow the Trust's Patient Safety Incident Response Plan (PSIRP) in terms of PSR methodology and supporting the statutory duty of candour process. This is detailed in section 11 of this report.

4. Midwifery Continuity of Care (MCOC)

The Three-Year Maternity and Neonatal Delivery Plan states the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings. The delivery and roll out of midwifery continuity of carer, in line with the principles around safe staffing that NHS England set out in September 2022, should be considered.

At Salisbury NHS Foundation Trust, there are no midwifery continuity of carer teams presently. Due to historic midwifery vacancies and having a less experienced workforce, plans to implement this model are paused as per recommendation from NHSE and as advised, following the publication of the Ockenden report. When staffing and skill mix improves, significant consideration will be given to reviewing a team for continuity of care in line with national recommendations.

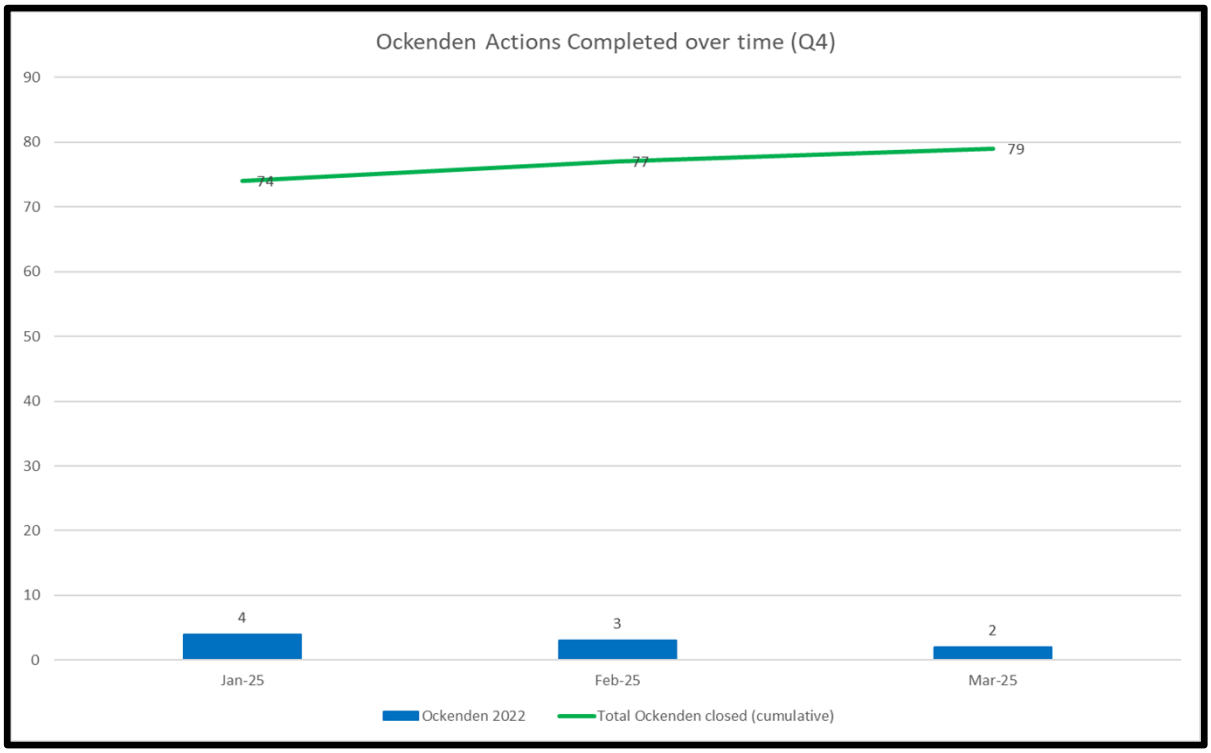
5. Ockenden updates

Figure 7. Current progress with Ockenden 2022 IEAs

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Apr-25	1	Workforce Planning and Sustainability	0	1	0	6
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	0	0	5
	9	Preterm Birth	0	0	0	4
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	0	0	4
	13	Bereavement Care	0	0	0	4
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	5	0	80

For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 sub-actions. The multi-disciplinary Ockenden Working Group meets monthly to drive progress on the immediate and essential actions. Current progress is detailed in the table above.

Figure 8. Numbers of actions closed per month in Q4 against the total number of closed actions.



The key achievements and next steps to progress the closure of Ockenden 2022 IEAs are highlighted below:

- **Key achievements:** With just 5 actions remaining open, the formal Ockenden working group has now ceased and monitoring of the final actions will now take place in the monthly Maternity Improvement Group meetings.
- **Next steps for progression:** Ongoing work continues around a succession planning gap analysis and leadership development training, maternity self-assessment, centralised CTG monitoring, anaesthetic documentation and working towards Neonatal staffing models becoming BAPM compliant.

6. Three Year Delivery Plan

Ongoing work continues around the three-year delivery plan.

All actions are now either in progress or complete with evidence collated to demonstrate this. Actions are now reviewed and signed off as complete at the maternity improvement group once a month. With 24 of the 44 actions now complete progress is being made at pace. This is demonstrated in the chart below.

Figure 9. Three Year Delivery Plan Q4 progress

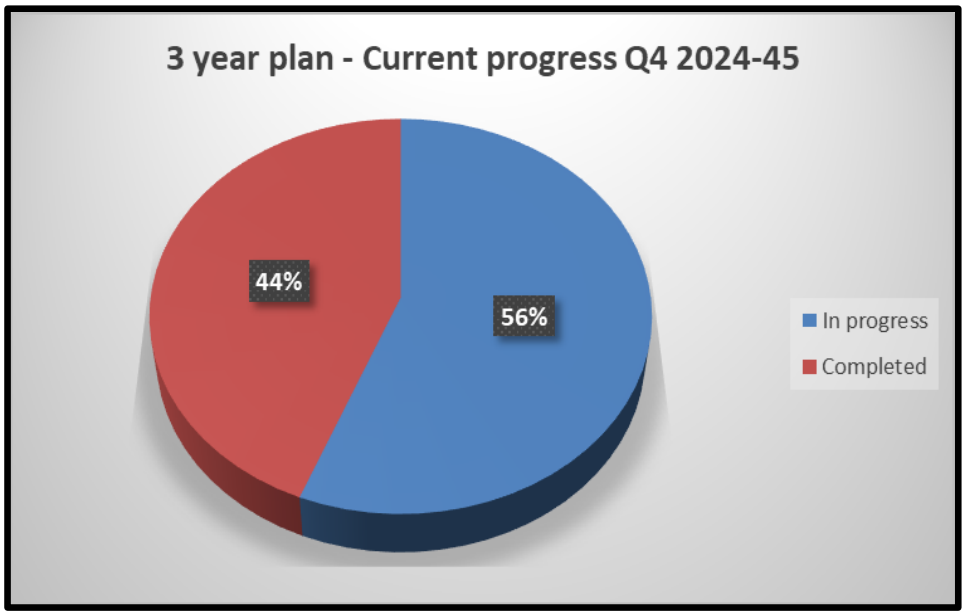
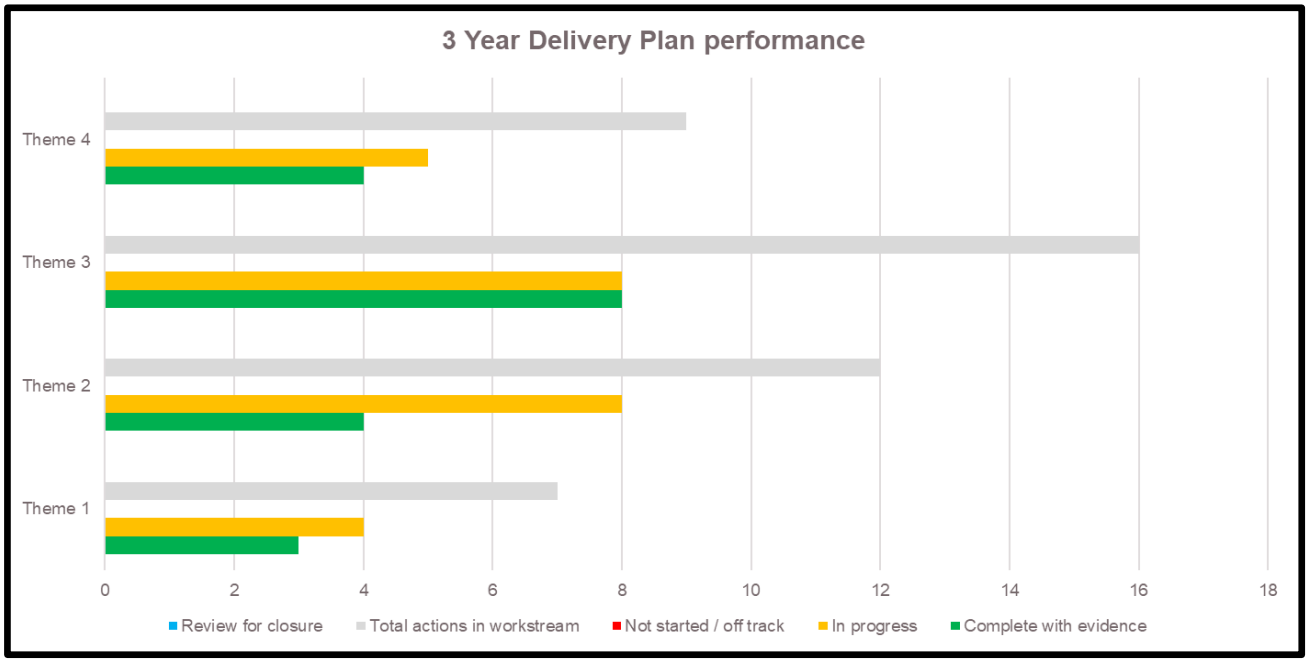


Figure 10. Three Year Delivery Plan overall performance by theme



7. Training compliance for all staff groups in Maternity related to the core competency framework and wider job essential training

The full report is contained in the appendices. The following is a summary of key highlights.

Safety Action 8 of the Maternity Incentive Scheme (MIS) requires all maternity units to implement all six core training modules of the Core Competency Framework (CCF) (version 2). This safety action aims to address known variation in training and competency assessment across England and address areas of significant harm. A three-year training plan was developed for maternity and neonatal services (2025-27) and agreed with the quadrumvirate and signed off by the LMNS/ICB. There are six core modules of the CCF:

- Saving Babies Lives Care Bundle
- Fetal monitoring and surveillance
- Maternity Emergencies and multi professional training
- Equality/ equity and personalised care
- Care during labour and immediate post-natal period
- Neonatal basic life support

The MIS year 6 requirement was for 90% attendance for each relevant staff group at fetal monitoring training, multi-professional maternity emergencies training and neonatal life support by 30th November 2024. The other core modules were not measured within the MIS requirements. Training compliance ≥90% for relevant staff groups within the MIS training requirements were fully met on the MIS deadline (30th November 2024) during Q3.

During Q4, training compliance has since fallen below the ≥90% target. Anaesthetic and

obstetric compliance has been compounded by workforce pressures and sickness. This has been escalated to the relevant divisions, and an action plan has been co-created with leads to achieve compliance across all relevant staff groups by 30th November 2025 for the MIS year 7 submission.

For 2025, a plan has been created across all professions to ensure consistent attendance at PROMPT, fetal monitoring and NLS throughout the year.

Figure 11. PROMPT Training Day Compliance

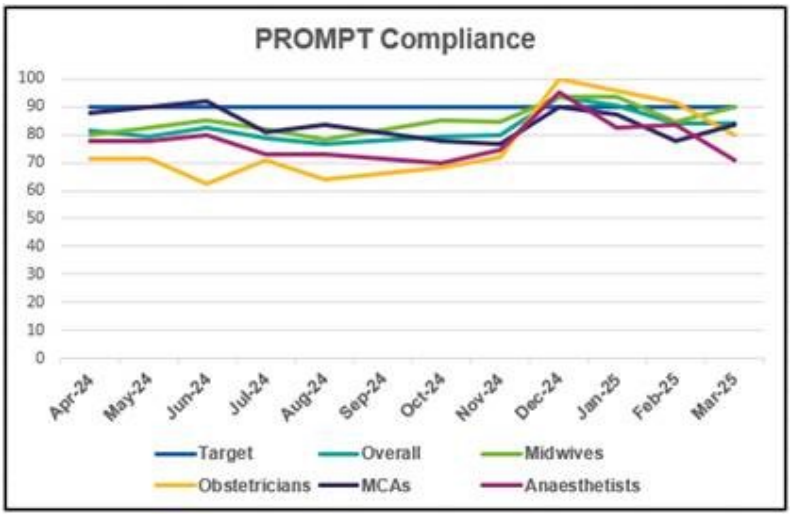


Figure 12. Fetal Monitoring Training Compliance

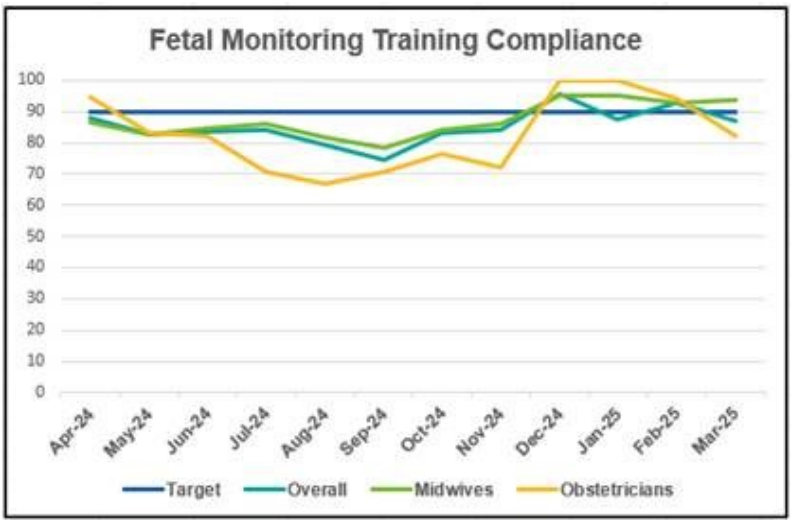
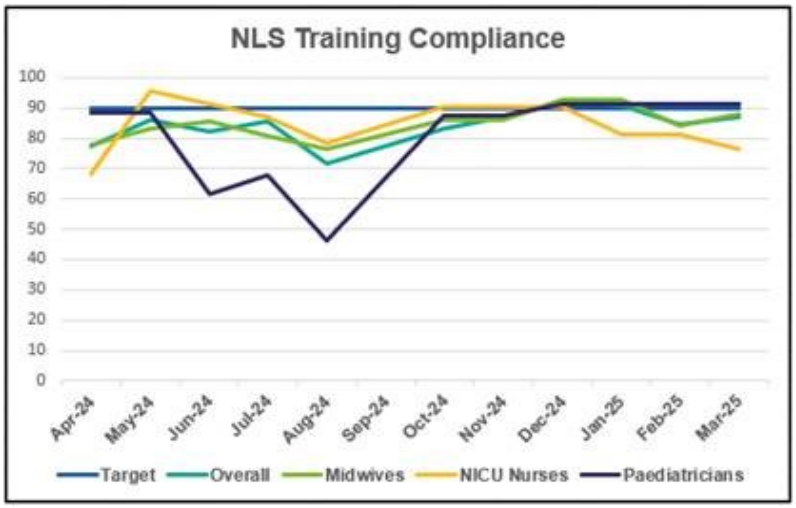


Figure 13. NLS Compliance Training



8. Maternity & Neonatal Safety Champions meetings

This section provides evidence of staff and service user feedback from frontline champions and walk-abouts and outline discussions regarding safety intelligence.

The Maternity and Neonatal Safety Champions meetings occur on the third Thursday of each month. Please see below the recently agreed Terms of Reference for further details of the meeting requirements.

MATERNITY SAFETY CHAMPIONS ToR APF

8.1 Maternity and Neonatal Safety Champions meeting attendance by role for Q4

Figure 14. Maternity and Neonatal Safety Champions attendance by role in Q4.

Staff groups	January	February	March
Trust Executives	Non-Executive Director	Non-Executive Director	Chief Nursing Officer Non-Executive Director
Obstetric	Consultant Obstetrician	Consultant Obstetrician	Consultant Obstetrician
Midwifery	Director of Midwifery Band 6 Midwife Representatives Operational Manager	Director of Midwifery Band 6 Midwife Representatives Operational Manager Preceptee Lead Midwife	Head of Midwifery Quality & Safety Matron Operational Manager Band 6 Midwife Representatives Band 5 Midwife Representatives Community Midwife
MSW			MSW for Education
Neonatal	Consultant Paediatrician	NICU Practice Development lead	Consultant Paediatrician

MNVP	MNVP Representative	MNVP Representative	MNVP Representative Maternity & Neonatal Independent Senior Advocate
Secretarial support	Quality & Safety Administrator	Quality & Safety Administrator	Quality & Safety Administrator

8.2 Positive points recognised

Over the course of the Q4 period, the following positive points were highlighted:

- MNVP reported positive feedback regarding sonographers in antenatal clinic. Families reported being given very detailed information and lots of reassurance from the sonography team
- CQC report has been published as 'Good' for maternity and neonatal services for all domains and overall.
- Positive steps in procuring a solution for women and families where English is not their first language, to help with translation and understanding in clinic, community, and inpatient environments.
- Successful recruitment of a new maternity Practice Education lead to cover maternity leave.

8.3 Concerns raised in Q4

Figure 15. Concerns raised in Maternity and Neonatal Safety Champions meetings*

Concerns raised	Action and progress
Concerns raised regarding scanning of paper-based medical documents onto BadgerNet.	Additional scanners purchased and process in place for each paper document.
Additional support for staff regarding recovery of women following General Anaesthetic.	Piece of w4rk to be done around escalation process.
Shortage of laryngoscope handles on NICU.	Urgent order placed and received.
Emergency proformas not used frequently as inaccessible.	Emergency proformas moved near doorways to improve visibility in all birthing rooms.
Episiotomy scissors are blunt.	Programme for sharpening scissors has been provided by sterile services and reminder to staff re process for this outside of these times.
Delays in getting hold of amnihooks and delivery packs.	Issues have now been resolved, Amnihook procurement as a result of national delivery issues.

**The detail above informs the 'You said, we did' information displayed on the Maternity Safety Champions boards.*

8.4 Concerns raised by service users

There have been 6 formal complaints and 1 concern logged in Q4 24/25. There has been an increase in formal complaints in Q4, with 'unsatisfactory treatment' being the top theme.

Figure 16. Summary of complaints in Q4

Sub-subject (primary)	Location (exact)
Inappropriate treatment	Labour ward
Attitude of nursing staff	Labour ward
Insensitive communication	Maternity Day Assessment Unit
Unsatisfactory treatment	Maternity Day Assessment Unit
Early discharge	Postnatal
Unsatisfactory treatment	Postnatal
Unsatisfactory treatment	Postnatal

In Q4, there were 3 complaints closed, none closed within target time, offering a 0% compliance rate. Although there was close liaison maintained with complainants regarding any delay this was often due to aligning diary capacity of both parties. 1 concern was closed in Q4 within the agreed target time, offering 100% compliance rate.

For learning and action points taken from closed complaints in Q4 please see appendix 3.

8.5 Additional safety champions intelligence

Both executive and non-executive safety champions conduct regular walk-arounds to seek intelligence regarding safety concerns. The following findings were reported in Q4:

Figure 17. Walk around findings

Area/date visited	Discussion points	Concerns raised	Actions
Executive Safety Champion visit - 7/1/2025 - Labour ward and Day Assessment Unit	Staffing was good in all areas no patient safety concerns raised any of the areas.	No safety concerns raised.	Visit to be fed back at next Safety Champions meeting.

8.6 Culture/SCORE survey findings

Following the initial support from a culture coach to the Perinatal Quadrumvirate in 2023, and several cultural conversations with staff in early 2024, an action plan has been produced working with the themes identified for improvement in the SCORE survey and subsequent stakeholder sessions.

To continue to understand the data found during these sessions, a further staff questionnaire was circulated at the end of Q2, and the action plan has been further developed and prioritised based on the feedback from the team in this survey.

The quad continues to use the action plan produced following the SCORE survey and subsequent staff questionnaires to prioritise their workstreams. There is a staff event scheduled for early Q1. This will focus on OD&L, wellbeing, celebrating Maternity & Neonatal services, and will be an opportunity to learn about what the Perinatal Quad is doing.

9. Saving Babies Lives V3

Saving Babies Lives Care Bundle version 3 (SBLCBv3) was published on 31st May 2023. The SBLCBv3 represents Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.

The full report is contained in the appendices. The following is a summary of key highlights.

9.1 Update

Saving Babies Lives Care Bundle Version 3 (SBLCBv3) is improving with progress towards full implementation. NHS England produced a national implementation tool in July 2023 that maternity services are continuing to use to track and evidence improvement and compliance with the requirements set out in Version 3.

Whilst the full report included in the appendices details the specific ongoing action planning and work, as detailed above, trajectory has been slow. SFT's initial assessment was validated at 7%, followed by submissions of 37%, 40%, 51%, 66% and currently 73%. SFT self-assessments are largely in-line with LMNS validated assessments. Targeted assistance continues to be offered to action leads by the Quality Assurance Midwife until June 2025 to support the trajectory to increased compliance.

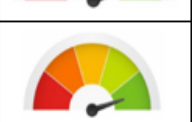
10. NHS Resolution Maternity Incentive Scheme

MIS Year 7 requirements were published on 2nd April 2025 and SFT is required to be compliant by 30th November 2025.

Following full 10 out of 10 compliance with MIS Year 6, Salisbury is aiming to continue the monthly CNST working groups to ensure compliance against year 7 requirements.

Figure 18. Current compliance with Maternity Incentive Scheme (MIS) Year 6 2024/25 requirements

Are we well led?

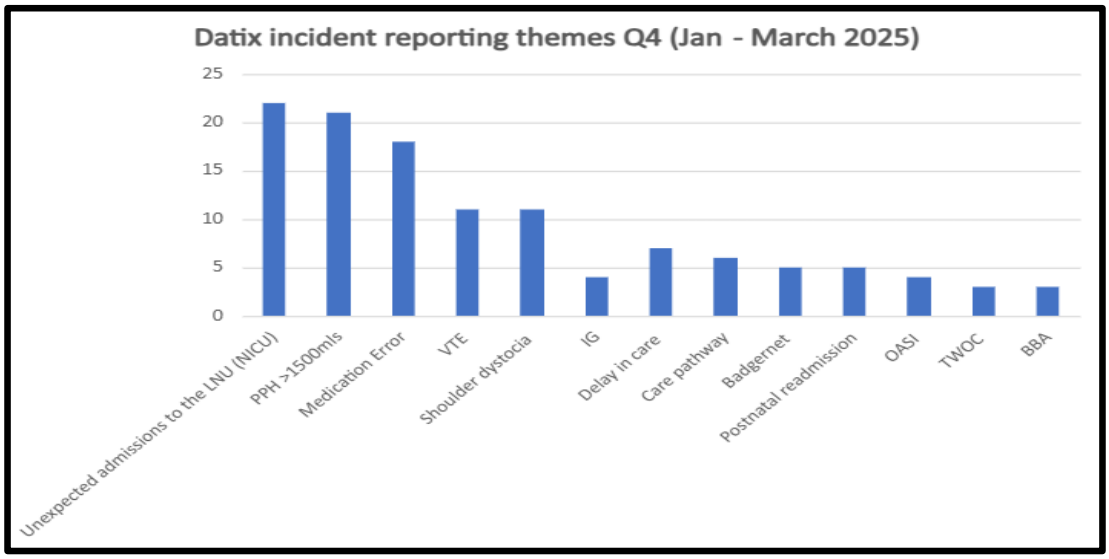
	Description	Yr 5 Submission	Comment	Current Assessment
1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
8	**Multidisciplinary Training**	Compliant	All Standards Met	
9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

11. The number of incidents in Q4 and actions being taken

A summary of incidents themes reported in Q4 are provided below.

Figure 19. Datix incident report themes during Q4

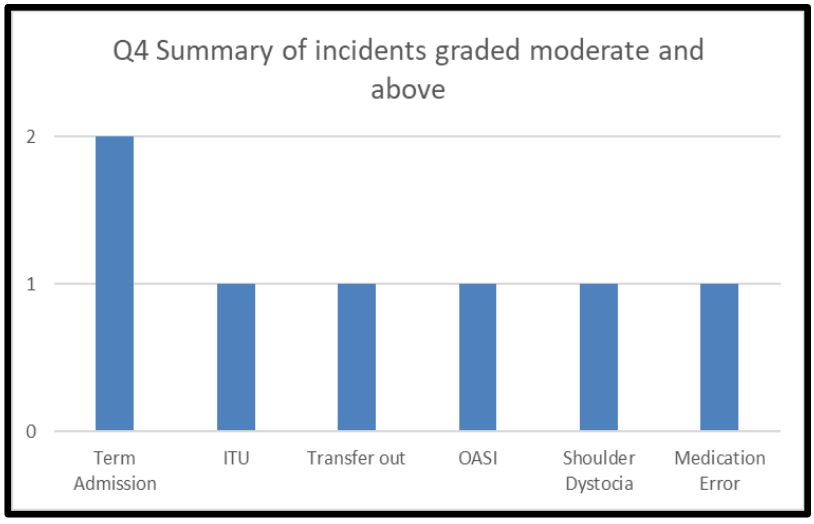


Unexpected admissions to NICU throughout Q4 has remained consistent. This is below national and local ATAIN targets. Further information is provided within the ATAIN report, appendix 6.

The incidents graded moderate or above at the end of Q4 is provided below. This data includes cases that have been reviewed, reclassified and closed. It may also include open cases awaiting review by nature of the live reporting system. These numbers were extracted from the Datix reporting system and a search created using the following data:

Date: 01/01/2025:31/03/2025
Severity: Moderate and above
Directorate: Women and Newborn Division

Figure 20. Summary of incidents graded Moderate or above incidents at the end of Q4.



The Trust Patient Safety Incident Response Plan (PSIRP) outlines nationally and locally mandated responses to incidents. This includes PSII triggers and PSR processes with associated methodology. All moderate harm or above Datix reported incidents and their outcomes in the last quarter are listed below.

Figure 21. Description of 'Moderate' or above incidents reported in Q4.

DATIX Number	Incident Category	Outcome/Learning/Actions
173513	ITU	Patient attended Emergency Department (ED) via ambulance. Delay commencing medication and omission of septic bundle. Transferred to LW several hours later, deteriorated, Diabetic Keto Acidosis (DKA) and required emergency delivery of baby and recovery in ITU. The Patient Safety Review (PSR) part 2 is in progress with ED representation. Learning: Teaching in ED, including the use of the new national Maternity Early Warning Score (MEWS) and not POET, sepsis pathways. Joint teaching from maternity on nursing study days.
173673	Term Admission	Emergency delivery categorised as Cat 3 leading to potential delay. Reporting through Patient Safety Summit (PSS) and PSR 2 awaiting presentation at Patient Safety Oversight Group (PSOG) with actions to be discussed.
173909	Term Admission	Difficult delivery of baby and admitted to NICU for seizures. HIE grade 2. Referred to MNSI and initially rejected – re-escalated to MNSI as concerned rejection inappropriate. Awaiting final decision.
174396	Transfer Out	Transferred out to London as a twin pregnancy at 29+2/40 gestation. However, both twins over 1kg in weight, NICU can facilitate multiples from 28/40 and there was cot availability. In process of PSS / PSR workstreams.
174567	OASI	Obstetric Anal Sphincter Injury (OASI) identified during operative delivery. Concerns highlighted around individual practice and escalation omissions. Subsequent readmission following discharge with ongoing urology involvement.
175305	Shoulder Dystocia	Excellent identification and care provided within the emergency. PSR P1 submission for APGAR 6@5 mins with recommendation for reclassification and close.
175349	Medication Error	IV Tocolytic administered incorrectly. Once recognised, immediate escalation, correction, apology and DOC provided. Learning: ongoing work through PSR to identify if this medication should be used for 1st line IV Tocolytic with Magnesium Sulphate.

12. Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017), states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Maternity and Midwifery staffing is reported separately to the Women & Newborn Division and Trust Board biannually to meet the requirements for the maternity incentive scheme.

A full report is contained in the appendices (appendix 5). The following is a summary of key highlights.

12.1 Midwifery Staffing

Planned Versus Actual Midwifery Staffing Levels
The following table outlines percentage Registered Midwife (RM) fill rates for the inpatient areas by month.

Figure 22. Percentage shift fill rates for the inpatient areas by month in Q4.

Month	RM Day %	RM Night %
January 2025	**98.3**	**97.5**
February 2025	**97.1**	**94.6**
March 2025	**91.4**	**96.7**

When staffing is less than optimum, the following measures are taken in line with the Maternity Operational Escalation Policy:

- Elective workload prioritised to maximise available staffing.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Support of Maternity and Neonatal Duty Manager Day and night, as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the Maternity Services.
- Liaise closely with maternity services at opposite sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

12.2 Obstetric staffing

The Obstetric Consultant Team and Maternity Senior Management Team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person.

Figure 23. Table showing compliance of consultant attendance meeting above criteria.

Date	Clinical Situation(s)	Comments
05/01/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
20/01/25	Caesarean birth for major placenta praevia / abnormally invasive placenta.	Consultant present.
31/01/25	4th Degree perineal tear repair.	Consultant present.
04/02/25	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
11/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
12/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
14/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
17/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
17/02/25	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
25/02/25	Caesarean birth for women with BMI >50	Consultant present.
12/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
24/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present
25/03/25	Caesarean birth for women with BMI >50	Consultant present.
29/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.

The table above shows that for Quarter 4 (1st January 2025 – 31st March 2025) there were 14 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard.

12.3 Short Term Locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
   or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

An audit of compliance with our Medical HR colleagues was completed for the time period 1st January 2025 – 31st March 2025. The audit demonstrated that during this period, 21 (short term) middle grade locum shifts were required. 4 Doctors completed these shifts, 2 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and held a Certificate of eligibility (CEL), therefore the trust is 100% compliant with the criteria described above.

12.4 Long term locum usage

During the time period 1st January 2025 – 31st March 2025 the trust has utilised 1 long term middle grade locum doctor. This doctor has been working in the trust for many months prior to Q4 and therefore standards 1-6 are not applicable during this time period.

For all standards that were applicable the trust was 100% compliant. The compliance can be seen in Table 1.

Figure 24. Long-term locum compliance with standards

Standard	Compliance % for Locum 1 (in post prior to Q4)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	N/A
Standard 3 Departmental induction by consultant on commencement date	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	N/A
Standard 5 Named consultant supervisor to support locum	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%
Standard 8 Feedback to locum doctor and agency on performance	N/A (remains in post)

12.5 Anaesthetic staffing

For safety action 4 of the Maternity Incentive Scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1).

The following table demonstrates compliance with this standard by month. The service will continue to audit this standard monthly.

Figure 25. Anaesthetic staffing compliance

Month	January 2025	February 2025	March 2025
% compliance	100	100	100

12.6 Neonatal Services Staffing

Neonatal medical staffing

The Neonatal Unit remains non-compliant with BAPM standards for the medical staffing. A report has been submitted through the Maternity and Neonatal Safety Champions meeting to ensure the Trust board have a full overview of the situation. A business case has for additional staffing has also been submitted which is in the process of being reviewed. Further information has been sought from Local Neonatal Units to allow for a review of the medical staffing model.

Neonatal nursing staffing

To meet safety action 4 of the Maternity Incentive Scheme the Neonatal Unit needs to demonstrate that it meets the service specification for neonatal nursing standards and the Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in March 2025 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for non-QIS registered nurses but under-funded for QIS registered nurses and non-registered nurses. The requirement would be an additional 1.52WTE QIS registered nurse and a 2.09wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 1.92WTE are in training. An action plan to review neonatal staffing was shared at Trust Board March 2024, however, it is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

1.92WTE are now on Maternity leave and we have had 0 leavers. 3 WTE band 5 registered nurses from the maternity service have moved over to support the Bad 5 vacancy which has now reduced to 1.83WTE.

13. Insights from service users and Maternity Voices Partnership Co-production -

A full report is contained in the Patient and Staff Experience Report in the appendices (appendix 3). The following is a summary of key highlights.

- The response rate to the Friends and Family Test (FFT) in Q4 has seen a small decrease of 1.24%. Due to the implementation of BadgerNet, there was a pause placed on FFT during this transition. Analysis of the data is discussed at the Maternity Governance and quarterly Triangulation meetings.
- There has been an increase in complaints this quarter, with the top theme being 'unsatisfactory treatment'.
- The Triangulation meeting is embedded into the Governance structure. In-depth conversations have facilitated some discussion around supporting families who access the Neonatal Unit.
- The Neonatal Parent Survey (June -Dec 24) results are included within section 7 of this report. The results were reassuring; with a 9.5/10 positive (satisfaction) rating score. The development of the action plan will be reported in the next Quality and Safety report.
- Work is ongoing to create a Health Inequalities clinical dashboard, with the focus on birth outcomes related to ethnicity and social deprivation to aid an understanding of local health inequalities. The work on the data warehouse is scheduled for September 2025.
- A listening event was held in February with families who have been patriated to Britain under the Afghanistan Relocation and Assistant Policy (ARAP). The feedback from this event will be shared at the next Triangulation meeting, scheduled in April 2025.
- The referral process to the Birth Reflection Service was reviewed in this quarter. The expansion of the referral criteria to include self-referrals has been agreed. Work continues to ensure service users can access the service directly via our maternity website.

Key priorities for patient experience and inclusion, next quarter includes:

- To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with the poorer maternity outcomes.
- To support the implementation and monitoring of the 'Pocketalk' translation device.
- Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey.
- Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities.
- Development of a local Health Inequalities dashboard.
- Continued monitoring of the 2024 National Patient Experience Maternity Survey action plan.
- Progress the actions detailed in the Three-Year Delivery Plan.
- Drive the changes to the website to enable service users to self-refer to the Birth Reflection Service.
- To facilitate and support the 15-step assessment – coordinated and undertaken by the MNVP and service users' representation.

- Ensure the coordination of service users feedback to identify service improvements opportunities, through the quarterly Triangulation meetings.

14. Quality Improvement projects/ progress

The Maternity and Neonatal department follow the Trust wide 'Improving Together' methodology which focusses on a programme of continuous improvement underpinned by coaching support and training. The Senior Leadership Team have undertaken the training, and it is currently being rolled out to some of the individual teams. The drivers for the QI projects are locally driven being aligned to both divisional and the main trust drivers.

Projects which have been rolled out and are continuing include:

- New National Maternity Early Warning Score (MEWS) to replace MEOWS.
- New Neonatal Early Warning Score (NEWT2) to replace NEWS.
- Fluid balance compliance.
- RCOG clinical escalation toolkit launched on 1st October – campaign continues once Badgernet embedded locally.
- Ultrasound scan review process.
- Compliance to NICE Category 1 & 2 caesarean section delivery timings

Projects planned in the next quarter (Q4):

- Exit interviews
- Working group to increase Flexible working patterns
- Increasing the use of Beatrice Birth Centre
- Self-Administered Medication (SAM) on Beatrice Maternity Ward

15. Implementation of the A EQUIP model

The Professional Midwifery Advocate (PMA) Team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement), which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

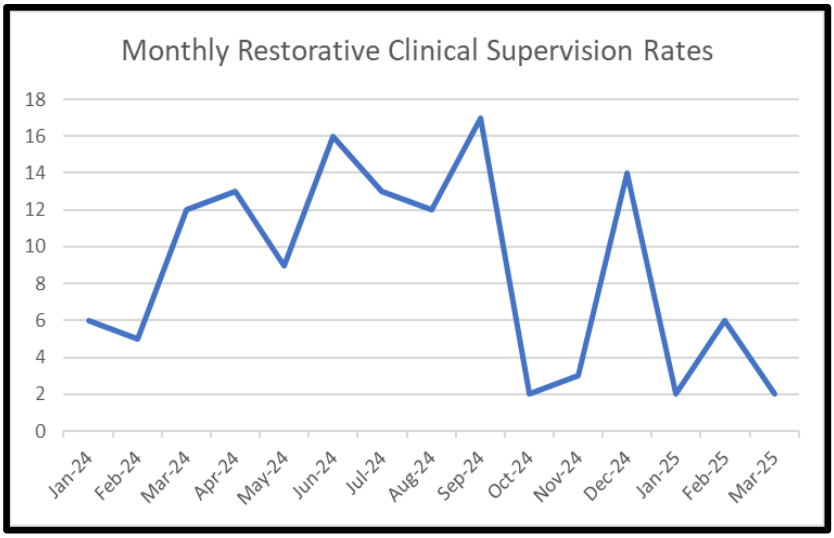
15.1 PMA Update

- Restorative Clinical Supervision (RCS): In Q4, we aim to offer RCS to all new starters including midwives, maternity care assistants and all returning from long term sickness, this is more challenging now have the new sessional model. Four preceptees received at least 1 RCS session. During Q4, a total of 10 RCS sessions were carried out (incorporating wellbeing and Career conversations). This is a decrease on the 19 sessions held in Q3.
- RCS support: the PMA team aim for all NQMW continue to receive RCS as part of a retention initiative. The current cohort consists of 8 preceptees, who started in September and a further 2 in November. As per the Preceptee plan, they receive quarterly teaching to help support them to thrive during their transition

from student to qualified Midwife and they each offered quarterly 1:1 restorative supervision from a PMA. This is a team priority for the PMA team operating on a sessional model.

- Anonymous data is kept on themes and numbers of RCS sessions. These are shared with Director of Midwifery for awareness and via appropriate channels to support action and improvement.

Figure 26. Restorative Clinical Supervision Rate (p/m)



15.2 Plans and Actions

The structure of the PMA Service changed at the end of October 2024, as it moved back to a sessional model. There is a team of 8 trained PMA's that are being given protected time from their substantive hours each month. This is to carry out restorative supervision, teaching activities and other PMA activities. The PMAs are now able to support the birth reflections service. The focus and priority during this quarter was to continue upskilling and supporting sessional PMAs, and ensuring the support offered to Preceptees and Midwives returning from either long-term sickness or maternity leave is sustained, unfortunately the level of completed RCS has continued to fall. Priority for the next quarter is to reintroduce regular PMA team meeting, to explore how we can increase the uptake of RCS and promote visibility.

The PMA team has met with the Perinatal Quad and the team will support with improving culture work stream, this will include anonymous feedback of themes from RCS and ongoing initiatives.

16. Avoidable Admission into the Neonatal Unit (ATAIN)

The full report is contained in the appendices. The following is a summary of key highlights.

16.1 The National Ambition

In August 2017, NHSI mandated a patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however, Trusts should strive to be as low as possible.

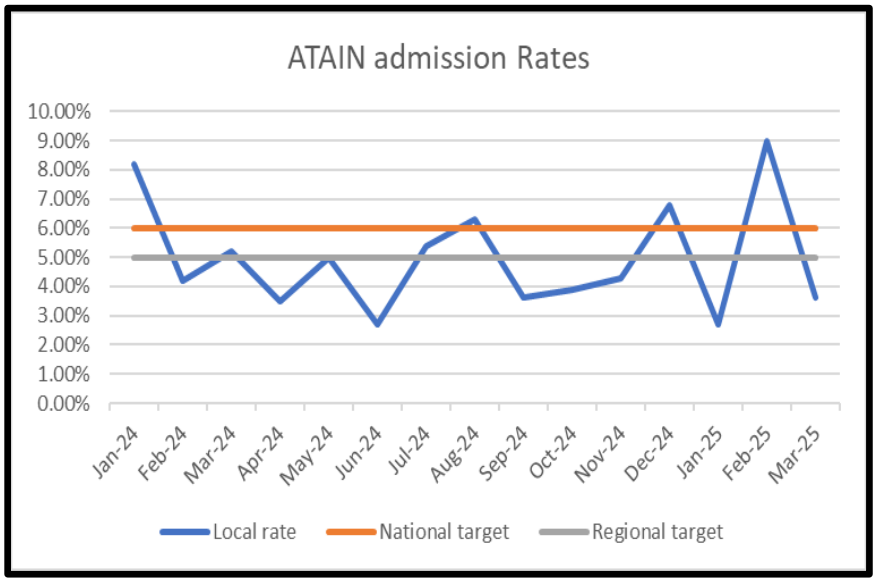
This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims.
- Improving culture, teamwork and improvement capability within maternity units.

16.2 Why is it important?

There is strong evidence that separation of mother and baby soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Figure 27. Monthly ATAIN rates 2024 for Salisbury NHSFT Trust



The ATAIN meeting action tracker contains evidence of actions agreed by both maternity and neonatal leads, which address the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

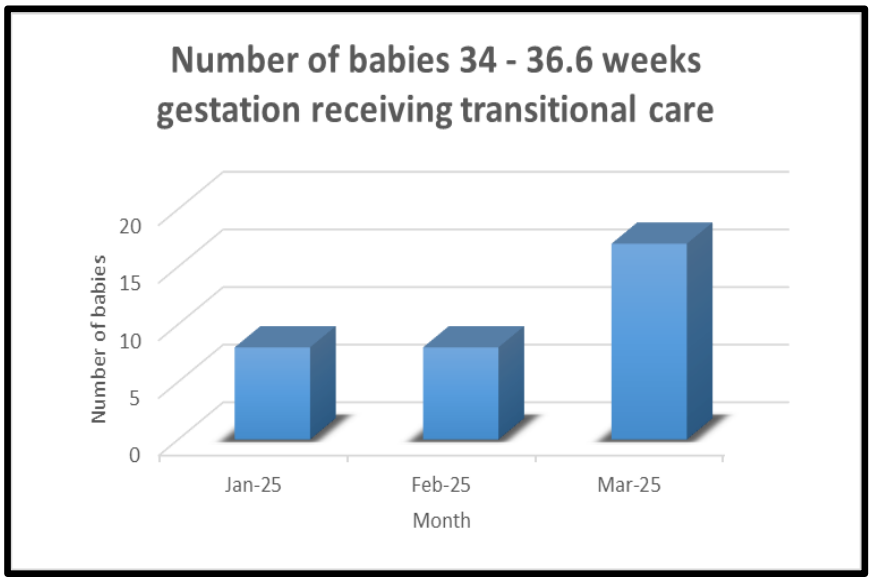
Figure 28. ATAIN reviews during Q4 (babies equal or >37 weeks gestation)

	January 2025	February 2025	March 2025
Total number of admissions in month	**4**	**13**	**3**
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	**0**	**0**	**0**
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	**0**	**0**	**0**
	January 2025	**February 2025**	**March 2025**
Total number of case reviews undertaken in month	**13**	**5**	**10**
Total number of case reviews with both maternity and neonatal staff present	**13**	**5**	**10**

16.3 SFT Trust transitional care rates

The number of late pre-term babies (34-36+6 weeks gestation) born that met transitional care criteria in the last quarter are shown below for Q4. Further detail is contained within the appendices.

Figure 29. Total number of 34-36+6 babies born each month in Q4 receiving Transitional care.



All late pre-term babies were cared for on either the Special Care Baby Unit (SCBU) within the Neonatal Unit or on Beatrice Maternity Ward, as outlined in the full report in the appendices.

17. Staff Survey

The most recent annual NHS Staff survey was published in March 2025 (Q4 24/25), with data having been collected in October and November 2024. The questions in the NHS Staff Survey are aligned to the People Promise as well as two themes, staff engagement and morale.

As a division we are just working through analysing the data and creating an action plan to address any areas which require attention.

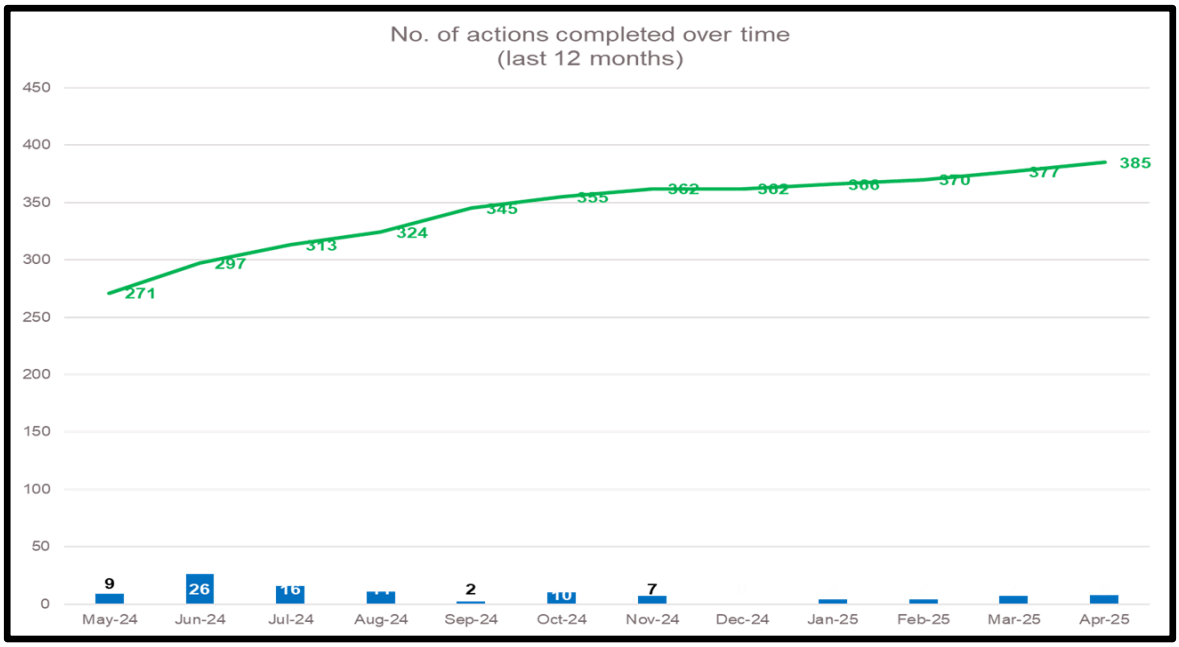
18. Maternity and Neonatal Safety Improvement Plan

Every Trust is required to develop a bespoke Maternity Safety Improvement Plan, which brings together existing and new plans to progress these projects into one place. Salisbury NHS Foundation Trust exited the NHSE Maternity Safety Support programme in November 2024 but continue to focus on and utilise the Maternity Improvement Plan to support SFT's progress and improvement journey.

18.1 Progress made over the last quarter

In Q4, progress continued with closing actions on the Maternity Improvement Plan. More of an 'inch-wide mile-deep' approach is being taken due to the complexity of the actions being tackled, hence a reduced quantity of actions completed in that period. A number of actions within the digital workstream had a dependency on the implementation of the BadgerNet maternity EPR system which went live in February 2025.

Figure 30. Progress with Maternity Improvement Plan actions Q4



The board report and application to exit, and the sustainability plan were presented and approved by the Trust Board, ICB Board, LMNS Board and Regional PQSSG in Q2.

It was also approved by the Regional Quality Group, Regional Support Group, and National QPC on 19th November 2024 which completes the exit process.

19. Risk Register highlights

The Divisional risk register is reviewed bi-monthly with leads being encouraged to review and update any risks ahead of this. On 2nd April 2025, the current open risks on the risk register are noted below.

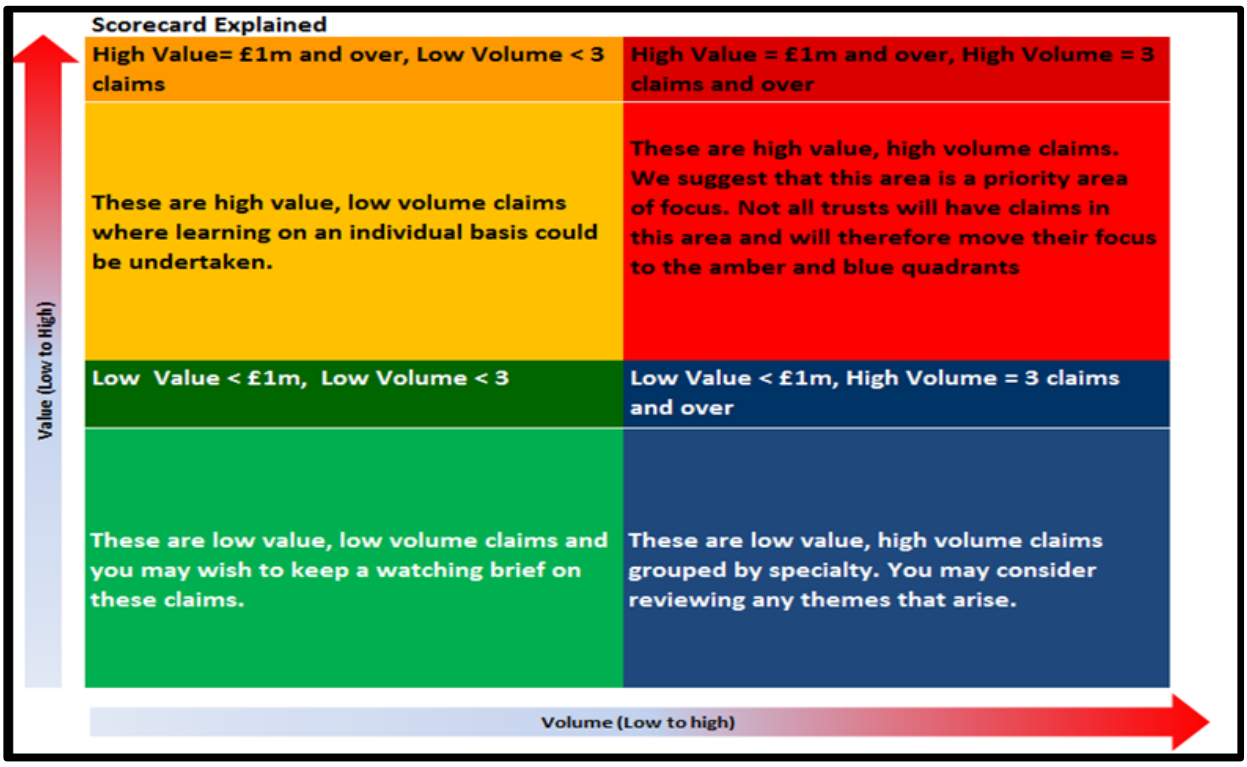
Figure 31. Current Open Risk Register items for Maternity and Neonatal services

ID	Title	Opened	Risk Type	Rating (current)	Review date
8310	AUDIT NON-COMPLIANT re timing of delivery for Intrahepatic Choleostasis (IPC)	04/02/2025	Clinical Risk	12	30/06/2025
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	28/04/2020	Clinical Risk	12	03/03/2025
7923	Neonatal unit heating	08/12/2023	Corporate Risk	10	28/03/2025
8013	No robust system for checking results on review	14/03/2024	Clinical Risk	9	31/05/2025
8309	AUDIT NON-COMPLIANT re Documentation of BP, Urine, CO testing, FM's, FH and risk assessment in ANC	04/02/2025	Clinical Risk	8	30/06/2025
8049	Maternity Information system back and forward copying issue	29/01/2024	Organisational Risk	2	31/10/2024
7623	Neonatal ROP	02/03/2023	Organisational Risk	5	30/03/2026
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	15/11/2021	Clinical Risk	5	01/01/2026

20. Litigation Scorecard and Triangulation of Incidents and Complaints

The NHSR Litigation Scorecard is updated and published annually for the Trust. It contains 10 years of claims data and is based on incident date. The scorecard is a Quality Improvement Tool for CNST, and it is a requirement that a quarterly review of incident and complaints data against the annual scorecard themes is reported to Trust Board level Safety champions as part of the Year 6 Maternity Incentive Scheme. The scorecard can be understood within the following table.

Figure 32. NHSR litigation scorecard explained in terms of value and volume of claims

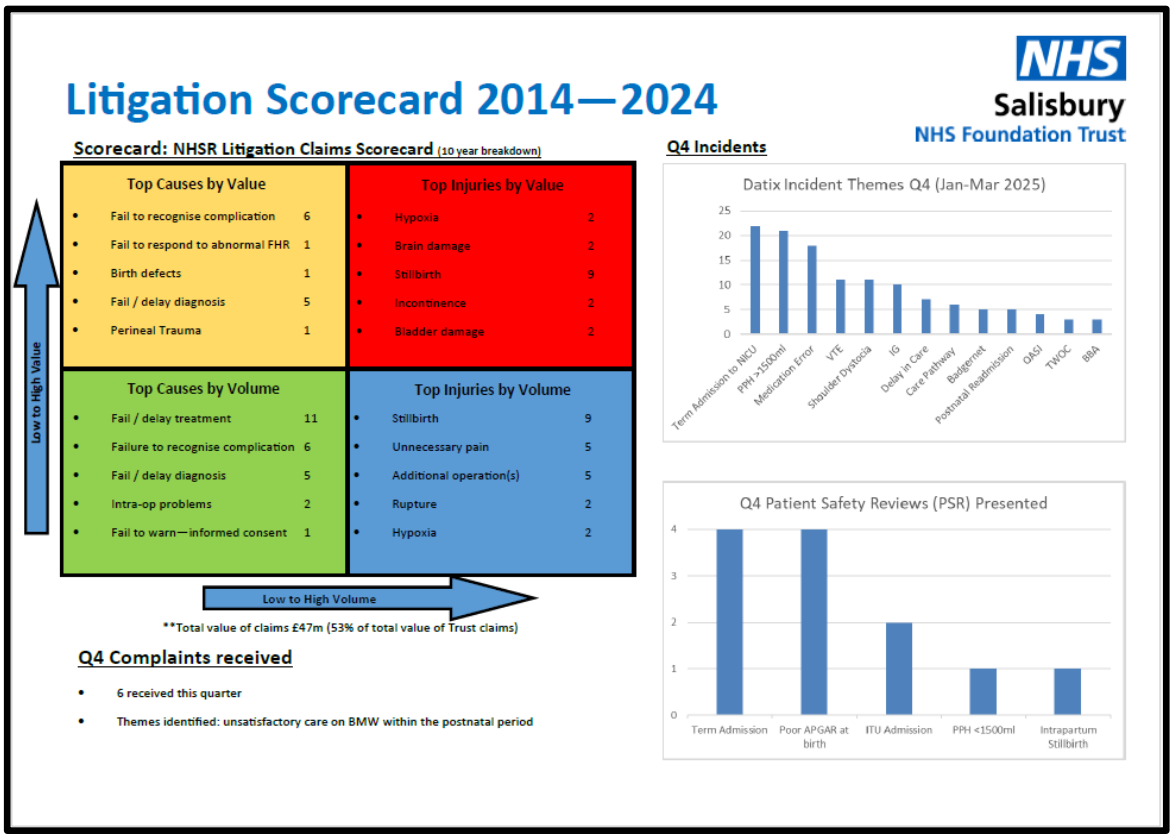


Themes from incidents, claims and complaints are reviewed at the quarterly triangulation meeting and Maternity Governance meeting.

These can be summarised as follows and, in the figure, below:

- Legal claims - the top injury claim by value is failure to respond to abnormal fetal heart rate (2) and by volume is failure / delay in diagnoses (5).
- Incidents – the top 3 DATIX including term admissions, medications and postpartum haemorrhage (PPH). Term admissions and PPH are listed on the trigger list, therefore all cases are reviewed in line with the Trust PSIRF plan and learning identified.
- Complaint themes – these include a term admission, poor experience in antenatal clinic and communication issue re appointment.

Figure 33. Litigation scorecard - triangulation of complaints, incidents and legal claims in Maternity and Neonatal services



21. Recommendation

The Board of Directors/ Trust Board is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

Perinatal Mortality & Morbidity Review Group
Perinatal Mortality Review Tool (PMRT) Quarterly Report
Maternity and Neonatal Services
(Quarter 4 2024-25)

1. Introduction

The aim of this quarterly report is to provide assurance to Salisbury NHS Foundation Trust Maternity Safety and Board level Safety Champions and Trust Board that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 Definitions

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 24^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

MIS Year 6 requirements to notify:

The following deaths should be notified to MBRRACE and reviewed under PMRT to meet safety action one standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth)
- Terminations of pregnancy: terminations from 22+0 weeks are cases which should be notified plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death. Notification only.

At the time of preparing the Q4 report, the MIS Year 7 schemes released the requirements in April 2025. The following will change (highlighted below in blue) will apply to notification of deaths to MBRRACE and reviewed under PMRT to meet safety action one standards:

- Terminations of pregnancy: terminations from 24+0 weeks are cases which should be notified plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death. **Notification only.**

2. Standards

A report has been received by the Trust Board each quarter from Salisbury NHS Foundation Trust Maternity and Neonatal Services that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b), c) and d) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

The MIS Year 7 scheme was released in April 2025 and will apply to babies who die between 1st December 2024 until 30th November 2025.

Figure 1. MBRRACE-UK/PMRT standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days. As of 8th January 2025, Neonatal deaths are to be notified within 2 working days due to the Child Death Review Statutory and Operational Guidance (England).	**100%**
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	**95%**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 1st December 2024 • 95% of reviews should be started within two months of the death, • minimum of 75% of multi-disciplinary reviews should be completed and published within six months. • Minimum of 50% of the deaths reviewed should have an external member present at the multi-disciplinary review panel meeting and this should be documented within the PMRT	**95%** **75%** **50%**
d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 1st December 2024.	**100%**

Figure 2. PMRT Report

PMRT screenshot showing that there were 0 published reviews for perinatal deaths in Q4. However, there were 2 reviews performed in Q4 for deaths that occurred in Q3.

The Q4 PMRT board report is embedded below and covers the perinatal losses that were reviewed in Q4. Further detail is provided in Appendix A. These babies died in Q3 and were reviewed in Q4.

PDF
PMRT_BoardReport_
Salisbury NHS Found

3. Recommendations

3.1 Eligible Incidents in 2024-2025 (appendix A)

There has been a total of 1 incident reported to MBRRACE-UK in Quarter 4.

One antenatal stillbirth at 32+6 weeks. This was notified to MBRRACE, surveillance was completed and PMRT review will take place in 2025/26 Q1.

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 4 (appendix B)

There have been 2 incidents closed in Q4. These were for 2 deaths that occurred in Q3.

During Q3 there was 1 further PMRT case that met the threshold for referral to the Maternity and Newborn Safety Investigations programme (MNSI). Once the final report has been received the PMRT review will go ahead.

For late losses and stillbirths this is broken down into the care provided to the mother and baby before the death of the baby and the care of the mother after the death of the baby.

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- 1 case had no issues with care identified up the point that the baby was confirmed as having died.
- 1 case identified care issues which would have made no difference to the outcome for the baby.
- 0 cases identified care issues which may have made a difference to the outcome for the baby.
- 0 cases identified care issues which were likely to have made a difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby:

- 0 cases had no issues with care identified for the mother following confirmation of the death of her baby.
- 2 cases identified care issues which would have made no difference to the outcome for the mother.
- 0 cases identified care issues which may have made a difference to the outcome for the mother.
- 0 cases identified care issues which they considered were likely to have made a difference to the outcome for the mother.

For neonatal deaths this is broken down into the care of the mother and baby up to the point of birth of the baby, care of the baby from birth up to the death of the baby, care of the mother following confirmation of the death of her baby.

Grading of care of the mother and baby up to the point of birth of the baby:

- 0 case had no issues with care identified up the point that the baby was born.
- 0 cases identified care issues which would have made no difference to the outcome for the baby.
- 0 cases identified care issues which may have made a difference to the outcome for the baby.
- 0 cases identified care issues which were likely to have made a difference to the outcome for the baby.

Grading of care of the baby from birth up to the death of the baby:

- 0 case had no issues with care identified from birth up the point that the baby died.
- 0 cases identified care issues which would have made no difference to the outcome for the baby.
- 0 cases identified care issues which may have made a difference to the outcome for the baby.
- 0 cases identified issues which were likely to have made a difference to the outcome for the baby.

Grading of care of the mother following the death of her baby:

- 0 case had no issues with care identified for the mother following the death of her baby.
- 0 cases identified care issues which would have made no difference to the outcome for the mother.
- 0 cases identified care issues which may have made a difference to the outcome for the mother.
- 0 cases identified care issues which were likely to have made a difference to the outcome for the mother.

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix D.

3.3 CNST Compliance as per MIS Year 6 Standards (appendix C)

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

3.5 Perinatal mortality rate per 1000 births compared to the national average (appendix E)

The graphs in appendix E demonstrate how Salisbury Foundation Trust is performing against the national ambition to reduce rates of stillbirths, neonatal and maternal death by 20 per cent by 2020 and 50 per cent by 2025.

There was 1 stillbirth (excluding MTOP's) in Q4. This makes a total of 4 stillbirths in the last 12 months, which equates to 2.1 per 1000 births in the last 12 months. The national rate per 1000 births is 3.9 per 1000 with a national ambition to reduce to 2.5 per 1000 births.

There were 0 neonatal deaths > 24 weeks in Q4. This makes a total of 0 NND >24 weeks in the last 12 months which equates to 0 per 1000 live births in the last 12 months. The national neonatal death rate is 1.65 per 1000 live births.

Appendix A - Summary of all Eligible Incidents Reported in Q4 2024/25

	PMRT ID	Reason for entry to MBRRACE/ PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	MNSI Case	CIIR/SI	Notify MBRRACE within 7 days	Seek parent's views of care	Start review <2 months	Complete and publish review <6 months	Report to Trust Executive
Q4	**97465**	Stillbirth	32+6	17/2/25	17/2/25	2430g	SFT	SFT	SFT	N/A	N/A	Yes	Yes	Yes	Due 2/5/25	Yes

Appendix B - Summary of all incidents closed in Q4 2024/25

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/Date	Update
95895	Severe growth restriction	A B	No preconceptual management.	Share learning with GP re preconception care.	ST 31/3/25	Email addresses identified and will be complete soon.
			No partogram used.	Discuss on update days.	ST 1/3/25	Now included within Badgernet.
			Some bloods not taken.	Take bloods and review findings.	ST/CLA 14/1/25	Completed
96493	Sacrococcygeal teratoma	B B	No evidence that mother was asked about domestic abuse at booking.	To discuss with maternity teams around asking question to everyone and to ask postnatally.	Education team 31/5/25 SMV at debrief appt	At update days SMV asked re DV
			Mental health history and antenatal care not appropriate.	Badgernet will require questions to be asked.	Badgernet go live 25/2/25	Completed
			No partogram.	Badgernet will have partogram inbuilt.	Badgernet go live 25/2/25	Completed
			Infection screening not carried out.	CMV and Toxo added to group tests and these tests undertaken on mother.	ST 7/2/25	Completed
			No Kleihauer despite being requested.	Education to staff to complete forms clearly and request Kleihauer for all stillbirths.	ST 31/5/25	Updated checklist, added to newsletter and tea trolley education.

*New MIS criteria for year 7

Appendix C - Summary of CNST Compliance as per MIS Year 7 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% Target	From 1 Dec 24 Q3 24/25	Q4 24/25	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days Neonatal deaths are to be notified within 2 working days due to the Child Death Review Statutory and Operational Guidance (England), commenced 8/1/2025.	100	5	1	6
		100%	100%	100%
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	95	2 eligible (1 MNSI)	1	3
		100%	100%	100%
A PMRT review must be commenced within two months following the death of a baby.	95	3	1	3
		100%	100%	100%
*Minimum of 75% of multi-disciplinary reviews should be completed and published within six months.	75	2 (1 MNSI)	0 (Plan in place)	2
		100%	0%	66%
*Minimum of 50% of the deaths reviewed should have an external member present at eh multi-disciplinary review panel meeting and this should be documented within the PMRT	50	2	0	2
		100%	0%	66%
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Boad on an on-going basis for all deaths from 1 December 2024	100	5	1	6
		100%	100%	100%

Appendix D - Summary of all Learning and Action Logs for Outstanding Cases

Case IDs	Issue	Action	Responsible / Target Date	Update / progress
PMRT ID 75880	SID's pathway not available.	NICU team and Bereavement MW to work together to develop a pathway for care of families experiencing SID in the neonatal period.	ST MW BR NN New date	SOP completed - in 2022. Delay in being ratified at Neonatal and Sarum governance. Will now need updating - in progress. Update and planned for ratification October- Maternity Audit and Guidelines meeting 2024. 12/25 - Updated and on Eolas under maternity- needs to go through Sarum and A+E governance. 31/3/25 - Will be on ED governance agenda next meeting - awaiting invite to confirm date- possibly June 2025.
PMRT ID 79097	This mother did not receive preconception care regarding severe pre-eclampsia or HELLP.	To consider postnatal follow up appointment for women with severe pre-eclampsia or HELLP to discuss appropriate pre-conception management and to add to hypertension guideline.	KEB and SE New action holders date put back to 12/24 - CXA	Update requested 16/5. To discuss at consultant meeting Sept 2023 for agreement then update policy. Emailed APH 16/2/2024 to add to guideline. KEB- 20/2/24 - Currently working with SE to incorporate picking these women up on PN ward and having the referral process clear. Document still in progress. Emailed KEB and SE 17/6/2024. 27/12 - CXA has taken on action. 2/4/25 - Patient info leaflet complete- needs approval. Plan for women to be seen in GOPD. PN referral being put into BadgerNet.
PMRT ID 88241	This mother did not receive aspirin.	Robust processes are required by the trust to ensure women who need aspirin are provided with it. To talk to staff to discuss the barriers around this and then decide an action plan.	ET - ANC S TR - CMW EJ - Trust	Clinic lead MW is reviewing PGD with pharmacy. Discussed at Maternity Risk and Governance 12/7/24 and Antenatal Quality meeting 5/8/24. Storage logistics and PGD in progress.

		To be discussed at the antenatal quality meeting for a plan. NED present at review will take this to the Executive Team for the Trust.	New date due to new action holder in post 12/24.	12/25 - Storage and thermometers for hubs in place- need to complete the PGD application for SDH- preliminary agreed at trust level. 3/4/25 - Aspirin PGD to go through next IATM meeting for approval.
PMRT ID 95895	Mother did not receive preconceptual management regarding her previous obstetric history (cared for in another country) and current hypertension.	Look into any current pathways to share learning with GP's and link in with these to share learning.	ST 30/04/2025	Emailed P. Russell 31/3/25 - Info to be shared with P. Russell to send out to GP's. 5/5/25 - In discussion regarding creating a newsletter to GP's for updates and feedback.

Appendix E - Perinatal mortality rate

Stillbirths

The graphs below show the monthly and annual stillbirth rates (per 1000 births) at Salisbury.

Figure 1. Monthly stillbirth rate per 100 births for SFT over the last 12 months set against national rate and ambition.

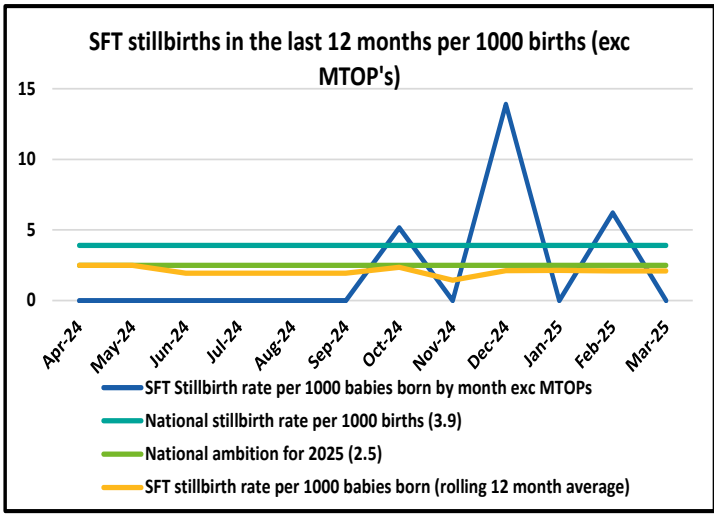
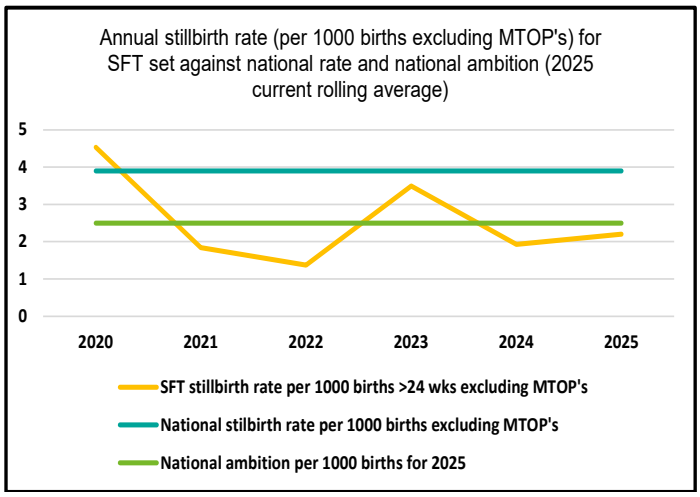


Figure 2. Annual stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2025 current rolling average)



Neonatal Deaths

The graphs below show the monthly and annual neonatal death rates (per 1000 live births) at Salisbury.

Figure 3. Monthly neonatal death rate>24 weeks per 1000 live births for SFT over the last 12 month set against national average

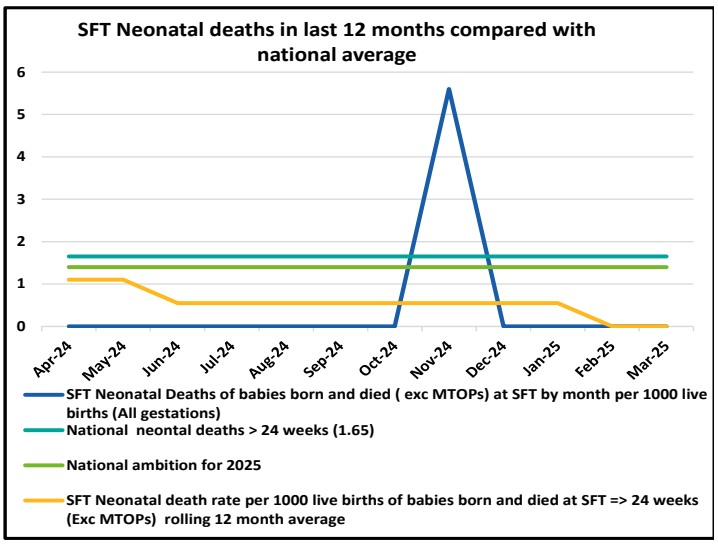
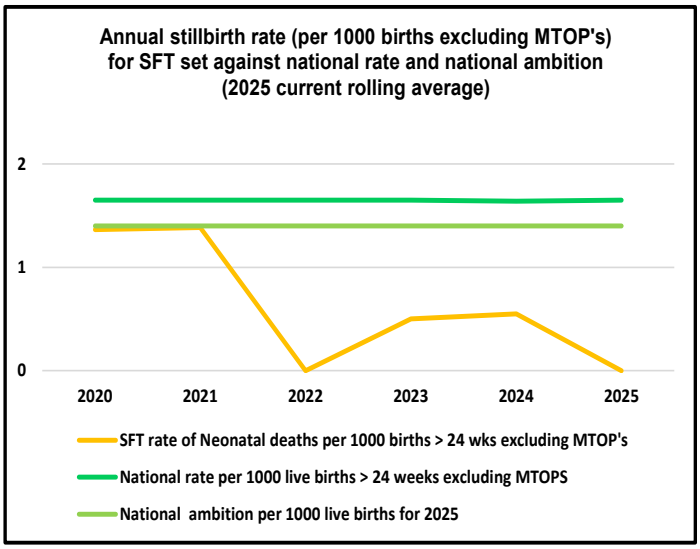


Figure 4. Annual stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2025 current rolling average)



Maternity and Neonatal Training Report
Maternity and Neonatal Services
(Quarter 4 2024-25)

The report provides an update on the local training and development that is ongoing within the Maternity and Neonatal service at SFT, including a response to current CNST Maternity Incentive Scheme action 8. The Maternity and Neonatal service must demonstrate that a local training plan is in place for implementation of the current Core Competency Framework (CCF) and that the plan has been agreed with the quadrumvirate and signed off by the Trust Board and the LMNS/ICB. The CCF (version 2) sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every Maternity and Neonatal service.

A training plan for the 3-year period of the Core Competency Framework (2025-2027) was noted and agreed by the LMNS on 17/09/2024, covering January 2025 – December 2027, as per the CCFv2. This included all training requirements for the multi-disciplinary team within maternity and neonatal services. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. The TNA was reviewed last quarter, in line with the CCFv2, to start a new 3-year programme for all maternity-specific training commencing January 2025.

This report is to demonstrate compliance to the mandatory obstetric and maternity training at the end of each quarter as well as the compliance to the aspects of corporate training that the maternity education team support.

The report aligns to the Maternity Training and Development Policy.

Contents

Maternity and Neonatal Compliance:

1. **Saving Babies Lives Care Bundle (SBLCB) version 3.**

1.1 Smoking in pregnancy

1.2 Fetal growth restriction

1.3 Reduced fetal movements

1.4 Fetal monitoring in labour

1.5 Preterm birth

1.6 Diabetes in pregnancy

2. **Obstetric Emergency Day** (PROMPT) (which includes Human Factors and recognition of the deteriorating patient and newborn)

3. **Neonatal Basic Life Support**
4. **Maternity Update Day** (which includes equality, equity, and personalised care)
5. **MDT safeguarding children level 3**
6. **BSOTs training**
7. **NIPE**
8. **Adult Basic Life Support**
9. **Blood Transfusion Training**
10. **Simulation Training**
11. **Education Dashboard**
12. **CNST Year 6**
13. **Plans for next quarter**
14. **Appendix A - Action plan**

Compliance

The target compliance for staff attendance is 90% for all elements within the CCF. The compliance is calculated in the number of staff members in each group excluding those on maternity leave or long-term sick (>2months). This provides evidence for safety action 8 of the Maternity Incentive Scheme.

Previously during Q3 (by 30th November 2024), training compliance of ≥90% for all staff groups at PROMPT, fetal monitoring and newborn life support was achieved to meet the requirements of safety action 8 in the Maternity Incentive Scheme. During Q4 training compliance has since fallen below the ≥90% target. Anaesthetic and obstetric compliance has been compounded by workforce pressures and sickness. This has been escalated to the relevant divisions, and an action plan has been co-created with leads to achieve compliance across all relevant staff groups by 30th November 2025 for the MIS year 7 submission.

Saving Babies Lives Care Bundle (SBLCB) version 3 minimum compliance with each of the 6 elements is 90% attendance – annual for each element (eLearning is appropriate for some elements on eLearning for Health). There is also an ambition to achieve the stretch target of ≥95% attendance. This was a new requirement for 2024 as per MIS year 6, and it was not achieved locally due to sickness and clinical escalations affecting attendance at the required study day. An action plan was created, in collaboration with the LMNS to meet this compliance requirement by end of Q4 (March 2025). Unfortunately, this was not achieved, and a further action plan has been developed and agreed with relevant leads. Compliance and actions continue to be monitored and escalated through governance mechanisms.

1. Saving Babies Lives Care Bundle

The CCF version 2 introduced training requirements for each element of the Saving Babies' Lives Care Bundle in 2023. However, each element is not currently required for all staff groups. The compliance graphs in the next sections of the report demonstrate which staff groups are required for each element of training.

1.1 Smoking in Pregnancy (SBL Element 1)

Minimum standard:

- All multidisciplinary staff trained to deliver Very Brief Advice to women and their partners (NCSCT eLearning).
- Local opt-out pathways/protocols, advice to give women and actions to be taken. CO monitoring and discussion of result.
- Individuals delivering tobacco dependence treatment should be fully trained to NCSCT standards.

For 2025, this training is provided face-to-face from the Health in Pregnancy team on the SBL study day. Compliance is held once attendance has been confirmed. The SBL study day is only attended by midwives and therefore obstetricians are expected to complete this training via the National Saving Babies' Lives eLearning package on eLearning for Health (eLfH).

Midwives are being provided with rostered time to complete training. During 2024 element 1 was delivered via eLearning for the SBL Care Bundle. Training compliance was not met and so from January 2025 training is now face to face within the mandatory study day. During Q4, it was also identified that Preceptee midwives had not all received training, and this has been addressed with compliance expected to improve in Q1 25/26.

Previously it had been identified that MSWs require training in Element 1 of SBL alongside midwives and obstetricians as they will provide CO monitoring/observations within their role. This has since been added to their study day requirements and they are being rostered to complete e-learning. Training completion is being followed up by the new MSW lead for Education. During Q4 training compliance noted a reduction for MSW's with the e-learning. The Education team are currently seeking approval to introduce face-to-face SBL training for MSWs, on smoking and fetal growth to improve compliance.

Within Q4, face-to-face training for reducing smoking in pregnancy was provided to obstetricians as there had been a lack of engagement with completing eLearning. This has led to an increase in compliance from Q3 although remaining non-compliant as a staff group. During Q4 a plan has been developed to implement face to face training for Element 1 for rotating resident doctors' during their local induction timetables

Figure 1. Compliance progress with SBL Element 1 eLearning in Quarter 4

	January 2025	February 2025	March 2025
Midwives	85.1%	77.4%	81.5%
Obstetricians	52.2%	52.2%	52.0%
MSWs	46.2%	33.3%	33.9%

1.2 Fetal Growth Restriction (FGR) (SBL Element 2)

Minimum standard:

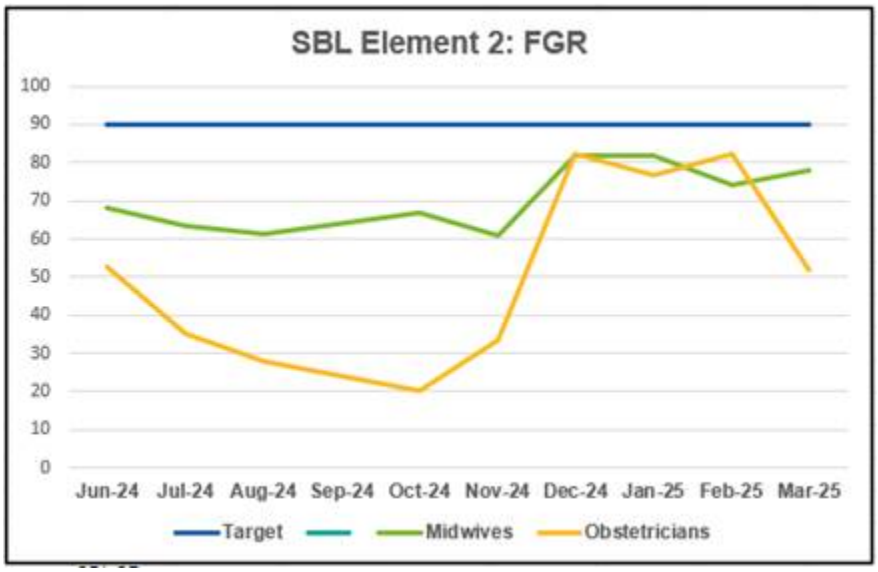
- Local referral pathways, identification of risk factors and actions to be taken.
- Evidence of learning from local Trust detection rates and actions implemented.
- Symphysis fundal height measuring, plotting, and interpreting results practical training and assessment, and case reviews from examples of missed cases locally.

From January 2025, FGR detection and surveillance is accessible via the eLfH eLearning website and data of compliance is kept within our Divisional Performance Review on PowerBI and is reported to Trust quarterly. The following chart demonstrates overall compliance for the last quarter.

The staff groups required to complete FGR training changed in April 2024. It is now only required for midwives and obstetricians as per the CCF and SBL Care Bundle. Midwives are now taught face-to-face on the SBL study day. 90% was not achieved for midwives due to sickness and clinical requirements taking priority. It was also identified that Preceptee midwives had not all received training and this has been addressed with compliance expected to improve in Q1 25/26.

Obstetric compliance remains challenging due to the rotations of trainee resident doctors. An obstetric training passport has been created and is shared with trainees for completion prior to their inductions. As per element 1, a plan has been developed to implement face to face training for rotating resident doctors' during their local induction timetables to improve compliance. For consultant obstetricians, as per element 1, face-to-face training for element 2 is now also being provided as there has been a lack of engagement with completing eLearning.

Figure 2. FGR compliance (Q4 Jan-Mar)



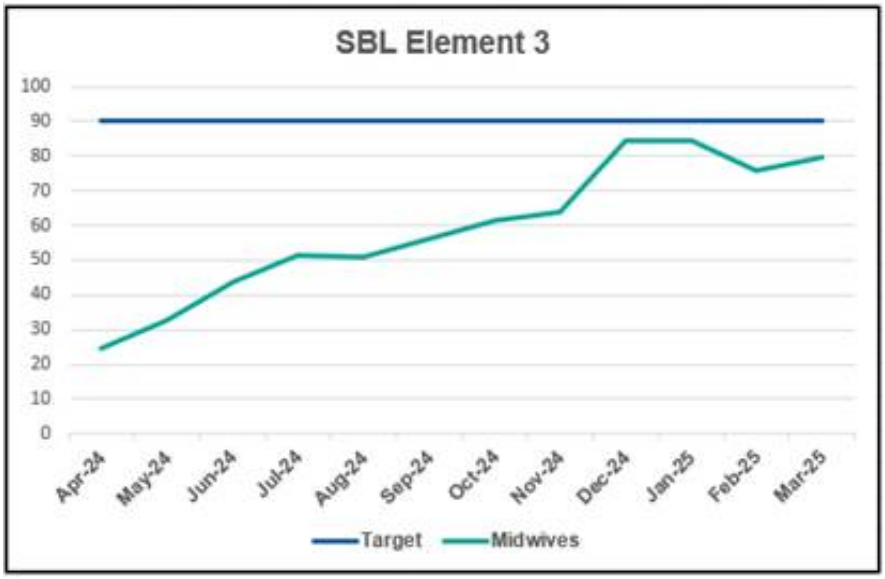
1.3 Reduced Fetal Movements (SBL Element 3)

Minimum standard:

- Local pathways/protocols, and advice to give to women and actions to be taken.
- Evidence of learning from case histories, service user feedback, complaints and local audits.

This element is now being taught face-to-face on the SBL study day for Midwives which has supported an overall increase in their compliance. However, 90% was not achieved for midwives due to sickness during their study week and clinical requirements taking priority. It was also identified that Preceptee midwives had not all received training and this has been addressed with compliance projections expected to improve in Q1 25/26.

Figure 3. SBL training compliance (Q4 Jan-Mar)



1.4 Fetal Monitoring (SBL Element 4)

Minimum standard:

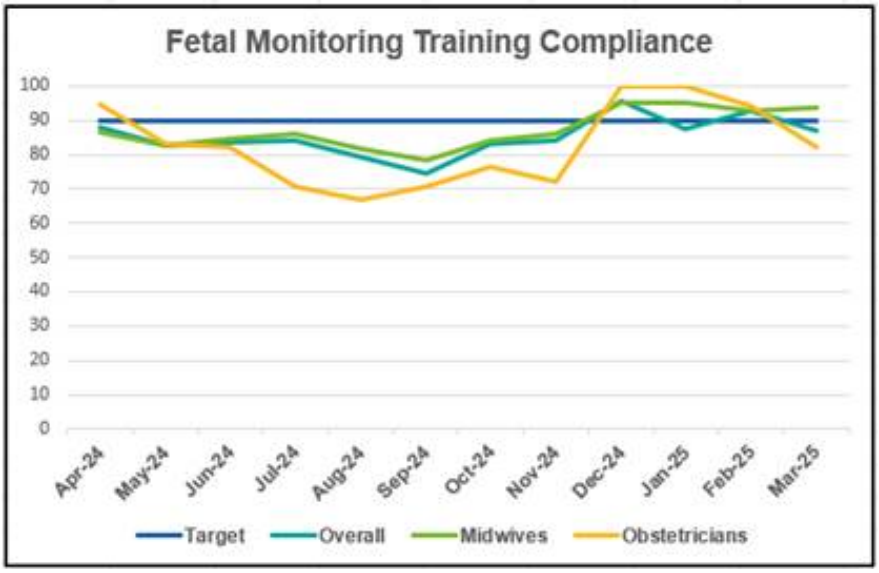
- 90% attendance.
- Annual update.
- All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the clinical network.
- One full day's training in addition to the local emergencies training day.
- Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit.

For MIS Year 6, the requirement for attendance at fetal monitoring training now excludes GP trainees and Foundation Year doctors, as they will not be interpreting CTGs and fetal wellbeing without supervision.

The following graph demonstrates compliance for midwives' fetal monitoring over the past 12 months and evidence of meeting and maintaining the required compliance since 30th November 2024 (data collected 1st of the month).

Obstetricians' compliance has fallen below the 90% target due to challenges with rostering, sickness and competing demands. A plan has been made to achieve compliance by November 2025.

Figure 4. Fetal Monitoring training compliance (Q4 Jan-Mar)



The below data is specific to attendance on the fetal monitoring study day.

Figure 5. Fetal Monitoring Training compliance

Attendance & overall compliance	Midwives	Obstetricians
January attendance	14	0

January % compliance	**95.0% ↓**	**100% ↔**
February attendance	**13**	**0**
February % compliance	**92.7% ↓**	**94.1% ↓**
March attendance	**10**	**1**
March % compliance	**93.6% ↑**	**82.4% ↓**

1.5 Preterm birth (SBL Element 5)

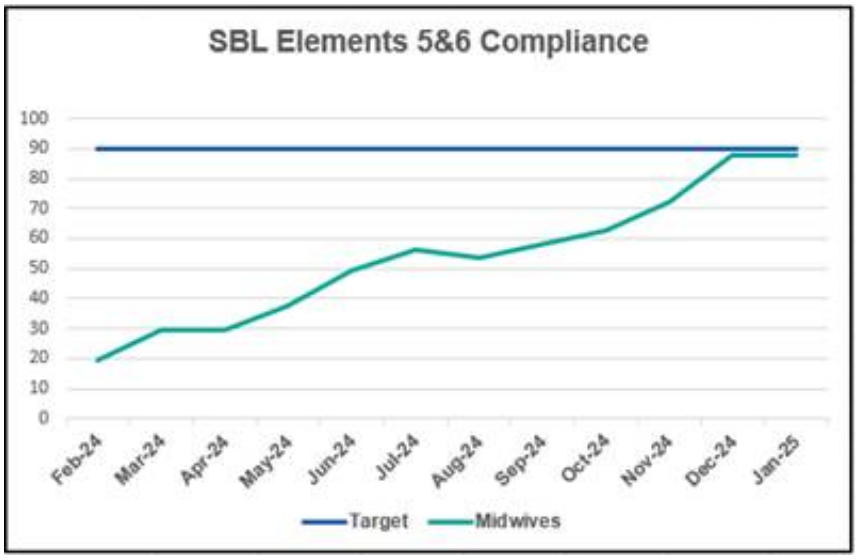
Minimum standard:

- Identification of risk factors and local referral pathways.
- All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care.
- A team-based, shared approach to implementation as per local unit policy.
- Risk assessment and management in multiple pregnancy.

For 2025, this training is provided via eLearning for Health (eLfH) online, as part of the national Saving Babies' Lives eLearning package. Compliance is held once certificates of completion are evidenced to the maternity education team.

The below graph demonstrates midwifery compliance with Preterm Birth and Diabetes in Pregnancy. Midwives are required to complete these elements during their maternity study week (preterm birth via eLearning and diabetes face-to-face on the SBL study day), Compliance has improved in Q4 due to the introduction of diabetes teaching face-to-face. However, 90% was not achieved for midwives due to sickness and clinical requirements taking priority. It was also identified that Preceptee midwives had not all received training and this has been addressed with compliance expected to improve in Q1 25/26.

Figure 6. SBL Elements 5&6 compliance (Q4 Jan-Mar)



1.6 Diabetes in Pregnancy (SBL Element 6)

Minimum standard:

- Identification of risk factors and actions to be taken.
- Referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams.
- Intensified focus on glucose management in line with the NHS Long Term Plan and NICE guidance, including continuous glucose monitoring.
- Care of the diabetic woman in labour.

This element is now being taught face-to-face on the SBL study day for 2025. Please see above training compliance within Element 5 (Preterm Birth) for further detail.

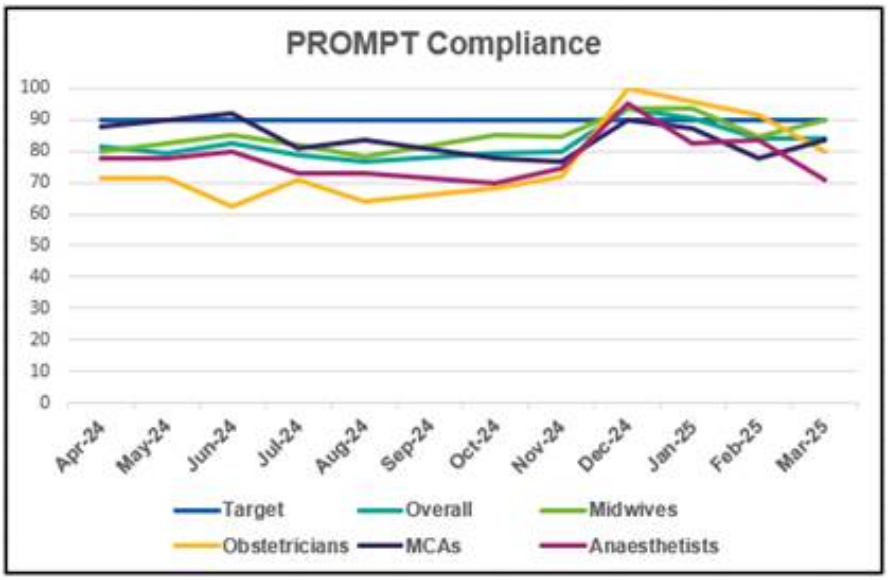
2. Maternity Emergencies and Multi-Professional Training Day (PROMPT)

CNST MIS year 6 minimum standards:

- 90% of each relevant maternity unit staff group has attended an ‘in-house’ MDT training day which includes a minimum of four maternity emergencies with all scenarios covered over a three-year period and priorities based on locally identified training needs:
    - Antepartum and postpartum haemorrhage
    - Shoulder dystocia
    - Cord prolapse
    - Maternal collapse, escalation, and resuscitation
    - Pre-eclampsia/eclampsia and severe hypertension
    - Impacted fetal head
    - Uterine rupture
    - Vaginal breech birth
    - Care of the critically ill patient
- Annual update
- Training should be face-to-face (unless in exceptional circumstances such as the covid pandemic).

The following graph demonstrates compliance for the specific staff groups over the past 12 months:

Figure 7. PROMPT training day compliance (Q4 Jan-Mar)



The MIS deadline for training compliance for year 6 was in December 2024. There have been multiple challenges in achieving consistent MDT attendance at the study day. PROMPT attendance has been affected by junior doctor industrial action, sickness and a conflict in workload for anaesthetists.

PROMPT had 10 planned study days throughout 2024 to enable opportunities for attendance, with 2 extra dates being added in October and November 2024 in anticipation for junior doctor rotations, newly qualified midwives being recruited and to overcome challenges of meeting compliance requirements. Training compliance of ≥90% for midwives, obstetricians, anaesthetists and MCAs were met on 30th November 2024.

During Q4, training compliance has since fallen below the required target due to staff sickness and competing work demands. A plan has been made to achieve compliance by November 2025 with contingency provisions made for additional dates in October/November if required. 4 anaesthetists per session are now booked to attend PROMPT training for the remainder of 2025. There remain challenges with obstetric attendance to remain in date due competing demands and workforce pressures. All obstetricians continue to be booked onto the training dates during 2025 with the aim of achieving compliance by 30th November. The Education lead midwife meets regularly with the obstetric operational lead to plan and review bookings and compliance.

The data below is specific to attendance on the PROMPT study day (compliance % taken 1st of the month).

Figure 8. PROMPT study day attendance

Attendance & overall compliance	Midwives	Obstetricians	Anaesthetists	MCAs
January attendance	**10**	**0**	**4**	**5**

1st January % compliance	**93.4% ↔**	**95.7% ↓**	**82.5% ↓**	**87.2% ↓**
February attendance	**10**	**1**	**2**	**4**
1st February % compliance	**84.7% ↓**	**91.3% ↓**	**83.3% ↑**	**77.8% ↓**
March attendance	**13**	**2**	**4**	**6**
1st March % compliance	**89.6% ↑**	**80.0% ↓**	**71.0%↓**	**83.8%↑**

3. Neonatal Basic Life Support

Minimum standard:

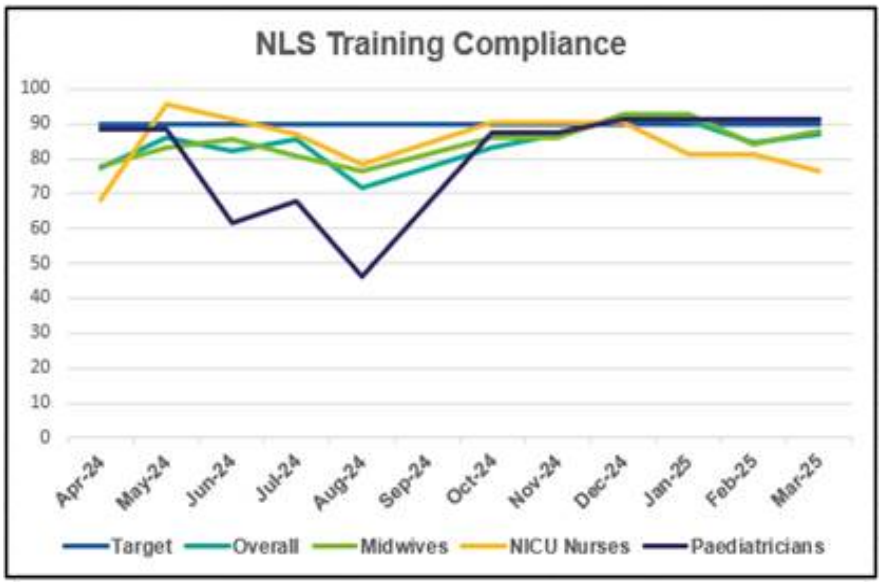
- 90% compliance at a neonatal basic life support annual update, either as an in-house neonatal basic life support training or newborn life support (NLS).
- Only registered Resuscitation Council (RC) trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.

Within Maternity and Neonatal services, there are 5 RC-trained instructors, with a further 2 midwives that have been invited to become instructors in the future. This has enabled the delivery of in-house updates with RC-trained instructors for all staff groups since 2023.

Although training compliance requirements were met on 30th November 2024, paediatricians and NICU nurses found monitoring their team's compliance difficult as it is currently held within the Maternity Education Team. It has been agreed that in 2025, paediatrics and NICU will hold their own training compliance data to ensure oversight into the requirements of their staff. Due to staff changes in the maternity and neonatal education teams, an update has not been obtained in Q4. Midwifery and NICU nurse compliance has fallen short of the target due to staff sickness and clinical demands. A plan is in place to meet compliance by November 2025.

The following graph demonstrates compliance for the specific staff groups in the past 12 months.

Figure 9. NLS training compliance (Q4 Oct-Dec)



**NB: This data includes staff that have completed an Resus Council NLS course.*

4. Maternity Update Day

The maternity update day is an annual day for midwives, nurses working in maternity and MCAs and includes training in modules 4 & 5 of the CCFv2 (Equality, equity and personalised care and care during labour and immediate postnatal period). This study day also includes content required locally, such as fire safety training and infant feeding. A trajectory for 2025 ensures by November 2025 all Midwives, MCA and maternity nurses will have attended and be compliant.

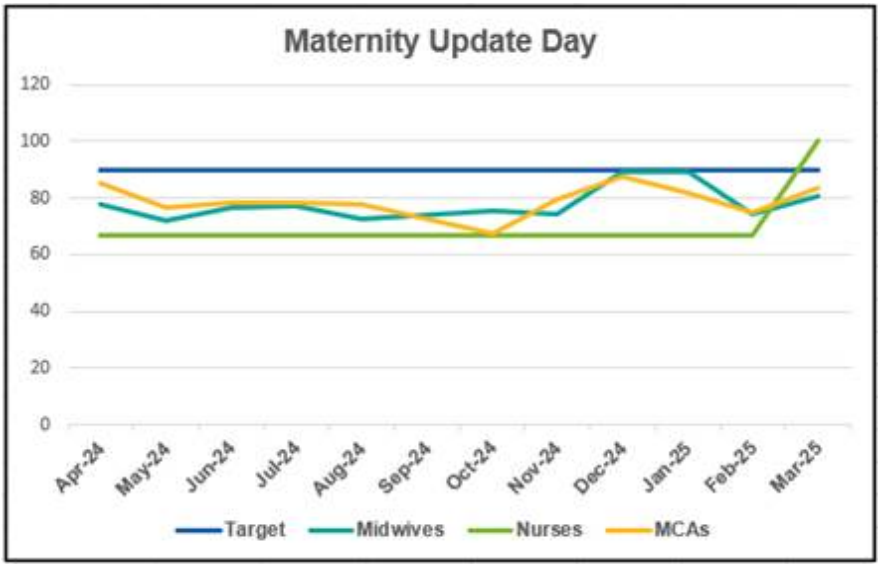
Minimum standard:

- 90% attendance (three yearly programme of all topics)
- Training should cover local pathways and key contacts when supporting women and families.
- Training must include learning from incidents, service user feedback, local learning, local guidance, audit reviews, referral procedures and 'red flags.
- Learning from themes identified in national investigations e.g., MNSI.
- Include national training resources within local training e.g., OASI Care Bundle, RoBUST.
- Be tailored to specific staff groups depending on their work location and role e.g., homebirth or birth centre teams/maternity support worker (MSW).

The CCF and MIS do not currently require submission of this training compliance, but the aim is still to achieve ≥90% attendance for staff development and safety.

The following graph outlines attendance data since April 2024.

Figure 10. Maternity Update Day attendance (Q4 Jan-Mar)



5. Level 3 Safeguarding Children

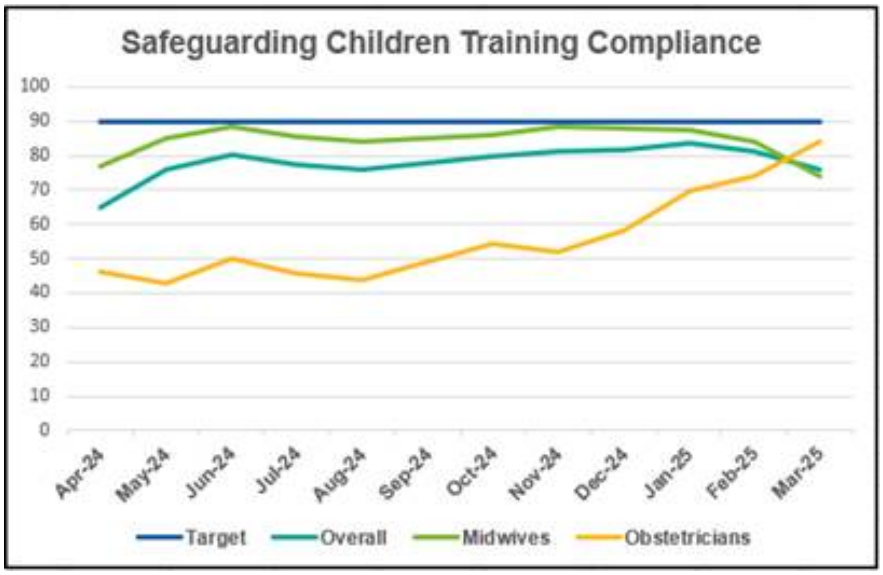
In line with the recommendations from the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: Intercollegiate document: All midwives, obstetricians and doctors in training who have posts in these level 3-affiliated specialties, are required to complete level 3 children's safeguarding training.

Initial training: Professionals will complete the equivalent of a minimum of 8 hours education, training and learning related to safeguarding/child protection. Those requiring role specific additional knowledge, skill and competencies should complete a minimum of 16 hours.

Refresher training: Over a three-year period, professionals should be able to demonstrate refresher education, training and learning equivalent to a minimum of eight hours for those requiring Level 3 core knowledge, skills and competencies a minimum of 12-16 hours for those requiring role specific additional knowledge, skills and competencies.

The level 3 training is currently delivered by the named nurse for safeguarding and is mandated for all staff across the Trust who are required to complete this level of training. Currently there is 1 training day (7.5 hours) running each month and there is a waiting list. There have been vacancies within the Trust safeguarding team which has been a challenge to support teaching on the safeguarding Level 3 study day. Recently eLearning for health online training has been introduced for experienced maternity staff who are non-compliant, this was due to the reduced compliance levels within maternity. The overall vision is for all staff to receive this training face to face. Another extra maternity session was supported in Q3 to target newly recruited midwives and rotating junior doctors and aided an overall increase in training compliance. During Q4 the Lead Safeguarding Midwife has looked further afield for training days taking place that meet the level 3 standards of knowledge, skills and competencies and ensured all the required staff are booked on, with the aim of achieving compliance by November 2025.

Figure 11. Safeguarding children training compliance (Q4 Jan-Mar)



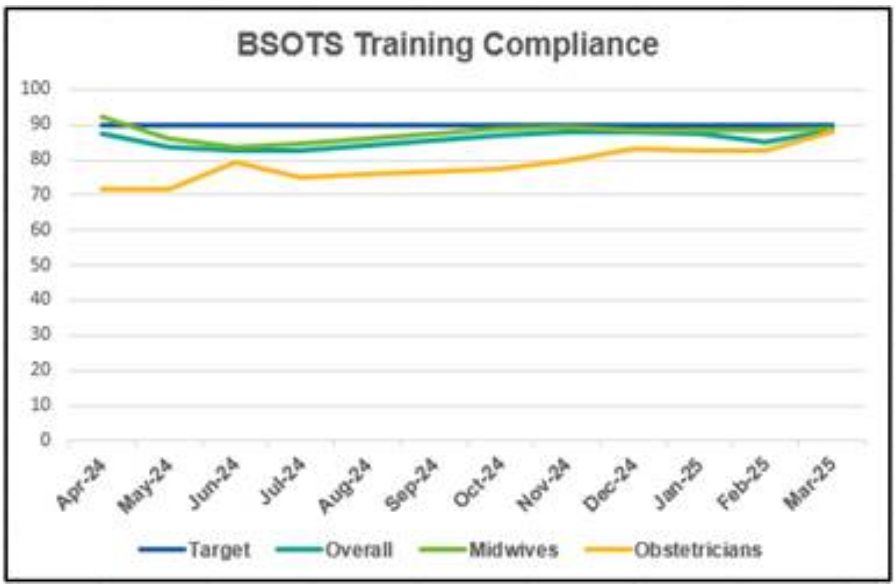
6. BSOTs Training

Birmingham Symptom Specific Obstetric Triage System (BSOTs) is a triaging system used within maternity day assessment unit and labour ward for all unplanned admissions. The aim of using BSOTs is to ensure that patients receive the level and quality of care appropriate to their clinical needs by prioritising the order in which they receive care following triage. This system was introduced in Salisbury in 2020 but requires ongoing training for all new and existing staff for it to be utilised successfully.

During 2024 BSOTs training was provided for all new midwives and obstetricians during their induction period by the DAU lead midwife or maternity education team, which saw an improvement in training compliance. Locally, the aim is to have refresher updates at least every 3 years to maintain competence and update on changes within BSOTs. It has been challenging to train all obstetric staff due to the frequent rotations of resident doctors but by providing BSOTs training during inductions, this has seen a steady increase in obstetric compliance in 2024.

In 2025, BSOTs training has been included within the Saving Babies' Lives study days for midwives and continue during induction for rotating resident obstetricians. The DAU lead midwife is also providing ad-hoc updates on DAU for staff to maintain compliance and clinical competency.

Figure 12. BSOTs training compliance (Q4 Jan-Mar)



7. Newborn and Infant Physical Examination (NIPE)

The Nursing and Midwifery Council's Standards of Proficiency for Midwives has included all newly qualified midwives to be able to perform full systemic physical examinations of the newborn (NIPE). This was introduced by the NMC in 2019, increasing the numbers of midwives who are now qualified at SFT to complete NIPEs. In addition, CPD funding is utilised to support midwives to gain this qualification as a post-graduation module, in collaboration with Bournemouth University.

Within the midwifery workforce, there are 50 midwives qualified to perform NIPE. To ensure their knowledge and skills are up to date, it is a requirement for them to complete the NHS NIPE Programme eLearning annually. The current compliance for this eLearning is at 92%, with 4 midwives expired. Their NIPE Smart accounts are suspended if they are expired until evidence of eLearning has been sent to the NIPE screening lead midwife. The NIPE lead has contacted all expired midwives and reiterated the importance of this eLearning in the NIPE forums. Due to the small numbers of those qualified, compliance should quickly increase following these contacts. SFT have 3 Midwives awaiting final sign off for their qualification from the university, all were submitted in December.

8. Adult Basic Life Support

Adult Basic Life Support (BLS) training is provided by the Trust's Resuscitation Department. All staff, including non-clinical, require BLS training but at different levels depending on their role.

Midwives are required to attend Level 3 Adult BLS, which is a 3.5-hour training session, every year. Nurses and MCAs are required to annually attend Level 2 Adult BLS, which is a 2.5-hour session.

It has been a challenge to collect the data on BLS compliance for staff groups as LEARN (Trust eLearning platform) does not appear to collect accurate staffing details within the Women and Newborn Division.

There are currently limited dates available for BLS for staff to book, with 3-5 options per month which midwives must attend around their clinical shifts/commitments.

The following table outlines RAG rated compliance with Adult Basic Life Support training.

Figure 13. Adult Basic Life Support training compliance (data collected from LEARN 30/04/2025)

Obstetricians	Midwives	Maternity Nurses	MCAs & MAs
66.6%	72.6%	100%	51.3%The n

All staff out of date for Adult BLS have been contacted and advised to book via the Trust's LEARN platform.

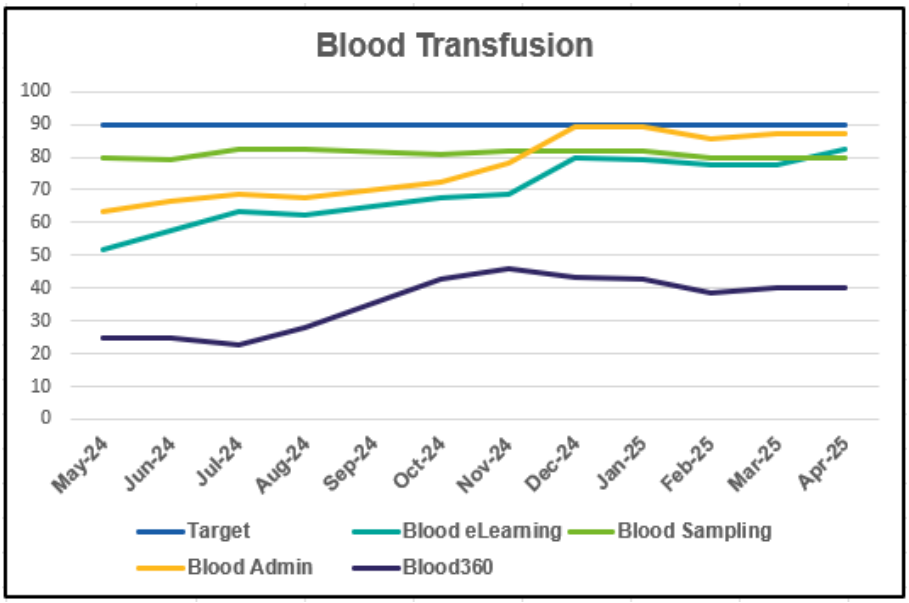
9. Blood Transfusion Training

The following graph outlines compliance with blood transfusion competency training for midwives. The Trust requires several elements in relation to blood transfusion for registered midwives, including 2 eLearning modules (essential transfusion practice and Anti-D), a blood sampling assessment, blood administration training (1.5 hours) and blood collection (Blood360).

For 2024, blood transfusion link nurses provided training on the SBL study day and includes time to complete the eLearning. This has shown an improvement in training compliance which has continued into 2025. In 2025, the Maternity Education Team will continue working with the blood transfusion link nurses to improve training compliance.

The midwives to be included in the Blood360 training compliance is currently under review as it has been recognised that many non-clinical midwives are extremely unlikely to be collecting blood and therefore training may not be required for this staff group.

Figure 14. Blood transfusion training compliance (Q4 Jan-Mar)



10. Simulation Training

During Q4, due to competing demands and supporting the clinical teams, the Maternity Education Team were unable to support any ad-hoc in-situ simulation training. However, simulation training continued in PROMPT including pool evacuation, maternal sepsis, and newborn life support. The plan for Q1 would be to run more ad-hoc clinical simulations for staff during shifts if it is safe and appropriate to do so. This would require more simulation-trained faculty to support, in which additional training is being arranged.

The plan is to continue providing ad-hoc simulations within the clinical area throughout the whole year, with technical and equipment support when required from the Trust Simulation Team.

Figure 15. Simulation training in Q4

	Scenario details	Attendance	Findings	Actions Taken
January	Nil sessions			
February	Nil sessions			
March	Nil sessions			

11. Education Dashboard

All maternity-specific training is collated and monitored via the Education Dashboard, held by the Maternity Education Team. This includes the CNST training requirements, CCFv2 training, SBL study days and any local requirements for training e.g. BSOTs training. Data is collected following all study days and updated on the dashboard. The dashboard is presented at Maternity Risk and Governance meetings every month and presented via the Perinatal Quality Surveillance report. All training data within this appendix has been pulled from the maternity education dashboard.

All Trust mandatory training data is held on the eLearning platform LEARN. Reports for maternity's training compliance for mandatory training is requested from our MLE team quarterly to monitor, however, the quality of this report can make analysing the data challenging as staff numbers appear inaccurate.

12. CNST Maternity Incentive Scheme (MIS)

Safety action 8 of the Maternity Incentive scheme compliance is dependent upon an agreed local training plan which demonstrates implementation of Version 2 of the Core Competency Framework. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB on 17/09/24.

The Maternity Education Team have developed an action plan which is outlined below. This plan will be reviewed and updated quarterly, and any concerns will be escalated to the Senior Management Team at Quality and Safety meetings.

13. Plans for next quarter

The objectives for the team in the next quarter are:

- Continue new 2025 programme for maternity update day and saving babies' lives study days and ensure all midwives, maternity support workers, obstetricians and anaesthetists are booked onto the relevant training sessions for the remainder of the year.
- Follow Maternity Training and Development pathway for those who were unable to attend training during Q1-Q4 due to sickness – rebook as soon as possible in Q1.
- Liaise with anaesthetic and obstetric rota co-ordinators to ensure for 2025 there is evenly spread attendance at maternity-specific training to receive effective learning and MDT quoracy where required.
- Escalate concerns regarding training compliance, sickness and reasons for non-attendance to Staff group leads and, Risk and Governance meetings.

14. Appendix A

The following action plan includes actions taken to maintain or improve training compliance and any other actions in relation to training and education.

Figure 16. Action plan

Actions to maintain or improve training compliance				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Ensure all obstetricians are booked to attend all required study days before MIS deadline in December.	Helen Showan Helen O'Shea Yazmin Faiza	June 2025	Complete	Helen O'Shea mapped all consultants and registrars for remainder of 2025.
Contact all bank-only staff to ensure attendance at all required study days for 2025	Helen Showan Justine Wren	June 2025	Bank-only midwives contacted in December 2024 by Scarlett to book 2025 training.	To send update to any outstanding/new bank staff in June.
Offer more PROMPT dates before MIS deadline of 30th November 2025	Helen Showan	October 2025	1 additional PROMPT date created in October. Many slots left for November session.	Date created and available for staff to book on if required. November PROMPT purposely under-booked to allow for rebooking staff who DNA earlier sessions.
Improve annual update compliance for NIPE qualified practitioners.	Donna Crayden	March 2025	Individual emails sent to those out of date. NIPE Smart accounts suspended until eLearning completed.	Increase from 88% to 92% since previous quarter
Introduce face-to-face SBL training (Elements 1 and 2)	Leah Millard	September 2025	Planning and approval required	Requires approval. Planning around teaching and rosters required.

Book preceptee midwives onto SBL study day	Helen Showan	April 2025	Complete	All booked onto May 2025
Improve Level 3 Safeguarding Compliance for Midwives	Laura Ware	June 2025	All out-of-date staff contacted 21/2/25 to book onto available sessions	To obtain update on whether the out-of-date midwives are now booked on.

Actions from simulation training				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Increase simulation faculty within maternity to allow more in-situ simulations to be run.	Helen Showan SFT Simulation Team	October 2025	Next available course October 2025	Changes to the Maternity Education Team expected 2025, to ensure ongoing development to run clinical simulations.

Further Actions				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Create new PROMPT programme to run Sept 2025-Sept 2026	Maternity Education Team Yazmin Faiza Q&S Midwife Julia Bowditch/ Juliet Barker	August 2025	Plan for PPH scenario in development with anaesthetists	Faculty planning meeting to be organised

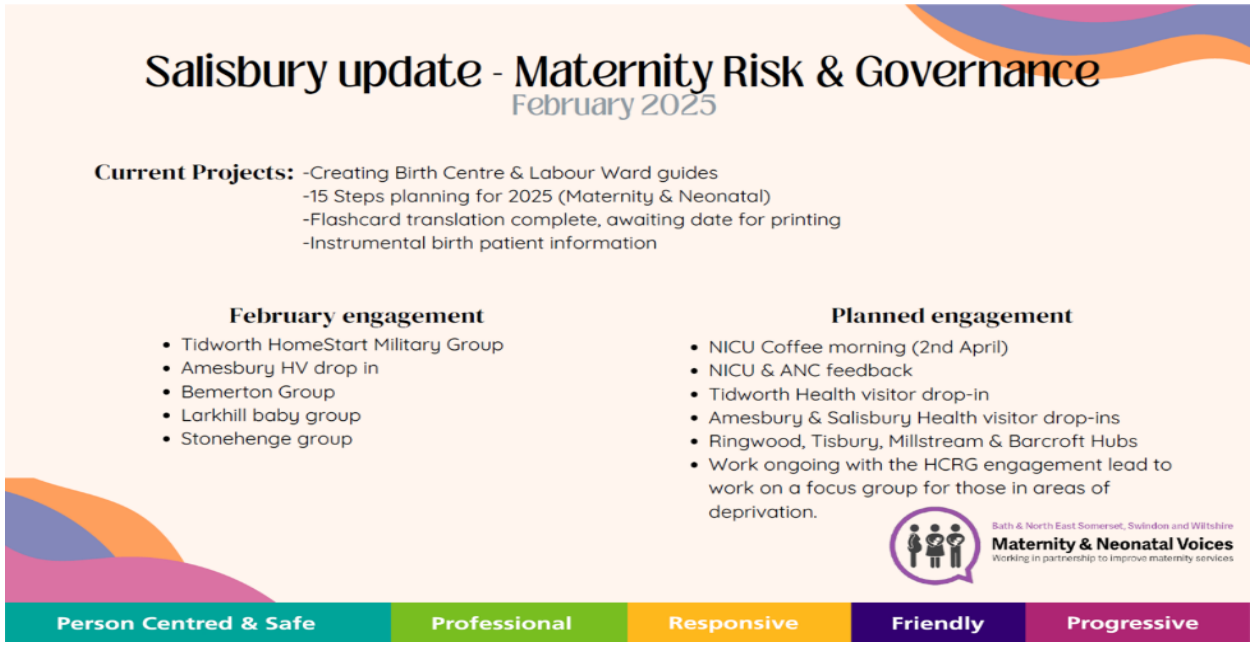
Patient and Staff Experience Report
Maternity and Neonatal Services
(Quarter 4 2024-25)

1.	Purpose of the Report
	The purpose of this report is to provide a quarterly overview of patient and staff experience within the Maternity and Neonatal Service. Any trends and themes are identified and shared, not only with those directly involved, but the whole team to ensure there is learning and continual improvement of the service. The report also outlines work and co-production with the MNVP. Escalation of feedback is shared monthly at the Safety Champions meeting, Maternity Risk and Governance meeting, and via the Perinatal Quality Surveillance slides. Themes from patient are discussed quarterly at the Triangulation meeting. Staff feedback is captured by the annual staff survey and work undertaken by the Perinatal Quadrumvirate, which is shared at the Safety Champions meetings and via the Perinatal Quality Surveillance slides.
2.	**Executive Summary**
	• The response rate to the Friends and Family Test (FFT) in Q4 has seen a small decrease of 1.24%. Due to the implementation of BadgerNet, there was a pause placed on FFT during this transition. Analysis of the data is discussed at the Maternity Governance and quarterly Triangulation meetings. • There has been an increase in complaints this quarter, with the top theme being 'unsatisfactory treatment'. • The Triangulation meeting is embedded into the Governance structure. In-depth conversations have facilitated some discussion around supporting families who access the Neonatal Unit. • The Neonatal Parent Survey (June -Dec 24) results are included within section 7 of this report. The results were reassuring; with a 9.5/10 positive (satisfaction) rating score. The development of the action plan will be reported in the next Quality and Safety report. • Work is ongoing to create a Health Inequalities clinical dashboard, with the focus on birth outcomes related to ethnicity and social deprivation to aid an understanding of local health inequalities. The work on the data warehouse is scheduled for September 2025. • A listening event was held in February with families who have been patriated to Britain under the Afghanistan Relocation and Assistant Policy (ARAP). The feedback from this event will be shared at the next Triangulation meeting, scheduled in April 2025. • The referral process to the Birth Reflection Service was reviewed in this quarter. The expansion of the referral criteria to include self-referrals has been agreed. Work continues to ensure service users can access the service directly via our maternity website.

	Key priorities for patient experience and inclusion, next quarter includes: • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with the poorer maternity outcomes. • To support the implementation and monitoring of the 'Pocketalk' translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities. • Development of a local Health Inequalities dashboard. • Continued monitoring of the 2024 National Patient Experience Maternity Survey action plan. • Progress the actions detailed in the Three-Year Delivery Plan. • Drive the changes to the website to enable service users to self-refer to the Birth Reflection Service. • To facilitate and support the 15-step assessment – coordinated and undertaken by the MNVP and service users' representation. • Ensure the coordination of service users feedback to identify service improvements opportunities, through the quarterly Triangulation meetings.
3.	**Patient Story**
	No patient story presented this quarter. A patient has come forward who is wishing to share their story through a short film in Q3 and for use in local training. Due to the current demands placed upon the Communications team, they are unable to support the patient stories at the present time. The Maternity department is working with PALS to look at alternative means of capturing this valuable insight into service users experience of their pregnancy journey at SFT.
4.	**Patient Surveys – National and Local (including CQC national maternity survey)**
	The National Maternity Survey is a requirement by the CQC for all NHS Trusts providing maternity services. Women receiving maternity services in January and February 2024 were selected for the survey. • The top five scores compared nationally were around the areas of partners being able to stay, induction of labour information and mental health support. • The bottom five scores were around care at home after birth and support with feeding. The full survey results and preogress can be viewed in the embedded documents below:

	 RNZ_Salisbury NHS Foundation Trust.pdf !  Action progress Tracker.docx
5.	**Maternity and Neonatal Voices Partnership (MNVP), Staff and Patient Experience - Triangulation**
	The Triangulation meeting aims to triangulate insights and feedback from the following: staff via DATIX risks, legal claims, local and national patient feedback surveys, the Birth Reflections Service and through the intelligence obtained by the Maternity and Neonatal Voice Partnership (MNVP). These themes inform and drive the priorities of service development and quality improvement. Themes from the last Triangulation meeting included information provided to parents of babies who are cared for on the Neonatal Unit, and to increase awareness of the Ficare role amongst the workforce and families. It was agreed that the MNVP will support this work by canvassing service users thoughts on the information provided to them following the birth, with the focus being on if they would like to receive instruction on newborn resuscitation.

Figure 1. Update provided from the MNVP regarding planned and completed engagement events (from the February Maternity Risk and Governance meeting)



6. Friends and Family Test (FFT)

Friends and Family Test: January – March 2025 (Q4)

Maternity services were chosen to be part of the initial role out of the digital SMS messaging service across the Trust, with the touch points including:

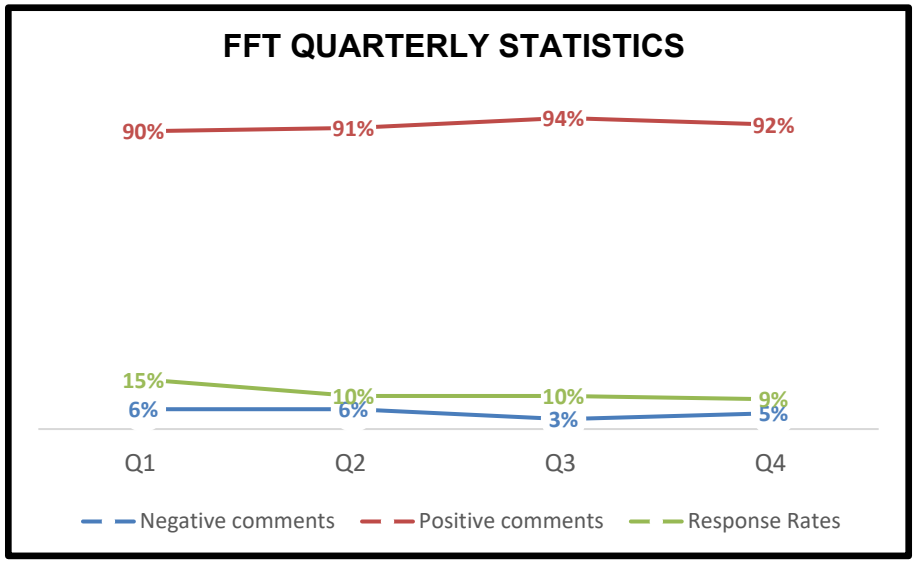
- Maternity Antenatal (at 20 weeks)
- Maternity Birth (at 7 days)

- Maternity Postnatal (at 14 days)
- Maternity Community (at 28 days)

FFT Q4 2024/25 Data:

In quarter 4, it was identified that 2,474 women were eligible to receive the FFT survey request, with a total of 226 responses, offering an 8.86% compliance rate, which demonstrates a 1.24% decrease from Q3. It is important to note that, due to the implementation of BadgerNet (electronic maternity records), since the end of February there has been a pause placed upon FFT whilst work is completed on the new data warehouse. However, a review will be undertaken of the logic when recreating Maternity FFT (collating patient cohorts for messaging) in the new data warehouse, hopefully extending the criteria to allow more service users to receive FFT surveys.

Figure 2. FFT positive and negative response rates over the last 4 quarters



FFT Priorities for the next quarter (Q1 25/26):

- The FFT data will be presented at the next Triangulation meeting and used to inform any learning opportunities or service improvements.
- A review will be undertaken of the logic when recreating Maternity FFT (collating patient cohorts for messaging) in the new data warehouse, hopefully extending the criteria to allow more service users to receive FFT surveys.

7. Feedback from Neonatal and Bereaved Families

Neonatal feedback:
The analysis of the Neonatal Parent Survey was undertaken in Q3 and reported in Q4. There were 85 responses to the survey. Overwhelmingly, the response was positive, with parents rating the service provided as 9.5/10.

What local families want and say
Full survey results are embedded below:

NNU Parent feedback survey results and act

Actions:

- Following the appointment of the new Diabetes Midwife role, it is hoped that signposting to the NNU Padlet and unit tours will be shared more readily with women who are at increased risk of requiring NNU services
- With the new appointment of the Educational Lead in NNU, the role will include increasing awareness of the Ficare role with the workforce and families.
- Weekly ward round to be attended by Paediatric Consultants will be facilitated on the NNU.
- Introduction of an AI translation device, Pocketalk, to enhance translation services already provided by the Trust.

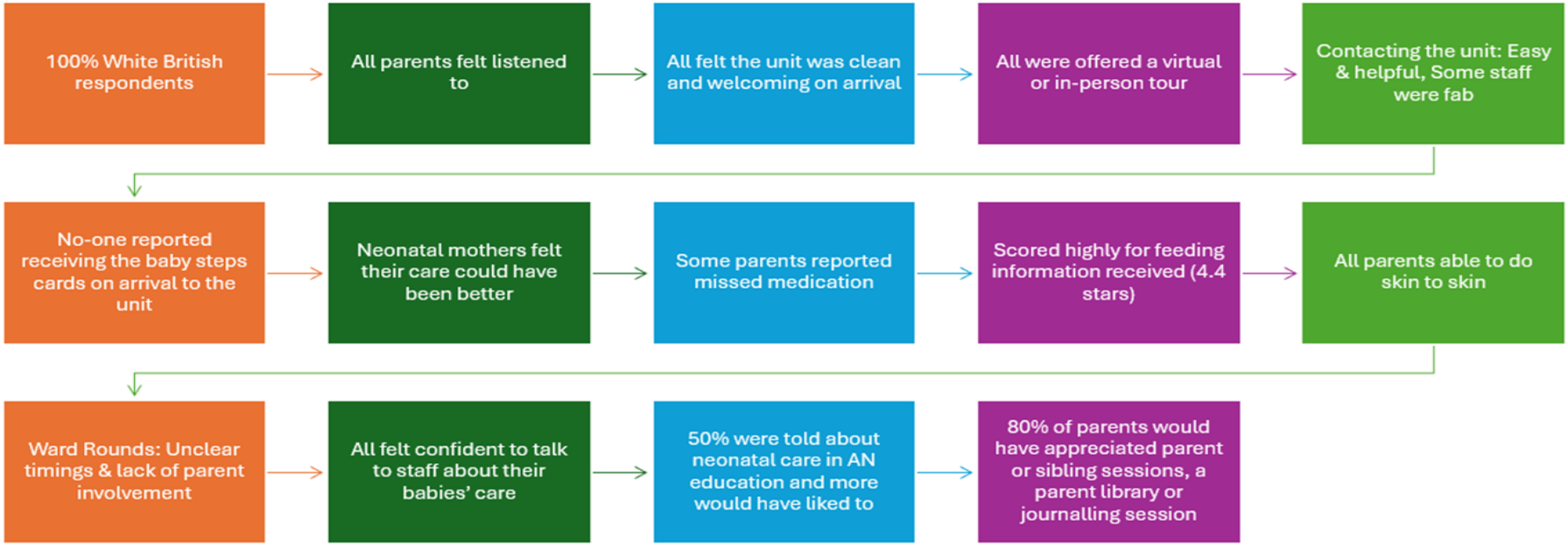
Thames Valley & Wessex Neonatal network ODN Survey Q4 2024
The delivery of neonatal care for premature and sick babies is organised into geographical areas where hospitals work together, called neonatal operational delivery networks. Operational delivery networks, or ODNs, are formal structures in which hospital Trusts, commissioners and patients work together to optimise healthcare and ensure the best possible outcomes. The Thames Valley and Wessex

(TVW) neonatal ODN covers an area where there are approximately 60,000 births each year. Across TVW there are 13 acute trusts and 14 hospitals delivering neonatal care.

The ODN focuses on coordinating patient pathways between hospitals over a wide area to ensure access to specialist resources and expertise.

The findings below are due to be presented at the next Triangulation meeting in Q1 (April 25).

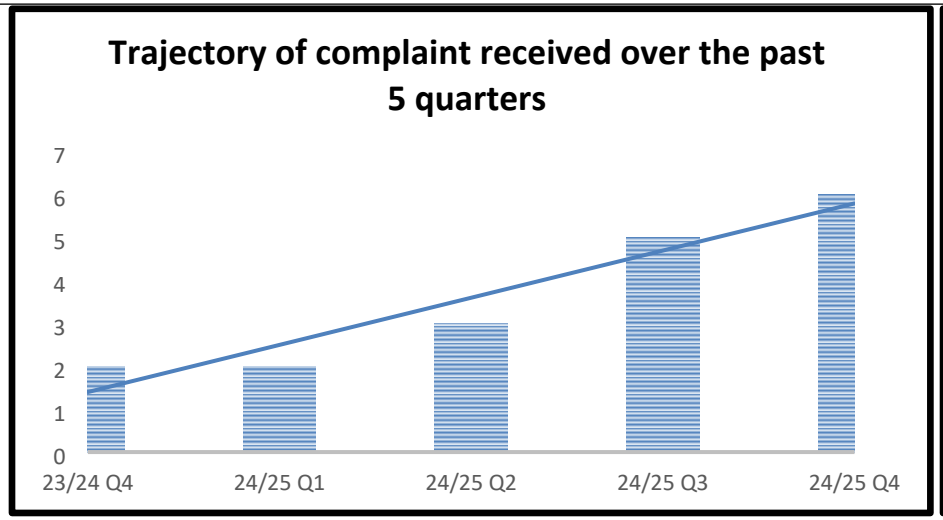
Figure 3. Results of SFT parents' feedback through the ODN survey



Feedback from Bereaved Families

	Women (birthing person) who have experienced the unexpected loss of a baby from 22 weeks gestation, are asked as part of the Perinatal Mortality Review Tool (PMRT) to share their feedback with either the Bereavement Lead or the Family Experience Midwife. The aim of the PMRT is to support the standardised perinatal mortality reviews across NHS maternity and neonatal services in England, Scotland, and Wales. The tool supports the multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding the deaths of babies who die in the postnatal period. Active communication with parents is encouraged, therefore, parents are asked prior to the PMRT meeting if they have any questions they would like addressed by the panel. The outcome of the multidisciplinary review, together with the family's questions, are shared with the family during the (post PMRT meeting) follow up with their named consultant obstetrician. If there are concerns raised by the family which cannot be addressed by the panel, these are then taken forward an investigated through the complaint procedure. No complaints were raised regarding the care bereaved families received in Q4. Several compliments were reported with the focus on 'support', with one family rating the support received as 10/10.
8.	**Feedback from Black, Asian and Minority Ethnic Backgrounds and Families Living in Areas with High Levels of Deprivation**
	An Inclusion Midwife has been successfully recruited to support the development of this workstream and started in post at the beginning of Q2. A deliverable objective of the 3 Year Delivery Plan is that Trusts collect and disaggregate local data and feedback by population groups, to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified. In the previous quarter, analysis of birth outcome data in relation to the ethnicity and social deprivation for the local population commenced. This continues as a priority across the LMNS. **Continued priorities for Q4:** • Collaborative working with the Communications Team and IT to ensure our Trust website has a translation function. There has been a delay in the implementation of this due to the Project Lead's repatriation back to the Transformation Team, following the end of a secondment to the Division. The delay has been escalated to the safety champions, as sadly work has not progressed during this quarter. The IT Department is leading on the implementation of a translation tool bar, and it is hoped that progress will be made in Q1 2025/26.

	• To develop strong links with Wessex Health Innovation to continue the ongoing work to secure funding for a new 'at the point of contact' translation device. Together with Health innovation Wessex, discussions are being had with the provider to map out the implementation and evaluation of the device in practice. The project is due to be presented at the next Digital Steering Group. • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with poorer maternity outcomes. • Development of a Health Inequalities dashboard.
9.	**Compliments and SOX**
	Thank you cards are collected from both inpatient and outpatient areas throughout the year and are now added to DATIX by the PALS team. Themes of compliments, together with examples of service user's gratitude, are shared with the workforce on a quarterly basis. If a compliment is sent via the PALS department, this is then shared with the individual staff member and a SOX nomination completed. In Q4 2024/25, Maternity and Neonatal Services received 22 compliments. The top theme reported in this quarter was 'gratitude'. Acknowledging excellence and celebrating successes within the workforce is prioritised within the Maternity and NNU services. These compliments and SOX are shared with the workforce quarterly.
10.	**Complaints/PALS Contacts**
	Q4 Maternity and Neonatal complaints and concerns data 6 complaints were received and 1 concern was received, with the top theme being 'unsatisfactory treatment'. There has been a significant increase in complaints logged this quarter, but concerns remain consistent with the previous quarter. Figure 5 shows the trends over the last 5 quarters. **Figure 4.** Number of complaints and concerns received over the past 5 quarters



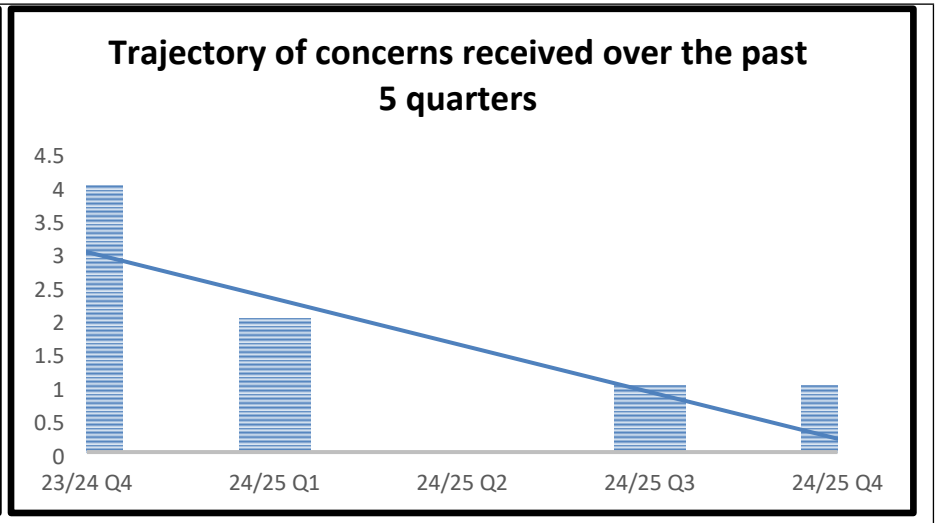
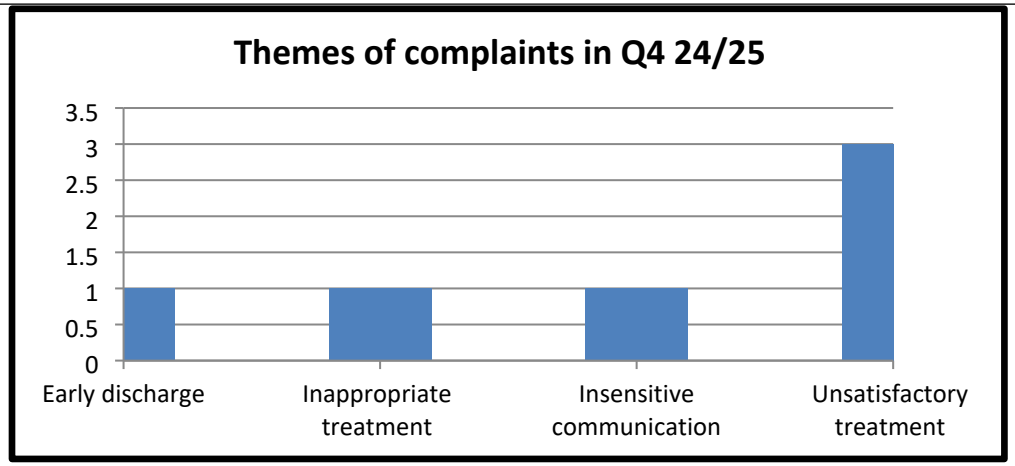
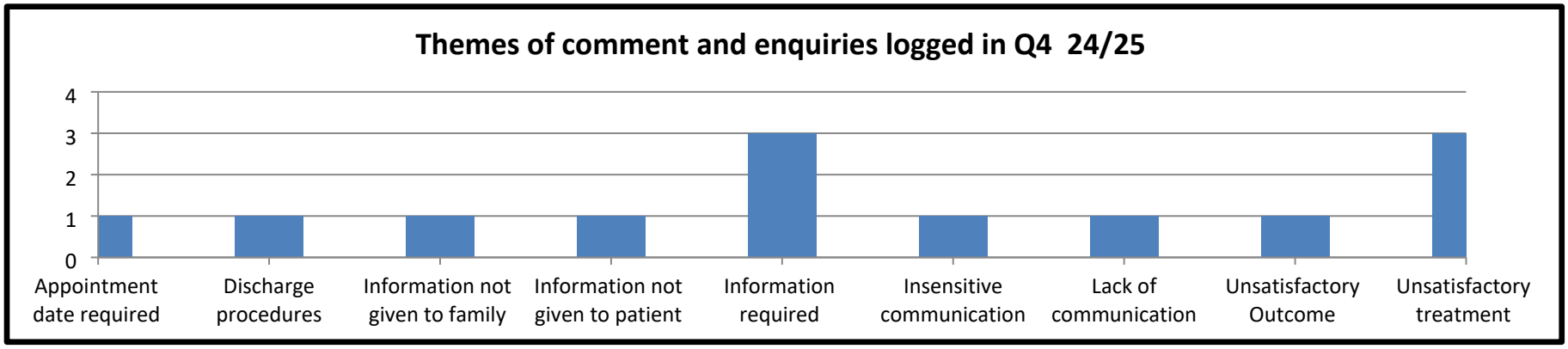


Figure 5. Themes of concerns/complaints



Only one concern was reported in Q4, which was themed as 'attitude of nursing staff'.

Figure 6. Themes of comments and enquiries



Top themes include 'unsatisfactory treatment' and 'information required'.

Learning and action points taken from closed complaints in Q4:

	• MDT approach to the maternity patient's ongoing care. • Referral to the Positive Birth service, to enable the service user to discuss birth preference should she consider a future pregnancy. • Feedback and additional clarity sought from a member of staff in regard to advice offered to the service user about reduced fetal movements. In Q4, there were 3 complaints closed, none closed within target time, offering a 0% compliance rate. Although there was close liaison maintained with complainants regarding any delay, this was often due to aligning diary capacity of both parties. 1 concern was closed in Q4 within the agreed target time, offering a 100% compliance rate. **Birth Reflections Service** The Birth Reflections Service aims to provide women and their families with an opportunity to discuss and reflect on their birth experience with a view to nurturing psychological wellbeing in preparation for parenting, and future pregnancies. Birth Reflections sessions can also provide valuable feedback for the maternity service, facilitating change and improvements in the care that is provided. The Birth Reflection Service offers a confidential, one to one midwifery-led listening service for women who have given birth in Salisbury Foundation Trust. It has been agreed that SFT will expand the referral criteria to include self-referrals. A priority in Q3 was to continue the work to enable women to self-refer to the service via the maternity website. Steady progress has been made during Q4, the SOP and patient information leaflet have been approved through our governance process. With support from the IT Department, work is now ongoing to ensure that women (birthing people) can access the service via the website.
11.	**Matron/ Ward Manager Audits**
	During the previous quarter (Q3), antenatal services undertook a service review in response to feedback from service users regarding waiting times in Antenatal Clinic (ANC) and the Day Assessment Unit (DAU) for obstetric review. As part of the Improving Together Strategy, an audit was completed to understand waiting times in ANC and the number of women requiring obstetric reviews, following scans on the afternoon that the ANC is not in operation. The audits demonstrated that the waiting times in Antenatal Clinic were not as long as anticipated, however, the waiting times in the DAU for obstetric review following an ultrasound scan were at times two to three hours and therefore of concern. The latter has now become the focus of one of the speciality drivers for Improving Together. Following on from the work completed in Q3, further stratified data is to be captured around obstetrician's opinions on the reason for delays. This evidence will help inform and support a collaborative approach in improving the wait times.

12.	**Internal/ External Visits (relating to patient or staff experience)**
	In Q4, the planned listening event was undertaken in the Larkhill clinic dedicated to service users from Afghanistan. The results are as seen below: Listerning event.docx It is intended that a bespoke PIL will be developed to support families who have been homed in the UK under the ARAP entitled people programme. No Listening Events are scheduled in Q1 25/26, as the focus is on undertaking a 15 Steps Assessment (facilitated by the MNVP) in June 2025.
13.	**Staff Survey Results**
	The National Annual Staff Survey was not published in Q4.
14.	**Staff Experience/ Wellbeing**
	Restorative Clinical Supervision (RCS): Four preceptees received at least 1 RCS session. During Q4, a total of 10 RCS sessions were carried out (incorporating wellbeing and Career conversations). This is a decrease on the 19 sessions held in Q3. RCS support: the PMA team aim for all NQMW continue to receive RCS as part of a retention initiative. The current cohort consists of 8 preceptees, who started in September and a further 2 in November. As per the Preceptee plan, they receive quarterly teaching to help support them to thrive during their transition from student to qualified Midwife and they each offered quarterly 1:1 restorative supervision from a PMA. This is a team priority for the PMA team operating on a sessional model.
15.	**Key Activities in place for both Staff and Patient Experience**
	The focus this year is on Health Inequalities. The family Experience and Inclusion Midwife is undertaking sessions on health inequalities and cultural competence during the annual maternity study days.

	Conversation was had around promoting the FiCare role amongst the workforce and looking at ways to promote the NNU Padlet to increase signposting to this information with service users. The MNVP will undertake some targeted engagements work with service users on the Beatrice Maternity Ward (BMW). In order to better understand whether families feel they have enough information about escalation of a deteriorating baby.
16.	**Sharing of Best Practice**
	Patient and staff experiences are shared as follows: • Friends and Family Test (FFT) feedback is shared via email and posters in ward areas. • SOX can be seen in inpatient and ward areas. • MNVP feedback is shared via email, in team meetings, and through Maternity Governance and Safety Champion meetings. • Compliments • Learning from incidents • New guidelines • Maternity and Neonatal Services Newsletter Access to translation services Memo.pdf Example of a memo shared with the workforce, following an audit undertaken to establish whether non-English-speaking service users were offered translation services. The full report can be seen in section 8.
17.	**Update on Actions Outlined in the Previous Report**
	The 3 main priorities were previously identified in the last Quality and Safety report: 1. **To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device.**

	Update: Working party has been established to support the implementation of the new 'Pocketalk' AI translation device. Following the implementation of the device, a comprehensive and robust evaluation will be undertaken. **2. Review themes from the feedback obtained via FFT.** Update: Quarterly review of the feedback from FFT is correlated and themes discussed at the Triangulation meeting. Once work has been completed on the data warehouse, work will be ongoing to promote FFT amongst service users. **3. Working with the LMNS Inclusion Lead to align the service with the National agenda related to reducing health inequalities.** Update: Work is ongoing to agree clinical outcomes to be monitored across the LMNS, via a collective dashboard. **New Priority for Q1 25/26**: **4. Self-referral to the Birth Reflections Service** Work is ongoing to enable service users to self-refer to the Birth Reflections Service, via the maternity website. It is anticipated that this will be available by the end of Q1.
18.	**Next Steps/ Looking Forward**
	Key priorities for Patient Experience and Inclusion in the next quarter includes: • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with poorer maternity outcomes. • To support the implementation and monitoring of the 'Pocketalk' translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities. • Development of a local Health Inequalities Dashboard. • Continued monitoring of the 2024 National Patient Experience Maternity Survey action plan. • Progress the actions detailed in the Three-Year Delivery Plan. • Drive the changes to the website to enable service users to self-refer to the Birth Reflections Service. • To facilitate and support the 15 Steps Assessment – coordinated and undertaken by the MNVP and service users' representation. • Ensure the coordination of service users feedback to identify service improvement opportunities, through the quarterly Triangulation meetings.

Saving Babies Lives Quarterly Report
Maternity and Neonatal Services
(Quarter 4 2024-25)

1. Background

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three. SBLCBv3, in line with MIS Year 6, maintains an approach of continuous improvement and comprehensive evaluation of organisational processes and pathways as part of developing an understanding of where improvements can be made.

A national implementation tool was launched in 2023 to help maternity services to track and evidence improvement and, compliance as set out in Version Three. This has been continued for use with MIS Year 6 requirements. The national implementation tool contains a 'Board Report & Progress' and 'LMNS review' sections for monitoring progress on actions. This is part of the quarterly assessment of evidence collated by providers which is reviewed by the LMNS and validated accordingly. This is shared with the Trust Board quarterly via this report as part of MIS Year 6 requirements and with the ICB.

2. Introduction

This report provides a quarterly update on the implementation, monitoring and training of all six elements of the Saving Babies Lives care bundle v3. Maternity services are working towards a consistent high level of compliance to improve care for women and their families, which in turn will assist in reducing the still birth and neonatal death rates.

Saving Babies Lives audits for quarters 1-3 2024/25 have been completed to provide assurance to the Trust and LMNS that all six elements have been implemented. Due to the process of submission to LMNS and dates associated with this, **Q4 data** is currently being collected to submit the LMNS on 13th May and **will be reported in the next report (Q1 2025/26).**

Each organisation is expected to look at their performance against the outcome measures for each element using the new national implementation tool, with a view to understand where improvement may be required. Previously, the Year 5 MIS requirements required providers to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The current MIS Year 6 requirements mandate that providers should fully implement Saving Babies Lives Version 3 by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours and sufficient progress have been made towards full implementation, in line with the locally agreed improvement trajectory.

3. Progress and LMNS Review Record

Figure 1. Percentage of interventions fully implemented following each LMNS validation.

% of Interventions Fully Implemented (LMNS Validated)	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Review Quarter	**Initial**					
Assurance Review Date	**25.10.2023**	**23.12.2023**	**24 06 2024**	**13.09.2024**	**02.12.2024**	**04.03.2025**
Element 1	10%	29%	20%	40%	60%	80%
Element 2	5%	50%	50%	70%	70%	80%
Element 3	0%	100%	50%	50%	100%	100%
Element 4	0%	0%	20%	40%	60%	40%
Element 5	11%	37%	48%	52%	63%	78%
Element 6	7%	33%	17%	17%	67%	33%
TOTAL	7%	37%	40%	51%	66%	73%

4. Implementation Progress

SFT has made steady progress and has several actions in place to move towards full implementation. The LMNS validated implementation progress has *decreased for element 4 and 6* of SBLv3 although overall there has been an *increase in the % of interventions fully implemented* (see below). Progress was hampered by audit and guideline challenges which have action plans to continue to make progress.

Figure 2. Implementation progress for Q3 2024-2025 with self-assessment of 79% and LMNS validated of 73%.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	**Partially implemented**	80%	**Partially implemented**	80%	CNST Met
Element 2	Fetal growth restriction	**Partially implemented**	90%	**Partially implemented**	80%	CNST Met
Element 3	Reduced fetal movements	**Fully implemented**	100%	**Fully implemented**	100%	CNST Met
Element 4	Fetal monitoring in labour	**Partially implemented**	40%	**Partially implemented**	40%	CNST Not Met
Element 5	Preterm birth	**Partially implemented**	81%	**Partially implemented**	78%	CNST Met
Element 6	Diabetes	**Partially implemented**	50%	**Partially implemented**	33%	CNST Not Met
All Elements	TOTAL	**Partially implemented**	79%	**Partially implemented**	73%	CNST Met

The graphs below show the breakdown for each element of interventions partially or not yet implemented which have been validated by the LMNS and those which have been fully implemented as validated by the LMNS. This shows that the LMNS agree, for the most part, with SFT's self-assessments.

Figure 3. Self-assessment vs LMNS assessment Q3 2024-25

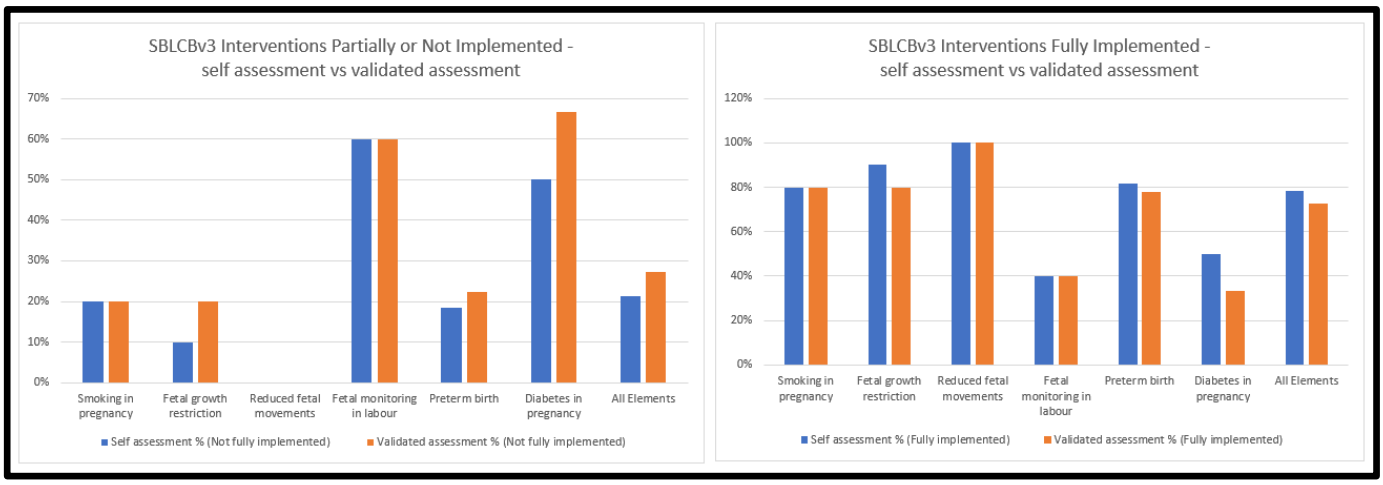
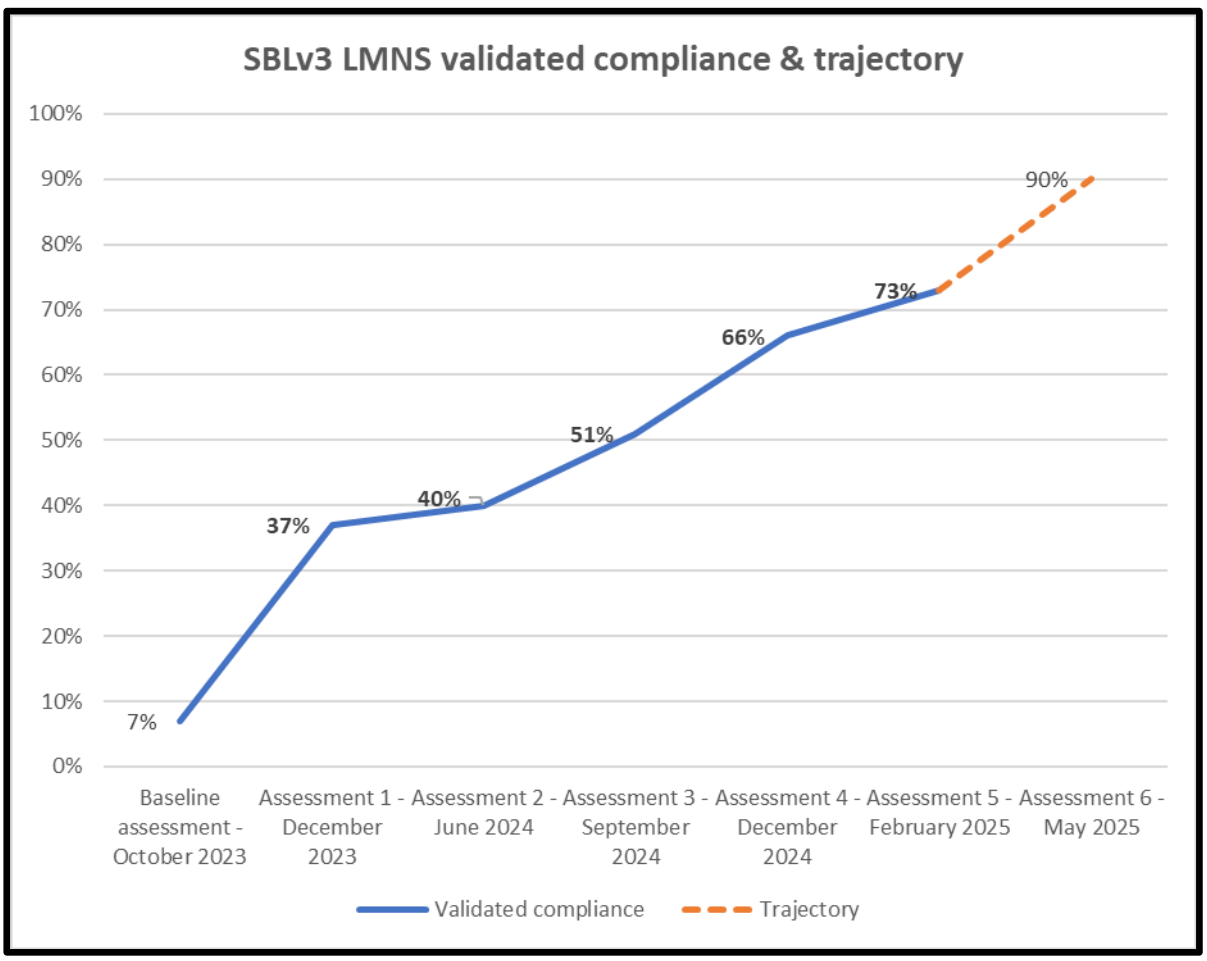


Figure 4. LMNS validated compliance and SFT trajectory Oct 23 – June 25



5. Saving Babies Lives v3 Care Bundle Elements

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundles elements:

- **Element 1: Reducing Smoking in Pregnancy**
- **Element 2: Fetal Growth: Risk assessment, surveillance, and management**
- **Element 3: Raising awareness for reduced fetal movements**
- **Element 4: Effective fetal monitoring during labour**
- **Element 5: Reducing pre-term birth and optimising perinatal care**
- **Element 6**: **Management of Pre-existing Diabetes in Pregnancy**

Element 1: Reducing Smoking in pregnancy

Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser is offered to all pregnant women who smoke, using an opt-out referral process.

Compliance%	Actions taken and progress made during last quarter
80%	• Acknowledgment of current non-compliance with training actions regarding carbon monoxide (CO) screening and 'very brief advice' (VBA) for Obstetricians, Midwives and Maternity Care Assistants (MCAs). SMART action plan created with a clear goal to achieve compliance with targeted study days. **Ongoing.** **Update:** • Plan to provide training for new Band 4 PIMS/HiP practitioners and for there to be a rolling audit plan for the collation of data. **Ongoing.**

Element 2: Risk assessment and surveillance for fetal growth restriction

Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Quarter audit %	Actions taken and progress made
80%	• Meeting with Trust Medical Devices Team to identify possible alternative BP machines, which are still compliant. Conclusion of this meeting highlighted that procurement is a national issue. Discussed with Head of Midwifery who will feed this back in a regional forum for escalation to the national SBL team. **Complete.** **Update:** • Outpatient Matron has liaised with other BSW Trusts who are sending details of the BP machines that they use. **Complete.** • Outpatient Matron acquiring quotes for BP machines. **Complete.** • Outpatient Matron has now purchased BP machines which are now at SFT and currently waiting to be allocated asset numbers. **Ongoing.**

Element 3: raising awareness for reduced fetal movements

Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Quarter audit %	Actions taken and progress made
100%	• No further actions in this quarter.

Element 4: Effective fetal monitoring during labour

Quarter audit %	Actions taken and progress made
40%	**Update:** • Fetal Surveillance Midwife leaving role. Awaiting role to be filled and for handover of SBL asks. **Ongoing**

Element 5: Reducing preterm birth and optimising perinatal care

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.

Quarter audit %	Actions taken and progress made
78%	• Discussion with Neonatal Matron around new ventilators. Procurement ongoing and as soon as they are acquired, a new SOP will be created and implemented. **Ongoing.** **Update:** • SOP is in progress. **Ongoing.**

Element 6: Management of Pre-existing Diabetes in Pregnancy

Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. The recent Ockenden report has highlighted the need for continuity of experienced staff within Diabetes in Pregnancy teams to reduce poor outcomes in women with diabetes. Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g. continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Quarter audit %	Actions taken and progress made
33%	• In discussion with Antenatal Clinic Lead Midwife. Plan: make minor amendments to guideline as current guidance advises incorrectly that women with Type 1 diabetes are currently not being offered continuous glucose monitoring. **Complete.** • Feedback received from LMNS advising that main Trust-wide guideline does not include any guidance or policy on management diabetic ketoacidosis (DKA) specifically in pregnancy. ANC Lead Midwife to liaise with authors of this guideline to collaboratively write a passage/appendix for management of DKA in pregnancy. **Complete.** **Update:** Diabetes Midwife appointed and awaiting start date **Ongoing.**

Midwifery, Maternity and Neonatal Staffing Report
Maternity and Neonatal Services
(Quarter 4 2024-25)

1. Background

It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2. Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the current maternity incentive scheme year 7.

3. Birthrate Plus Workforce Planning

A formal Birth Rate Plus assessment was completed in 2024, which reviewed the acuity of women who used maternity services at Salisbury NHS Foundation Trust. This review recommended a birth to midwife ratio of 1:24 across the Trust.

NICE (2017) recommend that an assessment is carried out every three years. The 2024 formal Birth rate Plus assessment indicated that an increase of 3.27 WTE was required to the establishment and the midwifery staffing budget has been augmented to reflect this and agreed by the Trust board.

4. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas by month.

Figure 1. Percentage fill rates for inpatient areas by month

Month	Day qualified %	Night qualified %
January 2025	98.3	97.5
February 2025	97.1	94.6
March 2025	91.4	96.7

Fill rates have reduced over this quarter due to high levels of both short and long term sickness absence. SFT do however continue to have 5.94 WTE on maternity leave and some long-term sickness. Staffing is monitored daily, and staff redeployed based on the acuity.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Elective workload prioritised to maximise available staffing.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Support of Maternity and Neonatal Duty Manager Day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the maternity services.
- Liaise closely with maternity services at opposite sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

5. Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:24. Following review of individualised data, this considers anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This has now been added to the maternity dashboard, so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

Figure 2. Birth to Midwife ratio

Month	January	February	March
Birth to midwife ratio	1:25	1:23	1:27

6. Specialist Midwives

Birth Rate Plus recommends a percentage of the total establishment is not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centred. These roles include management positions and specialist midwives. These roles include Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Birth Environment Lead, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons amongst others.

Following the birthrate plus review in February 2024, the current percentage for Salisbury is calculated to be 13%.

7. Birth Rate Plus Live Acuity Tool

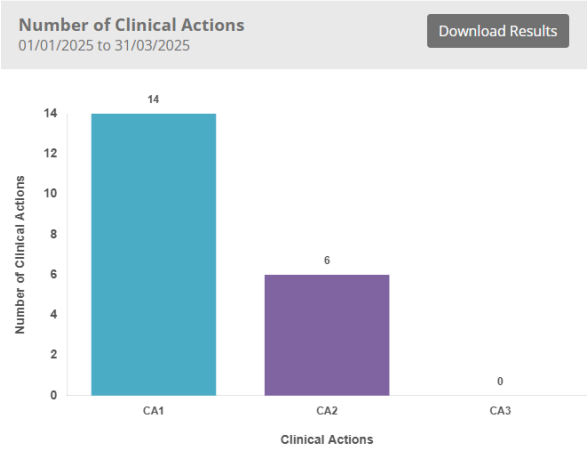
The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas on 1st December 2014 and has since gone live in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four-hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories, and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

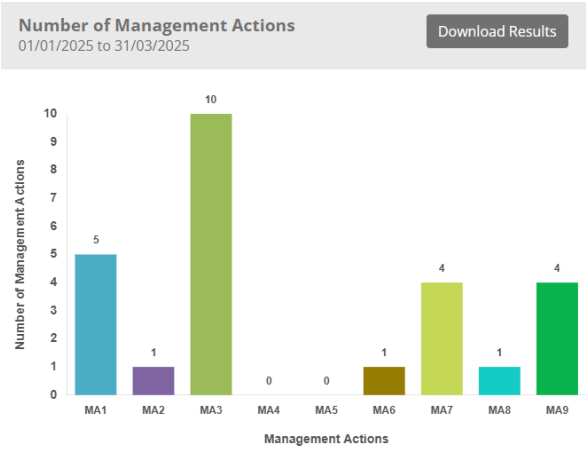
Figure 3. Number and percentage of clinical actions taken



Number of Clinical Actions 01/01/2025 to 31/03/2025			Download Results
Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay commencing IOL	14	70%
CA2	Delay on-going IOL	6	30%
CA3	Delay/cancel Elective LSCS	0	0%
TOTAL		20	

*The % is rounded to nearest whole number

Figure 4. Number and percentage of management actions taken



Number of Management Actions 01/01/2025 to 31/03/2025			Download Results
Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff from ward	5	19%
MA2	Redeploy staff from community	1	4%
MA3	Staff unable to take breaks	10	38%
MA4	Staff working beyond rostered hours	0	0%
MA5	Staff sourced from Midwifery Bank	0	0%
MA6	Matron/Midwifery Managers working clinically	1	4%
MA7	Specialist Midwives to work clinically	4	15%
MA8	Initiate the escalation policy	1	4%
MA9	Contact on-call duty Manager	4	15%
TOTAL		26	

*The % is rounded to nearest whole number

The data above indicates that there is a low incidence of occasions where clinical or management actions are taken to mitigate for high acuity and when needed the escalation process is followed for support. The management of induction of labour (IOL) without any delay is an issue with which all maternity units struggle due to its complex process pathways and unpredictable nature of its management.

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. SFT have ensured that rostering reflects this requirement. The Birthrate Plus acuity tool monitors this every 4 hours.

The following table outlines the supernumerary status compliance by month:

Figure 5. Supernumerary status of Labour Ward Co-ordinators by month

	Number of days per month	Number of shifts per month	Compliance
January	31	62	100%
February	28	56	100%
March	31	62	100%

8. One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

Figure 6. 1:1 care in labour compliance by month

	January	February	March
Birth Centre	100%	100%	100%
Labour Ward	100%	100%	100%

9. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events for the 3-month period from 1st January 2025 to 31st March 2025. Out of 546 data admissions (confidence factor of 79%

recorded), there were four red flags entered onto the system with the reasons detailed below:

Figure 7. Number and percentage of red flags recorded during Q4

Number of Red Flags recorded
01/01/2025 to 31/03/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	4	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of 30 minutes or more between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of labour ward coordinator not achieved	0	0%
TOTAL		4	

Each red flag is recorded on the acuity tool and reported via DATIX, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

10. Obstetric staffing

10.1 Consultant Attendance

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* (updated 2022) document. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as the LMNS.

Clinical situations listed in the RCOG document when a consultant is required to attend in person:

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input.
- Any return to theatre for obstetrics or gynaecology
- Team debrief requested if requested to do so.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia/ abnormally invasive placenta
- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- Premature twins <30/40
- 4th Degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal Collapse e.g., septic shock, massive abruption
- PPH 2L where the hemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

For Quarter 4 (1st January 2025 – 31st March 2025) there were 14 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard.

Figure 8. Consultant attendance audit for Q4

Date	Clinical Situation(s)	Comments
05/01/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
20/01/25	Caesarean birth for major placenta praevia/ abnormally invasive placenta.	Consultant present.
31/01/25	4th Degree perineal tear repair.	Consultant present.
04/02/25	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
11/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
12/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
14/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
17/02/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
17/02/25	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
25/02/25	Caesarean birth for women with BMI >50.	Consultant present.
12/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
24/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present
25/03/25	Caesarean birth for women with BMI >50	Consultant present.
29/03/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.

10.2 Short Term Locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
   or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

An audit of compliance with our Medical HR colleagues was completed for the time period 1st January 2025 – 31st March 2025. The audit demonstrated that during this period, 21 (short term) middle grade locum shifts were required. 4 Doctors completed these shifts, 2 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and held a Certificate of eligibility (CEL), therefore the trust is 100% compliant with the criteria described above.

10.3 Long term locum usage

During the time period 1st January 2025 – 31st March 2025, the trust has utilised 1 long term middle grade locum doctor. This doctor has been working in the trust for many months prior to Q4 and therefore standards 1-6 are not applicable during this time period.

For all standards that were applicable the trust was 100% compliant. The compliance can be seen in Figure 9.

Figure 9. Long-term locum compliance with standards

Standard	Compliance % for Locum 1 (in post prior to Q4)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	N/A
Standard 3 Departmental induction by consultant on commencement date	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	N/A
Standard 5 Named consultant supervisor to support locum	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%
Standard 8 Feedback to locum doctor and agency on performance	N/A (remains in post)

11. Anaesthetic staffing

For safety action 4 of the Maternity Incentive Scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to

delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1).

The following table demonstrates compliance with this standard by month.

Figure 10. Anaesthetic staffing compliance

Month	January 2025	February 2025	March 2025
% compliance	100	100	100

The service will continue to audit this standard on a monthly basis.

12. Neonatal medical staffing

To meet safety action 4 of the Maternity Incentive Scheme, the Neonatal Unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in previous years, there should be an action plan with progress against any previously developed action plans.

Salisbury Neonatal Unit is designated a Local Neonatal Unit (LNU) and there are no current plans for this to change.

Compliance has never been met for medical staffing against BAPM criteria. A trainee ANNP has started their training which is a first step towards increasing medical staffing numbers and in turn compliance with BAPM.

Figure 11. Action plan for medical staffing against BAPM criteria

Action	Owner	Deadline	Rating
Business case has been submitted to Divisional Director of Operations for review and now awaiting submission to financial services	Mary Pedley-Duncalfe	May 2025	

The above action plan serves to put in motion a plan to achieve BAPM compliance. Both the LMNS and Neonatal ODN are aware of non-compliance to BAPM and of the above action plan.

13. Neonatal nursing staffing

To meet safety action 4 of the Maternity Incentive Scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards, and the Trust is required to formally record to the Trust Board minutes compliance to BAPM

Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in March 2025 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for non-QIS registered nurses but under-funded for QIS registered nurses and non-registered nurses. The requirement would be an additional 1.52wte QIS registered nurse and a 2.09wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 1.92WTE are in training. It is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

1.92WTE are now on Maternity leave and we have had 0 leavers. 3 WTE band 5 registered nurses from the maternity service have moved over to support the Band 5 vacancy which has now reduced to 1.83WTE.

Figure 12. Compliance with BAPM standards for Neonatal Nurses with respect to QIS

	Funded March 2025	**In post March 2025**	**BAPM calculated requirement** *(from ODN tool, based on NNU activity)*	**Variance** *(BAPM less funded)*
Total direct care nurses	24.08	22.83	24.55	-0.47
of which QIS	13.64	13.27	15.16	-1.52
Total Non-QIS	9.64	7.54	6.50	3.14
Total Non-Reg	0.80	2.02	2.89	-2.09
% Registered Nurses QIS Qualified		58%	70%	

14. Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes agreement to the action plan, in place due to non-compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce.

Avoidable Term Admissions into Neonatal Units (ATAIN) and Transitional Care (TC) Report
(Quarter 4 2024-25)

1. Report Overview

ATAIN is an acronym for Avoiding Term Admissions into neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

This report outlines the term admission rates at 5.1%, findings from audits of the pathway/ policy, findings from the ATAIN reviews both term and late pre-term babies and provides assurance of actions being taken and progress being made.

2. The National Ambition

In August 2017, NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims.
- Improving culture, teamwork, and improvement capability within maternity units.

2.1 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals. Collaboration between neonatal and maternity staff at Salisbury NHSFT has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use maternity and neonatal services.

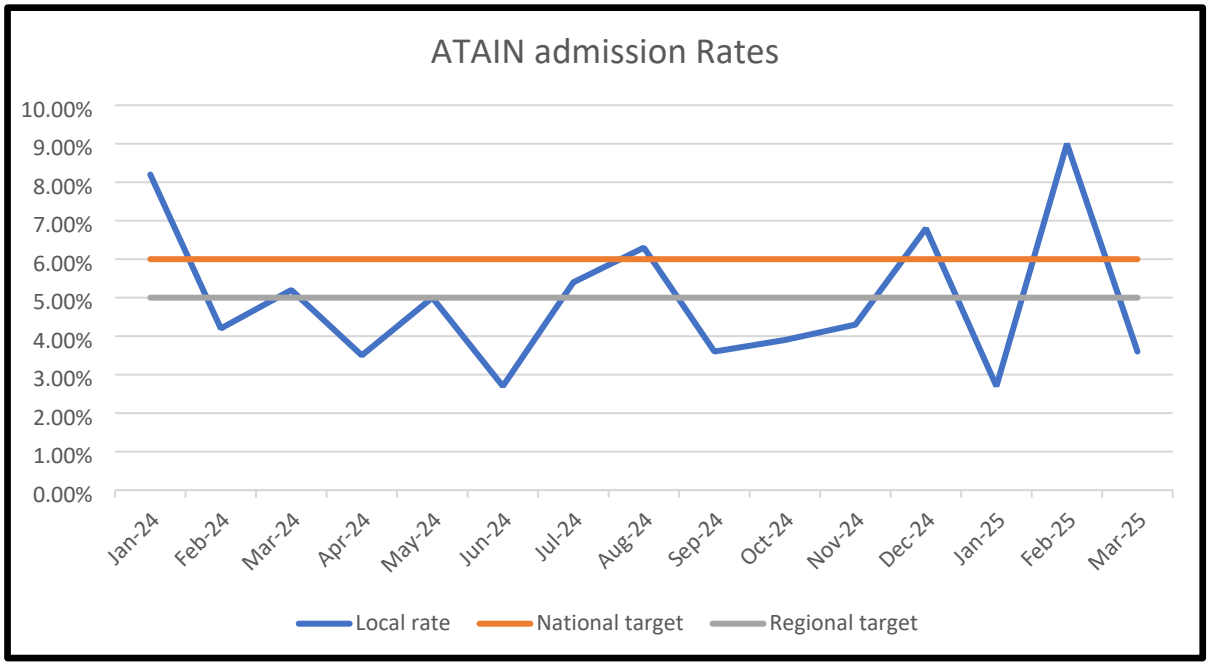
Using the 'Improving Together' methodology, SFT are embarking on a Separation Improvement Times (SIT) project. This project aims to produce a culture change in maternity and neonatal services that will support mothers to have where possible, immediate access for to their infants admitted to the neonatal service. With multidisciplinary working across all stake holders, women should feel empowered and have a seamless experience when their infant requires unexpected admission to the neonatal unit.

The national aim for term admissions to the neonatal unit is less than 6% of all term babies, however, Trusts should strive for this rate to be as low as possible. This is covered in the next section of the report.

3. ATAIN rates

The following graph outlines the rolling calendar year ATAIN rates for Salisbury NHSFT Trust.

Figure 1. Monthly ATAIN rates since January 2024 for Salisbury NHSFT Trust



Updates and progress from the last report are included in the action plan in Section 8.

Figure 2. ATAIN reviews (babies equal or >37 weeks' gestation)

	January 2025	February 2025	March 2025
Total number of admissions in month	**4**	**13**	**3**
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	**0**	**0**	**0**

Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	**0**	**0**	**0**
	January 2025	**February 2025**	**March 2025**
Total number of case reviews undertaken in month	**13**	**5**	**10**
Total number of case reviews with both maternity and neonatal staff present	**13**	**5**	**10**

4. Findings and learning from the ATAIN review meetings

4.1 Maternity

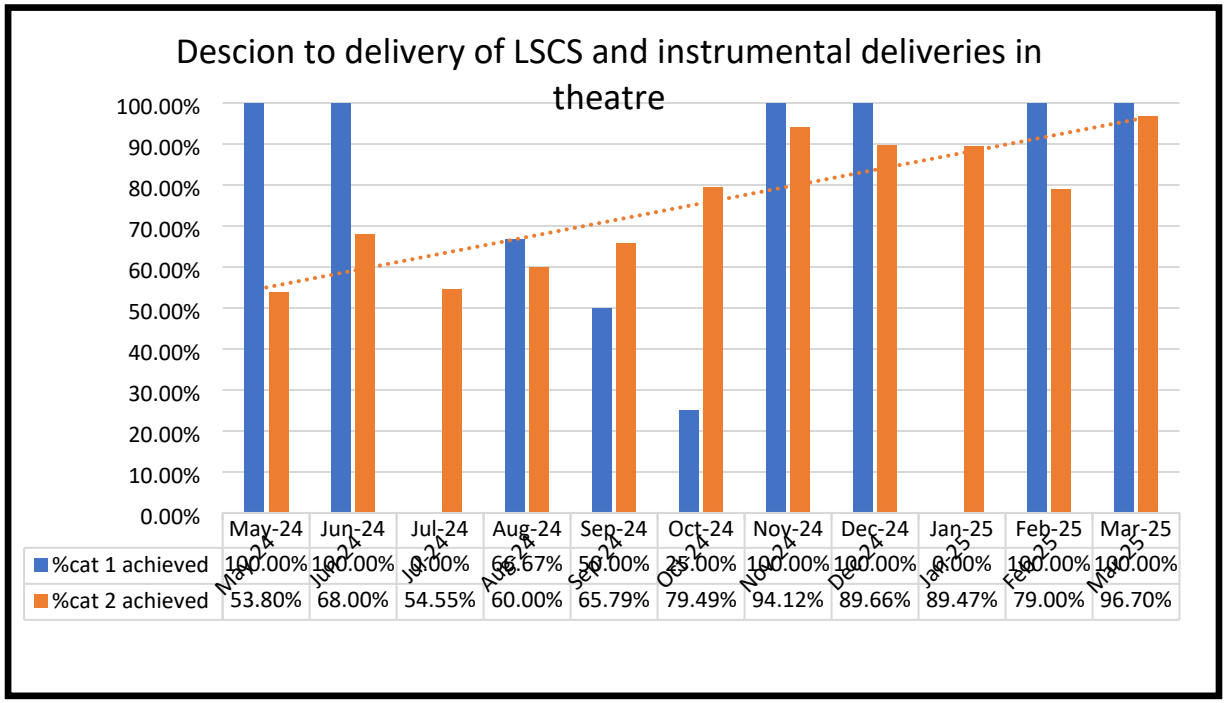
Previously during Q2, a theme had been identified during ATAIN case reviews around delays in 'decision to delivery' timeframes for category 1 & 2 emergency caesareans and instrumental deliveries in theatre as recommended by NICE.

NICE guidance recommends that category 1 births occur within 30 minutes (decision to birth) and, that category 2 births occur within 75 minutes.

A change in practice was implemented whereby all category 1 & 2 caesareans are communicated to the team using a '2222' call. This has resulted in a significant improvement and continues to be audited monthly.

It is worth noting that during the months of July 2024 and January 2025, there were no category 1 births, hence why compliance appears as 0%.

Figure 3. Decision to delivery of LSCS and instrumental deliveries in theatre audit results



	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
%cat 1 achieved	100.00%	100.00%	0.00%	66.67%	50.00%	25.00%	100.00%	100.00%	0.00%	100.00%	100.00%
%cat 2 achieved	53.80%	68.00%	54.55%	60.00%	65.79%	79.49%	94.12%	89.66%	89.47%	79.00%	96.70%

4.3 Learning

During February 2025, there was a focus with maternity staff to revisit the golden hour, the initial hour post birth supporting the neonates transition from in utero to external living. This included

- Skin-to-skin contact
- Delayed cord clamping
- Early initiation of breastfeeding
- Initial thermoregulation

During Q4, the ATAIN multidisciplinary reviews of every admission identified no themes were ascertained for points of learning. During this quarter, no avoidable admissions were identified.

.

5. Transitional Care Service (TC)

Please see appendix below regarding local policy:

Salisbury TC policy 1.6 (2023).pdf

SFT's TC policy was updated in 2023 and includes a clear staffing model for TC. It is recognised that SFT's neonatal services are not consistently BAPM compliant with the additional TC work, and there is ongoing work for a business case to increase NICU staffing to offer more standardised care.

6. TC Audit

6.1 How many TC babies did SFT have and how long did they stay for?

The graphs below demonstrate the numbers of babies born each month that fit within the TC gestational criteria and the length of stay.

Figure 4. Total number of 34-36+6 babies born requiring transitional care

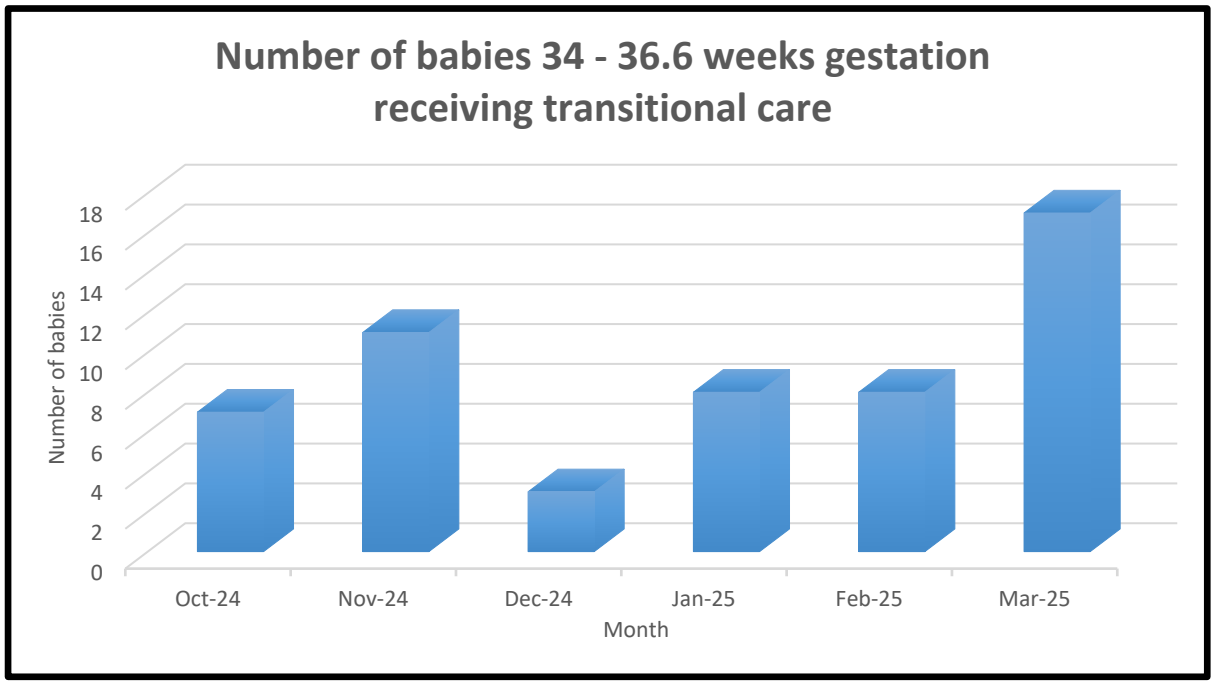
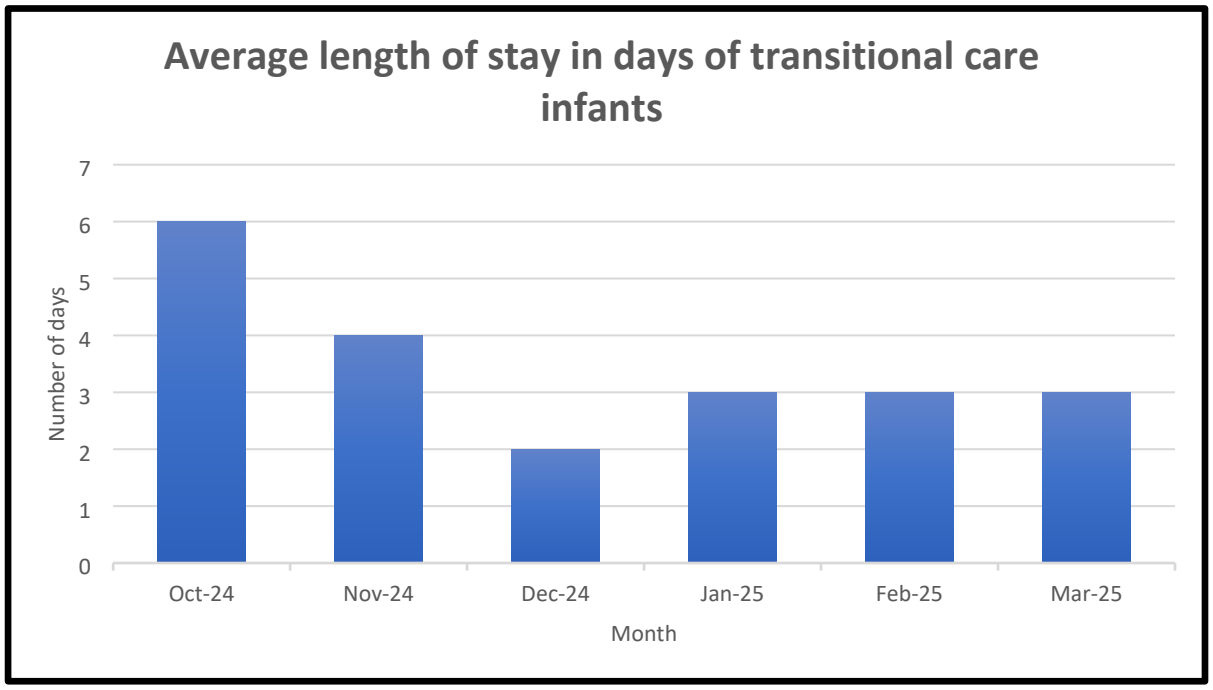


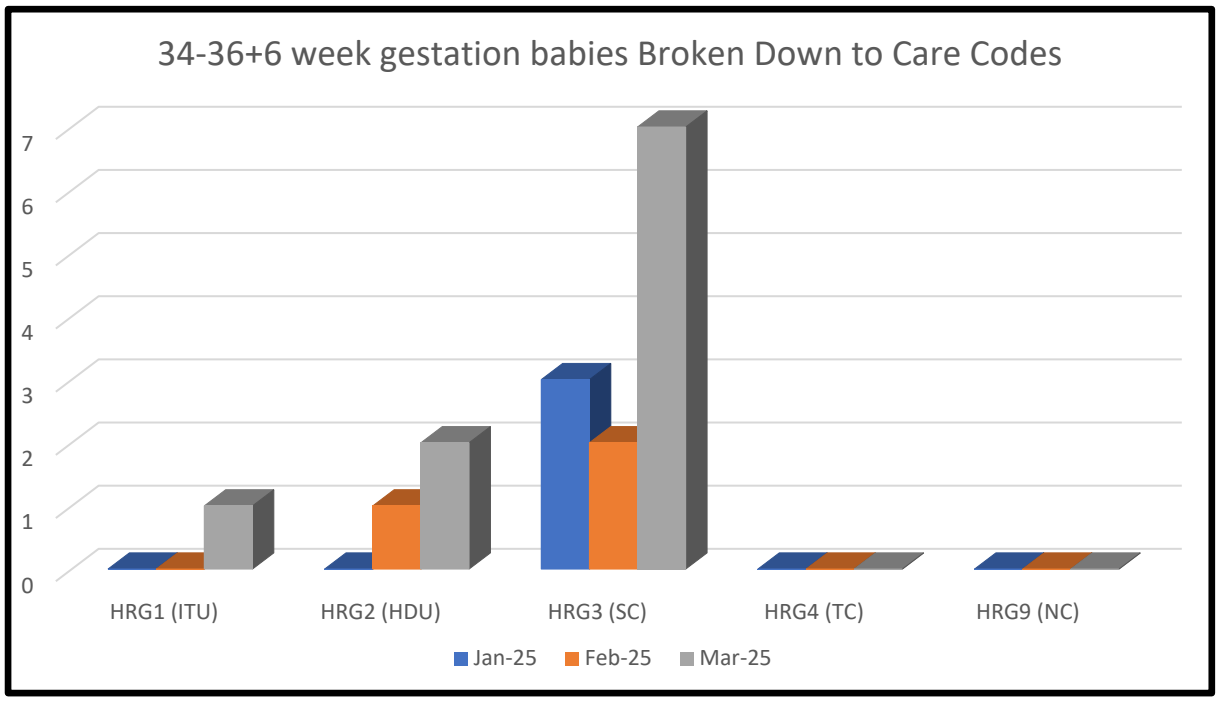
Figure 5. Average length of stay in days for TC infants



6.2 Did SFT admit the correct babies to TC and SCBU?

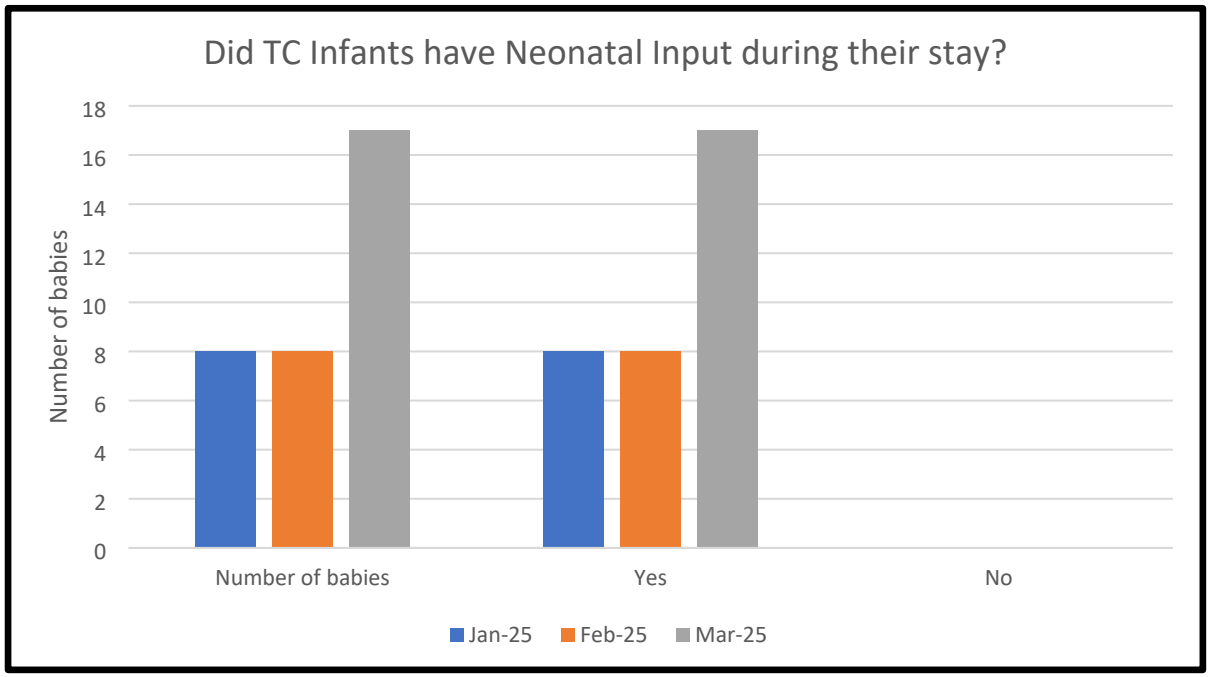
This graph below shows that SFT are further interrogating care codes for infants that fall within the Transitional Care gestation. This helps to understand if these are correct for each baby.

Figure 6. TC babies identified by care codes each month in Q4



These numbers are monitored monthly via CNST audit. These are very low and can be anything from 'place of safety'; a twin that does not require specialist neonatal care, but a sibling does; lack of space on BMW/TC, etc. Due to this monitoring, it will be easy to recognise and act on changes to this number.

Figure 7. Location of care setting



Neonatal input can be any input from neonatal nursing team or medical staff. These results are taken from National Neonatal Audit Programme (NNAP) data, showing if they have been seen by a senior medical member of staff. There has been a sustained improvement in this over Q4 as all infants have had neonatal input.

The TC pathway is integrated and known to staff.

The action plan in Section 8 provides updates and progress from the last report.

7. Action Plan

The following combined action plan outlines actions being taken in response to audits of compliance with the pathway/ policy and actions being taken in response to ATAIN reviews for both term and late pre-term babies.

Figure 8. ATAIN and TCU action plan

Actions from TC pathway /policy audits				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Maternity nurses to become part of the NNU nursing team to enhance neonatal experience which will be transferable and compliment maternity nurse skills to enable further cohesion between maternity and NNU and enhance TC care.	MPD/GD/BR	30/05/25	Maternity nurses now within NNU nursing team. Skills developing with high-risk neonates.	
Nursing model to be reviewed and business case written to support greater nursing numbers in line with BAPM standards.	MPD	30/9/25		
Actions from ATAIN reviews for babies >37 weeks				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
CAT 2 C-section timing audit.	BR/SM-G	Q4	Significant improvement now in a sustained period to ensure continued compliance.	
Update ATAIN meeting TOR as >3yeas old.	ATAIN group	May 2025		

9. Recommendations

The Trust Board are asked to note the contents of the report and agree to sign off the action plan.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	3rd July 2025		

Report tile:	Perinatal Quality Surveillance Report - Salisbury NHSFT Maternity & Neonatal services –**May 2025 (April 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Maternity Governance 09.05.25 Maternity and Neonatal Assurance Committee 15.05.25 CGC – 24th June 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the Board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – Year 7 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (Safety Action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The Perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance Report for SFT for April 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW.

Summary:

Staffing:

- Midwife to birth ratio 1:28– SFT recommended ratio 1:24.
- Increase in band 6 Midwifery vacancies to 6.93 WTE

- 1:1 care in labour achieved 100% of time.
- Supernumerary status of labour ward maintained 100% time.

PMRT:

- 2 stillbirths in April.
  - SFT are now above the national ambition rates (2.5 per 1000) for stillbirth at 3.13 per 1000, but remain under the national stillbirth rate (3.9 per 1000).
- 0 Neonatal death in April.
- No PMRT review in April as none due.

Incidents reported as moderate:

- 7 Incidents reported as moderate or above. Immediate review complete, but more detailed review not yet complete due to access to notes and new Badgernet system causing delay in review.
  - 4 Term admission to Neonatal Unit.
  - 2 PPH >1500 ml.
  - 1 postnatal readmission.

Service user and staff feedback:

- Feedback received from varying sources including MNVP, friends, and family survey and PALS.
- Safety Champions meeting cancelled due to availability but CNO walkaround and staff engagement in place of this.

Compliance to National Standards:

- Three-Year Delivery Plan – focus on action and compliance in this final year.
- Work continues as per infographic other national workstream.

Themes:

- Shoulder Dystocia 2024 thematic review.
- Clinical deterioration and Cat 1 and 2 theatre times. Improving together focus showing significantly improved timeframes.
- Plan to continue to focus on demographic and inequalities when reviewing incidences and themes.

Perinatal Culture and Leadership Programme:

- 'Team of the shift model' adopted across Maternity Services.

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

NHS
Salisbury
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

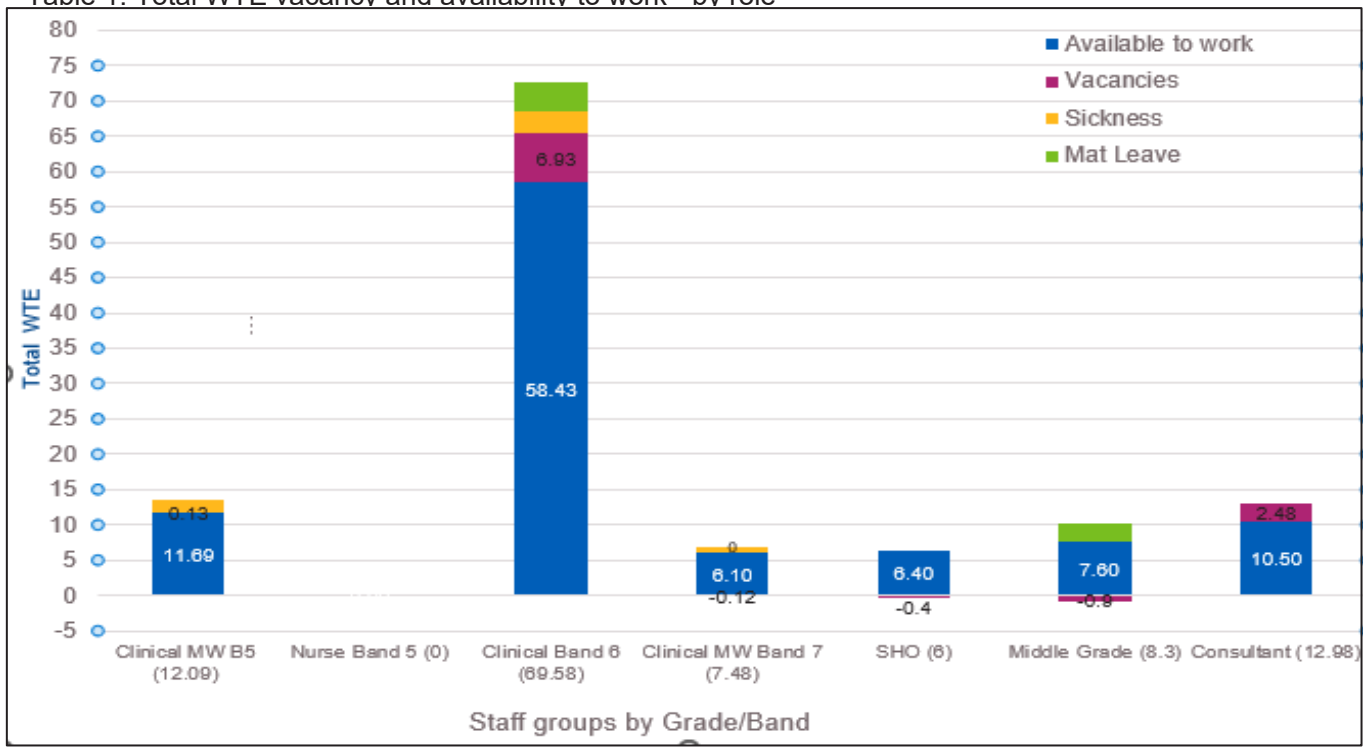
May 2025 (April Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was positive this month showing 95% compliance of required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show an increase due to decreased levels of short and long-term sickness.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this.

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Feb '25	Mar '25	Apr '25
Midwives	Day	97.1%	91.4%	93.6%
	Night	94.6%	96.7%	95.4%
MCA / MSWs	Day	87%	83.07%	83.8%
	Night	94.0%	83.9%	89.7%
NNU Nurses	Day	79.9%	95.2%	89.7%
NNU Nurses	Night	84%	98.7%	98.2%

Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/ HOM
NNU Band 6 recruitment	HOM

Countermeasures / Action (planned this month)	Owner
Review of sickness absence management compliance.	HOM

Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		Feb '25	Mar '25	April '25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1:23	1:27	1:28	Ratio increased this month due to an increase in births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	76.7%	73.12%	81.11%	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		60	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	50%	61.2%	55%	Business case being written and recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	

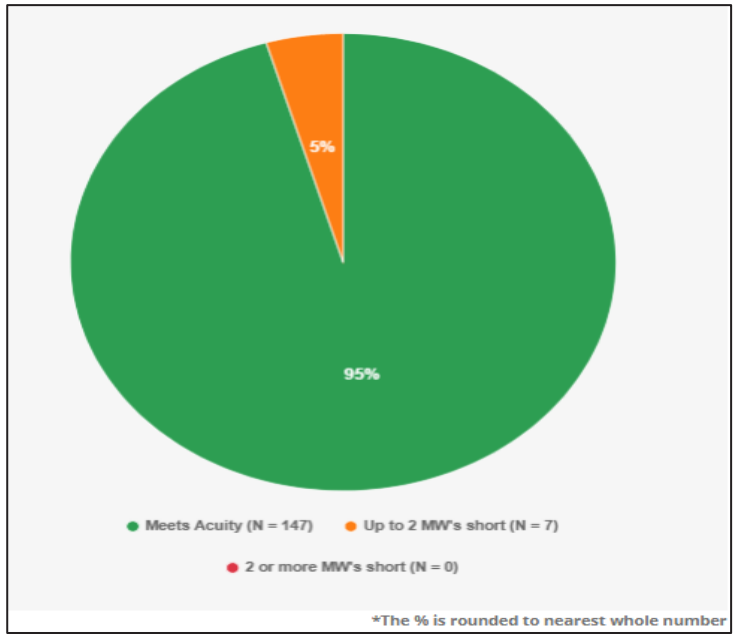
Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.

What are the top contributors for under/over-achievement?

- The Midwife to Birth ratio increased this month due to increased acuity and births.

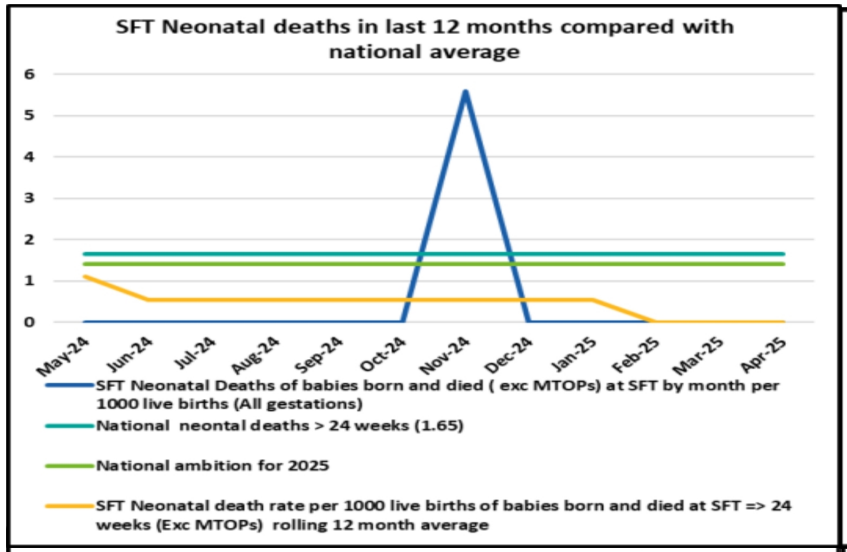
Graph 1. Acuity by RAG vs staffing data:

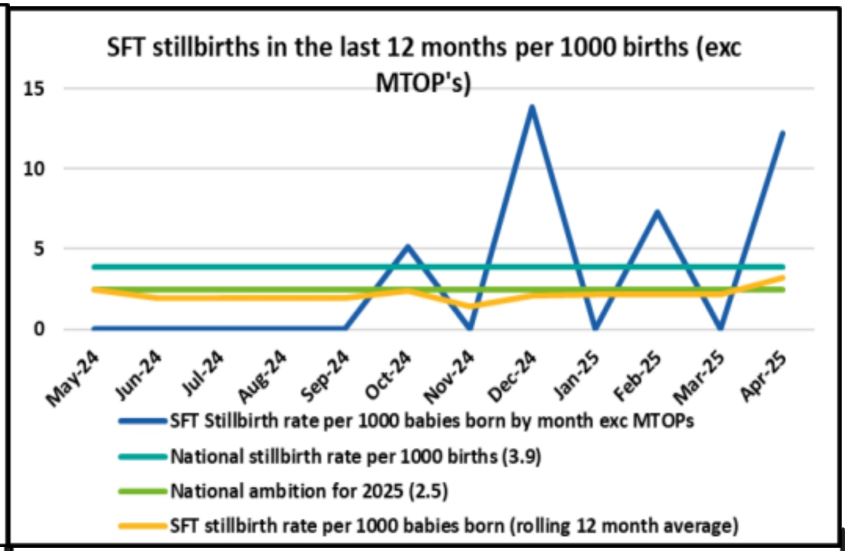


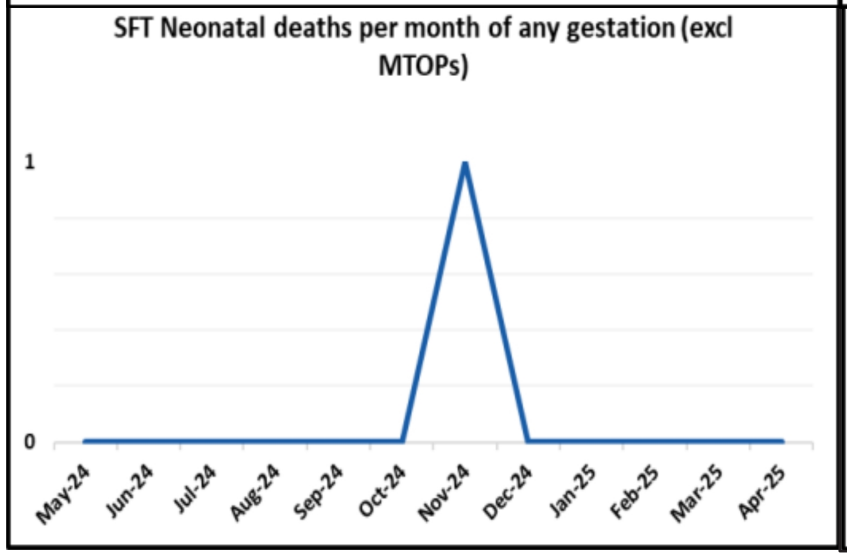
Countermeasures / Action (completed last month)	Owner
- NNU Nurse Band 6 recruitment	HOM

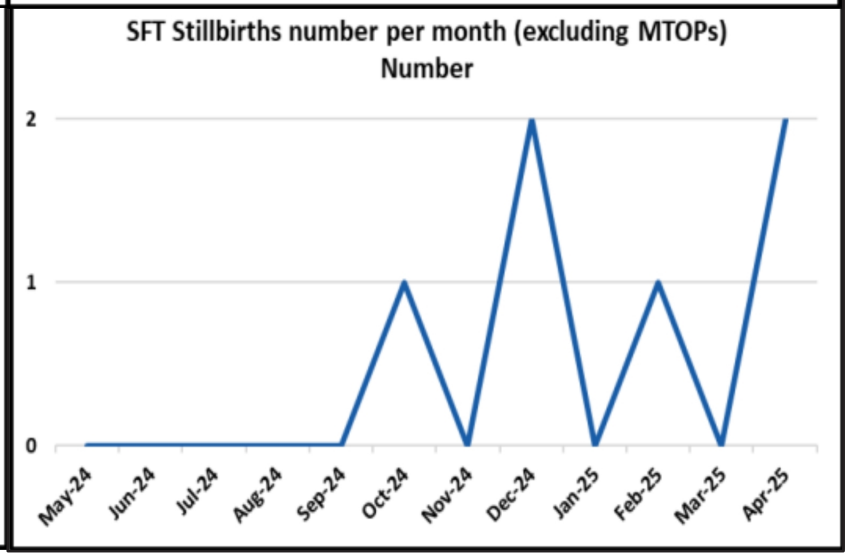
Countermeasures / Action (planned this month)	Owner
- NNU Nurse Band 5 recruitment - Interim Neonatal Matron role in place - Band 5 Preceptee Midwife recruitment (October cohort) - Band 6 Midwife recruitment	HOM HOM

Safe: Perinatal Mortality Review Tool (PMRT)









NHS Salisbury NHS Foundation Trust

- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 7. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- April stillbirth rate means SFT rate just over national ambition, however, remains under national stillbirth rate.

- There were 3 perinatal losses in April >12 weeks.
- One stillbirth at 37+2 weeks
- One Stillbirth at 26 weeks
- One stillbirth of a multiple at 37+3 weeks following a reduction procedure (MTOP) .

PMRT Action Plans for Salisbury Foundation Trust – April 2025 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
		No PMRT reviews in April 2025		

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
				No PMRT reviews in April 2025.		

INCIDENTS: Moderate Incidents and PSRs

DATIX Incidents classified as moderate harm and above at month end

Salisbury NHS Foundation Trust

Case Ref (DATIX)	Date of Incident	Category	Incident Summary	Comments	Commissioned Y/N	MNSI ref	PSII ref
175951	17/04/2025	Moderate	Term Admission to NICU	Retrospective Datix and pending review	N	N/A	N/A
175642	09/04/2025	Moderate	Postnatal Readmission SFT not delivering hospital	Awaiting further information and pending review	N	N/A	N/A
176063	21/04/2025	Moderate	PPH >1500ml	Awaiting notes and pending review	N	N/A	N/A
175925	16/04/2025	Moderate	Term Admission to NICU	IT issues, awaiting notes and pending review	N	N/A	N/A
176038	21/04/2025	Moderate	PPH >1500ml	Notes received and awaiting review	N	N/A	N/A
176163	24/04/2025	Moderate	Term Admission to NICU	Notes received and awaiting review	N	N/A	N/A
176274	29/04/2025	Moderate	Term Admission to NICU	Awaiting clarification from FMU before review	N	N/A	N/A

INCIDENTS: Investigation update

Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date of Incident	Category	Incident Summary	Outcome / Learning / Actions
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report

PSR's Submitted

Case Ref (DATIX)	Date of Incident	PSR 1 or 2	Incident Summary	Outcome / Learning / Actions
175159	01/04/2025	PSR 1	Shoulder Dystocia and APGAR 4 @ 5 minutes	Shared learning for reminder of appropriate communiation and escalation
173673	Feb-25	PSR 2	Term Admission to NICU	SBAR handover to be added to the daily safety briefing. Reminder for the usage of paired cord gas samples - poster created.
174567	05/03/2025	PSR 1	OASI	Recommended for PSR 2
171321	Nov-24	PSR 2	Term Admission to NICU	Ongoing NEWTT2 auditing. Teaching on use of Naloxone in NLS situation.
175305	28/03/2025	PSR 1	APGAR 6 @ 5	Reminder for paired cord gas samples in obstetric emergencies
175674	08/04/2025	PSR 1	37/40 IUD	for PMRT

Responsive – Patient Experience

Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Great overall care from Salisbury.
- Parents feel midwives listened to them and explained things well.
- Great experience in birth centre.

Areas for improvement:

- Conflicting advice from different consultants.
- Women wanting to mobilise in labour felt room was small vs women with epidural having a lot of space.

Complaints and Concerns

Complaints received	Summary / themes
1	Dissatisfied with aspects of their postnatal care in relation to bladder management

Concerns received	Summary / themes
0	None

Safety Champions

April update

No meeting held this month.

Friends and Family Test

- As Maternity Services moved to BadgerNet in February, this has had an impact on FFT maternity reporting during March and April 25.
- Only 6 women received the FFT survey in April.

Response rate	% Positive	0% Negative
100%	85.7%	14.2%

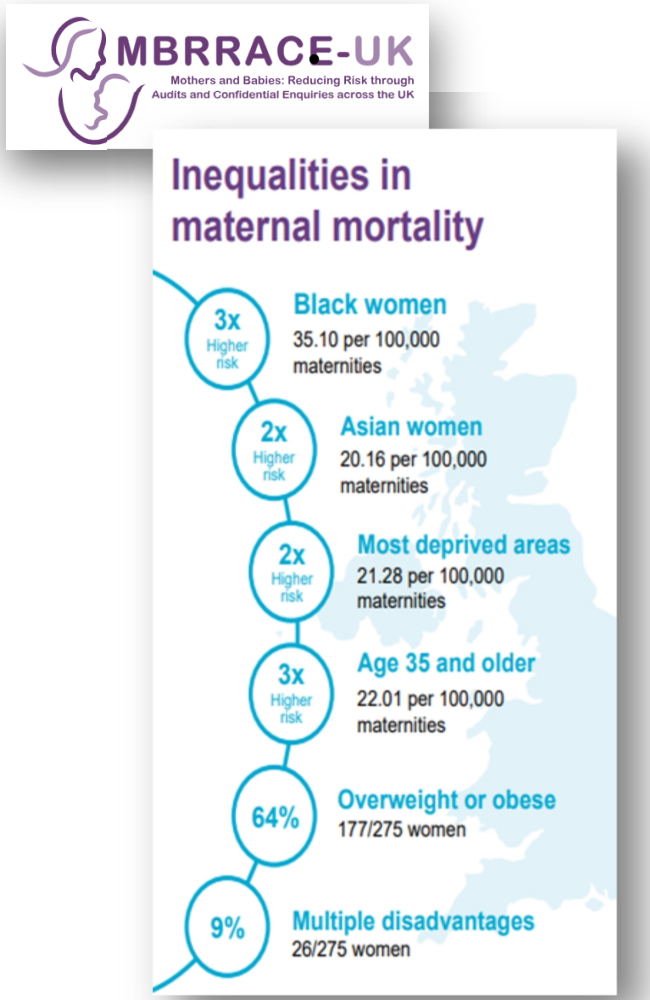
Top themes of FFT	
Positive	**Negative**
1. Staf attitudes 2. Implementation of care	None

Service User Compliments

- **0 compliments reported on Datix in April for NNU and maternity services.**

Compliments - top themes	Numbers received
None	0

Health Inequalities – Priorities



Listening events: No listening events held in April.

Ongoing Projects: Work is ongoing to establish a pathway to enable all Community Hubs to offer in-person parent education classes.

Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data.

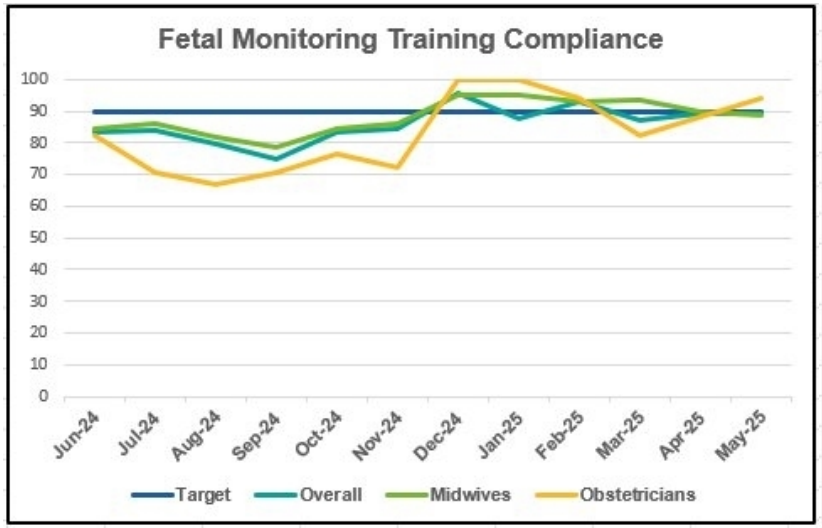
Translation service:

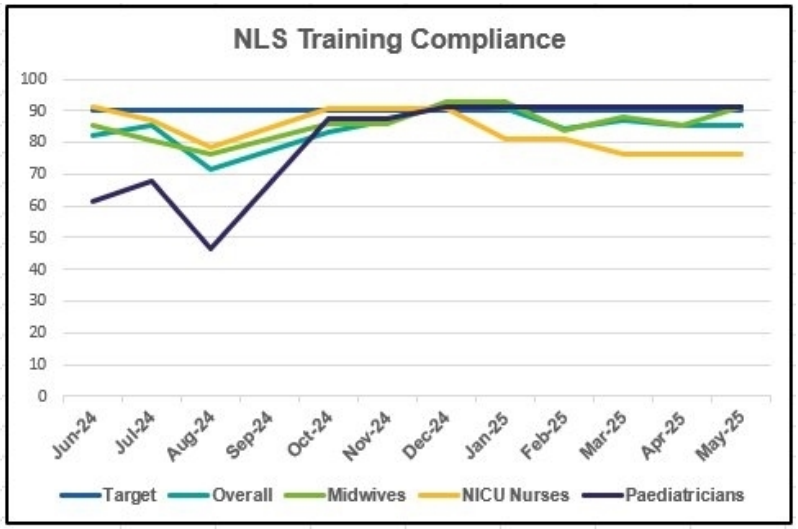
- Renewed emphasis has been placed on the implementation of the Translation toolbar on the Trust's website. The Translation toolbar is on the risk register. IT department are in talks with the provider, in the hope of securing a competitive quote for all three Trusts.

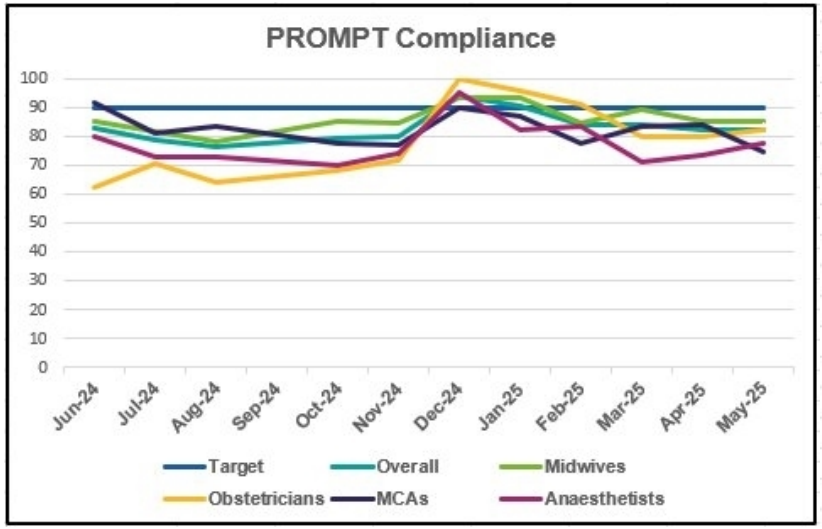
- Implementation of Pocketalk: Steady progress has been made, and it is hoped we will roll out the device in April 2025. The SOP and related documentation were approved at Maternity Risk Governance meeting. CSA and Hazard Log has been approved in principle by the CSO. Further conversation is needed to establish the next steps in the Governance process, as it is anticipated that the project will need approval from the Digital Steering Group.

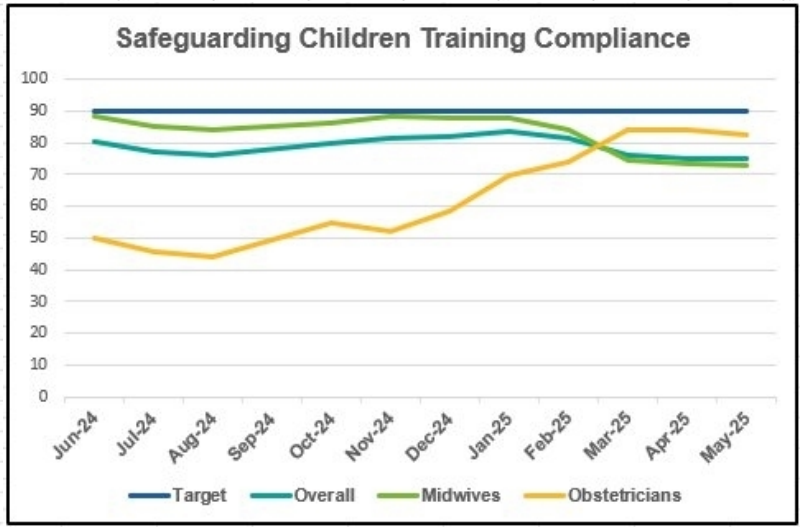
Well-led: Training - Helen

Salisbury NHS Foundation Trust









Training

Updated training plan commenced in 2025 to meet the Core Competency Framework Version 2 (CCFv2) requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/ action:

- Anaesthetics planning to send staff on every PROMPT date evenly throughout 2025 (to maintain compliance rather than see drop-off over summer as in 2024) - so far this has been maintained.
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team). All out-of-date midwives are now booked onto training this year.

Risks:

- MDT attendance (obstetric) at all PROMPT and fetal monitoring training is a challenge and has dropped below the 90% compliance required for PROMPT. All obstetricians continue to be booked to attend these study days but often have competing workloads on the day meaning they drop in and out of training.
- Obstetric face-to-face SBL Elements training has been incorporated into rotating obstetricians' induction programmes.

Compliance to National Guidance (1)

Salisbury NHS Foundation Trust

CNST Maternity Incentive Scheme (Year 6)

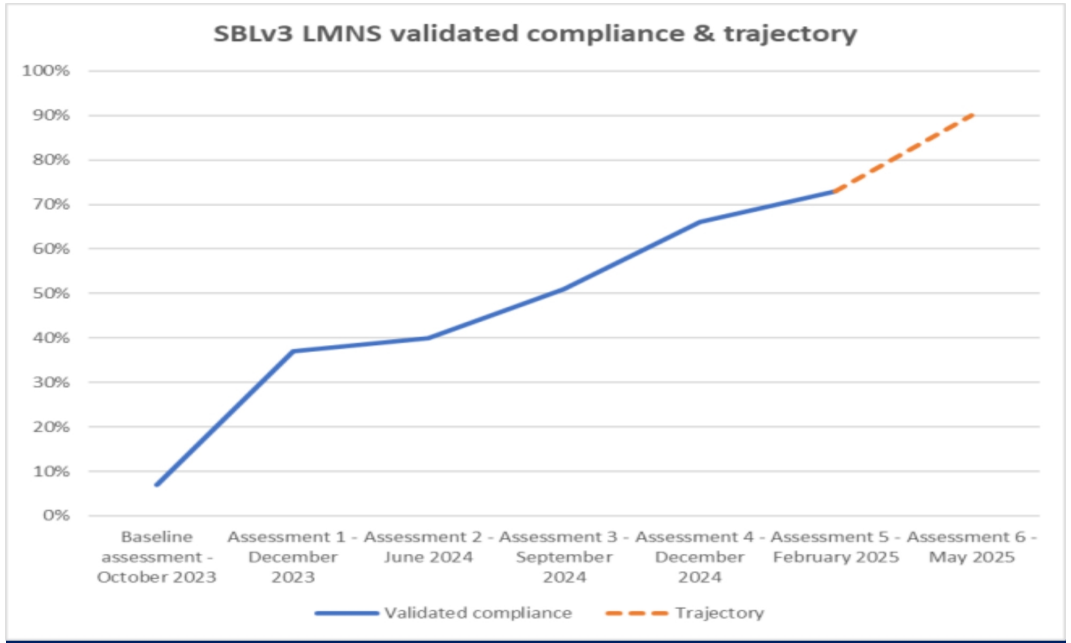
		NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
		Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Compliant	Met best endeavours of improvement	
	7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
	8	**Multidisciplinary Training**	Compliant	All Standards Met	
	9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Maternity Incentive Scheme (CNST)

Progress within month:

- Review of guidance for MIS Year 7, released 2nd April 2025.
- MIS Year 7 Launch event 28th April 2025 – provided further detail on changes to Year 7 guidance
- CNST working group to meet to discuss changes and technical guidance 8th May 2025.

Saving Babies Lives v3 - Faye



Saving Babies Lives v3

Key Achievements:

- SFT have achieved 73% compliance with our February 2025 submission.

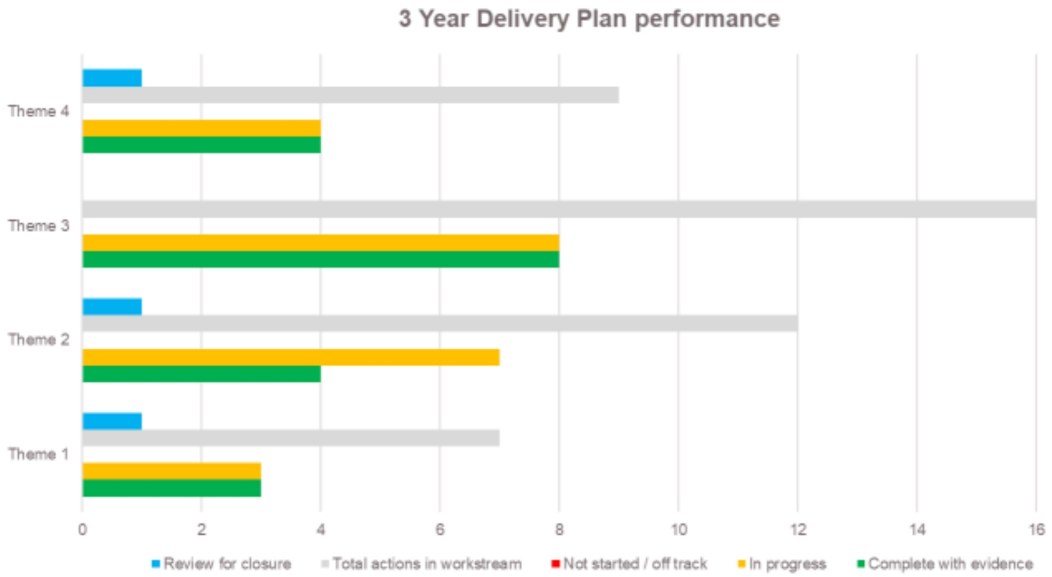
Next steps for progression:

- Action holders are currently collating data for Q4 2024-25 ready or submission in May.

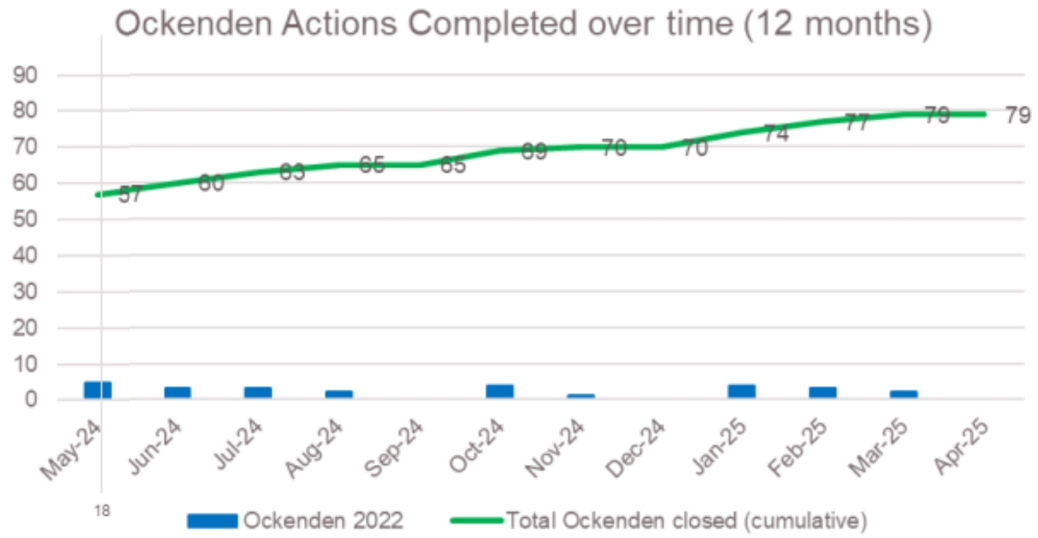
Compliance to National Guidance (2)

Salisbury NHS Foundation Trust

3 Year Delivery Plan - Faye



Ockenden 2022



Ockenden 2022

- Remaining 5 Ockenden actions continue to be monitored in monthly MIG meetings, anticipating closures by the end of the year.

3-Year Delivery Plan

Key Achievements:

- Of the 44 actions; 21 have been completed.
- The remaining 23 are in progress and no concerns identified.

Next steps for progression:

- Continue to meet with action holders.
- Provide evidence of completed actions for sign off at MIG

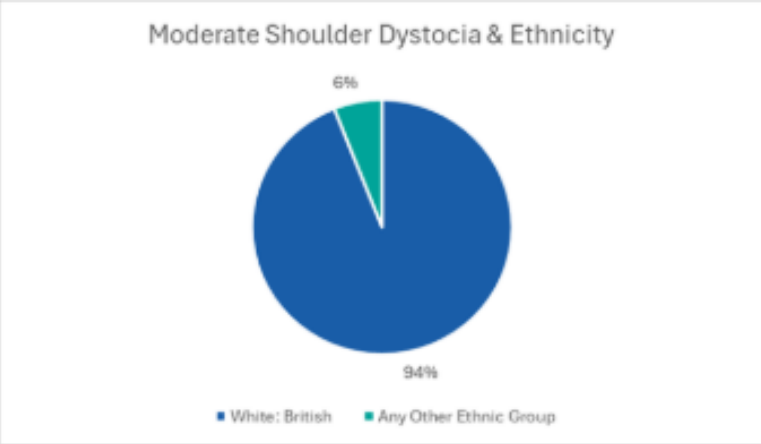
OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Apr-25	1	Workforce Planning and Sustainability	0	1	0	6
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	0	0	5
	9	Preterm Birth	0	0	0	4
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	0	0	4
	13	Bereavement Care	0	0	0	4
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	5	0	80

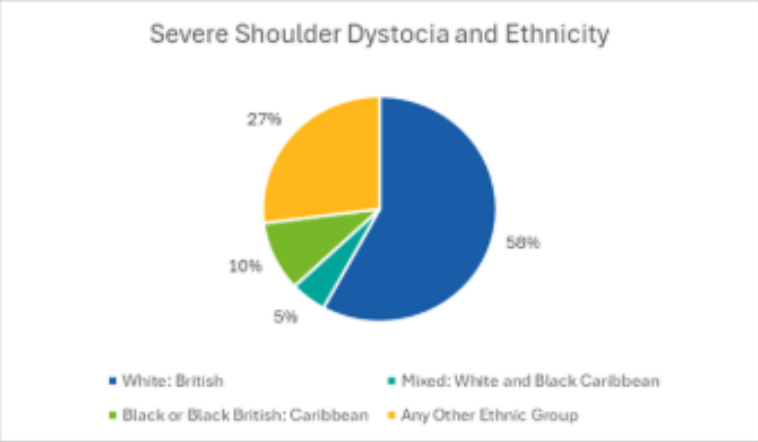
Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

Shoulder Dystocia from 2024 Thematic Review Data





Results:

- In 2024, there were 37 reported cases of Shoulder Dystocia.
- There was no statistical difference noted in birth weight (<4kg>).
- According to SFT data, women from the global majority appear to have an increased incident of Severe Shoulder Dystocia.

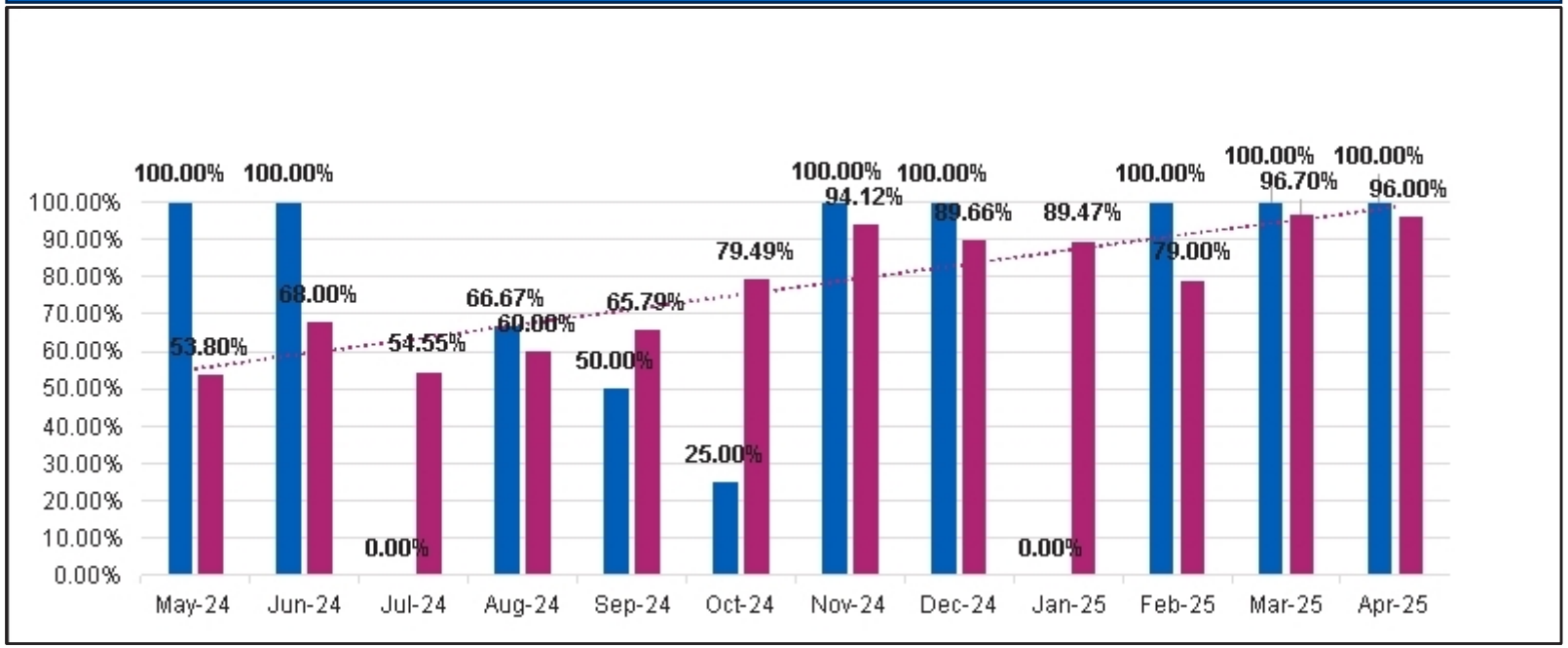
Actions:

- All cases have been incorporated into the ongoing rolling audit within W&NB for continuous data collection.
- The Shoulder Dystocia Thematic Review will be released soon
- There is ongoing work around interpretation services for women accessing maternity care.

Themes (cont.)
Clinical Deterioration

Salisbury NHS Foundation Trust

Cat 1 and 2 theatre delivery times



- In April only one category 2 case missed the required time as stipulated by NICE by 2 mins, taking 77 minutes from decision to birth.
- All cases will continue to be reviewed monthly and discussed at LW forum.
- If there are any themes or an increase in non-compliance further measures will be considered to improve compliance times.
- Ethnicity being explored as part of ongoing work to understand health inequalities.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- Staff event undertaken on Friday 25th April 2025; with a focus on OD&L, Wellbeing, opportunity to learn what we are doing as a quad and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024 . It was very positively received and staff appreciated the time to come together and celebrate the team.

Actions in progress:

- The "team of the shift" model continues to be used, to have a team check-in and support each other on shift.
- Members of staff offered 'MOMENTS' training from Wessex Health Innovation Network to support the Quad work in responding to, and discussing with, staff about cultural and safety issues.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	3rd July 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**June 2025 (May 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Maternity Governance 13.06.25 Maternity and Neonatal Assurance committee 19.06.25 Clinical Governance Committee 24th June 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the Board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – Year 7 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (Safety Action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly.

The Perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance Report for SFT for May 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW.

Summary:

Staffing:

- Midwife to birth ratio 1:29– SFT recommended ratio 1:24. Increased midwifery vacancy rate contributing to ratio.
- 1:1 care in labour achieved 100% of time.

- Supernumerary status of labour ward maintained 100% time.

PMRT:

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

Incidents reported as moderate:

- 7 Incidents reported as moderate or above.
  - 1Term admission to Neonatal Unit.
  - 1 PPH >1500 ml.
  - 1 incident relating to vacancies in admin team and urgent referral consequently missed.
  - 1 incident of Ferinject staining.
  - 1 shoulder dystocia.
  - 1 IOL – missed breech presentation.
  - Equipment issues at EMLSCS.

Service user and staff feedback:

- Feedback received from varying sources including MNVP, friends, and family survey and PALS.
- Safety Champions meeting did not highlight any concerns to be raised in May.

Compliance to National Standards:

- Three-year delivery plan – focus on action and compliance in this final year.
- Work continues as per infographic other national workstream.

Themes:

- Rolling audit of >PPH 1500ml, term NICU admission, shoulder dystocia, OASI continue.
- Plan to continue to focus on demographic and inequalities when reviewing incidences and themes.

Perinatal Culture and Leadership Programme:

- Follow up staff engagement event planned for September.
- Progressing a "who's who" leadership board for staff groups, following initial SCORE survey and culture conversations.

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

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Perinatal Quality Surveillance

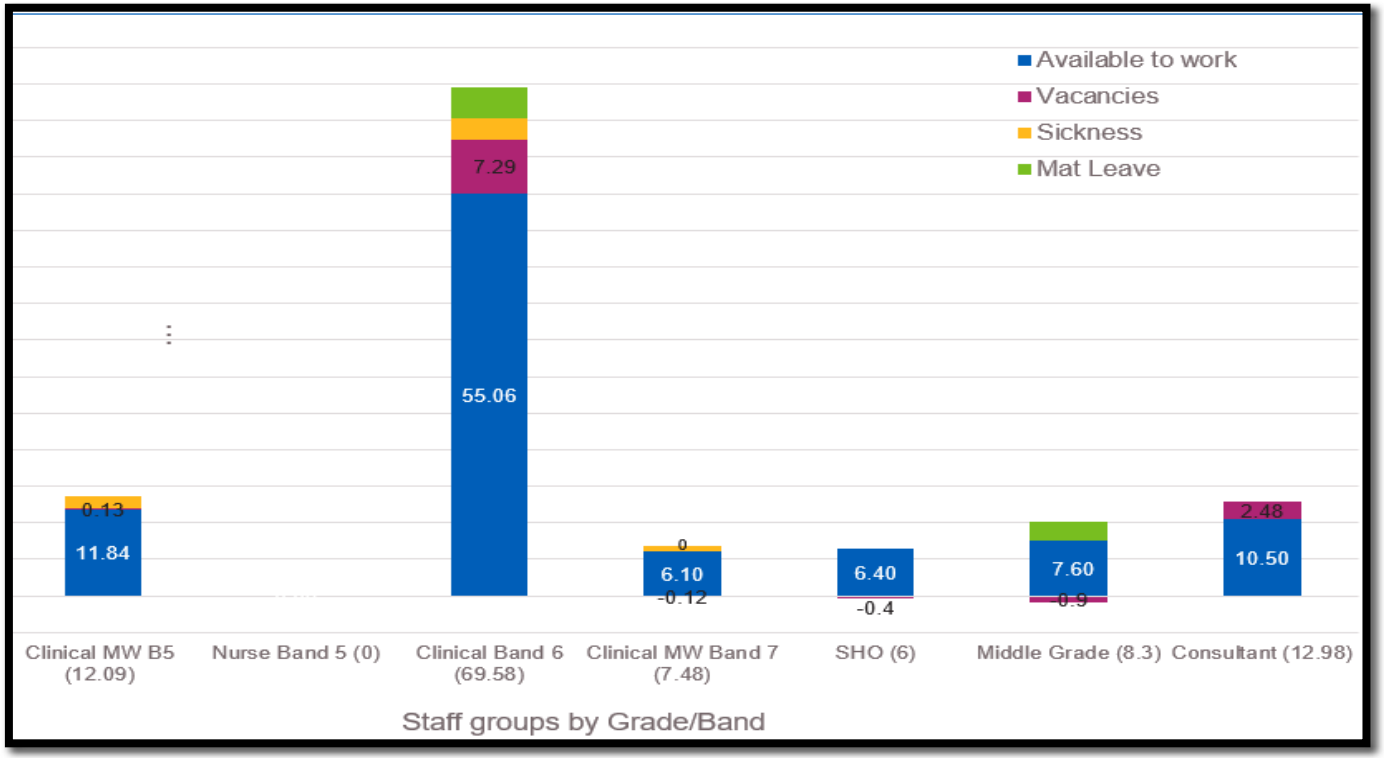
June 2025 (May Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was favourable this month showing 84% compliance of required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show a decrease due to increased levels of short long-term sickness and staff reduction in contracted hours.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this.

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Mar '25	April '25	May '25
Midwives	Day	91.4%	93.6%	96.2%
	Night	96.7%	95.4%	97.5%
MCA / MSWs	Day	83.7%	83.8%	78.3%
	Night	83.9%	89.7%	86.7%
NNU Nurses	Day	95.2%	89.7%	93.7%
NNU Nurses	Night	98.7%	98%	99.8

Countermeasures / Action (completed last month)	Owner
- Review of sickness absence management compliance – new process implemented. - MCA Recruitment	HOM Workforce lead

Countermeasures / Action (planned this month)	Owner
Monitoring of new sickness absence management process.	HOM

Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		Mar '25	Apr '25	May '25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1:27	1:28	1:29	Ratio increased this month due to an increase in births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	73.2%	81.11 %	79.03 %	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		60	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	61.2%	56%	37.1%	Neonatal staffing on risk register and acuity being assessed daily, datixed as appropriate. Business case being written and recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.
- BAPM compliance reduced, activity being monitored and support given on a shift-by-shift basis to maintain safe care.

What are the top contributors for under/over-achievement?

- The Midwife to Birth ratio increased this month due to increased acuity and births.

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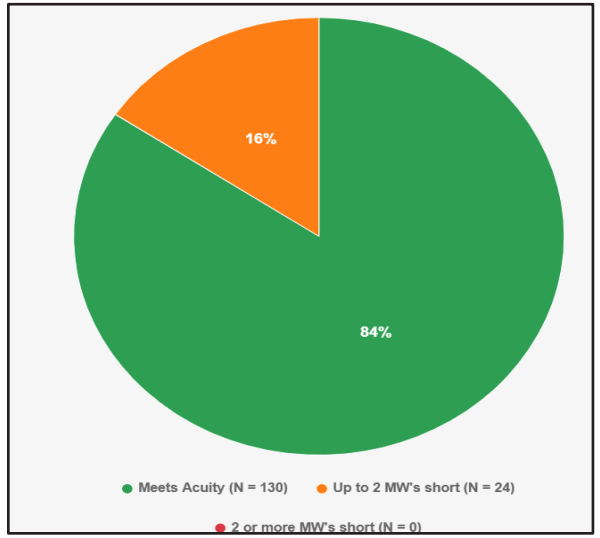
Graph 1. Acuity by RAG vs staffing data:

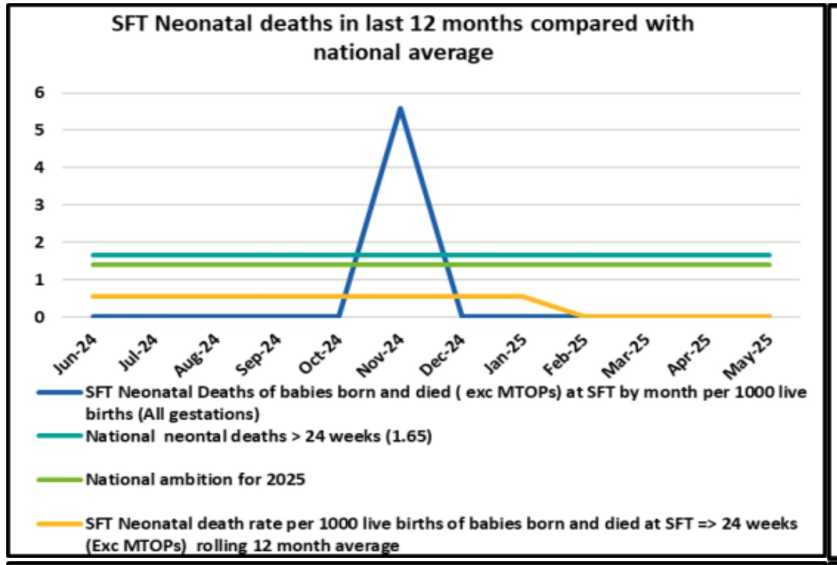


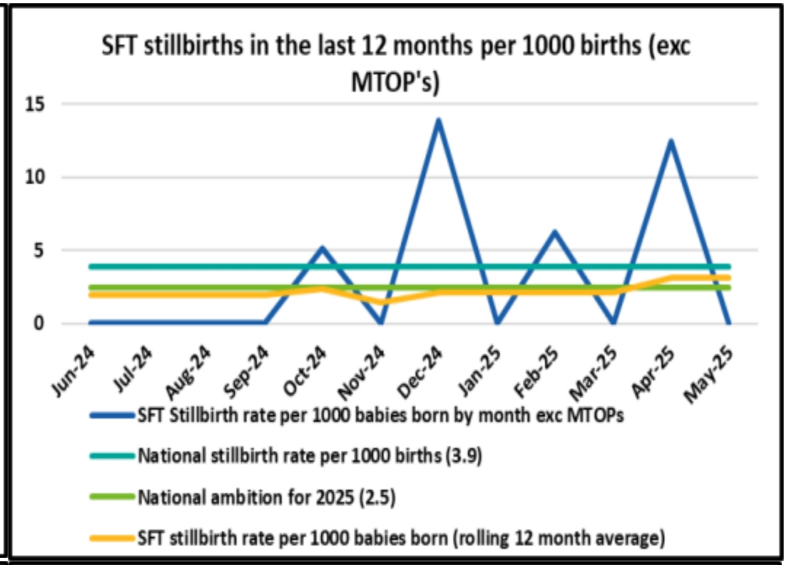
Countermeasures / Action (completed last month)	Owner
- NNU Nurse Band 5 recruitment - Band 5 Preceptee Midwife recruitment (October cohort) - Band 6 Midwife recruitment	HOM Practice Ed lead Inpatient Matron

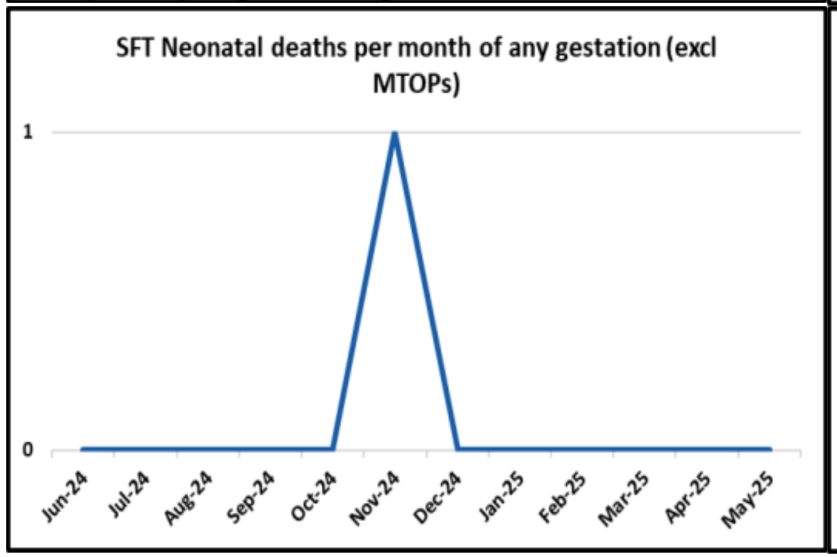
Countermeasures / Action (planned this month)	Owner
- Neonatal Matron recruitment - Neonatal Quality and Safety Lead Nurse recruitment	HOM Interim Neonatal Matron(s)/ HOM

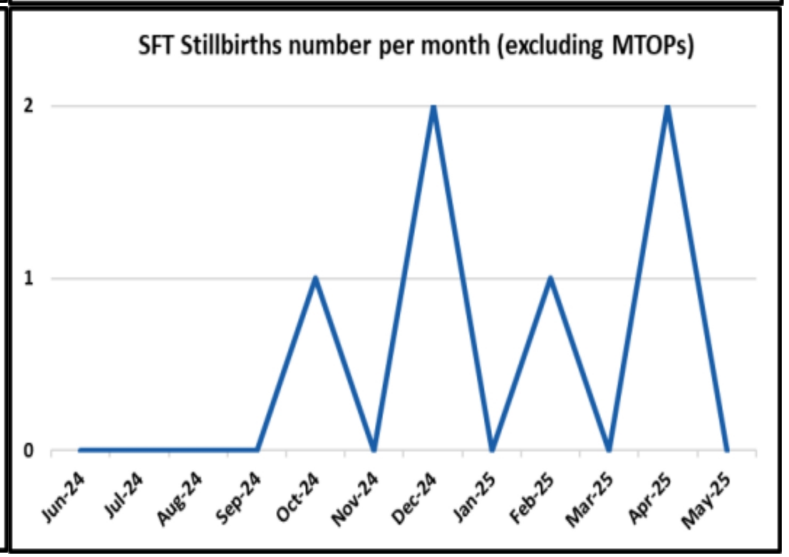
Safe: Perinatal Mortality Review Tool (PMRT)

Salisbury NHS Foundation Trust









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 7. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- May's stillbirth rate means SFT rate just over national ambition, however, remains under national stillbirth rate.

- There were 4 perinatal losses in May >12 weeks.
- One stillbirth of a multiple at 37+3 weeks following a reduction procedure (MTOP) . (Please not this was added to April's comments in error, this does not impact on the figures.
- One Miscarriage at 12 +4 weeks
- One MTOP at 14+3 weeks
- One MTOP at 22.2 weeks

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

PMRT ID and PMRT Review date	Incident	Grading of care	Outcome/Learning/Actions	MNSI Reference	SI? Reference
97465 2/5/2025	Antepartum stillbirth at 32+6 weeks	Grading of care up to the point the baby had died: GRADE C Grading of care of the mother after the baby had died: GRADE B	**Issue:** no DNA policy for patients planned to attend DAU **Action:** explore the processes used by SFT and other local care providers around follow up of women not attending within the recommended time frame by the triage midwife. **Issue:** delay in transfer of the patient from the home setting to the maternity unit **Action:** support SWAST in their case review. To share case learning with LMNS once SWAST case review complete for exploration with LMNS RE centralised triage. **Issue:** there was a delay in processing initial blood results. **Action:** safety notice circulated for staff to call the lab when sending bloods via the pod system (whooshy) or, taking bloods to the lab by hand when urgent results are needed. **Issue:** discussions are ongoing with the transfusion team regarding processes and equipment used to support the use of blood products in a major haemhorrage in maternity and actions will be confirmed following further discussions.	NA	NA

INCIDENTS: Moderate Incidents and PSRs

Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (Datix)	Date of Incident	Category	Incident Summary	Comments	PSII Commissioned?	MNSI Ref	PSII Ref
176861	13/05/25	Moderate	Term Admission to NICU	Initial triage complete, pending full review		N/A	
176882	15/05/25	Moderate	Equipment issues EMCS	Initial triage complete, pending full review		N/A	
177109	30/04/25	Moderate	Ferinject staining	PSR 1 presented, awaiting PSR2	N/A	N/A	N/A
177164	24/05/25	Moderate	IOL – Breech presentation	Initial triage complete, PSR 1 in progress	N/A	N/A	N/A
177163	23/05/25	Moderate	ANC inbox not checked and missed urgent referrals	Initial triage complete, pending full review		N/A	
177224	22/05/25	Moderate	Shoulder Dystocia	Initial triage complete, pending full review		N/A	
177305	29/05/25	Moderate	2L PPH (needed transfer to main theatres)	Initial triage complete, pending full review		N/A	

INCIDENTS: Investigation update

Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date of Incident	Category	Incident Summary	Outcome / Learning / Actions
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report

PSR's Submitted

Datix	Date presented	Category	Incident Summary	Outcome / learning / actions
174396	13/5/2025	Moderate	In utero twin transfer	PSR 2 in draft as further questions asked
175961	20/5/2025	Moderate	Term Admission to NICU	PSR 2 in draft as further questions asked
176186	20/5/2025	Moderate	25+5 IUD	For PMRT
171321	22/5/2025	Moderate	Term Admission, Naloxone Use	All babies requiring Naloxone must be admitted to NICU for monitoring
173673	22/5/2025	Moderate	Term Admission	Reminder of paired cord gas sampling, use of NEWTT, consideration of Terbutaline, paediatric attendance reminder to be sent

Responsive – Patient Experience

NHS Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Positive birth experiences
- Parents feel well looked after

Areas for improvement:

- No Cot Cards given – parents sad to see this go
- Badger – Not giv
- Lack of continuity of midwives and doctors (especially hard when high risk)

Complaints and Concerns

Complaints received	Summary / themes
4	• Dissatisfied with aspects of their labour ward and postnatal care • Feedback following management of postnatal bladder care • Poor communication in the AN period. • Poor communication and management of postnatal complications

Concerns received	Summary / themes
0	None.

Safety Champions

Concerns from staff	Action
• *No safety concerns raised by maternity or neonatal staff*	N/A

Items for escalation...

None.

Friends and Family Test

- **As Maternity Services moved to BadgerNet in February, this has had an impact on FFT maternity reporting during March/April/ May 25.**
- **No responses in May.**

Service User Compliments

- **3 compliments reported on Datix in May for NNU and maternity services.**

Compliments - top themes	Numbers received
Friendly /Gratitude and Support	3

YOU SAID WE DID

You said, we did...

Improve the environment on labour ward.

Labour rooms have now been repainted.

Health Inequalities – Priorities

NHS Salisbury NHS Foundation Trust

Listening events: No listening events held in May.

Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data.

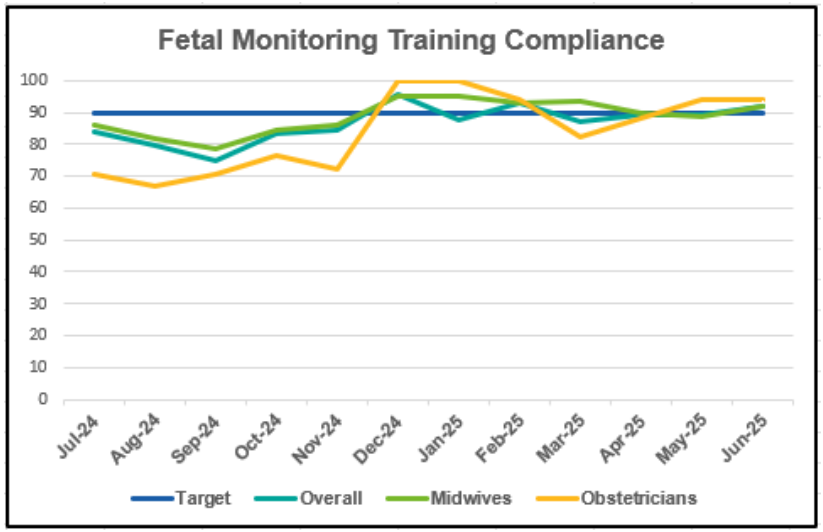
Translation service:

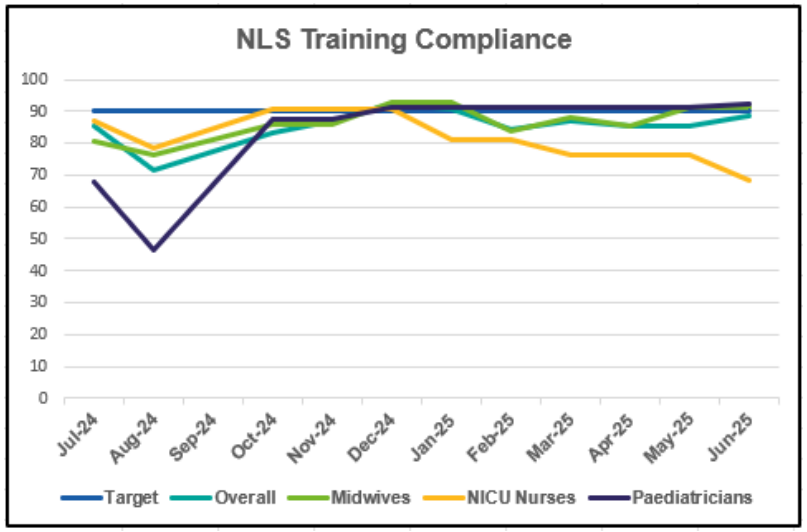
- Renewed emphasis has been placed on the implementation of the Translation toolbar on the Trust's website. The Translation toolbar is on the risk register. IT department are in talks with the provider, in the hope of securing a competitive quote for all three Trusts.

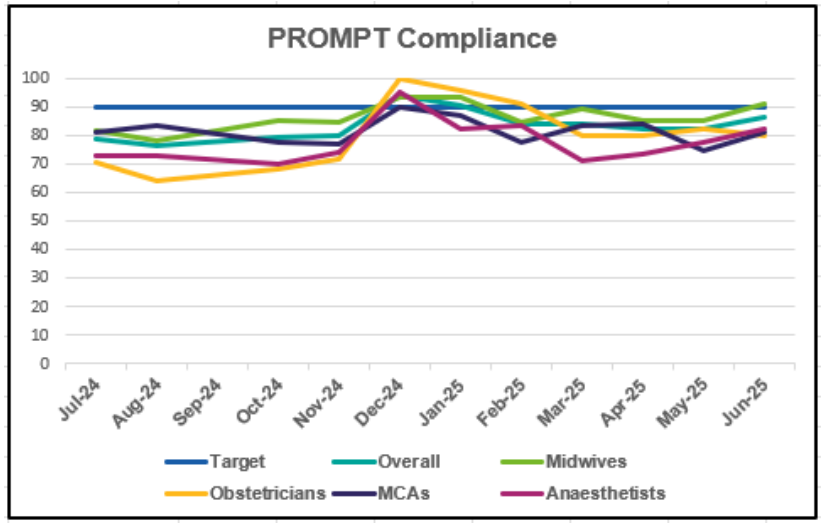
- Implementation of Pocketalk: Steady progress has been made. CSA and Hazard Log has been approved in principle by the CSO. Further conversation is needed to establish the next steps in the Governance process, as it is anticipated that the project will need approval from the Digital Steering Group and OMB

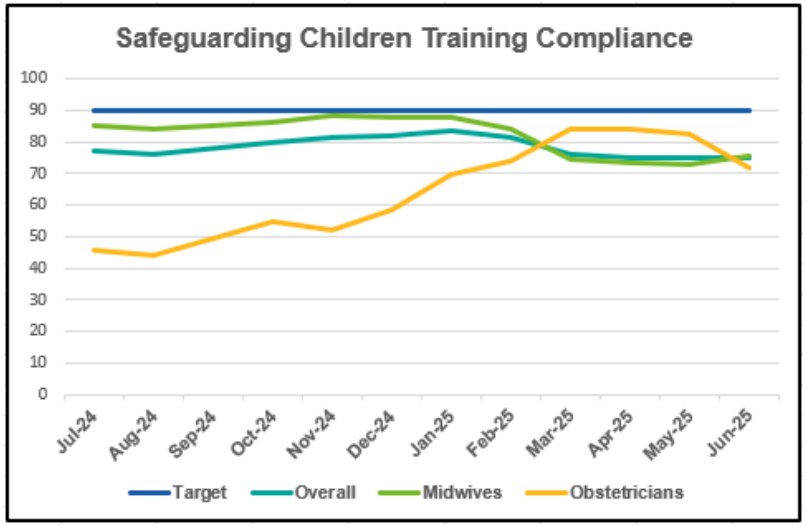
Well-led: Training

Salisbury NHS Foundation Trust









Training:
Updated training plan commenced in 2025 to meet the Core Competency Framework Version 2 (CCFv2) requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/ action:
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team). All out-of-date midwives are now booked onto training this year.
- NICU staff are trained in NLS on an adhoc basis when staff are available. This has fallen recently due to shift patterns (nights/weekends) but all out of date nurses are booked in for June.

Risks:
- MDT attendance (obstetric) at all PROMPT and fetal monitoring training is a challenge and has dropped below the 90% compliance required for PROMPT. All obstetricians continue to be booked to attend these study days but often have competing workloads on the day meaning they drop in and out of training.
- Obstetric face-to-face SBL Elements training has been incorporated into rotating obstetricians' induction programmes, scheduled for July and August.

Compliance to National Guidance (1)

Salisbury NHS Foundation Trust

CNST Maternity Incentive Scheme (Year 7)

Maternity Incentive Scheme (CNST)

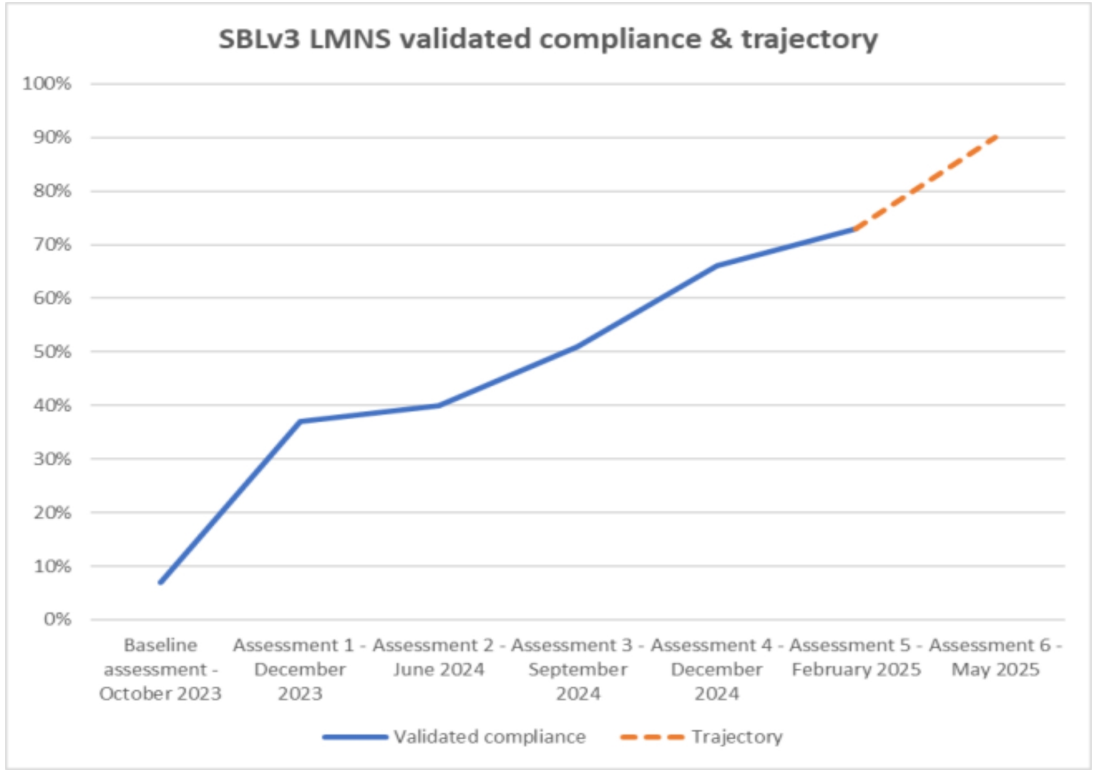
Progress within month:

- The working group continues to meet monthly to monitor compliance of all Safety Actions and have an opportunity to raise any concerns.
- Business Case for Neonatal Nursing workforce submitted to Trust Investment Group meeting in June, in line with action plan for Safety Action 4.

Next steps for progression:

- Action holders to identify reporting timeline for each safety action and minimum evidence requirements – for discussion at June's working group.

Saving Babies Lives v3



Saving Babies Lives v3

Key Achievements:

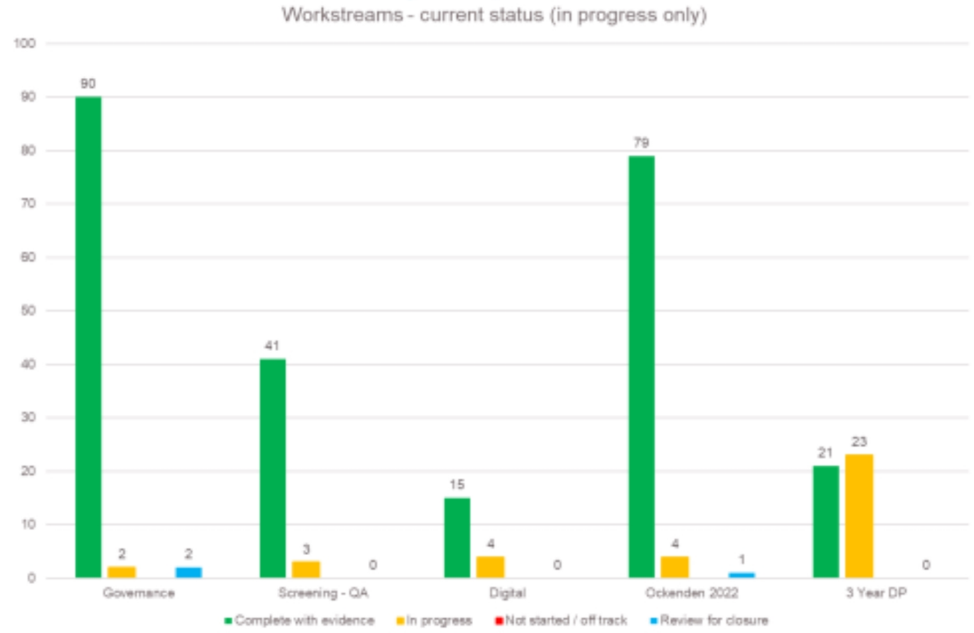
- SFT have achieved 73% compliance with our February 2025 submission.
- May submission submitted 13/05/2025

Next steps for progression:

- Final feedback for latest submission will be given in mid June.

Compliance to National Guidance (2)

Maternity Improvement Plan



Maternity Improvement Plan

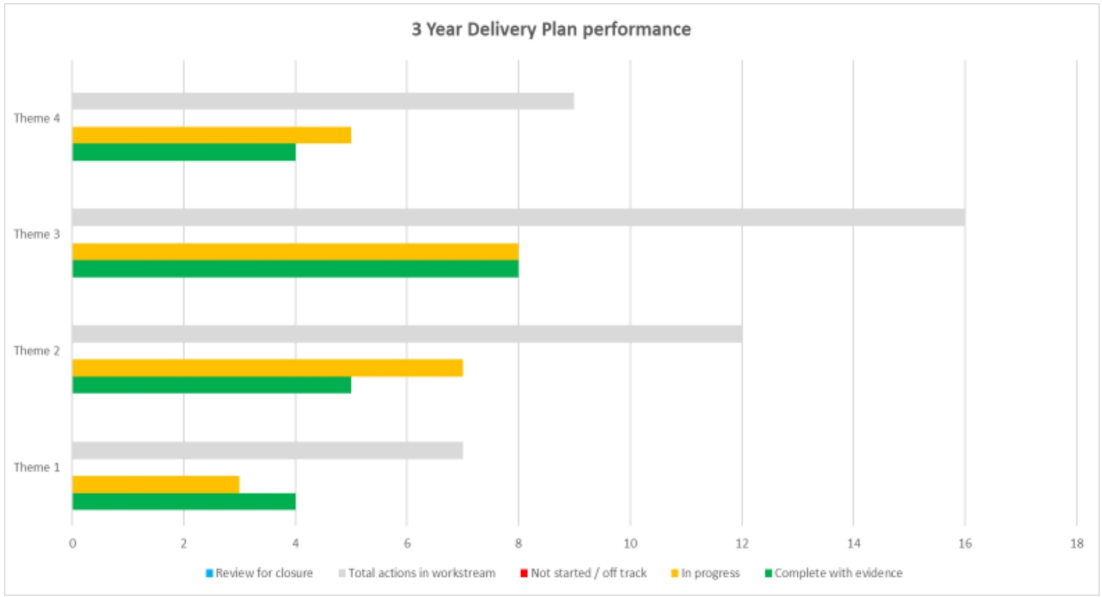
Key Achievements:

- Continue to progress all actions month on month
- Majority of workstreams now included in monthly Maternity Improvement Group meetings

Next steps for progression:

- Continue to focus on remaining 5 open workstreams; Governance, Screening – QA, Digital, Ockenden 2022 & 3 Year Delivery Plan.

3 Year Delivery Plan



3-Year Delivery Plan

Key Achievements:

- Of the 44 actions; 21 have been completed.
- The remaining 23 are in progress and no concerns identified.
- Trust board updated of progress

Next steps for progression:

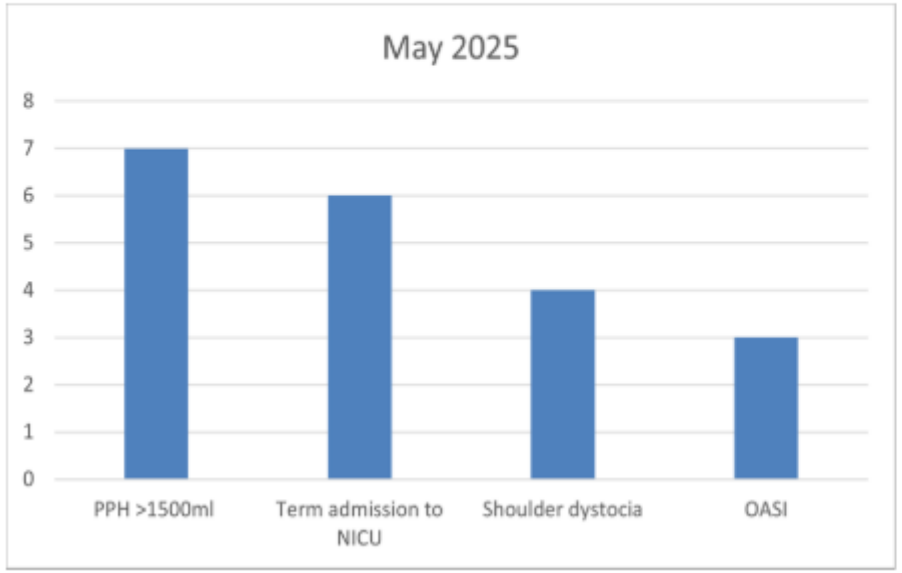
- Continue to meet with action holders.
- Provide evidence of completed actions for sign off at MIG

Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

Ongoing Rolling Audits



Results:

- Ongoing rolling audit data for PPH >1500ml, Term Admission, Shoulder Dystocia and OASI are ongoing.
- All are currently within the trust target range for May.

Actions:

- All cases are currently reviewed using the Datix Proforma and uploaded to the Datix case through the portal.
- Any emerging themes are identified and if learning is available, this is disseminated.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- Staff event undertaken on Friday 25th April 2025; with a focus on OD&L, Wellbeing, opportunity to learn what we are doing as a quad and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024. It was very positively received, and staff appreciated the time to come together and celebrate the team.

Actions in progress:

- Follow up staff event planned for September.
- Progressing a "who's who" leadership board for staff groups, following initial SCORE survey and culture conversations.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	
24 June	03 July 2025		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee, Finance and Performance and People and Culture Committee have reviewed the BAF in the June Committees			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Lisa Thomas, Managing Director			
Appendices:	Board Assurance Framework June 2025 Summary CRR Tracker v1 June 2025 Corporate Risk Register June 2025			

Recommendation:

Trust Board are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- Risk Appetite

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

The risk appetite was approved by the Board in October 2024. This was a significant process change which included adoption of new risk types, risk definitions and risk appetite. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to

risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and CRR dashboards. Given the pace of change across BSW and the rapidly evolving leadership and operational delivery model, the Board have acknowledged that a review of the risk appetite is required. This workshop will require the subject matter experts who were involved in the development of the latest risk definitions to be present. A date is being worked through for September.

There is significant change impacting the organisation over the coming 12-18 months, predominately driven from moving into a group structure, the changing NHS landscape of changing role of ICB, regional expectations of financial recovery and significant changes in leadership roles at SFT, namely Chair, MD, CPO, and NEDs.

The overall risk profile acknowledges the elevated level of risk due to the pace of change required across the system to ensure financial sustainability with associated increases in scores for finance and workforce related risks. Three corporate risks have moved within tolerance.

Key risk areas remain unchanged:

- Collective response to new operational models and navigation of the overall strategic landscape and complexity with the right leadership and skills to address all the competing priorities.
- Managing demand and capacity and delivery of operational performance targets.
- Responding effectively through partnership models to financial and workforce instability.
- Investment in and development of digital and technological infrastructure and skills to support the business.
- Have sufficient workforce (both clinical and non-clinical) with the correct skills and competence.
- Investment in and development of the estate.

The strategic risk profile (BAF) has not changed significantly since last reported. Noting the above, the risk profile is reflective of the significant risks the Trust is facing as we enter 2025/26 relating to the financial position, risk to delivery of the 2025/26 Operational Plan given the scale and pace of transformation required, the estate and digital resilience.

The 12 strategic risks remain unchanged. Score increase for BAF risks 2 and 10 reflect the system capacity to offer mutual aid to support fragility in services and the National NHS landscape changes and uncertainty this has generated.

There are 11 BAF risks out of tolerance, unchanged since the last report. The key risks noted above are under regular Board scrutiny.

There are 20 risks on the CRR, unchanged since the last report. There are no new risks. The corporate risk profile is reflective of the key challenges relating to the financial position, workforce sustainability, the estate and operational challenges relating to demand and capacity. Three risks have moved within tolerance since the last report, with 14 risks now out of tolerance compared with 17 risks last reported. This reflects strengthening of clinical service provision (ERCP and gastro) and ongoing work to mitigate the risk relating to data quality with the Trust Mandatory training reporting.

The Trust Internal Auditors, KPMG concluded a review in May 2025 of the top strategic and emerging risks across their internal and external audit client base as at quarter 3 2024. This includes 50 NHS Trusts and Foundation Trusts across England (31 acute providers and 19 specialist, ambulance, mental health, community providers and ICB's). The Trust has received the report which provides analysis and questions for consideration by the Board and Audit Committee to consider.

The report findings need to be considered by the Executives and will be reported in the next report.

In the June Board Committee meetings, the discussion focussed on the risk appetite and need to review this given the current operating context. This will be picked up in a Board seminar session in the coming months.

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

Salisbury NHS Foundation Trust

Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report

Purpose

1.1 The purpose of the report is to provide an updated BAF and CRR providing all relevant information to the Board and Board Committees on the risks to achievement of the strategic objectives and their management.

2 Background

2.1 The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. The provision of healthcare involves risks and being assured is a major factor in successfully controlling risk.

3 Summary Strategic Risk Profile

3.1 Overall summary

The overall risk profile acknowledges the elevated level of risk due to the pace of change required across the system to ensure financial sustainability with associated increases in scores for finance and workforce related risks. Three corporate risks have moved within tolerance.

Key risks going into 2025/26 areas remain unchanged:

- Collective response to new operational models and navigation of the overall strategic landscape and complexity with the right leadership and skills to address all the competing priorities.
- Managing demand and capacity and delivery of operational performance targets.
- Responding effectively through partnership models to financial and workforce instability.
- Investment in and development of digital and technological infrastructure and skills to support the business.
- Have sufficient workforce (both clinical and non-clinical) with the correct skills and competence.
- Investment in and development of the estate.

The strategic risk profile (BAF) has not changed significantly since last reported. Noting the above, the risk profile is reflective of the significant risks the Trust is facing as we enter 2025/26 relating to the financial position, risk to delivery of the 2025/26 Operational Plan given the scale and pace of transformation required, the estate and digital resilience.

3.2 BAF summary

The 12 strategic risks remain unchanged. Score increase for BAF risks 2 and 10 reflect the system capacity to offer mutual aid to support fragility in services and the National NHS landscape changes and uncertainty this has generated.

3.3 BAF Risks Out with Tolerance

There are 11 BAF risks out of tolerance, unchanged since the last report. The key risks noted above are under regular Board scrutiny.

3.4 **CRR summary**

There are 20 risks on the CRR, unchanged since the last report. There are no new risks. The corporate risk profile is reflective of the key challenges relating to the financial position, workforce sustainability, the estate and operational challenges relating to demand and capacity. Three risks have moved within tolerance since the last report, with 14 risks now out of tolerance compared with 17 risks last reported. This reflects strengthening of clinical service provision (ERCP and gastro) and ongoing work to mitigate the risk relating to data quality with the Trust Mandatory training reporting.

New risks since May 2025:

There are no new risks.

Risks removed:

No risks have been removed.

Risks with an increased score:

- Risk 8102 (Population): Vacancies within central booking. Score 10 to 12. Score reviewed and change reflects increase in likelihood but decrease in consequence.
- Risk 7734 (Partnership): Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services. Score 15 to 20.
- Risk 7308 (Partnership): The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Score 15 to 20.

Risks with a decreased score:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 12 to 9
- Risk 8188 (Population): Inability to recruit ERCP practitioners and service impact. Score 12 to 8.
- Risk 8344 (People): The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects. Score 12 to 9.

3.5 **KPMG Strategic Risk Benchmarking**

The Trust Internal Auditors, KPMG concluded a review in May 2025 of the top strategic and emerging risks across their internal and external audit client base as at quarter 3 2024. This includes 50 NHS Trusts and Foundation Trusts across England (31 acute providers and 19 specialist, ambulance, mental health, community providers and ICB's). The Trust has received the report which provides analysis and questions for consideration by the Board and Audit Committee to consider.

The report findings need to be considered by the Executives and will be reported in the next report.

4 Summary

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The overall risk profile acknowledges the elevated level of risk due to the pace of change required across the system to ensure financial sustainability with associated increases

in scores for finance and workforce related risks. The current risk profile reflects the operational, financial and workforce challenges which ultimately have potential to impact the quality of care provision.

5 Recommendations

5.1 The Trust Board is asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework
- Corporate Risk Register
- The risk appetite

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.

Fiona McNeight
Director of Integrated Governance

Salisbury NHS Foundation Trust

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

Board Assurance Framework
June 2025

Fiona McNeight

Director of Integrated Governance

Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Trust Values

The core values and behaviours to support the achievement of the Trust vision:

Strategic Priorities

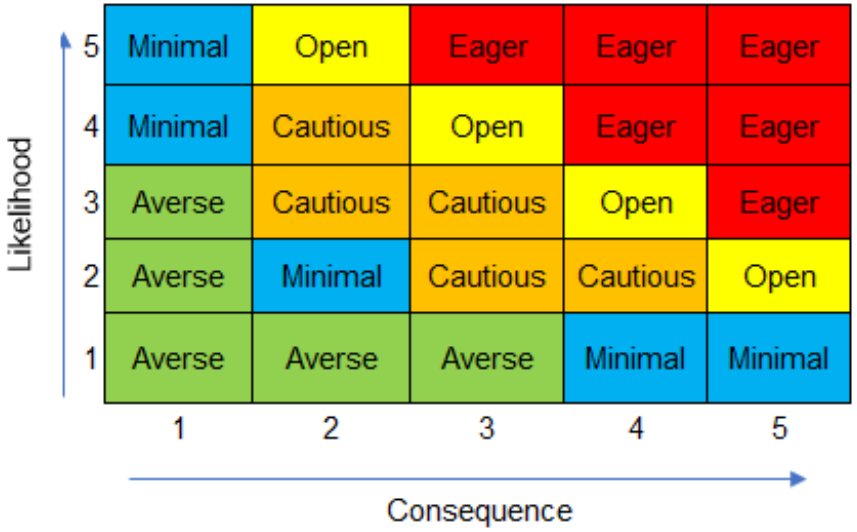
Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	Consequence/Impact →				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	Moderate 5	High 10	Significant 15	Significant 20	Significant 25
4 Likely	Moderate 4	High 8	High 12	Significant 16	Significant 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Significant 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Tolerance Scores	Risk Appetite Level
15+	Eager
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Risk Appetite



Averse — Avoidance of risk and uncertainty is key objective

Minimal — Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Cautious — Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Open — Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Eager — Willing to be innovative and take on a very high level of risk but only in the right circumstances

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Jun-25	Target	Risk Type	Risk Appetite	Risk tolerance
Risk Detail			Score Trend											
POPULATION - Improving the health and wellbeing of the population we serve														
BAF 1	Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model	Chief Finance Officer	12			12	12	12	16	16	6	Operational	Cautious	
BAF 2	Due to the size of our catchment population there is a risk that some services are not sustainable	Chief Medical Officer	15	10	12	12	12	8	8	12	8	Clinical	Minimal	
BAF 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff	Chief Digital Officer	16	12	12	12	12	12	12	12	9	Operational	Cautious	
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Finance Officer / Director of estates	12	16	16	16	16	16	16	16	12	Operational	Cautious	
BAF 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.	Chief Digital Officer	20				20	20	20	20	15	Operational	Cautious	
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20	16	16	12	12	12	12	12	9	Clinical	Minimal	
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work														
BAF 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2025/26.	Managing Director	16			16	16	12	12	12	8	Workforce	Cautious	
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20	16	12	12	12	12	12	12	9	Workforce	Cautious	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Jun-25	Target	Risk Type	Risk Appetite	Risk tolerance
PARTNERSHIPS - Working through partnerships to transform and integrate our services														
BAF 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability	Chief Finance Officer	12	16	16	16	20	20	20	20	9	Financial	Cautious	
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Managing Director/ Chief Operating Officer	9	9	9	9	9	9	9	12	6	External	Cautious	
BAF 11	Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan	Managing Director	16						16	16	9	Financial	Cautious	
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16	12	12	12	12	12	12	12	9	Clinical	Minimal	

Risk Score Key
Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

	Within tolerance
	Out of tolerance

BAF Risk 1	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic and financial benefits not being realised including and impact the delivery of the Trust future operating model.
Strategic Priority	People, Population, Partnership
Linked Corporate Risks	
Executive Lead	Chief Transformation and Innovation Officer
Lead Committee	Finance and Performance
Risk Type	Operational
Risk Appetite / tolerance	Cautious

Risk Score 2024/26

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	Mar 25	Jun 25	Target Score
12				12	12 3Lx4C	12 3Lx4C	16 4Lx4C	16 4Lx4C	6 2Lx3C

Context

Becoming a digitally mature organisation with a fit for purpose, integrated Electronic Patient Record (EPR) is a key enabler of the Trust's strategy. The EPR business case articulates the range of anticipated clinical, strategic and financial benefits expected to be achieved through transformation in part driven by the implementation of the EPR. This includes the reduction of duplication and waste as well as the ability to improve access and reduce variability in outcomes across the BSW Acute Hospital Alliance.
Deployment of a common EPR across three acute Trusts is a complex technical and change management process, requiring significant acquisition of skills within our existing workforce and through new recruitment. The level of change both in pathways and culture to maximise the potential of the Shared EPR. Given the multifaceted nature of the programme and the wide range of strategic plans the EPR will enable, the risk that delay or ineffective delivery is substantial.

Score 16 given delays in completion of data collection workbooks and the care identity service 2 integration with the Shared EPR. Plan expected to see a c.2 month delay (see point 3 in current challenges below). Risk score will reduce once assurance is provided on mitigating further risk of delay.

Controls

- BSW shared EPR programme board in place.
- Joint Committee established to oversee EPR programme at AHA level. Both meet monthly.
- Monthly EPR Delivery Group (Dep COO led) established, with EPR Oversight Group (MD led) to oversee delivery of local actions, any emerging risks/mitigations and impact of wider change.
- SFT board level engagement in all key aspects of EPR delivery.
- Delivery partnership with Oracle Health.
- Weekly EPR Programme Team meeting with workstream leads
- Delivery partners in areas such as Data Migration in place. St Vincent's critical friend role in place.

Assurance

- Joint committee governance reporting to three boards within AHA
- Phased deployment plan with project milestones overseen by programme board, escalating to joint committee
- NHSE oversight of EPR programme progress and gateways with assurance reviews
- Berkeley independent assurance
- Internal Audits for local Audit Committee assurance

Progress

What is going well/ Future Opportunities?

Implementation oversight governance agreed including NED led Joint Committee meeting bi-monthly.
Resourcing for the programme including local and central team established.
First "align" gateway passed in November 2024 with a few areas work in progress, remediation actions largely complete.
Localisation phase nearing completion with Future State Review in July 2025.
Requirement to develop plan to consolidate EPR impacted digital teams across group by June 2025.

What are the current challenges including future risks?

1. Digital transformation has a legacy reputational issue within SFT.
2. Significant change programme delivery already occurring with SFT and the Hospitals Group, engagement with staff up requires improvement to ensure ownership and benefits realisation.
3. Delivery of programme on time and budget.
4. Lorenzo end of life with limited supplier development to resolve issues identified and comply with Information Standard Notices.

How are these challenges being managed?

1. Strong executive oversight at all levels of digital governance, increased leadership briefings to be embedded by Apr 25.
2. Strengthened digital clinical leadership capacity, recruit Group CSO role, EPR programme integrated with Improving Together continuous improvement methodology at Hospitals Group and organisational level, oversight of quantum of change through MD led group. St Vincents reviewing EPR comms and engagement plan to improve it where required.
3. EPR Programme Director in post, EPR governance manages risk portfolio, St Vincent's critical friend role commenced. Paper approving delay and rephased plan to be signed off by EPR Joint Committee. Group CTIO commenced and reviewing programme.
4. National escalation on any severe incidents/requirements, monthly supplier engagement to influence development priorities

BAF Risk 2	Due to the size of our catchment population there is a risk that some services are not sustainable		
Strategic Priority	Population		
Linked Corporate Risks	8188, 5704		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	Risk Appetite / tolerance	Minimal

Risk Score 2024/26									
Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25	June 25	Target Score
15	10	10	12	12	12 3Lx4C	8 2Lx4C	8 2Lx4C	12 3Lx4C	8 2x4

Context

Increasing public professional and regulatory requirements resulting in increasing specialisation which is resource intensive and difficult to provide in a Trust of this size.

Sustainable services is a clear priority for BSW ICB and the Trust strategy.

The Group model provides opportunities for strengthening fragile services that are critical to the sustainability of the Trust to be identified through the development of the Group Strategic Planning Framework (SPF)

This risk links with BAF risk 7 given the challenges to recruitment and retention of staff in these fragile services.

Increasing recognition in the South-West region in relation to coalescence of fragile services in certain areas and specialties.

Controls

Work has been initiated at BSW Hospitals Group level to develop an approach to transformation and rationalisation of services in line with NHS Planning Guidance.

Development of service 5 year strategies aligned to SFT and BSW Hospital Group Strategic Planning Frameworks.

Work commencing in SW Region to understand fragile service hotspots.

Assurance

Sustained and/or improving performance metrics

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
The requirement of health and Care legislation to actively collaborate affords an opportunity to redesign services to ensure delivery for the population of BSW as a whole which may be impacted by the developing Group Model with transitional support in place.	1. Pace of change required for large scale reconfiguration. 2. Cultural change required to deliver service benefit through collaborative transformation. 3. Recent increased instability in Oral and MaxFax surgery requiring Mutual Aid. 4. Failure of controls compromising ability to deliver a service. 5. Requirement for high-cost agency staff to provide temporary resilience.	1. Development of Group Model effectiveness with transitional support. 2. As 1. 3. Procure mutual aid where necessary. 4. Mutual aid, and/or consider closing or reconfiguring service. 5. All the above plus internal governance on temporary medical spend.

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks	7472		
Executive Lead	Chief Transformation and Innovation Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/26

Initial Score	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Dec 24	Mar 25	Jun 25	Target Score
16	12	12	12	12	12 3Lx4C	12 3Lx4C	12 3Lx4C	12 3Lx4C	9 3Lx3C

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.

As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks a slower response to identified clinical or operational risks and requirements, meaning the Trust will be accepting a higher level of associated risk until programmes can be completed/systems introduced. The Trust also may not be able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Current score remains at 12, recognising Trust financial position increases risk associated with sufficient funding to deliver wider elements of the Digital Plan.

Controls

- Monthly Digital Steering Group in place with robust digital governance below this, including programme governance.
- Comprehensive clinical digital leadership in place.
- Digital Innovation Network launched to increase digital profile including digital champions and digital superusers to support change and ownership, further maturing expected with EPR
- Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
- Joint CDO, CIO & Deputy CIO across SFT & GWH. Interim Group CTIO commenced.

Assurance

- Monthly Digital Steering Group minutes.
- Regular Digital Plan updates to Board sub-committees.
- Annual board Digital Plan update
- Regular minutes from BSW shared EPR programme board with updated governance being set up.
- Rolling cyber desktop exercises results
- Rolling local digital comms plan
- Fortnightly risk review meetings in place

Progress

What is going well/ Future Opportunities?

Opportunity to build resilience across Hospitals Group Digital structures, building on Corporate Services Review work in Nov 23. Plan to be delivered in line with timeframes of Corporate Services Review.

What are the current challenges including future risks?

1. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
2. Some digital programmes are behind original plans.
3. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
4. Clinical engagement is limited due to operational pressures.
5. Recruitment and retention of Clinical Coders and gap in Business Intelligence leadership.
6. Clinical Safety Officer role currently vacant and not sufficient for Hospital Group working.

How are these challenges being managed?

1. Prioritisation of programmes through Corporate Projects Prioritisation Group to ensure the change agenda is realistic and QIAs completed for those unfunded or de-prioritised programmes.
2. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
3. Seeking opportunities for national funding to support programmes.
4. Shared EPR leads identified to champion and engage with wider peers, EPR critical friend supporting review of EPR comms and engagement plan.
5. External coding support agreed at risk for 2025/26 with wider business case awaiting approval with ICB. Hospitals Group digital service development work to resolve Business Intelligence leadership risk.
6. CNIO holding CSO responsibilities with Group CSO commencing in Aug 24.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	7734, 6229		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	Risk Appetite/Tolerance	Cautious

Risk Score 2024/26

Initial Score	Jun 23	Sept 23	Jan 24	May 24	Sept 24	Dec 24	March 25	June 25	Target Score
12	16	16	16	16	16 4Lx4C	16 4Lx4C	16 4Lx4C	16 4Lx4C	12 3Lx4C

Context

SFT has a substantial estates backlog (£78m – 2024) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long-term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond) but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on compliance reporting completed in 2024 and recommendations currently being followed through.

Assurance

Significant improvements in estates governance and risk management introduced including the 10 year capital programme compiled, with investment forecasts for estates backlog and a 5 year plan for year on year spend.
Estates compliance status clearly recorded. Majority of targets achieved. One extreme risk outstanding, most highs reduced. Continued progress to mitigate and conclude compliance actions Mid 2025 before moving to business as usual.

Progress

What is going well /Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Estates strategy renewal, mobilised with target completion March 2025
- Estates strategy update will incorporate Campus project for long term development
- Funding allocated for development of urgent care centre
- Seed funding allocated for DSU replacement
- Bid of circa £5m approved by National Estates Safety Fund

What are the current challenges including future risks?

1. Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
2. Competing demands for Trust capital each year.
3. Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.
4. Estates backlog value (£78m) is not actual cost to deliver Likely value £140m
5. Limited electrical infrastructure on campus impacting future redevelopment opportunities
6. Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
7. Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
8. Day surgery unit remains Trust highest priority.
9. Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
10. Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
11. National targeted resources do not address key resilience issues
12. Patient environment quality being compromised e.g., spinal unit
13. Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

1,2 - Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework alongside digital, medical equipment
1,8- Continued lobbying for major service developments – DSU
3- The frequency of maintenance is adjusted where possible, trying to ensure statutory requirements and best practice are maintained, this can result in increased issues at a later date and increased cost pressures.
6 - Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
9 - Investigations into strategic partnership models to allow development and investment of the estate.
7,9,10 - Continued review of poor-quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
10 - Increased scrutiny of estate requests via space management committee. Management of space utilisation 'creep'.
12 - Estate's strategy mobilised
11 - Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
13 - Board paper planned to present options for on-site residential accommodation

BAF Risk 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.
Strategic Priority	People, Population, Partnership
Linked Corporate Risks	Nil
Executive Lead	Chief Transformation and Innovation Officer
Lead Committee	Finance and Performance
Risk Type	Operational
Risk Appetite / tolerance	**Cautious**

Risk Score 2024/26

Initial Score	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Dec 24	Mar 25	Jun 25	Target Score
20					20 4Lx5C	20 4Lx5C	20 4Lx5C	20 4Lx5C	15 3Lx5C

Context

The Global cyber position is a continuous evolving picture with new threats on a daily basis, therefore the inherent risk to the NHS remains high. The impact of a cyber attack is wide reaching, disrupting clinical care and operational delivery, increasing the risk of reputational damage and legal challenge due to the risk of data availability and loss. A cyber attack will impact whether it is directly against the Trust or indirectly against a partner or third-party supplier.
The Trust has a range of controls and processes in place, engaging with national, regional and local peers to provide a networked approach to cyber security. However, a cyber attack can commence very easily, and it is impossible to have complete cover. Recent cyber events highlight that the healthcare supply chain is an increasingly targeted area.
The NHS's cyber strategy for healthcare to help ensure organisations maintain good cyber posture, protect as one and focus on staff awareness and development as this is often an attack vector.
Given this is an inherent risk, the expectation is that this risk will always be out of tolerance.

Controls

- Local cyber security team in place
- Digital Steering Group oversight of cyber plans
- Modern and secure cyber security technologies including VPN, antivirus, Bitsight, endpoint protection, medical equipment, IoT, modern firewalls, etc
- Security patching controls
- Multifactor authentication on NHS Mail
- Cyber awareness programme and phishing feedback/retraining
- Member of ICB TDA Cyber Group and National forums including Cyber Associates Network and Executives Forum
- Close engagement with NHSE regional cyber lead

Assurance

- Weekly tech group minutes,
- Unsupported servers replacement programme
- Monitoring of Infrastructure downtime
- IT Health Assurance Dashboard oversight
- Quarterly cyber report to FIDC
- Annual Data Security and Protection Toolkit (DSPT) internal audit and penetration testing
- DSPT submission with annual internal audit assessment as part of this
- Cyber awareness plan
- Phishing testing
- Annual cyber framework reviewed at Trust Board

Progress

What is going well/ Future Opportunities?

Trust met DSPT standards for 2024/25.
Good coverage of cyber toolsets to monitor the Trust and respond to cyber events.
The Trust has a high Bitsight score showing good internet facing cyber posture.
Opportunity for closer ICS working and national funding through ICS wide procurements.
Opportunity with corporate services review to align cyber tooling across group and move towards joint oversight and management of cyber risk.

What are the current challenges including future risks?

1. Improvement required in Cyber Security Preparedness, in particular stronger planning for business continuity for longer term cyber attack.
2. Trust is required to expand Multi-Factor Authentication (MFA) in line with national policy.
3. Alignment of cyber security controls and policies across the Hospitals Group and ICS will enable improved support in the event of a cyber attack.
4. Supplier controls and oversight requires enhancement given recent cyber attacks.

How are these challenges being managed?

1. Review existing and planned system business continuity plans for extended outages and for systems which are shared across the region/clinical networks to ensure plans are fit for purpose. Starting with new Pathology LIMS.
2. MFA improvement actions to provide assurance of application MFA compliance ahead of June 2025 CAF (new DSPT) deadline. Challenge provided to internet facing suppliers who do not offer MFA.
3. Softcat cyber gap analysis for all ICS partners completed in Feb 2025 highlighting variation. Group corporate services restructure a key enabler to align security controls.
4. Engaging with existing suppliers to clarify the current position on sub-contractors/dependant suppliers, assurance of supplier penetration testing and preparedness with support from ICS procurement team.

BAF Risk 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2025/26.		
Strategic Priority	People		
Linked Corporate Risks	7308		
Executive Lead	Managing Director		
Lead Committee	Board of Directors		
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/26

Initial Score	June 24	Sept 24	Dec 24	March 25	June 25				Target score
16	16	16 4Lx4C	12 3Lx 4C	12 3Lx 4C	12 3Lx 4C				8 2Lx4C

Context

The Board is transitioning to a new group model which alongside the change in National policy and expectations alongside system transformation plans bares a significant impact on resources and capacity.

There are several key changes in the coming months including, new interim Chair, new MD, the CPO post becoming vacant pending a group model. There are still two interim executive Directors COO and CFO. Changes in executive team can mean loss of organisational knowledge and experience which in the short term can slow progress or risk delivery which impacts on the reputation of the organisation.

There are a number of strategic objectives which will render significant leadership capacity including replacement EPR and financial recovery which dilutes capacity on BAU improvements.

Controls

Board oversight of key metrics through IPR

BSW Hospitals Group Joint Committee on EPR to ensure oversight and shared delivery.

Interim mitigation plans enacted for all roles

Remuneration committee for oversight of performance.

Succession planning in place

Assurance

- Engine room oversight of breakthrough metrics/strategic initiatives and vision metrics to focus on delivery and risks which is demonstrating slow, steady progress in the achievement of our objectives.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interim roles predominately held by SFT substantive employees maintaining organisational knowledge. Managing Director substantively recruited to	• Uncertainty about group governance structures leading to further attrition in key roles. • Attracting high calibre candidates in context of uncertainty as group governance develops.	- Regular executive team development . - Recruitment process planning underway - Board oversight of risks and strategic programme

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.										
Strategic Priority	**People**			**Risk Score 2024/26**							
Linked Corporate Risks	7472, 8102, 5704, 8188			Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25	June 25	Target Score
Executive Lead	Chief People Officer												
Lead Committee	People and Culture Committee			20	16	16	12	12	12 3Lx4C	12 3Lx4C	12 3Lx4C	12 3Lx4C	12 3Lx4C
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**										

Context	Controls	Assurance
Quarterly pulse survey continues to show a maintained position against all elements of the People Promise although a slight deterioration in some areas (show initiative and make suggestions at work). National Staff Survey shows an improved position across all elements 7% uplift in engagement and lead Trust for "looking forward to coming to work" There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, golden handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme' which continues to be successful. Financial target includes a WTE reduction of 220wte for 25/26 which has remained off track all year. Breakthrough objective maintained this year to increase staff retention/reduce turnover of HCAs from 20% to 15% as not achieved for 24/25 (17.93% M12). Current position at month 1 is 18.3%. Alongside a revised Trust all staff turnover of 12% (12.25% M1). On-going challenge to attract Consultant medical workforce in specific specialties (links to BAF risk 2) and major cause of Agency spend Significant focus of work channelled into corporate services redesign seeking to achieve a 17% cost reduction.	Weekly Workforce Control Panel overseeing vacancies Financial recovery group meet monthly and includes workforce HCA recruitment and retention facilitator in post Staff retention remains a breakthrough objective with clear focus Active update and review of all people policies which are being written and implemented in support of a just and restorative culture. Workstreams for all 7 elements of the People Promise benchmarked against staff survey. Monthly and quarterly governance schedule established. Established leadership development programme plus launch of the people management skills modular programme and Scope for Growth People Promise Manager retained with an extended portfolio to include widening participation IPR metrics monthly reporting Corporate services redesign steering group	Improved vacancy position as a result of attraction incentives; less than 2% - the lowest ever Maximum take up on the leadership development, wellbeing and appraisal training courses Time to hire recruitment process – significant reduction to 35 days Sickness absence 3.7% (M1) - higher on wards/ nursing staff Turnover c 13%

Progress

What is going well/ Future Opportunities?	What are the current challenges/future risks?	How are these challenges being managed?
Leadership including clinical leads first introduced this year with good uptake. Leadership engagement – practical support including investment and participation Head of Education leading improvement projects e.g. increasing apprenticeships/Safe Learning Environment Charter Development of a strategic workforce plan. NHS Ambassadors and take up of work experience in the Trust Data preparation and focus on workforce controls Dedicated focus on Talent Strategy and succession plan for Exec direct reports	1. Increasing retention and reducing turnover 2. Line managers capacity & capability to manage exit interviews and complete appraisals 3. Non-Medical Appraisal compliance – slow improvement 4. Manager's capacity to manage staff wellbeing and career development due to operational pressures. 5. Lack of Strategic workforce planner 6. HCA retention 7. Increasing ward-based absence	1. A comprehensive improvement programme against all 7 elements of the People Promise and focus on breakthrough objective (turnover). 2. Approach to appraisal & career conversation part of talent and succession planning launch. Soft launch of c18 modules for Line managers, formal launch of required core modules April 25 (Licence to Manage). 3. Improving line manager training. 4. As per 2. 5. Outstanding – post to be considered at WCP 6. Breakthrough objective for 25/26 7. Detailed breakdown of absence data to be shared with ward leads

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	7573, 8260, 5751, 8250		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	Risk Appetite / tolerance	Minimal

Risk Score 2024/26

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25	June 25	Target score
20	16	16	16	12	12 3Lx4C	12 3Lx4C	12 3Lx4C	12 3Lx4C	9 3Lx3C

Context

Our operational context remains challenging with demand for Urgent and Emergency services currently outstripping our capacity and this is consistently meaning patients are waiting for treatment longer than the national constitutional standard, which can also lead to substandard care.

Demand within urgent care continues to grow at 10% year on year, coupled with sustained high levels of No Criteria to reside (NCTR) patients which is leading to the continued use of escalation capacity and putting undesired pressure on clinical services which is compromising efficiency and effectiveness of the operational flow and compromises patient care.

Inconsistent adherence to processes, both internally and externally contributing to prolonged length of stay and overcrowding in ED.

The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an ageing population . The ongoing level of patients in the hospital who are medically fit for discharge impact on available beds to see and treat planned care patients.
All of the above has the potential to impact on the quality and safety of care.

Controls

UEC Board with underpinning workstreams in place.

SFT escalation capacity plan in place.

BSW UEC plan to reduce demand and NCTR and enable bed closures, commenced April 2025.

Assurance

Overall bed escalation and bed occupancy has decreased since Q4 2022/23.

Model hospital showing reduction in length of stay from 12.5 days to 10.75 days.

The UEC programmes of work show positive benefits which have helped to mitigate growth and NEL growth, ED attendances and NCTR.

ED 4hour performance in line with the National average

Progress

What is going well/ Future Opportunities?

Improvement plan developed to deliver BSW UEC trajectories with system partners to help reduce NC2R to 9% of bed base during 25/26 and ED 78% & average ambulance handovers 18 mins.

Successful delivery of the UEC plan

What are the current challenges including future risks?

1. High NCTR bed occupancy limiting available bed capacity and ability to close beds.
2. Continued use of escalation areas (24 beds) which may compromise surgery rates and enhanced pay costs
3. On going workforce challenges within a number of specialities. Eg frailty team.
4. Continued growth in NEL demand and sustained level of NCTR that is higher than forecast/planned.
5. Ageing estate is limiting productivity opportunities.

How are these challenges being managed?

1 – 4: Throught delivery of the BSW UEC plan with oversight from SFT UEC Board

5. Capital programme

BAF Risk 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability		
Strategic Priority	Partnership		
Linked Corporate Risks	7472, 6857, 7308		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Financial	**Risk Appetite / tolerance**	Cautious

Risk Score 2024/26

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	Mar 25	Jun 25		Target Score
12	16	16	16	16	20 5Lx4C	20 5Lx4C	20 5Lx4C	20 5Lx4C		9 3Lx3C

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led to a reducing cash balance, in turn constraining its ability to invest in capital programmes.

Continued pressure on urgent case pathways and agency pressures driven by hard to recruit posts have led to this position deteriorating leading to a requirement for cash support, and due to the financial pressure across the NHS the availability of cash support is increasingly uncertain. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.

Although BSW has agreed a break-even plan for 2025/26 with cash-backed deficit support, with delivery contingent on a cash releasing savings programme of 5%, early financial performance within the system has led to deficit support funding being initially witheld.

Controls

ICB engaged in supporting SFT cash position through phasing of contractual payments.
Finance & Performance Committee oversight of cash position with escalation to Board.
Agreement of annual financial plan including cash requirements.
Escalation to ICB and engagement in NHSE revenue support process.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on maximising the clinical outputs of the Trust while maximising the input resource required.
Enhanced BSW recruitment and investment controls

Assurance

External audit value for money assessment.

Monthly reporting on performance and forecast through Financial Recovery Group, escalated to Finance and Performance Committee.

Cash flow forecasting included in Finance and Performance Committee reporting.

Reporting of improved productivity as demonstrated by Creating value for the patient: Improving productivity breakthrough objective measurement

Third party assessment on financial plans and efficiency programme undertaken with BSW

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maintain ERF delivery through a reduced cost base. BSW hospital group transformation programme to commence with implementation partners procured. Acute services transformation director appointed. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	1. Delivering CIP plans against identified opportunity in context of significant operational challenges. 2. Increasing proportion of savings programme will have to be delivered through clinical service transformation. 3. Adequate cash reserves to service capital programme 4. Medium term financial outlook is uncertain 5. Long term capital programme needs to be assessed against available CDEL and additional funding sources. 6. BSW transformation programme immature and not fully developed.	1. Improving together programme improving a structured approach to change. 2. Working with ICS to develop BSW sustainability programme. 3. Engagement in capital cash support programme 4. BSW mid-term plan under development 5. Trust and BSW strategic capital groups developing prioritisation. 6. BSW-wide oversight through System Recovery Group, chaired by BSW ICB CEO. 10 programmes of work established. Transformation director appointed.

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.		
Strategic Priority	Partnership		
Linked Corporate Risks	Nil		
Executive Lead	Managing Director/Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	External	Risk Appetite / tolerance	Cautious

Risk Score 2024/26									
Initial Score	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25	June 25		Target Score
9	9	9	9	9 3Lx3C	9 3Lx3C	9 3Lx3C	12 4Lx3C		6 2Lx3C

Context

The Integrated Care Board continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery. With NHSE announcement that ICBs are going to merge, the likelihood score has increased. This is driven by an increase in the uncertainty of the future model, the role of place and the disruption to existing relationships.

Without partnership working within Wiltshire, one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients. To help mitigate the challenges and changes in the NHS commissioning landscape, the Trust is focusing on its relationship with the key providers, ie Wiltshire Council and HCRG.

Controls

ICB and Wiltshire PLACE with SFT representation
SFT executive representation within ICS workstreams
SFT regular working forums with the Council and community providers
HCRG

Assurance

HCRG launching their transformation plan

BSW HG supporting relationships within ICB

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
New Community services tender creates an opportunity for a reset. Wiltshire Council have relaunched the aging well board.	1. Place based working still in infancy, further work to progress placed based strategy for integrated care. 2. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups. 3. New partner for SFT with HCRG winning community tender and establishing new models of care. 4. Ongoing challenges to reduce patients waiting for onwards care and working with Local Authority colleagues to improve pathways and length of stay.	1. The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. 2. Exec team members developing relationships with professional colleagues, attending stakeholder events. 3. Community service programme board being established.

BAF Risk 11	Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan.		
Strategic Priority	Partnership		
Linked Corporate Risks	7308		
Executive Lead	Managing Director		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2025/26

Initial Score	March 2025	June 25						Target score
16	16	16 4Lx4C						9 3Lx3C

Context

There is a risk the Trust does not have the capacity or capability to deliver the transformation required to meet the national planning guidance leading to reputational failure and risk of regulatory action.

The Trust is part of a group and ICS which has significant transformation priorities including reducing financial deficit, improving urgent care pathways and improving RTT performance. The scale and pace of change is significant.

There are significant layers of transformation required to achieve the performance, quality and financial targets including implementing system and group transformation programmes for urgent and planned care, internal change programmes to SFT to improve outpatients, length of stay and corporate services improvements. This also sits alongside the change in Electronic Patient record roll out.

Controls

Trust SPF
Planned care and urgent Care boards for transformation
BSW Delivery groups monitoring performance delivery.

Trust reports performance against agreed trajectories within the IPR.

EPR governance and oversight in Joint committee and programme boards.

Assurance

Limited assurance at present until plan initiated in 2025/26

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
• Trust SPF in place to guide transformation priorities alongside with CPPG process to ensure resources aligned. • Trust submitted compliant plan for 2025/26 but with key identified risks.	• Delivery groups across the system in infancy and establishing change programmes which may delay significant change e.g., reduction in demand management impacting on bed closures. • Group SPF in infancy so risk priorities may not be aligned and increase resource requirements.	• Group support in place to improve governance and oversight and alignment of priorities. • Group Board Assurance Framework to be developed to provide oversight of strategic risk at Group level

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	**Population**		
Linked Corporate Risks	5751, 7573, 8250, 8260		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2024/26									
Initial Score	Sept 23	Jan 24	June 24	Sept 24	Dec 24	March 25	June 25		Target score
16	12	12	12	12 3Lx4C	12 12 3Lx4C	12 3Lx4C	12 3Lx4C		9 3Lx3C

Context

There is a risk that all performance targets (Cancer, Planned Care, Diagnostic targets, Urgent Care standards) are not improving in line with the agreed trajectories or meeting the requirements of the national planning guidance due to significant gaps in workforce, continued NEL pressure, issues in discharging NC2R pts and increase in demand leading to potential harm for patients awaiting treatment.

There remains risk of regulatory action if the Trusts fails to meet agreed access targets.

Controls

Planned care and urgent Care boards for transformation
BSW Planned Care Board and Elective Recovery group
Delivery group monitors performance weekly
Cancer improvement group
BSW UEC plan.
Divisional restructure and appointment of lead for outpatient performance to focus on Time to First Outpatient Appointment (TT1OPA)

Assurance

Planned Care Board data showing reduction in surgical time to first outpatient appointment.
Improvement in cancer performance overall.
TT1OPA is reducing.
4hour ED performance in line with National average

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during 24/25 Q2& Q3 with additional capacity and focused recovery. Have eliminated all pts waiting over 78 weeks and almost completely eliminated 65 week wait The Trusts cancer performance has significantly improved during 24/25 and is anticipated to remain above the national target level. Launching additional outpatient transformation work.	1. Number of Patients referred for planned treatment is increasing; 2. Significant issue with Plastic breast reconstruction services due to Consultant capacity. 3. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients.	1. Strategic initiative in Strategic Planning Framework (SPF) focussed on right sizing specialties to meet future demand. 2. Service development plan being rapidly worked up. 3. Dedicated urology cancer improvement programme with the cancer alliance.

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link / (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Do not expect it to happen again but it is possible	Moderate	6	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/12/2025	6	Population	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings -Internal audit reports highlighting weaknesses in controls and processes. (Auditors are assured by responsiveness of recomendations)	N/A
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa												
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly												
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa												
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan												
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy												
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew												
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan												
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy												
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy												
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan												
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan												
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan												
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan												
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan												
										Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark												
										Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark												
										Financial management responsibilities reflected in managers 'appraisal process	30/06/2024	05/06/2024	Ellis, Mark												
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the BSW hospitals group. This could result in the Trust not being able to improve performance (quality, people, operational & financial) as far as it could have if the programme had stayed on track.	Do not expect it to happen again but it is possible	Moderate	6	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Trust Board	01/09/2025	6	People	Trust Board (Corporate Risk Register)	Director of Transformation	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by Managing Director. Reporting will include progress against the October 2024 to March 2026 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes. 03/09/24: Coach House beginning to track if improvement huddles are active and supporting teams to set up their performance review meetings. 03/03/25: Process in place through maturity self assessments to ensure performance review meetings at specialty and team level are rolling out and going ahead. Updated 03/03/25	05/06/24: Process confirmation of the routine use of Improving Together tools such as the improvement huddle boards and divisional weekly driver meetings. This is beginning to be picked up in Divisional Performance Review meetings and the Executive huddle. 03/03/25: Current gap remains in relation to assurance that this is happening on a weekly basis.	- Monthly reviews in preparation for the Improving Together Programme Board between the Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. 05/06/24: Any off-track workstreams have known and owned actions in place to bring them back on-track. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives including progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. 05/06/24: - Review and monitoring of training place utilisation on a weekly and monthly basis by the Coach House team. - Quarterly maturity self-assessment by the divisional management teams 03/09/24: Starting to be able to describe how many active huddles and PRMs we have. updated 03/03/2025	Behind trajectory of Improver Advanced training - 05/06/24: new training approach using masterclasses now in place to mitigate this - 03/09/24: It has been difficult to bring staff to this new set of classes. Attendance remains below optimal utilisation. 03/03/25: Attendance is rising in the masterclasses but still not optimal. 05/06/24: Process confirmation of the quarterly maturity self-assessment by the divisional management teams - who and how do we review the rationale and accuracy of the self-assessment. 03/03/25- Maturity self assessment by the divisional management teams now includes a peer review step. This is a new initiative and will be re-assessed in May 25. updated 03/03/25
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma												
										Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther												
										Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter												
										Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma												
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma												
										Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma												
										Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024	05/06/2024	Cox, Emma												
										Develop and deliver the next Improving Together sustainability roadmap session on 15th July 2024 to map out the next 18 months of the programme (October 2024 to March 2026).	16/07/2024	03/09/2024	Talbott, Alex												
										Socialise and develop the October 2024 to March 2026 roadmap with the deputies, divisions and corporate leads. Develop the workstreams in more detail with the leads and their respective executive sponsors so that come October we can manage against each workstream via the Improving Together Board.	30/09/2024	02/12/2024	Talbott, Alex												
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	8	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Department Team meeting	31/12/2025	8	Partnerships	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting	investigative fraud allegations show sporadic gaps in procedures.
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa												
8188	Surgery	Endoscopy	08/08/2024	Complaints, Directorate risk assessment, Incident reports	12	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the	Do not expect it to happen again but it is possible	Major	8	Intensive support for GI services	31/12/2024	17/03/2025	Dyos, Judy	Divisional Governance Committee	31/07/2025	6	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	09/08/2024	1. Clinicians in Southampton offer ad hoc support for complex cases that should be performed in tertiary units, and more clinically urgent cases that cannot wait to the next scheduled SFT session 2. There is some limited ability for the outsourcing company to deliver additional sessions to cover peaks in demand 3. An ERCP patient tracker has been introduced to have	1. The arrangement with UHS is ad hoc, reliant on good will and not supported by an SLA 2. Attempts at substantive recruitment to SFT posts have failed, and multiple options to provide more resilient and sustainable support from local partners in UHS and UHD have failed 3. An option to redeploy surplus capacity from a BSW AHA	1. Outcomes from the procedures that are performed at SFT (approx 115 per year) are satisfactory compared to regulatory standards Risk 7096: Able to provide lists confidently when team is in place	1. Recent complaint and related incident report 2. Informal concerns raised by service users (referring gastroenterologists) 3. Discussions with respected external expert opinions criticising service structure and model of provision Risk 7096:
										Surgery DMT to conclude discussions with GWH around mutual aid, requesting executive support as required.	31/07/2025		Insull, Victoria												
										Investigate options of creating a SLA with Southampton clinician to support ERCP lists once a week	30/06/2025		Insull, Victoria												
8344	Organisational Development and People	Educational Training	10/03/2025	Data quality	16	The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects. This has the consequence of the Trust being unable to assure themselves on the compliance of core MaST across all staff groups with a risk that: 1.non-compliant staff may be treating our patients without up-to-date knowledge and certification.	May recur occasionally	Moderate	9	Data quality review and data corrected for accuracy within safeguarding training	01/09/2025		Mulshaw, Cris	Divisional Governance Committee	01/09/2025	4		Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Mulshaw, Cris	13/03/2025	Education have instigated an Improvement Plan, using A3 thinking, to work through the series of Data quality issues identified by the MLE team now in place. These can be summarised as: 1. Data quality - within the system there are issues with duplicate accounts, accounts with no line manager, un-enabled accounts, excessive number of groups. These all impact the accuracy of the reporting data.	Current resources available to correct the MLE system to ensure data accuracy are insufficient in terms of capacity and in terms of expertise. The team is currently developing their knowledge and expertise in manipulating the system. Kallidus (the provider) have a help desk academy that supports them. Their focus is divided with manning the MLE helpdesk - responding to daily queries & issues from staff.	Good corrective progress has now instigated reliable reporting with a new Power Bi framework; Data feed issues and Divisional naming issues have been resolved; Issues of duplicate accounts, records with no line manager, and excessive unwarranted and inactive groups have all bee addressed. 9 out of 11 core mandatory / statutory training courses are	Primary gap in assurance is the poor quality data held in MLE of Adults & Children's SAFEGUARDING compliance. We are unable to report accurately in this. The team are manually working through all records, with anticipated completion date of the end of June. The nature of the system and the knowledge/skills available make it difficult to assure that changes being completed
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	01/09/2025		Mulshaw, Cris												
										Secure funding to achieve Kallidus support to manage corrections and correctly establish system processes	01/09/2025		Mulshaw, Cris												
8054	Chief Executive	Trustwide	09/04/2024	Clinical Governance	9	As a result of out of date policies, there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	May recur occasionally	Moderate	9	Meeting with all Divisional Management Teams to agree policy management framework	28/06/2024	10/12/2024	Nye, Kylie	Trust Management Committee	30/09/2025	6		Trust Board (Corporate Risk Register)	Director of Integrated Governance	McNeight, Fiona	09/04/2024	Oversight of policy compliance reported to Trust management Committee. Dedicated resource in some divisions (W&NB specifically) providing oversight of compliance Named authors for each policy. Policy compliance report from Eolas Microguide transitioned to new Eolas system with improved	Consistent ownership and oversight of policy management across all divisions. Capacity of policy owners to review and update the policy and system	Improving picture of compliance with out of date policies No reported incidents relating to out of date policies	Guideline compliance requires further oversight
										Draft a new policy management framework	28/06/2024	10/12/2024	Nye, Kylie												
										Policy Summit to be held 3rd September	30/09/2024	10/12/2024	McNeight, Fiona												
										Compliance report to be presented to TMC now Microguide transitioned to Eolas	30/09/2025	15/06/2025	McNeight, Fiona												
7573	Operations Directorate	Trustwide	16/01/2023	Bed meeting	15	The risk of sustained use of escalation bed capacity (e.g. DSU, boarded beds) has an impact on patient safety and experience due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	May recur occasionally	Moderate	9	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	31/10/2025	9	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce Tisbury ward will close to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
										expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa												
										work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa												
										finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa												
										expansion of SDEC for surgery, AMU and Frailty. As funded by business plan. to further prevent admissions and need for beds	29/07/2025		Prosser, Niall												
										Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa												
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa												
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali												

5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	There is a risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	May recur occasionally	Moderate	9	Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali	Trust Board	30/09/2025	8	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	31/01/2019	Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways. 7477: 2.1 wte IBD consultants (x1 substantive 0.9, x1 fixed term 0.2 and x1 wte Locum consultant) Pathway navigator case agreed at TMC in Oct 22. Update Mar 23 - Pathway Navigator now in post and endoscopy nurse has stepped in to support IBD CNS team on secondment. Update June 23 - Substantive clinician leaving at the end of July and locum consultant moved on to substantive post in another hospital. Update November 2023 - Dr Cummings from Southampton has agreed to continue support and additional locum support from experienced IBD clinician offering 1-2 sessions per week. 02/09/24: Further recruitment of fixed-term consultant gastroenterologists; currently only one ID Medical employed at SFT. 12/06/2025: Recruited a further substantive gastroenterologist, further stabilisation of the fixed term consultant workforce has reduced reliance on insourced capacity. Period of executive intensive support generated action plan which is reviewed at Surgery DPR. Pathway transformation has resulted in significant improved access across multiple pathways. Collaboration with GWH in advanced stages to stabilise onsite ERCP provision.	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue. May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. 7477: Team not staffed to national standards across all MDT positions. Team unable to manage clinical caseload to meet national standards without the appropriate databases and monitoring pathways No trustwide solution for management of patients on high cost drugs as is in place at GWH / RUH. 02/09/24: Resignation of fixed-term gastroenterologist and subsequent threatened resignation of single substantive gastroenterologist (current clinical lead). 12/06/2025: Substantive consultant committed to SFT.	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists 30/05:Current substantive Gastroenterologist as clinical lead for service. 7477: Weekly team meetings in place to prioritise actions against risk June 23 - Improved service data now available and a service improvement plan now in place. Improved feedback from patients. November 23 - Engagement with Southampton Hospital for IBD longer term support. Business case development in process. DAWN software in use within the ICS which improves monitoring of patients on high cost drugs. Team preparing a business case to purchase for SDH 02/09/24: Access times for first outpatient appointments in several sub-specialties have improved significantly. No increase in complaints for service. Regular audit of ERCP outcomes compliant with national benchmarking.	Service is not meeting all required performance standards but this is understood and related to post-Covid elective recovery challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control August 23 - as June update. All subject to ongoing work overseen by Deputy CMO 7477: Current staffing not utilised effectively due to lack of service data. June 23 - further data needed to evidence the required increase in CNS resource. 02/09/24: Internal concerns being voiced by team members around quality, capacity and cultural issues within the team.
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew																	
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy																	
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy																	
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy																	
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart																	
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine																	
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy																	
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy																	
										To recruit medical and nursing staff for the GI Unit	28/02/2025	17/03/2025	Insull, Victoria																	
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham																	
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham																	
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael																	
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael																	
										Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael																	
										Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul																	
										CMO to report outcome of GI services review once complete.	30/09/2024	02/09/2024	Murray, Dr Duncan																	
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael																	
										Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael																	
										GI Unit enhanced support programme ongoing to identify strategic aims for 24/25 to address stats and service	28/06/2024	28/06/2024	Insull, Victoria																	
										02/09/24: GI services to be put into intensive support	06/09/2024	21/11/2024	Murray, Dr Duncan																	
										Exec intensive support programme for GI Unit stood up - lead by Judy Dyos. Actions related to priority areas of cultural behaviours and collaborative working, safety specifically related to ERCP provision, and plan to ensure service has long term sustainability being progressed through this.	31/01/2025	17/03/2025	Insull, Victoria																	
										To work through the action plan generated by the Executive Intensive Support programme.	31/10/2025		Insull, Victoria																	
8174	Surgery	Audiology	30/07/2024	NHS England	10	A national review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A regional assessment of SFT services has identified a high risk of potential harm and mandated a detailed review of @200 cases from 2017 to the present. There is a risk that the assessment could discover significant harm to children inadequately assessed historically and this could result in reputational and	Do not expect it to happen again but it is possible	Catastrophic	10	Service doing retrospective harm review, consistent with NHSE incident requirements.	31/03/2025	07/03/2025	Smith, Rory	Clinical Governance Committee	31/10/2025	5	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	30/07/2024	National agreed process for review is being coordinated by NHS England and BSW ICS well engaged leadership team in audiology have been recognized by the initial review visit and the service is felt to be safe to continue with extra measures (external double reporting)	Department have identified that it will take time and resources to attain national accreditation Extra resource may be required to complete historic reviews in a timely fashion (this is being supported by NHSE) 12/06/2025: Latest report from NHSE outlines number of	Initial review identified a good culture of improving and ownership of the issues within the department Clinical Governance Committee is sighted on the risk and has requested regular updates Process of historic review has been agreed with department and ICB and region.	until the retrospective review is complete the extent of any harm will not be known
										Awaiting NHSE report	31/03/2025	12/06/2025	Smith, Rory																	
										Completion of report recommendations	31/10/2025		Smith, Rory																	
8102	Surgery	Central Booking Office	23/05/2024	Access targets, Complaints, Data quality, Trusts Objectives, Waiting times	20	Current vacancy in rate in Central Booking 9.5WTE with a further 2.5WTE due to leave the department in the next four weeks. Current theatre utilisation is not meeting Trust KPI's with approximately 70 - 90 theatre slots not booked each week, this will increase due to pending resignations. There is a risk of patient harm due to a significant backlog of referral which have triaged but have not been transferred from eRS to Lorenzo. There is also a delay to patient follow up due to a further significant backlog of e-outcome forms meaning patients are not being added to follow up access plans in a timely manner. The staff are taking between 50 - 150 calls a day (depending on role) which adds an additional pressure and is blocking them from booking and processing urgent referrals. This may result in a loss of confidence from our clinical teams and patients.	May recur occasionally	Major	12	Review and revision of current operational structure, to ensure fit for future state, including career progression opportunities, to support recruitment and retention. Support provided by OD&P specialist	30/09/2024	16/10/2024	Critchley, Jennifer	Trust Board	31/12/2025	8		Trust Board (Corporate Risk Register)	Chief Operating Officer	Critchley, Jennifer		2 bank staff have been approved by WCP to help with eRS transfers. Secretariat team are supporting with booking forms and e-outcome forms wherever possible but this is not keeping on top of the backlog as minimal hours across the week. DMT initiative has taken place whereby senior managers were present in Central Booking W/C 13/05/24. Processes have been updated where clinical buy in supports - for example moving over to electronic triage. 14/03/2025: staffing has improved to an improved position. the service is starting to see improvement. a new structure has been put in place.	Further bank staff required to increase establishment until successful recruitment has taken place. Band matching exercise needs to be finalised to boost staff morale and reinstate faith and confidence in management team.	Proposal to revise current structure, including roles and responsibilities supported by Exec 2/7. Working with OD&P specialist to redefine JD's and career progression structure. Recruitment Team to support with appropriate advertising campaign in recognition of the criticality of these roles. Recruitment Team to support with identifying external agency solution to support in short term	Approx 70 - 90 theatre slots unbooked each week. Approx 7000 follow up access plans to be added to Lorenzo, currently on e-outcome form report, this is across all specialties / divisions with some particular areas of concern requiring a focused tie period to catch up, this will be achievable with the support of bank staff. Approx 1500 routine referrals to be transferred from eRS to Lorenzo access plans
										Short term mitigation to be agreed for either bank or external agency support. Recruitment team to approach external agencies to scope options to coincide with conclusion of bank support post college/university summer holidays.	31/01/2025	14/03/2025	Critchley, Jennifer																	
										02/06/25: Finance performance committee reviewing implications of administering a recruitment freeze.	30/09/2025		Prosser, Niall																	
7807	Trustwide	Trustwide	16/08/2023	Incident reports, Trustwide risk assessment, Violence and Aggression	20	As a result of a lack of community and acute mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also impacts on staff morale and staff retention.	Will probably recur, but is not a persistent issue	Moderate	12	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024	24/02/2025	Osman, Laura	Trust Board	30/09/2025	9	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs. As required Meetings with key agency to discuss current patients and plans to mitigate risk. Risk Assessments and care planning in conjunction with AWP and Oxford Health. 02/09/24: Excellent Partnership working between CAMHS & Paediatric team to mitigate risk. E.g weekly onsite case	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge. 02/09/24: Out of hours cover provision is at arm's length. Recent changes to this service not fully embedded and impact of changes not yet understood. 21/11/24: Poor attendance at Adult & Children's Mental Health operational groups and the Mental Health Steering Group.	Recent audit 28/05/24 demonstrated improved compliance with Mental Health Act. 02/09/24: Operational KPIs of MHLS consistently good. 12/06: Minimal evidence of incidents reported relating to delayed access to Mental Health assessments.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients (alongside increase in patient load and acuity). 28/05/24: Recent audit identified variability in meeting the requirements as set out in the Mental Health Act regarding informing patients of their rights. 21/11/24: We rely on internally produced data
										Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/03/2024	21/11/2024	Murray, Dr Duncan																	
										Meeting to improve governance structures and assurance processes regarding Mental Health groups	31/07/2025		Murray, Dr Duncan																	
										Arrange meeting between SFT and AWP clinical leadership to discuss interface between the two Trusts.	30/09/2025		Murray, Dr Duncan																	
7946	Transformation & IM&T	Trustwide	02/01/2024	Departmental risk assessment	12	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work, delaying the start of new work and spend more corporate resource time than budgeted.	Will probably recur, but is not a persistent issue	Moderate	12	Training refresher on project documentation in the transformation team	29/03/2024	05/06/2024	Arnett, Louise	Divisional Governance Committee	01/09/2025	9	Population	Trust Board (Corporate Risk Register)	Director of Transformation	Talbott, Alex	02/01/2024	05/05/24: Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery 03/09/24: Annual review of transformation workplan and resource alignment in conjunction with business planning round started in Sept/Oct 2024. Corporate Deep Dive 25/11/24: Align and connect resource planning with business planning for 2025/26 03/03/25: Transformation team has a driver in their performance review meeting, focused on project delivery and use of budgeted resources. This is reviewed on a monthly basis and worked on weekly.	Capacity and capability to deliver to time 03/09/24: A routinely used standardised approach to scoping and scheduling projects with robust SRO engagement with the timeline (i.e. we have the standard, but do we use it routinely?) Corporate Deep Dive 25/11/24: Capacity to demand mismatch for resource allocation to top contributing projects for achieving the organisation's plan. 03/03/25: There is a risk that Corporate Projects may be prioritised and started outside of a multi-portfolio review. This gap in control can lead to too much change going on at once. updated: 03/03/25	Good knowledge of transformation programmes and projects underway 05/05/24: Monthly review of on/off-track to project/programme plan at Transformation team Performance Review Meeting. 03/09/24: Increasing use of standard scoping and project documentation across the Transformation team is increasing accuracy of timelines and what's needed to achieve them. Corporate Deep Dive 25/11/24: Seeing a longer-term view (6-12 months) of which projects are coming down the pipeline than before. 03/03/25: Agreed as correct/current.	Programme slippage remains in some projects started before the introduction of the new standards. Sub-standard documentation. 03/03/25: Agreed as correct/current.
										Support provided to the Project Managers to practise and develop their knowledge of the Programme Management Industry Standard (PMIS) as all new projects and programmes are stood up. Peer review to be used to highlight best practise and share learning.	31/10/2024	25/10/2024	Lewis, Neil																	
										05/06/24: Implementation of standardised project documentation - including scoping, scheduling and project plan sign off by the SRO.	30/06/2024	31/07/2024	Arnett, Louise																	
										Track project delivery via transformation senior leadership team meeting	29/03/2024	05/06/2024	Talbott, Alex																	
										Continue to strengthen the role of Corporate Project Prioritisation Group (CPPG) by ensuring it runs monthly and routing resource requests and major resourcing changes via CPPG.	30/09/2024	25/10/2024	Talbott, Alex																	
										Action agreed at CPPG November 2024 : Review through future CPPG agenda item where project work has started prior to formal prioritisation and filtering / or emerged outside of annual business planning to ascertain whether we could have been more effective in our approach. This learning will help understand any change needed to CPPGs role and remit - or whether a change in organisational practice is needed	31/01/2025	25/02/2025	Arnett, Louise																	
										Action agreed at CPPG November 2024: To sense check that projects prioritised under an SI or BTO can show the link back as a countermeasure in the relevant A3 and CPPG to take a harder line in wanting to see that evidence and linkage when reviewing new work	31/01/2025	25/02/2025	Ellis, Mark																	
										Transformation Team to explore "resourcing" which is emerging as the top contributor to projects currently being off track. This requires a deeper understanding of the root causes and identification of countermeasures to address potential improvements	28/02/2025	04/03/2025	Arnett, Louise																	

											Transformation Team to explore improving through a new driver metric the scoping phase to include the following countermeasures Countermeasures: 1. Agree a set of criteria for what our scoping standards are. 2. Complete a deep dive of our historical and current projects to establish how these align to the agreed scoping standards.	30/06/2025		Arnett, Louise												
8250	Medicine	Farley Stroke Unit	26/11/2024	National guidance	20	Current national guidance requires acute stroke units to have access to enhanced neuro-imaging assessments for patients with acute ischaemic stroke 24/7. Patients are required to have an available slot for imaging within an hour from arrival at hospital. This includes provision of CT angiography and CT profusion 24 hours per day.	May recur occasionally	Major	12	Business case submitted to TMC and escalated to ICB. ICB investment committee rejected request but now escalated back to MDs meeting for further guidance on next steps.	23/12/2024	14/03/2025	Needle, Sarah	Divisional Governance Committee	31/10/2025	6		Trust Board (Corporate Risk Register)	Chief Operating Officer	Barrett, Mrs Jessica	03/12/2024	The Trust current sends patients to Southampton for mechanical thrombectomy. 14/03/2025: Trust has now agreed to proceed with the recruitment of the posts.	There is currently a business case in development which would include recruitment and training which would ensure provision of CT angiography and CT profusion to the required national standard.	There are currently no incident or complaint forms linked to this issue.	Audits: a Recent audit of data relating to advanced imaging indicated that there would be likely 69 patients per year who would be eligible for reperfusion treatments if national guidance was met.
										Recruitment of necessary team to enable expansion	30/06/2025		Needle, Sarah													
8260	Medicine	Directorate Wide	06/12/2024	Access targets	15	The planning guidance stipulated that for 25/26 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2026, with further improvement in 2025/26. SFT signed up to 78%. Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2025/26 towards pre-pandemic levels. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with a No Criteria to Reside, the Trust has been unable to meet the nationally agreed targets.	Will undoubtedly recur, possibly frequently	Moderate	15	Medical SDEC expansion & GP Assessment area development	01/12/2025		Bagg, Danielle	Trust Management Committee	31/10/2025	9		Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	06/12/2024	OPEL Card and escalation plans in place Daily capacity meetings x 4 Silver bleep holders and Matron of the day in place for the Divisions Wait 75 actions implemented to support flow when at risk of ambulance holds over 75 minutes EDEL levels within ED Escalation plans in place to flex ED and Wards when needed to support flow UEC Board in place to support improvements in UEC pathway Medical SDEC in place with plans to expand over next 12 months Surgical SDEC plan in place for January Frailty SDEC commenced and more support at Front door from Frailty team Implementation of Virtual wards NCTR working group in place - Breamore ward in place for	Further redirection in ED to external partners ie No alternatives in working hours Out of hours- significant gaps in community pharmacy GP collective action Inability to control demand Medical staffing to meet demand in ED	Reductions in LOS for medicine Increase in 0 Day LOS Data that supports increased demand Shortages in professional groups	Performance is below target Higher numbers of patients with NCTR than anticipated 02/06/25: pre midday discharges below national average.
										Surgical SDEC on Downton Ward	01/04/2025	17/03/2025	Byelong, Collette													
										Development of Frailty SDEC	01/12/2025		Lee, James													
										Implementation of Virtual Wards	01/12/2025		Lee, James													
										Breamore ward for NCTR patients	20/11/2024	29/11/2024	Needle, Sarah													
										Discharge initiative across Medicine	31/12/2024	31/12/2024	Needle, Sarah													
										NCTR working group as part of UEC Board	01/05/2025	21/03/2025	Dickinson, Jane													
										Ward Processes working group as part of UEC board	02/06/2025	21/03/2025	Bagg, Danielle													
										Streaming in ED	31/10/2025		Garrett, Neil													
										Reconfiguration of ED to support more RATT space and in/out assessment space	12/12/2024	14/03/2025	Garrett, Neil													
8264		Trustwide	10/12/2024	Clinical Governance	15	There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment(MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for clinical staff.	Will undoubtedly recur, possibly frequently	Moderate	15	Safeguarding lead monitoring DOLS activity & training levels	07/07/2025		Cobham, Gill	Integrated Safeguarding Committee	31/07/2025	9	Population	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	08/12/2024	MCA and safeguarding training in place Safeguarding lead monitors training levels and reports to CGC Week day oversight of all incidents in previous 24 hrs. with safeguarding input. Audits regarding mental capacity assessments.	Training numbers is lower than we want it to be . Documentation poor Reports from dementia lead that staff not practicing least restrictive options	Reporting of data regarding mental capacity and safeguarding to ISC, CMB and onwards CGC Safeguarding leads monitoring on weekly basis Weekly patients safety look's at all moderates and above. Risk team monitor for high volume low harm themes for low harm, no harm	Training data , numbers failing Incident review data
										Recruitment to post to focus solely on training delivery	31/10/2025		Dyos, Judy													
										Safeguarding lead undertaking documentation audits	31/07/2025		Cobham, Gill													
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a consequence of a challenging financial position and a recruitment freeze in admin/clerical posts plus additional workforce controls, we may not be able to replace / recruit or train staff to key positions. To achieve an improved optimisation of workforce and commensurate reduction financially and in WTE , there is a need to reconfigure services and roles, and both current operational pressures and capacity/ capability of people managers is limited in this area of OD Vacancies may compromise service and safety, staff been asked to cover for vacancies in the team may chose to leave , sickness absence in the remaining workforce may continue to increase and none essential development training maybe restricted to accommodate only essential clinical skills training. Updated 02/06/2025	Will undoubtedly recur, possibly frequently	Moderate	15	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024	12/06/2024	Crowley, Ian	Trust Board	31/10/2025	12	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels Breakthrough objective - turnover - people promise improvement projects Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Weekly divisional and trust workforce control panels - Recent recruitment ban and exception requests to be submitted through group CEO and region. Monthly financial recovery - include oversight vacancies and bank and agency. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews. Monthly Organisation Development, Culture and Learning working Group providing oversight of training - MDT approach Absence data oversight in DPRs plus IPR Regular formal reporting against all elements of the People Promise. Updated 02/06/25	Limited resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Line managers failing to regularly conduct appraisals and failure to follow resignation processes - including exit interviews. Reviewed 02/06/25	Improving KPIs for vacancy rate, time to hire. Monthly IPR provides oversight of sickness absence and turnover which includes monitoring reasons for leaving. 22/08: Lowest vacancy rate and time to hire than we have ever had. 20/11 - no changes 03/03/25: Now 0.8% vacancy rate and 35 day time-to-hire. Changing picture on the quarterly pulse survey, divisional action plans include both annual results and quarterly.	Number of days absence/time lost due to short intermittent periods of absence being effectively managed within wards. Improving control and effective management of temporary staffing numbers - documentation gaps in medical and nursing workforce and more recently established gap in admin/clerical bank management. 22/08: Limited meaningful data from exit interviews Updated 02/06/25
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian													
										Delivery of the widening participation initiative.	31/07/2024	22/08/2024	Crowley, Ian													
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian													
										Movers and leavers project delivered.	31/12/2024	02/06/2025	Crowley, Ian													
										People Promise actions for this year to be delivered.	31/03/2024	12/06/2024	Crowley, Ian													
										Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian													
										Exit and appraisal policy review and application.	31/03/2024	12/06/2024	Whitfield, Melanie													
										12/06: Ongoing delivery of all elements of the People Promise.	31/01/2025	03/03/2025	Whitfield, Melanie													
										12/06: Conclude the line management skills build pilot in July and launch trustwide.	30/09/2024	22/08/2024	Crowley, Ian													
										Disaggregate turnover and absence data in IPR to highlight hotspots and tailor appropriate actions	31/12/2024	03/03/2025	Crowley, Ian													
										Execs to visit ward areas with high sickness absence (Go and See) to provide overight and support	30/04/2025	02/06/2025	Dyos, Judy													
										Monthly disvisional deep dive to review all recruitment.	31/10/2025		Whitfield, Melanie													
										Introduction of MARS scheme	31/07/2025		Whitfield, Melanie													
										Deliver whole time equivalents reduction against 11 projects	31/03/2026		Ellis, Mark													
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	15	As a consequence of hospital processses and current operating model, further exacerbated by no right to reside, there is a Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this. This risk is caused by capacity/resource constraints in out of hospital care, ultimately leading to longer length of stay for patients	Will probably recur, but is not a persistent issue	Major	16	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/10/2025	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	11/03/2019	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews all patients with LoS over 7 days with CTR. Monthly urgent care board which the COO attends. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality Improved use of e-Whiteboards on wards. 02/09/24: Working groups with BSW system to improve discharge process and capacity. Experienced subject matter experts - focussed on work to resolve current issues. 14/03/2025: Trust has implemented improvement sprint which is helping to improve processes and reduce the length of time between patients being non critieria to reside and being ready for discharge	Reporting of timelines in patients journeys challenging with current IT systems. - capacity gap in Council for community-based therapy which means significant shortage of available care. 02/09/24: Complexity in pathway management is leading to delays in discharge. 02/06/25: We do not have 7-day ward rounds, as a consequence of shortage in medical staff. Ward processes are not facilitating timely discharge.	02/09/24: Monthly reporting of number of patients waiting for discharge & pathways is well understood. 02/06/2025: Length of stay decreasing - Model Hospital demonstrates SFT's emergency length of stay is now at national average.	Understanding of discharge process at ward level (nursing and medical) is inconsistent. Use of e-whiteboards although improved is still inconsistent with no training delivered to new starters. 02/09/24: Understanding headline number in place but further work required to truly understand reasons for delays. 02/06/2025: No criteria to reside numbers not decreasing sufficiently enough. Bed occupancy is above national planning guidance. 4 hour performance below national target.
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy													
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy													
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy													
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy													
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy													
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy													
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy													
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy													
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy													
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy													
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy													
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy													
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran													
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy													
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul													
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa													
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa													
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa													
										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma													
										SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa													

										Further engagement with system partners to understand their actions	25/09/2024	19/11/2024	Cavill, Emma											
										02/09/24: Established A3 approach - Support delivery of NC2R challenges & joint system working group implementation.	31/10/2025		Prosser, Niall											
										Launching multi-agency dedicated team for 12 weeks to undertake further A3 thinking within pathway 1 and interface delay challenges.	31/03/2025	02/06/2025	Prosser, Niall											
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Cash balances have depleted with NHSE instructing that cash must be managed within the system. In the event of under-delivery of savings plans the constraint of capital expenditure will need to be considered. updated 07/03/25	Will undoubtedly recur, possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	31/08/2025	9	Partnerships	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2024/25 based on internal assumptions - Deficit support funding agreed. - Weekly agency usage monitoring - Fortnightly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock 02/09/2024: Medical rate card went live in August 2024. 27/05/25: Continuation of controls with enhanced oversight by NHSE.	- Delivery of 5% CIP dependent on external action - Uncertain impact of urgent care pathways, staffing gaps, and unintended effects of increased vacancy control.	2024/25 efficiency plan delivered £17 million. Improving Together methodology being used to underpin 25/26 programme. Continued upward trajectory in Trust productivity calculation. Theatre utilisation in the top quartile 02/09/2024: Downward trend in nursing bank and agency - continued reduction in UEC length of stay. 27/05/25: Downward trend sustaining but plateaued.	Ongoing agency bookings - particularly hard to recruit to medical posts. Pay overspend Opportunity identified for 5% savings programme but detailed plan yet to be worked up. Continued UEC growth outstripping planning assumptions and putting pressure on ability to reduce bed base. 27/05/25: uncertainty where group work releases cost in the short-term, but enabling work underway.
										24/25 Capital monitoring in place. Ongoing processes. Board reporting continues, including specific updates on digital & estates.	31/12/2024	21/11/2024	Ellis, Mark											
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark											
										Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/12/2024	07/03/2025	Ellis, Mark											
										Organisation wide communications strategy for financial recovery	30/09/2024	21/11/2024	Ellis, Mark											
										Work on 25/26 savings targets and plans.	30/06/2025		Ellis, Mark											
										Refresh of financial recovery group standard work. Aligned with SPF.	30/06/2025		Ellis, Mark											
6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports,	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed/cancelled procedures. Incidents relating to the building's condition are increasing and impacting on patient safety, care and experience.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	31/12/2025	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations
										seed funding allocated to SFT - requires development of the business case	30/06/2025		Arnold, Laurence											
7734	Finance and Procurement	Finance Department	16/06/2023	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Major	20	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024	05/06/2024	Ellis, Mark	Finance and Performance Committee	31/08/2025	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	21/09/2023	- capital control group prioritises capital programme - monitor Datix incident reporting related to infrastructure and equipment. 27/05/25: Rolling 15 month cashflow forecast	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids 21/11/24: High cost and high priority EPR programme underway - arising pressures may impact other programmes. 07/03/25: Slippage in the EPR programme, additional pressure likely to arise in 26/27	- incident reporting highlighting areas of concern to ensure appropriate prioritisation. - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps 27/05/25: National funding ensuring continuation of backlog maintenance programme.	21/11/24:Availability of cash to service capital programme. - increasing level of maintenance required - increasing number of incidents of operational disruption particularly in day surgery 21/11/24: Uncertainty of reporting in latter years of EPR programme. 27/05/25: Current revenue forecast would result in shortfall
										24/25 Capital prioritisation and planning underway - completed, but increased financial pressures requires review of plan for projects that can be ceased or paused.	31/08/2025		Ellis, Mark											

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Jun-25	Target	Risk Type	Risk Appetite/ Tolerance
Risk Detail				Score Trend									
POPULATION - Improving the health and wellbeing of the population we serve													
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	15	12	16	12	12	9	8	Workforce supply	Cautious
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	15	15	15	20	16	16	12	Capacity planning	Cautious
5955	Insufficient organisation wide robust management control procedures. **Risk tolerated**	Chief Finance Officer	13-Aug-19	15	9	6	6	6	6	6	6	Legal & Governance	Averse
7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Director of Transformation	02-Jan-24	12	12	12	12	12	12	12	9	Research, innovation and development	Open
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12	20	20	20	20	20	20	4	Estates / Physical assets	Cautious

7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20	12	9	9	9	9	9	9	Capacity planning	Cautious
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Medical Officer	16-Aug-23	20	15	15	12	12	12	12	9	Patient safety & outcomes	Minimal
8102	Current vacancy rate in Central Booking 9.5wte. Current theatre utilisation is not meeting Trust KPIs (approx 70-90 theatre slots not booked per week). Risk of patient harm due to significant backlog of referrals which are triaged but not transferred to Lorenzo. Risk to delay of patient follow up due to backlog of e-outcome forms.	Chief Operating Officer	01-Nov-24	20				20	10	12	8	Workforce supply	Cautious
8250	Lack of 24/7 access to CT perfusion and CT angiography for patients with acute ischaemic stroke there is a risk that patients will not be able to receive life changing treatment as per national guidance.	Chief Operating Officer	03-Dec-24	20				20	12	12	6	Patient safety & outcomes	Minimal

8264	There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment (MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for clinical staff.	Chief Nursing Officer	10-Dec-24	15				15	15	15	9	Workforce performance	Cautious
8260	The planning guidance stipulated that for 2025/26 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments, with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2026. SFT signed up to 78%. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with NCTR, the Trust has been unable to meet the nationally agreed targets (including ambulance response times)	Chief Operating Officer	06-Dec-24	15				15	15	15	8	Patient safety & outcomes	Minimal

8188	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the next available list. Therefore some patients will not get timely intervention, with acute inpatients suffering deterioration in their condition possibly resulting in worsening organ failure, and outpatients waiting longer, resulting in a poor experience and possibly developing complications while waiting.	Chief Medical Officer	08-Aug-24	12			12	12	12	8	6	Workforce supply	Cautious
8174	A National review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A Regional assessment of SFT services has identified a high risk of potential harm and mandated a review of c200 cases from 2017 to date. There is a risk that the review could discover significant harm to children and this could result in reputational and litigation risk in the future.	Chief Medical Officer	30-Jul-24	10			10	10	10	10	5	Patient safety and outcomes	Minimal
8054	As a result of out of date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	Director of Integrated Governance	09-Apr-24	9		9	9	9	9	9	6	Legal and governance	Averse
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work													

7472	As a consequence of a challenging financial position plus additional workforce controls, we may not be able to replace/recruit or train staff to key positions. To achieve an improved optimisation of workforce and commensurate reduction financially and in WTE, there is a need to reconfigure services and roles. Vacancies may compromise service delivery and safety.	Chief People Officer	12-Oct-22	16	12	12	9	12	15	15	9	Workforce retention	Cautious
8344	The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects.	Chief People Officer	13-Mar-25	16					12	9	4	Information Governance	Cautious
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines **Risk tolerated**	Director of Improvement	13-Oct-21	12	9	9	6	6	6	6	6	Research, innovation and development	Open
PARTNERSHIPS - Working through partnerships to transform and integrate our services														
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8	8	Counter-fraud	Averse
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15	15	15	15	15	15	20	8	Revenue funding & cash management	Cautious
7308	The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside	Chief Finance Officer	12-Mar-21	15	20	20	20	20	15	20	9	Financial Management	Cautious

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Risk Appetite

Outwith tolerance

Within tolerance

Report to:	Trust Board (Public)	Agenda item:	5.6
Date of meeting:	03 July 2025		

Report tile:	Patient Feedback Report – Q4 2024/25 and Annual Patient Engagement Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Patient Experience Steering Group Clinical Governance Committee – 24 June 2025.			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	None.			

Recommendation:
This report is for assurance and noting by the Committee.

Executive Summary:
This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q4 of 2024/25. This report also contains an overview of the Trust's patient engagement activities over the past 12months. **Patient Experience Feedback – Q4:** To summarise the contents of this section of the report: **Complaints/concerns/compliments and enquiries:** Overall patient activity across the Trust has declined slightly this quarter, the total number of complaints and concerns has increased marginally. A total of 111 were logged for Q4, compared with 110 in Q3. A total of 353 comments/enquiries were logged by the PALS team in Q4, this is slightly more than the previous quarter. The top three locations these related to were ED (7%), Orthopaedics (6%) and Cardiology (6%). These enquiries were largely related to requiring an appointment date (Orthopaedics and Cardiology) and being unsatisfied with treatment (ED). A total of 142 compliments were recorded on Datix this quarter across the Trust (115 less than last quarter). For Q4 the top three most prevalent high-level themes for complaints across the Trust were largely the same as those seen in both Q1 and Q2. These were in relation to Patient Care (36%) and Communication (25%). Appointments including delays and cancellations was a new theme in Q3 and this has continued into this quarter (13%) – see Table 1.2. Within these themes unsatisfactory treatment, lack of or insensitive communication and appointment system procedures were the highest sub-categories (see Tables 1.1a - 1.2c).

Meeting the 85% target for complaints response within timescale continues to be a challenge, (see Figure 1.3), the Trust averaged a 48% closure on target rate for complaints and concerns in Q4.

The number of reopened complaints/concerns this quarter is currently estimated to be around 7%, this is reflected to be higher than the Trust's target of 5%.

The PALS team and the Divisions continue to focus on early resolution and de-escalation of complaints. 33 complaints/concerns were considered to achieve an earlier resolution than anticipated in Q4, the highest number so far this year. 45% of these were achieved by Medicine.

Friends and Family Test (FFT) in total for Q4 there was a total of 15,964 a small decrease on Q3. This equates to an average response rate of 17% (of eligible population), exceeding the Trust's target. FFT experience ratings have stabilised at 94%, however, this is marginally below the Trust's target for satisfaction. Most prevalent positive themes around staff attitude. New negative theme this quarter around communication was noted.

Triangulation of data with ICB Acute Trusts:
Themes for complaints are largely similar, communication and clinical/nursing care being the top themes across all three Trusts.

Positive themes for FFT are similar with staff attitude being top. Amongst the top negative themes, communication is a common theme noted across all three.

Local Surveys:

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, improvements seen this quarter on Q3. However, some issues still noted around noise at night and involvement with discharge plans. High levels of satisfaction related to cleanliness of the ward areas, and having trust in those undertaking your care.

A total of 370 surveys across all inpatient wards have been completed this year with an average overall satisfaction rating of 86% being achieved. This a 10% increase on the number of surveys undertaken in 2023/24.

The **NACEL Survey** is noted to have had the lowest uptake so far this year. Annual summary of the NACEL findings is positive with the Trust's comparative performance with our Southwest peer ranking 3rd overall. Areas of improvement have been focused on pain relief and recognition of dying.

From the 1st of April 2025 the trust will be reverting back to its Your View Matter local survey.

Annual Patient Engagement Report

The following report seeks to provide assurance to the Committee of the progresses made in the last 12months against the Patient Experience Engagement Strategy, Improving Together objectives and our progress towards co-production with our service users, visitors, as well as veterans, carers, and those with learning disabilities.

To summarise the contents of this section of the report:

- PESG continues to provide assurance to Clinical Management Board, expanding its membership and agenda. Assurances of a good governance structure is also regularly evidenced through escalation reporting and an annual workplan.
- There is assurance that the Trust is on a positive trajectory for increasing opportunities for patient engagement, utilising patient stories to influence and shape service improvements. This is further supported by the emergence and continued development of our Patient Panels and further recruitment of more Patient Safety Partners.
- There was overspend within the translation and interpreting services budget and this can be evidenced as being attributed to a local Afghan resettlement programme taking place in Wiltshire. This evidence has been submitted to the ICB to bid for additional support with this cost pressure.

There are no challenges for the Board to note from this paper, with the exception that current capacity and resourcing within the Patient Experience Team is anticipated to be unable to continue to grow these areas of work at the same rate seen in the past 12months.

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

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints and demonstrate that learning and actions are being taken to improve services in response to feedback.

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight into how patients experience our hospital.

Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback and in transparency and honesty on when healthcare goes wrong.

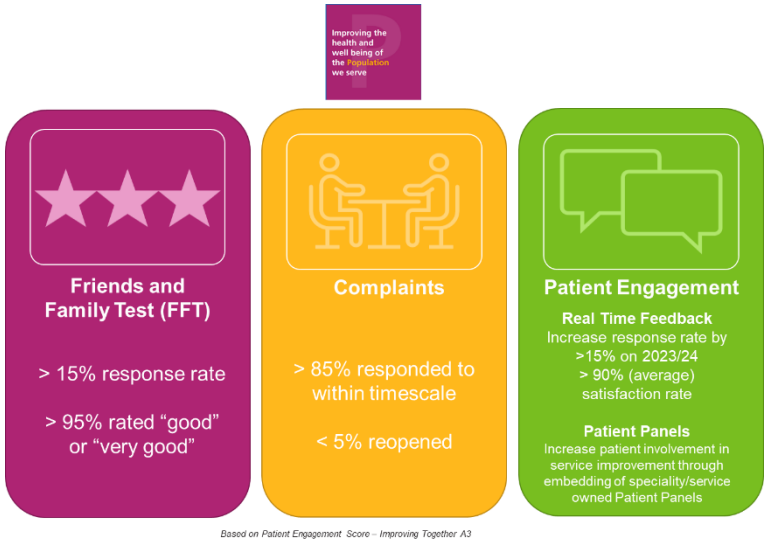
Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

In line with the Trust’s Improving Together Methodology and under the Patient Experience Quality Priorities approved through the Patient Experience Steering Group, the following areas remain the focus for 2024/25. Friends and Family Testing, Complaints and Patient Engagement.

Friends and Family Testing and Complaints are covered in this Patient Experience report and reported on every quarter.

Progress against the Patient Engagement objectives are covered annually and have been included with this Q4 Patient Experience Report. **See Annual Patient Engagement Overview**.

Summary of the performance metrics in relation to these areas for 2024/25 is summarised below:



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1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 3 items of feedback posted on the NHS Website* in Q4.

Average rating on responses for this quarter: ★★★★★

	Positive	Neutral	Negative	Average star rating
Q4 24/25	**2**	**1**	**0**	«««««
Q3 24/25	1	0	1	««
Q2 24/25	4	0	3	«««
Q1 24/25	3	0	0	«««««
Rolling year Total / Average	**10**	**1**	**4**	«««««

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate feedback on a per 1,000 basis within this report (see Figure 1.1). The Trust is continuing to see a higher level of patient activity, when compared with the same quarter last year.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q4 2024 - 25	36,076	36,343	43,856	4,976	121,251
Q3 2024 - 25	36,087	37, 514	44,472	5,052	123,125
Q2 2024 - 25	36,567	36,800	43,222	5,273	121,862
Q1 2024 - 25	36,630	38,139	42,344	5,291	122,404
Q4 2023 - 24	36,547	37,402	41,456	4,576	119,981

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for formal recognition. Whilst compliments continue to be retained locally within the department areas, the PALS team continue to work to promote the importance of sharing these to allow for more formal reporting enabling correlation with complaints and FFT.

Complaints and Concerns

Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

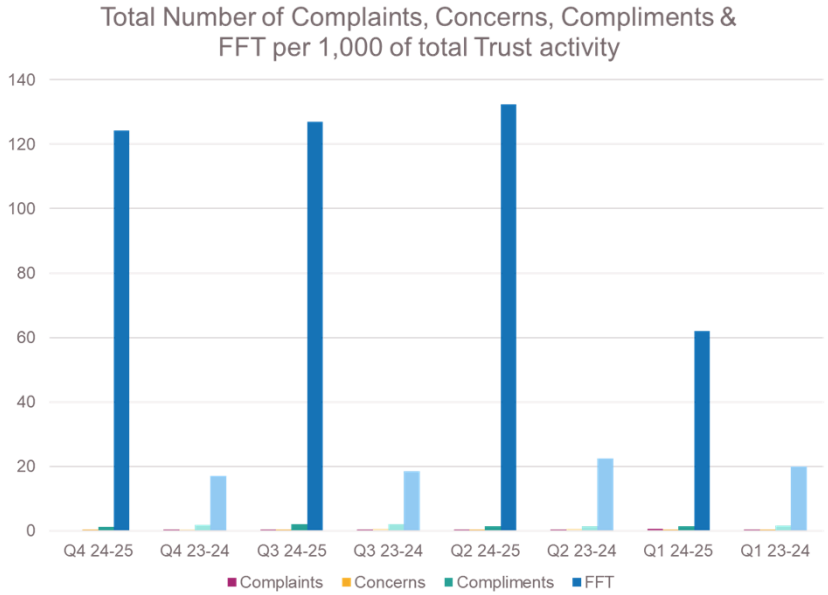


Figure 1.1 shows an overall decrease in the total number of both complaints and concerns received for Q4, in comparison with Q3. These numbers are comparative with the same period last year *(opaque graphs show 2023/24 reporting)*.

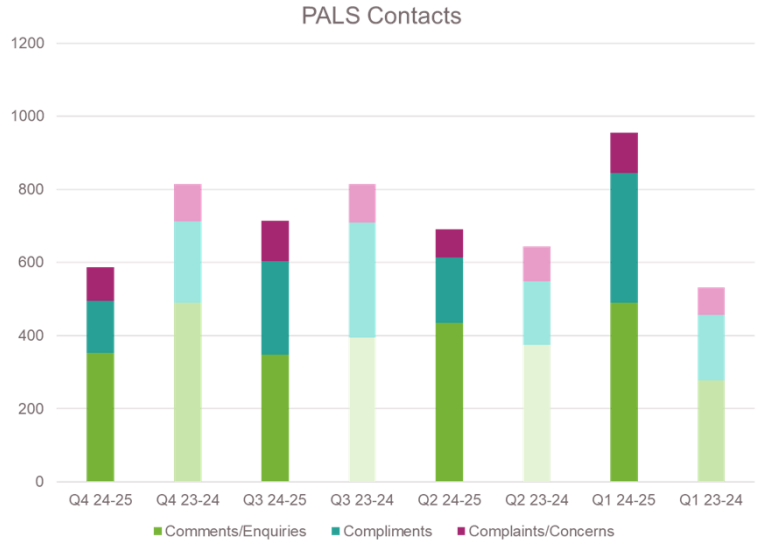
FFT feedback continues to maintain high response rates, exceeding the Trust target again this quarter. An average 94% satisfaction rate is maintained from Q3.

Compliment numbers have continued to fluctuate, as we balance the continued promotion of formally recording these with PALS and the resources needed to undertake this. At the time of writing this report, there were at total of 142 compliments recorded on Datix for Q4. 115 less than Q3.

In Q4 the PALS department logged 353 comments/enquiries. 6 more than Q3. The top three locations these related to were ED (7%), Orthopaedics (6%) and Cardiology (6%). These enquiries were largely related to requiring an appointment date (Orthopaedics and Cardiology) and being unsatisfied with treatment (ED).

This equates to an average of 2.9 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2023/24 – 2024/25



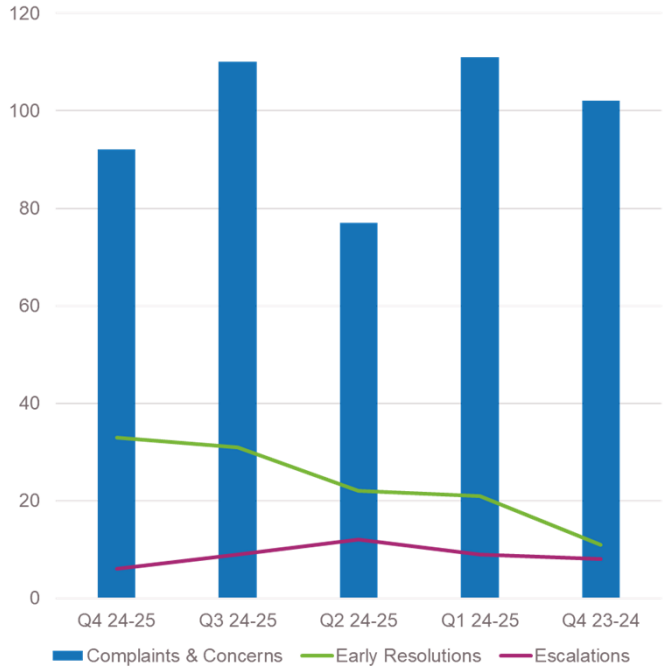
During Q4 there were a total of 92 complaints and concerns logged (110 in Q3).

The trust has seen an overall drop in contacts this quarter, the lowest its been for the whole year. Overall contacts have also significant reduced on comparison to this quarter last year.

PALS capacity has been on the risk register (8159) since July 2024, these reductions have meant this risk can not be downgraded to within acceptable tolerance and was closed on the 10th May 2025.

Work continues across the Divisions to promote the principles of **early resolution** of complaints.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations



33 complaints/concerns were considered to achieve an earlier resolution than anticipated in Q4.

6 were noted to have escalated from a comment or enquiry into a concern or complaint.

Figure 1.1b shows how this correlates with previous quarters and demonstrates a steady positive trajectory of early achieving earlier resolution.

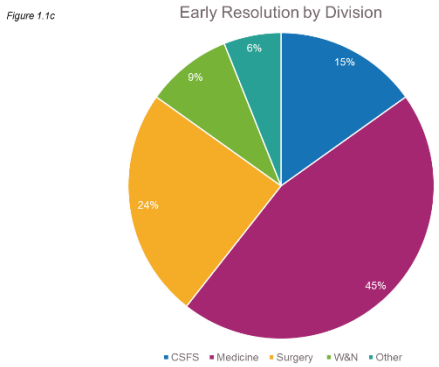


Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.

Medicine continue to lead in their efforts for successful de-escalation of complaints/concerns.

Themes from Complaints/concerns

Table 1.2 below shows the themes for complaints and concerns received in Q4 (trust wide).

Highlighted are the top three most prevalent themes. **Patient Care** and **Communication** are consistent themes with the previous quarter, however **Appointments, including delays and cancellations** is a new theme for this quarter. These are the same as Q3.

These top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a, 1.2b and 1.2c.

Table 1.2 Raw data - Themes from Q4 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	Total by theme	% of total by theme
Access to treatment or drugs			10	1		11	10%
Admissions, discharge and transfers		4				4	4%
Appointments including delays and cancellations	**3**	**2**	**9**			**14**	**13%**
Clinical Treatment						0	0%
Commissioning Services						0	0%
Communications	**3**	**14**	**3**	**8**		**28**	**25%**
End of Life Care	1	1	1			3	6%
Facilities Services						0	0%
Other						0	0%
Patient Care	**5**	**13**	**21**	**1**		**40**	**36%**
Prescribing errors		1	1			2	2%
Privacy, dignity & wellbeing						0	0%
Trust Administration	1					1	15
Values and behaviours (Staff)	3	1	3	1		8	7%
Total by Division	**16**	**36**	**48**	**11**	**0**		
Divisions Total	**111**						

The following tables show a further breakdown for these three themes across the Trust.

Unsatisfactory treatment was again the highest sub-category this quarter under **Patient Care** (see Table 1.2a). This was the same for both Q1, Q2 & Q3.

Insensitive and lack of communication was again the highest causes for complaints under the **Communications** category (see Table 1.2b). This was the same for Q2 & Q3.

Appointments including delays and cancellations continues to be theme this quarter from Q3. **Appointment system procedures** and **unsatisfactory outcome** featuring as the highest causes under this category (see Table 1.2c).

Table 1.2a

Patient Care	40	36%
Unsatisfactory treatment	**17**	**43%**
Further complications	8	20%
Nursing Care	5	13%
Inappropriate treatment	3	8%

Table 1.2b

Communication	28	25%
Insensitive communication	**10**	**36%**
Lack of communication	**8**	**29%**
Delay in making diagnosis	2	5%
Delay in receiving/sending information	3	11%
Wrong information	3	11%
Falls	1	3%
Information not given to family	2	7%
Information not given to patient	1	4%
Opening times	1	4%

Table 1.2c

Appointments including delays and cancellations	14	13%
Appointment system - procedures	**4**	**29%**

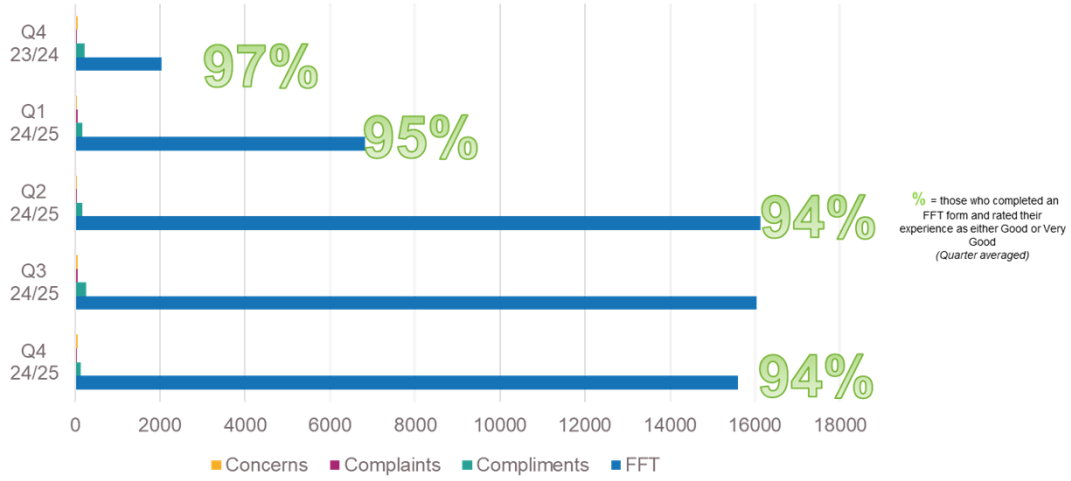
Unsatisfactory Outcome	**4**	**29%**
Appointment date required	3	21%
Delay in receiving appointment	3	21%
Appointment system - procedures	4	29%

Further analysis of these themes has been undertaken at the Triangulation Leads Meeting this quarter, the findings are summarised in that section of this report.

Figure 1.2. represents the proportion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern.

We have continued to see a slight decrease in satisfaction this quarter, dropping below the 95% Improving Together target, however it is recognised that this is largely due to the significant increase in quantity of feedback in this period.

Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.

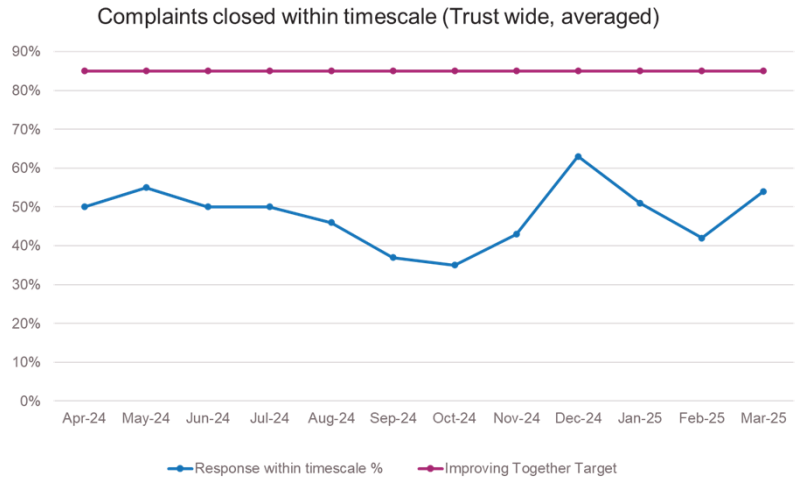


Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale for 2024/25 is 85%. Overdue complaints will therefore continue to be a focus for the Patient Experience Quality Priorities going into 2025/26.

Live performance data is monitored monthly via the Patient Experience Steering Group, and the tracking of this target through this forum is being demonstrated in Figure 1.3.

Figure 1.3 – Complaints closed within timescale (live, in month reporting at PESG)



There are various factors that can influence the inability to achieve the timescale for response.

PALS continue to work with individual areas to understand these challenges and to help improve processes to progress towards achieving the 85% target.

Significant strides towards this were evident in December 2024 and an upward turn noted again in March 2025.

This target also continues to be monitored via the Integrated Performance Report (IPR) as a watch metric and also features in the "Our Population Helps Improve our Services" A3.

The Trust averaged a **48%** closure on target rate for complaints and concerns in Q4.

Reopened Complaints

Figure 1.4 – Number of re-opened complaints or concerns

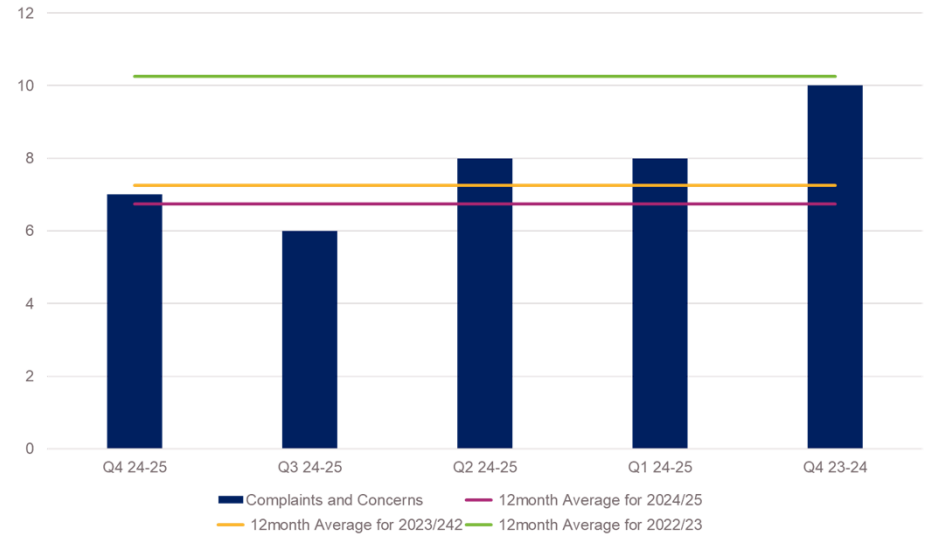


Figure 1.4 shows the number of reopened complaints and concerns (in total), compared with previous quarters. There is a slight increase noted this quarter.

The lines indicate the average number of re-opened complaints for that year. This is demonstrating a year-on-year reduction to the number of reopened complaints.

This is indicative of an increasing success rate of first time resolution.
The Patient Experience Quality Priorities for 24/25 aimed for a less than 5% of total number of complaints/concerns to be reopened. For 2024/2025 the Trust achieved approximately 7%. The 5% target will be carried into 2025/26.

2. Learning from Patient Experience

Patient Stories

February PESG:
Patient story presented in person by Allan as part of the Trust's Fundamentals of Care month focusing on Communication. Allan's story was about his experience of living with Aphasia. Jess Willetts - Speech Therapist shared her experience supporting Allan during his journey over the last 8 months. Jess gave some background on Allan's story and experience, explained what aphasia affects, and what it means to have aphasia. Allan spent 2 weeks in hospital following a stroke and was discharged, he is a self-employed personal trainer with his own business. He explained the challenges he faces with finding the right words and following conversations. On the surface these challenges are well masked and often overlooked. He described the things that were helpful for his condition and the importance of staff ensuring patients understand what is being communicated to them, and not making assumptions.

Patient Experience Division Presentations

The development of the Patient Experience Steering Group agenda ensuring there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q4, complaints and FFT data from Q3 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which are being done well.

Work continues to embed the process for Divisions attending the Patient Experience Steering Group to reflect on their data and provide updates on any areas of focus which they are pursuing which may be informed by this.

Table 1.3 – Q3 Patient Experience data presented to Divisions during Q4:

Division	Data presented to Division	Division update to PESG
Surgery	16th April 2025	*Deferred to April 2025*
CSFS	31st March 2025	*Deferred to April 2025*
Medicine	11th February 2025	*Deferred to April 2025*
Women & Newborn	21st February 2025	*TBC*
Facilities (Food & Nutrition /PLACE)	4th February 2025	26th February 2025

Facilities Update to PESG (26th February 2025):

Summary of the following:

- SSL contract moved to facilities
- SOX – 3 in 2024 none yet in 2025
- Complaints – 1
- 100% electric courier vehicle – introduced in late November. NHS cannot lease or purchase petrol/diesel vehicles after 2027 so all vehicles to be moved over to electric.
- Xmas lunch was very successful as was the lunch to staff. Seeking funding for 2025.
- Sophie's legacy – which is funding used to provide Christmas lunches for parents who have children on the ward on Christmas day. The trust was able to offer Christmas meals to all family members visiting a minor. Vouchers and meals were offered to the NICU and Sarum units. This is planned again this coming year.

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads and individual staffing groups to ensure staff are understand the complaints process and the role of PALS within this.

Training following training packages were delivered this quarter:

- 20th February – Amesbury Ward Staff – Introduction to complaints and the importance of good record keeping (PALS/Legal Services)
- 24th February - B7 ED staff – Introduction to the Complaints Process
- 4th March – F2 Core Teaching - Introduction to the Complaints Process and Communication
- 20th March – Amesbury Ward Staff – Introduction to complaints and the importance of good record keeping (PALS/Legal Services)

Introduction to PALS and use of actual events-based scenario is now included within the Trust's communication course, this launched in November 2024 and continues to be developed.

4. CQC & PHSO Complaints Summary

CQC

Concerns raised through the CQC can emit three main types of action/response.

- These can be for information only and no further action.
- These can be general action requests for assurances either related to a specific area of the hospital or particular staff group.
- These can be actions, responses or assurances related to a specific complainants case details.

In Q4 the Trust received 6 concerns from the Care Quality Commission (CQC) – these are summarised below, with outcomes and listed chronologically.

Summary of the requests for this period are shown in Table 4.1:

Table 4.1 Summary of concerns received via the Care Quality Commission (CQC) for Q4

Concern (listed chronologically)	Location / Area related	Request from CQC	Outcome
Concern 1	ED	Request for further information.	Information sent and following review CQC confirmed no further action required. Case was closed 21/02/2025.
Concern 2	*Not detailed.*	Safeguarding – request for further information.	Submitted the required information. There were found to be no omissions in care and bruising was related directly to the patient's admitting injury. After review, CQC confirmed they did not require any further information and the case was closed 22/01/25.
Concern 3	Longford Ward	Request for further information.	Copy of the complaint response letter sent to the patient was shared with the CQC on the 03/02/25.
Concern 4	*Not detailed.*	Request for information regarding the discharge process and how the Trust maintains oversight of its effectiveness.	Commentary about the Trust's discharge processes and oversight was shared with the CQC on the 12/03/25. A complaint response letter is being written and is currently outstanding in relation to this query.
Concern 5	ED	No specific request from CQC – shared for feedback.	As this was anonymous to CQC, we could not review as an individual case. The email was shared with the ED team for discussion/reflection and learning if required. No follow-up.
Concern 6	Longford Ward	Request for further information. Safeguarding referral made to local authority.	The team are collating information to answer the initial CQC queries, safeguarding concerns and concerns that went to PALS.

Table 4.1a Concerns received via the Care Quality Commission (CQC) – quarterly comparison

	Q4 24-25	Q3 24-25	Q2 24-25	Q1 24-25
Across all Directorates	56	62	56	4

Parliamentary Health Service Ombudsman (PHSO)

The Ombudsman investigate complaints about government departments and the NHS in England. They make the final decisions on complaints that have not been resolved by the Trust. Every complainant is advised of their option to take their complaint to the PHSO once they have received their final response from the Trust. The service is free for everyone.

In Q4 the Trust received 0 requests for further information from the PHSO – these are summarised below, with outcomes and listed chronologically.

Table 4.2 Summary of concerns received via the Ombudsman (PHSO) for Q4

Concern / Complaint	Location/Area related	Request from PHSO	Outcome
Complaint	AAA Screening	Request for copies of the complaint file and further information in relation to reasonable adjustments made.	Outcome still pending.

Table 4.2a Concerns received via the Ombudsman (PHSO) – quarterly comparison

	Q4 24-25	Q3 24-25	Q2 24-25	Q1 24-25
Across all Directorates	61	52	0	0

5. Triangulation of data (Risk, Safety, Experience, Freedom to Speak Up)

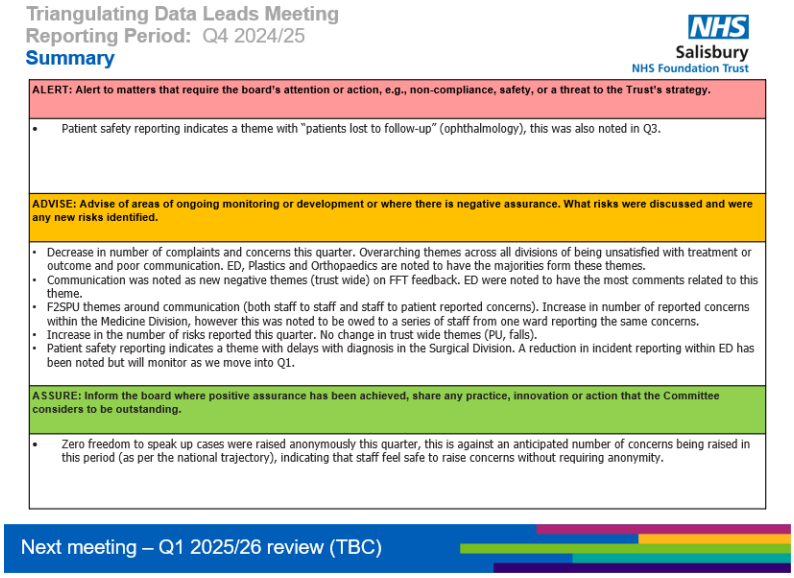
This quarter leads from Risk, Patient Safety, Experience and Freedom to Speak Up held the fouth data triangulation meeting this year.

This meeting reviewed data from Q4 and Table 5.1 below is a summary of the key conclusions from these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q4 24/25

This is scheduled to be presented to the Clinical Management Board in June as the appropriate escalation committee for this report.

This escalation report will also be presented to the “We Are Safe and Well Committee”.



Triangulating Data Leads Meeting
Reporting Period: Q4 2024/25
Summary

NHS Salisbury NHS Foundation Trust

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

- Patient safety reporting indicates a theme with "patients lost to follow-up" (ophthalmology), this was also noted in Q3.

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

- Decrease in number of complaints and concerns this quarter. Overarching themes across all divisions of being unsatisfied with treatment or outcome and poor communication. ED, Plastics and Orthopaedics are noted to have the majorities form these themes.
- Communication was noted as new negative themes (trust wide) on FFT feedback. ED were noted to have the most comments related to this theme.
- F2SPU themes around communication (both staff to staff and staff to patient reported concerns). Increase in number of reported concerns within the Medicine Division, however this was noted to be owed to a series of staff from one ward reporting the same concerns.
- Increase in the number of risks reported this quarter. No change in trust wide themes (PU, falls).
- Patient safety reporting indicates a theme with delays with diagnosis in the Surgical Division. A reduction in incident reporting within ED has been noted but will monitor as we move into Q1.

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

- Zero freedom to speak up cases were raised anonymously this quarter, this is against an anticipated number of concerns being raised in this period (as per the national trajectory), indicating that staff feel safe to raise concerns without requiring anonymity.

Next meeting – Q1 2025/26 review (TBC)

6. Triangulation of data – ICB Acute Trusts

The Heads of Patient Experience across the three acute Trusts (Salisbury, Bath and Swindon) are working together to create a format to compare activity and themes across complaints, concerns, compliments and FFT. A template has now been agreed and trialled with Q3 data. This has demonstrated the following contrasts across the three acute trusts:

- PALS and Patient Experience department structure and resourcing

- Trust KPIs for response to complaints/concerns within timescale;

Table 6.2a Trust KPI's for complaints/concerns

Trust	Complaint	Concern
GWH	25 working days	7 working days
SFT	40 or 60 working days	25 working days (5 working days for informal concerns)
RUH	35 working days or Agreed with complainant	2 working days for acknowledgement

- The Trust's compliance with these timescales;

Table 6.2b KPI complaint response target (Q4)

	Salisbury Hospital	Great Western Hospital	Royal United Hospital	
Target	85%	80%	90% (for within 35 w/days)	75% (for within 14 w/days)
Performance	48%	61%	82%	79%

- Total number of contacts (including complaints, concerns and compliments) recorded through the PALS and Patient Experience department (calculated on a per 1,000 patient activity for relative comparison);

Table 6.2 Total contacts via PALS (per 1,000 patient activity) – Q4

	Salisbury Hospital	Great Western Hospital	Royal United Hospital
Total patient Activity	121, 251	167, 565	199, 542
Number of complaints and concerns (per 1,000 patient activity)	0.76	6.35	4.2
Number of total PALS contacts (per 1,000 patient activity)	4.8	9.64	7.10

Themes for complaints are largely similar, communication and clinical/nursing care being the top themes across all three Trusts.

The full data set used to make these comparisons is available on request.

SFT's PALS team undertook a "Go See" in December 2024 and the findings were presented to PESG in January. Factors for why SFT's compliance with timescale is poorer than that of GWH were attributable to:

- GWH have better engagement from medical staff (Consultants/ward staff), resulting in statements and responses being received back timely.
- There was more resource allocated to pulling together responses
- Concerns resolved via phone call/email/meeting where possible
- GWH PALS team have insight and training on current waiting lists for specialities, helping to manage the patient expectations in the first instance
- More overall resourcing within the PALS team, individual roles which means there can be emphasis on chases etc.

Table 6.3 FFT performance comparisons – Q4

	Salisbury Hospital		Great Western Hospital		Royal United Hospital	
	Response rate *(of eligible population)*	Satisfaction rate	Response rate *(of eligible population)*	Satisfaction rate	Response rate *(of eligible population)*	Satisfaction rate
Q4 2024-25	16.96%	93.74%	27.00%	90.00%	24.90%	94.50%
Q3 2024-25	16.13%	93.82%	27.00%	90.00%	21.50%	94.00%
Q2 2024-25	17.00%	94.00%	28.00%	89.20%	20.32%	94.19%
Q1 2024-25	10.00%	94.00%	39.00%	89.80%	*Not available*	

Positive themes for FFT are similar with staff attitude being top. Amongst the top negative themes, communication is a common theme across all three Trusts.

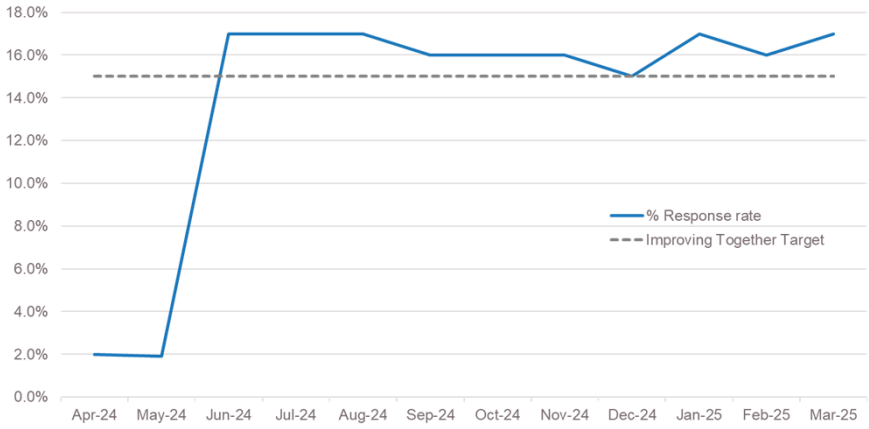
7. Process reviews, audits and policies

Nil to update this quarter.

8. Friends and Family (FFT)

Response Rates

Fig 9.1 Number of FFT responses, broken down by quarter with Trust response rate target.



A total of **15,964** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q4. This is **75 less** than the previous quarter.

The up surge in June 2024 was owed to the launch of the digital SMS system. From the 1st June 2024 the Trust commended SMS messaging of the FFT questions for ED and all maternity and outpatient services. The FFT card system remains in place for Daycase and Inpatient areas.

The overall target response rate for the quarter has achieved the Trust target, however the overall satisfaction rate has decreased below the Trust's target of 95%.

94% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q4 2024-25)

17%* Response rate (*of eligible population and averaged for Q4 2024-25)

Of the 15,964 comments received during this period the following positive/negative themes (and their proportion of these comments) are demonstrated below:

Positive

50% Staff attitude

27% Implementation of care

Negative

3% Staff attitude

2% Environment

Communication was noted to be a new theme this year on FFT, with the top three locations for this theme being ED, Radiology and the Eye Clinic.

Table 9.1 and 9.1a show the quarterly comparatives for both response rates and satisfaction rates. The satisfaction rate is noted to have dropped below the Trust's target of 95% however, this was anticipated owed to the significant increase in sampling.

Table 9.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

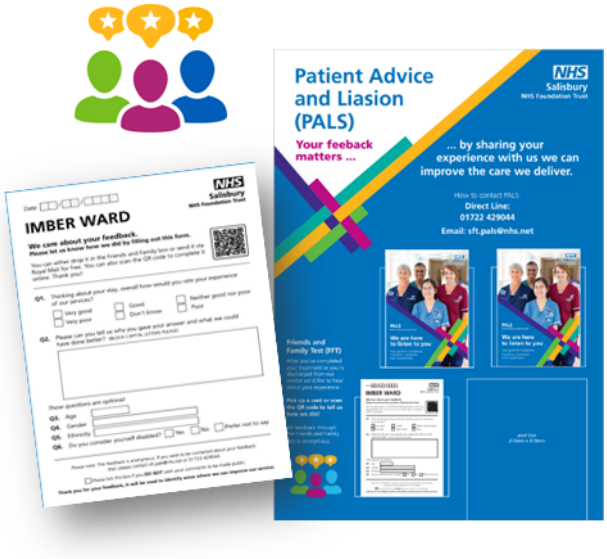
	Q4 24-25	Q3 24-25	Q2 24-25	Q1 24-25	Q4 23-24
Across all Directorates	6124.25 (121, 251)	6126.86 (123, 125)	5132.31 (121, 862)	561.91 (122, 404)	617.00 (119, 981)

Table 9.1a Satisfaction rate across the (averaged from responses received)

	Q4 24-25	Q3 24-25	Q2 24-25	Q1 24-25	Q4 23-24
Across all Directorates	94% (15, 964)	94% (16, 039)	694% (16, 123)	696% (7, 578)	697% (2, 042)

Friends and Family Test – Digital Go Live

Progress to update all FFT boards in the inpatient areas is now complete and phase 2 rollout of the outpatient boards is now underway.



The Trust overall this year achieved a **17%** response rate, exceeding the response rate target this year. The Quality Priorities for 2025/26 have increased this target to 18%.

Between the 1st April 2024 and 31st March 2025, a total of **43,394** comments were received via FFT for 2024/2025 themed as follows:

9. Patient and Public Feedback – Local Surveys

Real-Time Feedback (RTF)

The aim of RTF is to give a "real-time" view of a patient's perspective of their care.

Surveys are taken at the patient's bedside and results are sent to ward leads within one week of these being completed for reflection. Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward.

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 & Nurses, care and treatment, operations and procedures, leaving hospital, respect & dignity and overall experience.

In Q4 a total of 110 surveys were completed – achieving an overall average satisfaction rating of 87.6%. This quarter has seen slightly more surveys completed to that in Q3 (n~94), and the overall satisfaction score has remained the same as. See Table 10.1 for in month breakdown.

RTF is a standing agenda item presented to the Patient Experience Steering Group.

Table 10.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
January	**31**	**10**	Amesbury, AMU, Breamore, Britford, Chilmark, Downton, Durrington, Imber Tisbury, Whiteparish	89.3%
February	**41**	**12**	Breamore, Farley, Imber, Laverstock, Longford, Odstock, Pembroke, Pitton, Redlynch, Spire, Tisbury, Whiteparish	85.4%

March	**37**	**12**	Amesbury, AMU, Britford, Chilmark, Downton, Durrington, Farley, Imber, Laverstock, Longford, Odstock	88.7%
Total	**94**	**13**	87.8%	

Table 10.1a Average ratings breakdown by ward (January 2025):

Area	Number of inspections	Average score
Durrington	**3**	**95.24%**
Breamore	**2**	**93.48%**
Britford	**3**	**93.32%**
Downton	**5**	**91.21%**
Tisbury	**4**	**89.22%**
Whiteparish	**3**	**89.09%**
Imber	**2**	**87.68%**
Chilmark	**3**	**86.39%**
AMU	**3**	**85.45%**
Amesbury	**3**	**81.28%**

Table 10.1b Average ratings breakdown by ward (February 2025):

Area	Number of inspections	Average score
Pembroke	**2**	**94.78%**
Breamore	**3**	**94.51%**
Redlynch	**4**	**92.14%**
Pitton	**5**	**91.32%**
Odstock	**2**	**90.83%**
Whiteparish	**4**	**88.24%**
Imber	**2**	**88.17%**
Spire	**4**	**83.91%**
Farley	**4**	**78.06%**
Tisbury	**4**	**77.38%**
Longford Ward	**3**	**76.64%**
Laverstock	**4**	**72.81%**

Table 10.1c Average ratings breakdown by ward (March 2025):

Area	Number of inspections	Average score
Amesbury	**2**	**96.96%**
Farley	**4**	**92.86%**
Longford Ward	**3**	**92.57%**
AMU	**4**	**92.08%**
Sarum	**1**	**90.83%**
Laverstock	**6**	**90.53%**
Odstock	**3**	**90.30%**
Downton	**3**	**89.03%**
Imber	**2**	**84.42%**

Durrington	**2**	**84.14%**
Chilmark	**5**	**82.18%**
Britford	**2**	**75.91%**

Tables 10.2 and10.3 shows the breakdown of average response to specific questions (highest and lowest).

Table 10.2 highest scoring questions:

Question Text	Answer score (% good)	Responded Answers
How would you rate the level of privacy when being examined or treated?	91%	110
How would you describe the trust and confidence you have in those involved in your care?	90%	110
How would you rate the cleanliness of the ward you are in?	90%	110
How would you rate your wait time for your admission to Hospital?	75%	110
How well have the medical staff explained things to you?	76%	110

Table 10.3 lowest scoring questions:

Question Text	Answer score (% poor)	Responded Answers
How would you describe the noise level on the ward at night?	23%	110
How would you rate your overall wait time for your admission to hospital?	10%	110
How would you describe your understanding or involvement with your discharge plan?	10%	110
How well have the medical staff explained things to you?	8%	110
How would you describe the quality and selection of dietary options available to you?	6%	110

There are notable consistencies with last quarter in relation to negative themes across almost all areas however all percentages are noted to be an improvement on last quarter. Involvement with discharge plans continues to be a negative theme, there is an active quality workstream focusing on this currently. Further analysis is currently taking place around where noise at night is originating from and if it is actually causing a disturbance or not as we realist the original question is ambiguous

Positive themes that carry over are also largely consistent with some improvement on figures also.

Following consultation some questions have been amended for 2025/6 and may result in us having a clearer picture on issues like noise at night, access to pain relief and explanations around operations and procedures prior to them taking place. There will also be additional questions on the method of admission and where this has been via ED, further questions about the quality of care, access to basics such as nutrition and hydration and continuity of care.

Between the 1st April 2024 and 31st March 2025, **370** surveys have been completed by the patient bedside, these themed the following:

With an overall satisfaction rating of **86%.** This is slightly below our quality priorities target of 90%.

There was a **10% increase** this year on the number of surveys undertaken in 2023/2024, however this has fallen short of our quality priorities target of a 15% increase.

National Audit for End of Life Care (NACEL) Survey Summary – Q4 and Annual Report 2024/25

The survey response rate has significantly reduced this quarter (11% from 33% in Q3), despite an increase in the number of surveys being sent (38% compared to 23% in Q3). This has resulted in an overall sampling of just 4% of bereaved families, compared to the highest recorded back in Q2 (22%).

There was a total of 7 completed surveys received in Q4. NACEL have also advised that this number may reduce further, as one or more surveys have been identified as outside of the scope, with death occurring outside of this reporting period.

53% of these respondents described their overall rating of care and support given by the hospital to the dying person as “excellent”, compared with 14% who described this as “Poor”.

This is a decline in performance on the excellent rating for Q3 (67%) there is however a significant decrease in the poor rating (14% from 22%) - see Fig 2.2.

2 survey participants requested a call-back from PALS, one was uncontactable and the other has raised a formal complaint, for which a meeting has been arranged.

Due to the small number of responses received for Q4, it is difficult to make meaningful comparisons with previous quarters. This report will therefore also reflect a cumulative annual analysis of the NACEL results.

- In summary, the Trust’s comparative performance with our Southwest peers is positive overall, ranking 3rd in the overall ratings for the Southwest (see Table 2.1).

Successes to note: For 2024/25, the Trust has outperformed peers either/or both locally and nationally in the following areas:

- Overall rating of the care and support given by the hospital to the dying person
- Explained to the person that they were likely to die in the next few days
- The person had support to eat or receive nutrition if they wished

- The person had support to drink or receive fluid if they wished
- Staff at the hospital made a plan for the person's care which considered the person's needs and wishes
- Staff tried to provide care for the person's emotional needs
- Families and others were given enough spiritual/religious/cultural support
- There was a co-ordinated care approach by hospital staff during the final admission, including with health and care providers outside the hospital where appropriate
- The person had an advance care plan in place before they died
- If families and others wanted to be with the person when they died, they received timely communication to be there
- Staff looking after the person had the skills to care for someone at the end of their life
- Staff behaved with compassion and care– SFT is noted to have outperformed on this question when compared nationally, but marginally below in comparison with SW peers.
- Families and others were kept updated and had enough opportunity to discuss the person's condition and treatment with staff
- Staff looking after the person treated them with dignity
- Overall support for loved ones

Areas for improvement to note: For 2024/25, the Trust has been outperformed by peers either/or both locally and nationally in the following areas:

- A member of staff at the hospital explained to families and others that the person was likely to die in the next few days
- Staff at the hospital involved the person in decisions about care and treatment as much as they would have wanted in the last 2 to 3 days of life – also of note, (8%) felt the patient would like to have had more involvement, which was the highest proportion compared both Nationally and with Southwest datasets.
- The hospital staff regularly checked and addressed the person's needs – Contrast noted from case note review which suggests 56% evidence of a social or practical needs assessment, the vast majority of which were daily assessments Furthermore, 81% of these demonstrate being fulfilled
- Offers of interpreters or other language support for both the patient and their families
- The person had enough relief of symptoms other than pain and being given enough pain relief.

Participation in the NACEL bereavement survey over the past year has helped the Trust identify key areas for improvement, including decision-making involvement, communication, symptom relief, and support for diverse needs. However, limitations such as lack of ward-specific data has made it difficult to target improvements or align with other feedback sources like FFT or complaints. Feedback on services like chaplaincy and bereavement support were also missed.

From 1st April 2025, the Trust will return to using its local survey, “Your Views Matter (YVM)”, to better address these gaps. Bespoke YVM versions will also be developed to include feedback from deaths in ED and the Hospice, which NACEL had previously excluded.

The Trust plans to participate in NACEL again in 2028 for a year-long benchmarking exercise, ideally in coordination with RUH and GWH.

Full report was presented to the End of Life Care Steering Group on the 23rd April 2025 and the Patient Experience Steering Group on the 1st May 2025.

10. Patient and Public Feedback – National Surveys

Nil to report this quarter.

Background

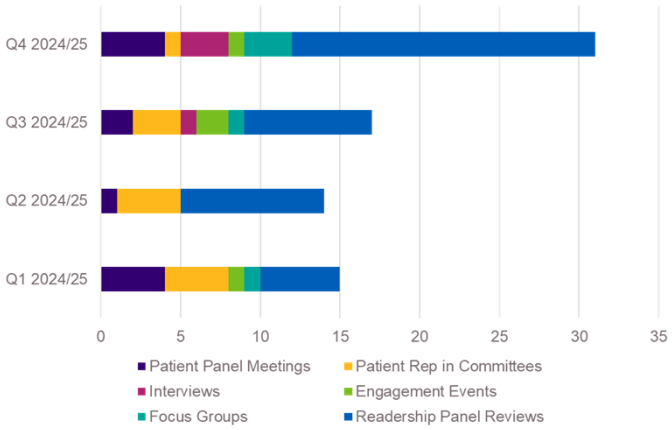
The Patient Experience team have been working to develop various methods, systems and forums to utilise, involve and use lived experiences of our patients to proactively develop our services.

By encouraging patients to be actively involved in their own care we can also maximise opportunities for co-production. Service improvements determined by the lived experiences our service users will not only result in better healthcare experiences, but potentially in better health outcomes and a greater connection to our local community.

1. Patient Engagement Projects

The Trust currently has various patient engagement projects underway and others planned for the coming year. These vary in commitment level from the patient and in the type of project being undertaken. Last year we spent time developing a secure mechanism to record and store engagement volunteers' details and the activities in which they are involved. This database continues to act as point of reference and record for engagement activities and will cover a vast array of opportunities for services users/carers and volunteers to be involved with our hospital.

Figure 1.1 – Patient Engagement Activities this year



Our service users have the option to participate in various types of projects and activities and these have varied commitment levels depending on the scope of the project/activity.

We have utilised opportunities such as the Hospital's Open Day and local community activities to recruit more engagement volunteers and updated the Trust website.

The Trust currently has several active projects including:

- Coming into hospital information booklet (using our PAT dogs!)
- Bedside storage boxes
- Stoma focus group
- Hard of Hearing Project
- Day-bed sleeper Chairs
- E-Menu

2. Readership Group

The readership group are a group of volunteers tasked with making sure information for patients, carers and families is clear. They provide a critical review of written information and surveys, ensuring these are clear on their purpose, understandable, accessible and are being delivered in the right way.

The readership group now has 11 active members

Over the past 12months, the group have been involved with reviewing 62 different types of patient literature including:

- Call for Concern leaflet
- E-menu Bedside Booklet
- Duty of Candour leaflet
- Car parking information
- SDEC information
- And various speciality and procedural patient information

Input from our readership group has ensured a patient friendly approach to various leaflets and patient information, including our new PALS complaints leaflet.

We continue to develop this group and are actively encouraging all new patient literature to be reviewed by the readership groups, 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.

This process has also been formalised into a guidance document "Producing Patient Information", which is available on EOLAS.

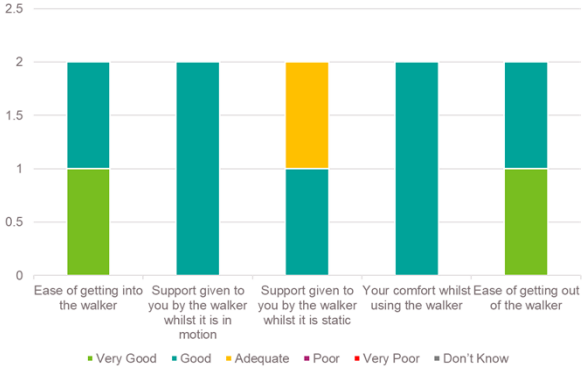
2.3 Patient Panels

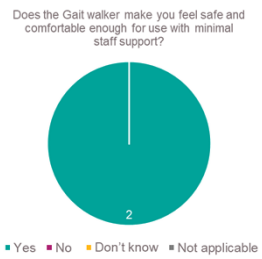
2.31 Spinal Patient Panel

The Spinal Unit wanted a dedicated Patient's Forum to ensure ways of getting patient feedback into regional oversight groups but also to inform changes and service improvements based on real patient experience.

The group have recently updated their Terms of Reference to reflect the evolved responsibilities of the patient chair and incorporated escalation reporting to the Patient Experience Steering Group.

This year, the group have successfully negotiated and implemented a 6month free trial of gait walker. The trial began in April 2025 and will run until October 2025. There are mechanisms in place to collect both patient and staff feedback on their experience of using the device, initial responses are positive.





The group are currently looking to increase its membership and considering an improving together style engagement event later this year.

2.32 Patient and Public Voice Partners - Cancer Services (PPV)

The group continue to meet regularly (every 8weeks) to progress patient experience initiatives.

The group have successfully implemented the following projects over the past 12months:

- The Macmillan information hub on Level 3
- The fresh fruit and veg stall on Level 3 - early feedback suggests that this has been well received by both patients and staff.
- Refresh of the Oncology OPD with artwork, working in partnership with Artcare.

They have recently updated their Terms of Reference to reflect the evolved responsibilities of the patient chair and incorporated escalation reporting to the Patient Experience Steering Group.

The group also piloted the Trust's first Patient Engagement Event using Improving Together methodology, this was supported by the Trust's Coach House Team. The event took place on the 4th March 2025 and was well attended by 17 patients.

The event has identified two key themes (communication and aftercare) from this event and these will be used to inform working groups tasked with undertaking a "A3 thinking" on the areas identified.

The group are also planning further engagement work over the next 12months, which will be reported on via the Patient Experience Steering Group and captured in the annual patient engagement report:

- An 18-30s Curry Night
- Patient journey photography exhibition
- Development of social media followings

2.33 Stoma Patient Panel

The Stoma Patient Panel have continued to develop and now meet on a regular basis, quarterly. They have been active in supporting the patient experience team in reviewing the "Stoma Friendliness" of all the toilet facilities across the Trust. There is now an action plan underway to install the additional equipment needed to meet this standard in the identified areas. The aim of the group is to ensure that the Trust has "Stoma Friendly" toilets across all areas of the trust (this currently includes all wards and disabled toilets), however there are further conversations about whether this should be extended to some public toilets too, reflecting that those with a stoma do not consider themselves to be "disabled".

The group have also acted as a readership for the Stoma patient information leaflets that have been developed and have been pivotal in encouraging access to exclusive swimming sessions. Funding for these sessions has now been secured for the next 6months.

Members of the panel also supported with attendance to at the PPV cancer engagement event in March demonstrating the additional benefits of cross pollination of patient experiences of both services.

2.34 Emerging Patient Groups

Over the next 12months specialty teams will be working with the Patient Experience team to develop their own patient panels and/or hold one off service improvement focus groups/events. The progress of these engagement activities will be reported on via the Patient Experience Steering Group and captured in the annual patient engagement report.

The following areas are currently working on these initiatives:

- Learning Disabilities (see related section of this report)
- Parkinsons
- Stour unit
- Gynaecology

2. Patient Safety Partners

In February 2025 the Patient Safety Partners were invited to the Clinical Governance committee to give a progress report on the embedding of their roles across the Trust.

The PSP role at SFT has been well supported, with the team feeling welcomed and their input valued at every event attended. They have received support from the Head of Patient Experience and Patient Safety, especially during induction. The role has allowed for a better understanding of how safety systems work at Salisbury and how these systems have adapted to new national guidance, such as PSIRF and changes in meeting structures. The involvement of the PSP role has evolved in collaboration with the SFT team, considering their other commitments.

Patrick Craig-McFeeley

Patrick is a retired local GP, bringing a wealth of knowledge from primary care coupled with his keen interest in joined up working across the NHS, patient involvement, quality and safety.

Peter Carey

Peter is semi-retired scientist who spent 30+ years working in public service dealing with government departments and statutory nature conservation organisations. Peter brings these skills and his experiences as a service user of Salisbury Hospital.

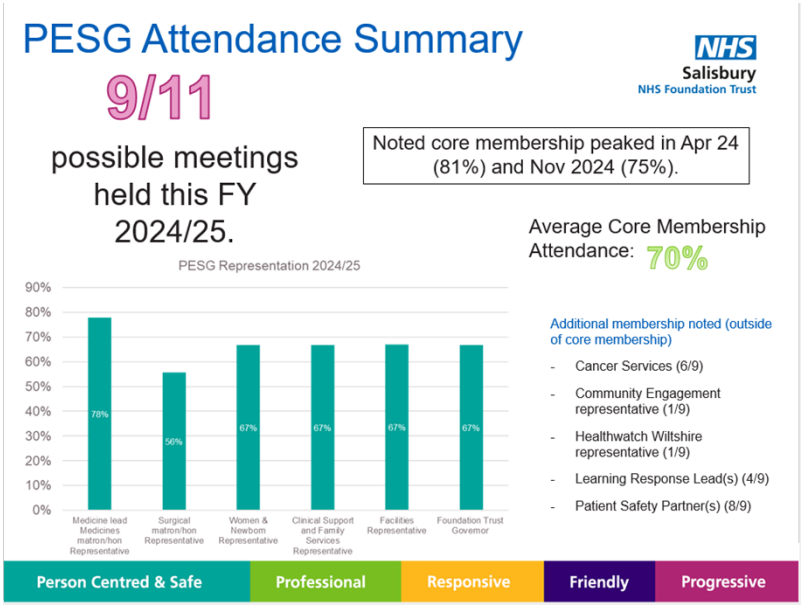
The PSP role varies across different organisations, with some lacking it entirely, others having PSPs who have left, or some with organised systems of paid PSPs and dedicated managers. The safety commissioner recommends involving PSPs at all levels, including board level. SFT is currently somewhere in the middle, which is appropriate for the first year of the role, but it should evolve as the role and safety culture mature.

Suggestions for the future development of the PSP role include:

- Expanding the number of PSPs to four, with one per division, to increase support for organization-wide activities and bring greater diversity.
- Keeping PSPs as unpaid volunteers to maintain independence, while recognizing that this limits diversity as those facing health inequalities may not be able to volunteer.
- Continuing board walks and targeted visits to areas in need, such as referrals or discharges, to better understand challenges faced by staff.
- Encouraging PSPs to observe specific areas for a few hours, providing fresh insights that could lead to safety improvements.
- Considering regular PSP input into the organization's strategy, to embed the patient voice across the system once PSPs gain sufficient knowledge and experience.
- Allowing PSPs to sit on trust boards as equal members, with the ability to ask questions and contribute meaningfully, potentially involving at least two PSPs at the board level.

There is currently recruitment underway for up to 2 further PSPs. Interviews are scheduled for May 2025. This additional recruitment will enable options for a PSP to be aligned to each Division in the future.

3. Patient Experience Steering Group (PESG):



The meeting is held monthly on the last Wednesday of each month, with the exception of December. Two meetings were stood down this year due to the hospital being in OPAL 4.

The steering group continues to develop in both its governance structure and its membership. Terms of reference for the group have been reviewed and continued to develop over the past 12months with a key change being an inclusion of an escalation “style” reporting template coming from the two established patient panel groups.

PESG has an established work plan for 2025/26 which was agreed in April 2025.

Overall representation of the core membership has improved on 2023/24 (64%).

The meeting has developed a combination of fixed agenda items ensure key Improving Together Targets are evidenced and reported on, particularly when these are areas needing further work (i.e. overdue complaints and FFT responses).

4. Patient Stories

Patient Stories

Helen’s story was an Deaf inpatient’s recount of her experiences as a British Sign Language user, during her 12week inpatient stay.

The following learning was taking from Helen’s story:

✓Better methods of communicating what is available and empowering patients to tell us what they need

✓Diversifying the ways we can communicate

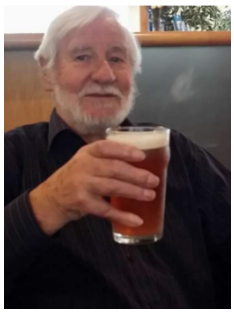
✓More education for staff on the rights to BSL interpreters under the Equality Act and how to access these

✓Better support for our staff on the importance of the right methods of communication, especially for key points in the patient’s journey

This tiggered the **Hard of Hearing Project** which launched during Deaf Awareness Week (May 2024).

During that week the PALS team with support from colleagues from Speech and Language undertook a Trolley Dash, which visited 17 different locations and spoken to over 60 members of staff. The aim of the trolley dash was to:

- ✓ Launch of refreshed SaLi resources and website pages
- ✓ Showcasing the HoH Resource Boxes
- ✓ Practical demonstration of the challenges of hearing loss using noise cancelling headphones
- ✓ Simple techniques and guidance for communicating with those who are Deaf or hard of hearing
- ✓ Launch the new on demand BSL services provider - SignLive



Harry's Story – Shared by his daughter, themes included, poor communication, the impacts of note feeling listened to and the additional distress caused by the clinical review process. Harry's story was also shared at Medicine's Divisional Learning from Incidents Forum to ensure their maximum impact and reflection.

Ken's Story – Ken shared his story from symptoms onset to diagnosis and through 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 – 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.

5. Patient Experience Week – 28th April – 2nd May 2025

Patient Experience Week in the NHS is an annual event dedicated to celebrating and highlighting the importance of patient experience in healthcare. It is a time for NHS staff, patients, and families to reflect on the care provided, share feedback, and recognise the work done to improve the quality of care and patient satisfaction. During this week, various activities, events, and initiatives were organised to promote engagement between patients and healthcare professionals, as well as to raise awareness about the impact that compassionate, patient-centred care has on overall health outcomes. It also serves as an opportunity to appreciate the contributions of healthcare teams and to encourage continuous improvement in service delivery across the NHS.

During this week the PALS and Patient Experience Team hosted three external talks from local community services:

- Julians' House GRTB Culutral Awareness
- Alabare Riverside Sanctuary
- Hospital Liaison Committee for Jehovah's Witnesses

These are available to view on SaLi.

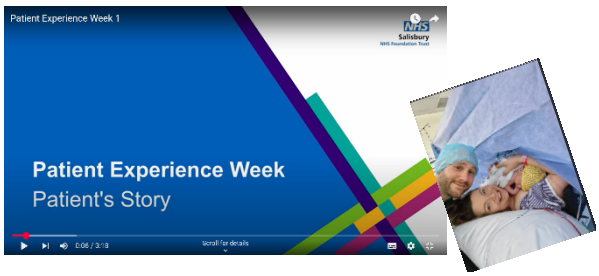
We also captured four patient stories in our Patient Story booth down in Springs that week, these can be viewed here:

Story 1 – Inpatient

Story 2 - ED

Story 3 – Outpatients

Story 4 - Maternity



In addition, a total of 19 staff and departments across the Trust were awarded certificates in recognise their dedication to improving patient experience. You can also view the full list of nominations **here**.

- Adrian Burholt (Chaplains)
- Becky Roberts (Midwife)
- Collette Byelong (Divisional Head of Nursing - Surgery)
- End of Life Care Team
- Jane Podkolinski – (Real-Time Feedback Volunteer and Governor)
- John Gardiner (Learning Disabilities Nurse)
- Julie Wadham (Help for Heroes Nurse)
- Katie Ransby (Surgical Deputy Divisional Head of Nursing)
- Kirsty Benfield (Deputy Divisional Head of Nursing, Medicine)

- Luke Curtis (Macmillan Lead Cancer Nurse Clinical Lead End-of-Life Care)
- Marley Blake, (Medical Secretary – Endocrine/Diabetes)
- Matthew Berry – (Real-Time Feedback Volunteer and Engage Volunteer)
- Matthew Flynn (Consultant)
- Radiology Department
- Rebecca Exton (Consultant)
- Richard Smith (Consultant)
- Sara Willan – (Real-Time Feedback Volunteer)
- Sharon Boyle – (Chaplains)
- Tori Newton (Imber Ward)

At the Patient Experience Steering Group that week, we had Divisional presentations from Surgery, FaSS and Medicine showcasing a patient experience improve project. These were:

FaSS: Learning Disabilities/Autism Boxes for Radiology

The first initiative is a sensory bag for learning disability and autism patients. The second one is a booklet 'Henry goes to Radiology'. Intended for paediatric patients. They have found that they both cover a broader range of patient groups, beyond just paediatrics.

The bags contain: noise cancelling headphones, fidget tangles, a stress ball, wooden fidget worm, visual card fans. They are now in all sub-areas as well as community sites.

There is a feedback process so the team can get feedback on how useful they have been. This initiative originated from patient experiences and has been driven by one of the Radiology Department assistants, Gilly Ansell.

The feelings fans are useful for helping where there may be communication challenges and has been particularly helpful with cannulation and has made a difference in a few cases already.

The booklet is laminated and cleanable and available in the reception areas.

Medicine: Improving medication administration together

Spire ward (a 30 bed elderly care ward) and Pharmacy collaborated on a deep dive into delayed and omitted time critical medications on Spire ward. It showed 16% of patients on the ward were not receiving their medications on time or omitted completely, 78% were delayed doses. This review was undertaken over a 14 month period.

Root cause analysis was done to look at the process factors contributing to these findings. There were numerous reasons including poor prioritisation tools on the electronic prescribing system being used, ward storage of medications, insufficient numbers of mobile computers, lack of awareness of critical nature of medications being given on time, and interruptions on medication rounds.

The impact on patient's was a gradual worsening of conditions, increase in pain, loss of mobility, infections and increased risk of life threatening events. Further consequences included:

- increased length of stay in hospital
- loss of trust or the patient feeing neglected or unsafe
- emotional distress for patients and their families
- legal and ethical issues which can result in complaints, litigation and harm to the hospital's reputation.

Actions taken from the findings included:

- an uplift in nursing numbers
- controlled drug administration times being changed (night staff now give early morning and bedtime medications to prevent clash with handover times)
- number of EPMA drug trolleys have been increased
- Engagement at ward huddles, has led to improved medication culture on the ward.

Results:

- There has been a two third reduction in the situation since 2024.
- The delay and omitted medications figure has reduced from 16% to 5%.

As a result of this success, this project is now being rolled out across other wards, Imber Ward was next to trial. Imber Ward were scoring 9.8% in medications being delayed or omitted and this has now reduced to 5.8%.

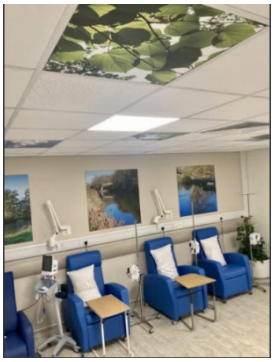
This has become a clinical priority and a fundamental aspect of patient centred care. It has led to timely escalation, robust systems for medications management, effective communication.

Surgery – Stour Infusion Unit

This is the new infusion unit that has combined the old Rheumatology unit and the Nunton unit into one infusion unit.

The space was previously used for physiotherapy and required work to improve the space for its new use. It has now opened as a 15 chair unit.

Patients were kept on board with the changes, but reflect that more that more could have been done in the earlier in the project to include patient engagement in its design phase.



A new nurses station and treatment rooms were created to provide a better spaces to prepare medications without disruption.

There were concerns about the size of the unit and where the unit is situated which were addressed. Patients were involved with the naming of the unit.

The unit collects feedback via FFT, as this is a Daycase patients do not receive text messages but are able to leave feedback using the FFT cards and will soon have table-top stickers with a QR code inviting this feedback.

Work is currently underway with the Patient Experience team to host a focus group towards the summer to review the patient experiences of the new unit.

6. Accessibility

6.1 Interpreting services

In 2024/25 the centrally held Trust budget for interpreting services was **overspent by £11,903 (35% of the annual budget)**. This spend includes language translations (telephone, face to face and conversion of printed materials) and British Sign Language (face to face) provision.

The need for interpreting services continues to increase and efforts to try and keep costs down despite this have been somewhat successful. Specialties and wards are encouraged to use telephone interpreting services instead of face to face where this is possible and appropriate, significantly reducing the cost of this provision on those occasions.

In total there were 815 provisions made for those where English was not a first language during, this is almost double the number of requests seen in 2023/2024 (471).

Dari saw the highest language demand, totalling 30% (Table 6.1), with Med/Surg Outpatients and Maternity seeing the highest proportion of requests (Table 6.2).

The overspend and the increase in this dialect request can be attributed to the Afghan Resettlement Scheme which is taking place in Wiltshire. This impact has been raised with the ICB and local council. Paul Russell is leading on this discussion.

Table 6.1 Proportion of total requests by language

Language	% of Requests
Dari (Afghanistan)	20%
PASHTO	13%
DARI	10%
Bengali (Sylheti)	7%
ROMANIAN	6%
Kurdish (Sorani)	6%
POLISH	6%
UKRAINIAN	4%
BULGARIAN	3%
NEPALI	2%
Chinese (Mandarin)	2%
FARSI	2%
Turkish	2%
Arabic - All or Any	2%
RUSSIAN	2%
BENGALI	2%
SYLHETI	1%
Thai	1%
SORANI	1%
Bengali (Dhaka)	1%
Spanish	1%
URDU	1%
Albanian	0%
Grand Total	**100%**

Table 6.2 Proportion of total requests by location

Location	% of Requests
MATERNITY	41%
MEDICAL SURGICAL OP	33%
EMERGENCY DEPARTME	7%
AAA SCREENING	3%
GYNAE	3%
DURRINGTON	1%
WESSEX REHAB	1%
SARUM	1%
ENDOSCOPY	1%
PEMBROKE WARD	1%
SURGICAL ASSESSMENT	1%
D.S.U.	1%
RADIOLOGY	1%
LAVERSTOCK	1%
ORAL & MAX FAX	1%
ORTHOPAEDIC OP	1%
Grand Total	100%

Table 6.3 Proportion of total requests by quarter

Row Labels	% of Requests
Q1	14%
Q2	31%
Q3	34%
Q4	21%
Grand Total	100%

The Trust also uses Deaf Action to provide British Sign Language (BSL) support where the patient's first language is BSL and SignLive for on demand BSL services (in emergency or out of hours situations).

There were 73 provisions for pre-arranged BSL interpreters during 2024/25 and 398 minutes used for the BSL on-demand service.

6. Working with our communities

7.1 Veterans

The Trust maintains its Employer Recognition Scheme, Gold Award Status.

The Trust continues to provide dedicated Armed Forces Champion training and education to staff, empowering them to identify, signpost and advocate for patients. The half day training involves local Armed Forces charities including DMWS, Help for Heroes, BLESMA, AFVBC and Alabare.

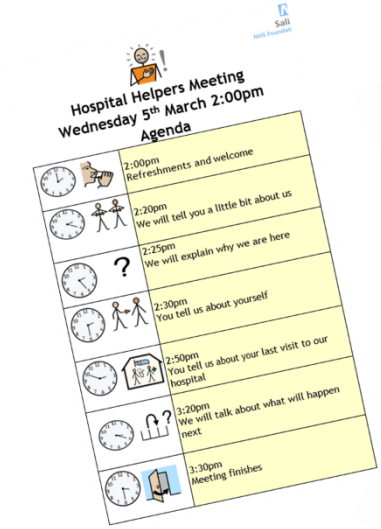
To date, it is estimated that there are over **250 armed forces champions** across the Trust.

Veterans can self-identify but are usually identified by a member of staff or armed forces champion and they are then referred onto our Military Welfare Support Worker and there plans underway for a Veterans status flag to be added to Lorenzo under the Patient's status.

In January 2025 the Trust expanded its support for Veterans with the introduction of out new Help for Heroes Nurse-led service.

7.2 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 held our first LD focus group in March 2025.



Themes from the discussion:

- Having appointments on the same day at different times would help
- We need to be clear what the Hospital passport is. Some patients and carers get given the wrong form.
- Text messages are confusing. Letters are easier to understand.

Things that meant a lot:

- Staff were kind
- Staff made sure you were comfortable
- Staff also made food how you liked it
- Staff should listen to the patient
- If possible, let the patient know what ward they will be staying on and what will be happening. Also a discharge date if possible

- Not having to wait long
- Having a side room
- All appointments on the same day where possible

What we will do next:

- Setting up Internet pages on the Hospital website, for patients and carers
- Looking at ways we can gather feedback from patients
- Working more with our “Hospital Helpers” We have lots of ideas of how they can help and we are going to meet again in May.
- Some ideas we have for the Hospital Helpers:
    - Helping us create EasyRead leaflets
    - Improving our waiting areas for patients with LD and Autism with a walkabout
    - Approve the internet pages we design
    - Help us produce a brochure for visiting Hospital to include pictures of all areas

7.3. Carers

The carers working group have provided assurance reports bi-annual this year to comply with the changes in the Quality Contract reporting requirements.

Key achievements over the past 12months:

- Successful launch of the new Carers Passport
- Successful bid through the hospital charity Stars Appeal for 34 reclining sleeper chairs to facilitate loved ones/carers overnight stays by the patient’s bedside
- Completion of the roll-out of recliner chairs to enable overnight bedside stays (May 2025)
- Reestablished the Carers Working Group, with refreshed membership and terms of reference, there is good assurance of regular escalation reporting in place to the Patient Experience Steering Group.
- Launch of new carers support email inbox during Carers Week (June 2024).
- Successful launch and continued development of the Staff Carers Network and associated resources, awareness and training.

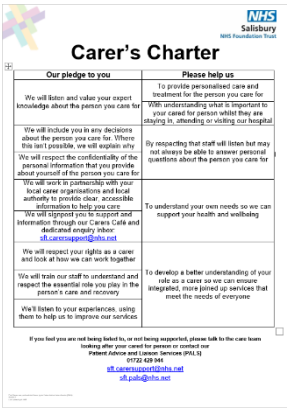
Challenges to note:

Resourcing for the Carers Café has been an area of concern and has been highlighted to the Patient Experience Steering Group. Unfortunately, despite collaborative efforts both internally within the Trust (through the volunteer services) and externally with partners such as Carers Together Wiltshire we have been unable to close this gap. This gap is also anticipated to widen over the coming year owed to the current volunteers needing to reduce their commitment to this.

One of the challenges we continue to face is the lack of carer awareness amongst front line staff. The Carers Working Group have attempted to mitigate this with the redevelopment of the Carers Passport which contains more information and guidance targeted at simultaneously educating the staff issuing these, with the information for carers. The Carers Passports are also being promoted through the Trust’s Real Time Feedback, with those inpatients who indicate they have a carer.

However, the greatest challenge to increasing carer awareness across the Trust is the capacity and resources need to develop the carer champion training model.

The current project is the development of a Carers Charter, which has now been finalised by the group and is currently going through the approval processes of Patient Experience Steering Group and Clinical Management Board.



Carer's Charter

Our pledge to you	Please help us
We will listen and value your expert knowledge about the person you care for	To provide personalised care and treatment for the person you care for
We will include you in any decisions about the person you care for. Where this isn't possible, we will explain why	With understanding what is important to your cared for person whilst they are staying in, attending or visiting our hospital
We will respect the confidentiality of the personal information that you provide about yourself of the person you care for	By respecting that staff will listen but may not always be able to answer personal questions about the person you care for
We will work in partnership with your local carer organisations and local authority to provide clear, accessible information to help you care	To understand your own needs so we can support your health and wellbeing
We will signpost you to support and information through our Carers Café and dedicated enquiry inbox: sft.carersupport@nhs.net	
We will respect your rights as a carer and look at how we can work together	To develop a better understanding of your role as a carer so we can ensure integrated, more joined up services that meet the needs of everyone
We will train our staff to understand and respect the essential role you play in the person's care and recovery	
We'll listen to your experiences, using them to help us to improve our services	

If you feel you are not being listed to, or not being supported, please talk to the care team looking after your cared for person or contact our Patient Advice and Liaison Services (PALS) 01722 428 346 sft.carersupport@nhs.net sft.pals@nhs.net

7. Other

8.1 Complimentary Therapies

Aromatherapy

Aromatherapy funded by the Stars Appeal is being provided by a licensed practitioner on a 3 year contract, this commenced in November 2022. The service covers Burns, Pembroke and Neonates (family therapies, not babies) and is managed under the Patient Experience team.

The service continues to be well received and demand have almost doubled over the past 12months.

Between 1st April 2024 and 31st March 2025 a total of 937 patients had been seen, providing over 470 hours worth of complimentary aromatherapy. Pembroke continue to have the highest demand for this service, equating to almost 89% of this activity.

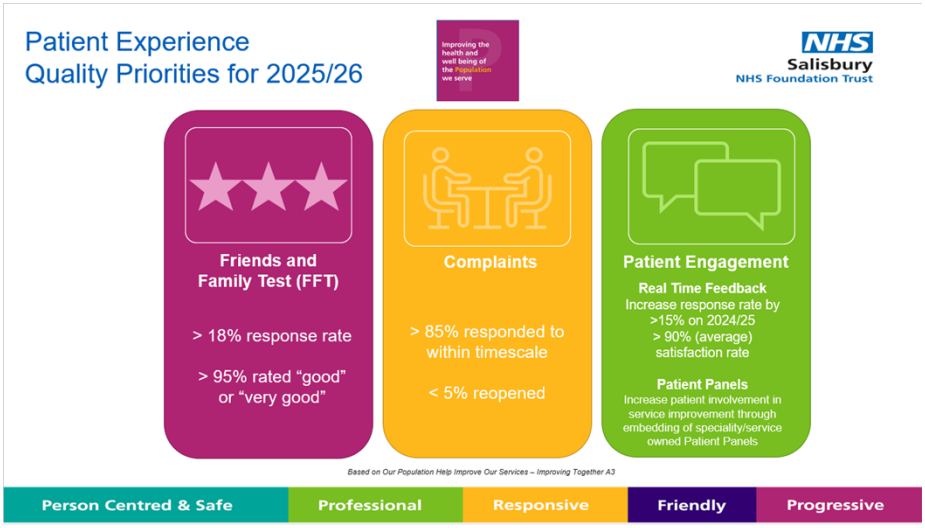
Plans are underway to develop a feedback mechanism for the service, similar in concept to that of the Friends and Family Test.

8. Patient Experience Quality Priorities for 2025/26

The Patient Experience Quality priorities for the coming year have been agreed to remain the same with an increase in FFT response rate proposed.

Complaints response within timescale was also maintained due to failure to achievement. There will continue to be a quality measure in place to monitor the percentage of re-opened complaints. Experience of the complaints process will also be considered alongside this as a quality measure.

Patient engagement priorities remain focused on increasing patient involvement through the patient panels and co-produced service improvements. There was an addition for Real Time Feedback, aiming to increase the number of responses and maintain high satisfaction rates. This data will be triangulated with the National Inpatient Survey results when these are published later this year.


Patient Experience
Quality Priorities for 2025/26
Improving the health and well being of the Population we serve
NHS Salisbury NHS Foundation Trust
Friends and Family Test (FFT)
> 18% response rate
> 95% rated "good" or "very good"
Complaints
> 85% responded to within timescale
< 5% reopened
Patient Engagement
Real Time Feedback
Increase response rate by >15% on 2024/25
> 90% (average) satisfaction rate
Patient Panels
Increase patient involvement in service improvement through embedding of speciality/service owned Patient Panels
Based on Our Population Help Improve Our Services – Improving Together A3
Person Centred & Safe
Professional
Responsive
Friendly
Progressive

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.7
Date of meeting:	3 July 2025		

Report tile:	Q4/End of Year Learning from Deaths Report 2024-25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee Mortality Surveillance Group			
Prepared by:	Mr Charles Ranaboldo, Trust Mortality Lead Dr Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Mr Duncan Murray, Chief Medical Officer			

Recommendation:

The paper is to provide assurance to the committee that the Trust is learning from deaths and making improvements.

Executive Summary:

Summary:

- The latest SHMI figure for the Trust is 0.94 (12-month period ending in December 2024). In the previous quarter this was reported as 0.96, and this continues to be the lowest figure that the Trust has observed in recent times. According to NHSE this figure remains statistically within the expected range for the Trust.
- Benchmarked statistics for Mortality continue to improve including the Summary Hospital-level Mortality Indicator (SHMI) provided by NHSE
- The most recent twelve month benchmarked period generated no SHMI Alerts for the Trust (which are flags or early warnings of possible areas for investigation or analysis)
- Specific areas with better than expected mortality figures such as fractured neck of femur and acute myocardial infarction have been confirmed
- Benchmarked mortality data are shared via the regional System Mortality Group which included Bath, Salisbury and Swindon Acute Trusts
- This group provides the opportunity to consider the effects of regional population-wide issues such as deprivation and hypertension as well issues affecting the Acute Trusts specifically
- The new online platform for Mortality reviews in the Trust which has been running for just over a year now includes over 400 Learning Points (LPs)
- Overall the ratio of good LPs to those LPs where areas for improvement have been identified is 2:1
- These LPs have been associated with 49 specific Actions which include sharing good practice as well as improvements discussed at specialty Morbidity and Mortality Meetings.
- Clinical teams are now expected to review their learning points and ensure actions are completed. This is a reflection of the Improving together culture that the Trust expects. There are 14 actions outstanding, only 4 are overdue.
- There are ongoing problems with the provision of space for Resident doctors to initiate completion of Mortality reviews in a timely manner. This cannot be resolved
- The use of i-Pads is being trialled as a way of mitigating the lack of access to desktop computers in the Bereavement Suite

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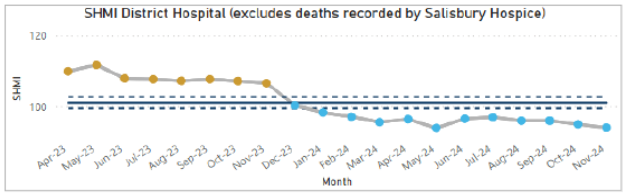

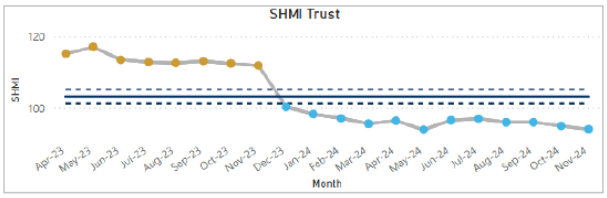

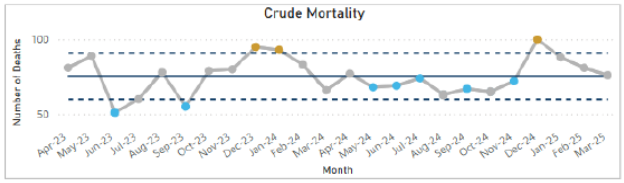

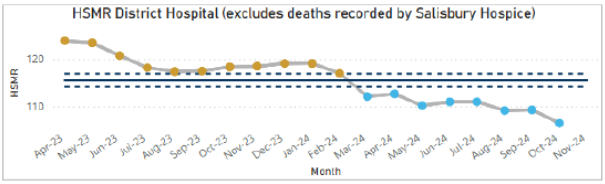

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust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

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QUARTER 4/END OF YEAR 2024/25 LEARNING FROM DEATHS REPORT

June 2025

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the final financial quarter of 2024/25. Data as available on 05.06.2025 [unless otherwise stated in the report]

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GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

MaMR
The Mortality and Morbidity Review Module that the Trust uses for electronic recording of learning from deaths.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

PSII
Patient Safety Incident Investigation

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

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SMR

A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX

Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

NHS Salisbury NHS Foundation Trust

Learning from Deaths Report – Quarter 4

Purpose and Background

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews, and investigations via a quarterly report to a public board meeting. The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

Executive Summary

- The latest SHMI figure for the Trust is 0.94 (12-month period ending in December 2024). In the previous quarter this was reported as 0.96, and this continues to be the lowest figure that the Trust has observed in recent times. According to NHSE this figure remains statistically within the expected range for the Trust.
- Benchmarked statistics for Mortality continue to improve including the Summary Hospital-level Mortality Indicator (SHMI) provided by NHSE
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- Overall the ratio of good LPs to those LPs where areas for improvement have been identified is 2:1
- These LPs have been associated with 49 specific Actions which include sharing good practice as well as improvements discussed at specialty Morbidity and Mortality Meetings.
- Clinical teams are now expected to review their learning points and ensure actions are completed. This is a reflection of the Improving together culture that the Trust expects. There are 14 actions outstanding, only 4 are overdue.

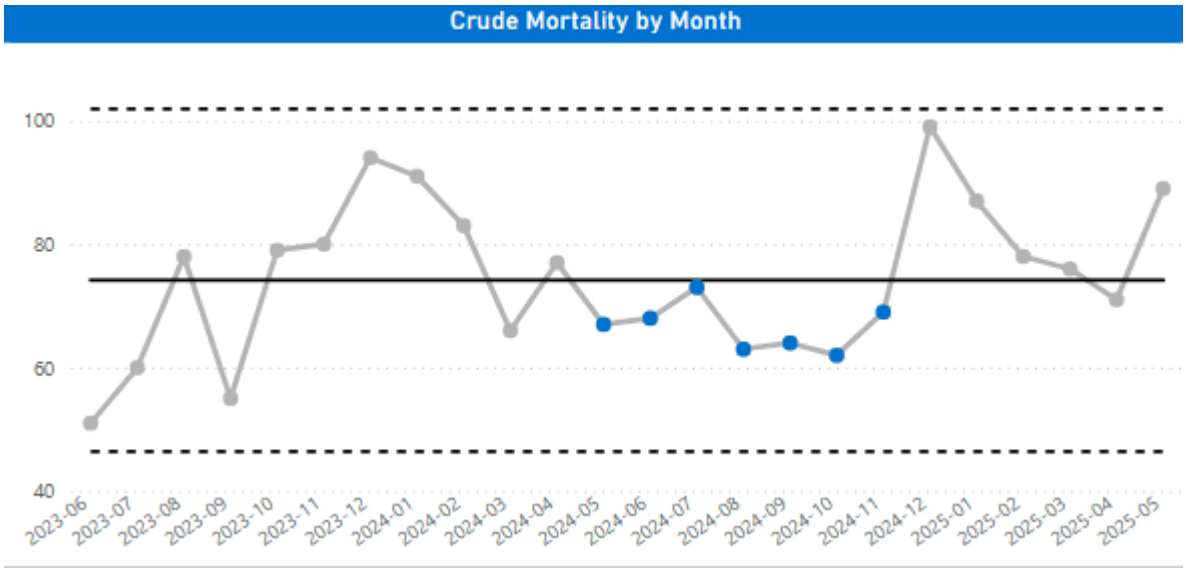
- There are ongoing problems with the provision of space for Resident doctors to initiate completion of Mortality reviews in a timely manner. This cannot be resolved

- The use of i-Pads is being trialled as a way of mitigating the lack of access to desktop computers in the Bereavement Suite

Learning from Deaths in Q4

The hospital mortality group (MSG) met on 11th February 2025 during Q4, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights, and the information reviewed and discussed at the MSG.

1. Data Overview



The graph above has been obtained from the Trust Power-Bi data dashboard and it shows the number of deaths occurring in SFT, as reported monthly. The crude mortality increased in December whereas below average numbers had been observed for the previous seven months recorded. A winter spike is consistent with previous year data trends. The graph and table on the next page provide a more detailed breakdown of these figures.

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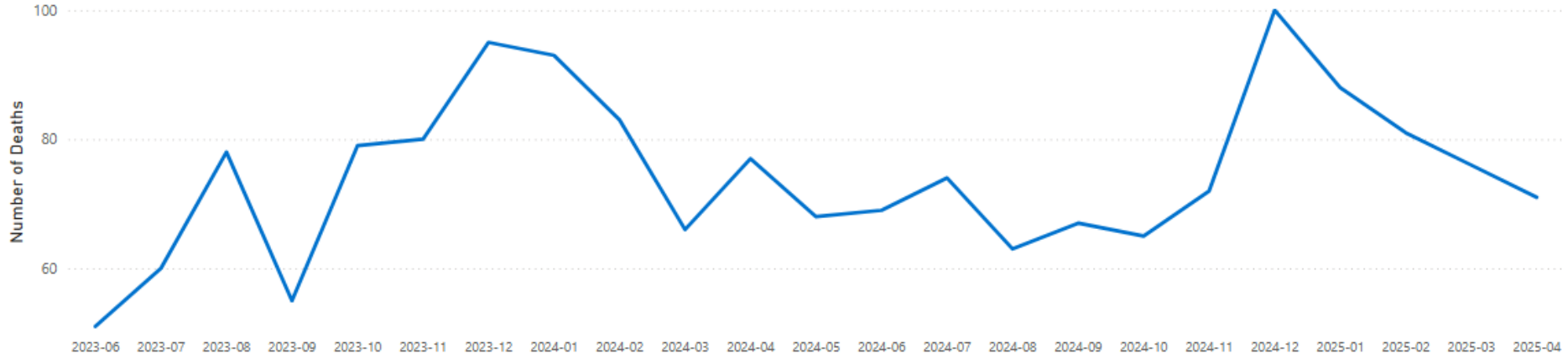
Total Deaths as Reported by the Medical Examiner: Jun-23 - Apr-25



Mortality Overview: Jun-23 - Apr-25

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2025-04	71	71	1	1	11	0							0	0
2025-03	76	74	0	2	10	0	0	0	0	0	0	0	0	0
2025-02	81	81	5	2	15	0	1	0	1	0	0	0	0	0
2025-01	88	88	4	2	19	0	0	0	0	0	0	0	0	3
2024-12	100	97	7	7	12	1	2	0	1	1	0	0	0	0
2024-11	72	70	2	6	14	2	0	0	0	0	1	0	0	0
2024-10	65	65	2	2	11	2	1	0	1	0	0	0	0	0
2024-09	67	66	3	2	18	2	0	0	0	0	0	0	0	0
2024-08	63	62	4	2	14	2	0	0	0	0	0	0	2	0
2024-07	74	72	5	5	17	1	0	0	0	0	0	0	2	0
2024-06	69	67	5	3	12	4	0	0	0	0	0	0	0	2
2024-05	68	67	5	2	14	0	0	0	0	0	0	0	1	1
2024-04	77	76	7	5	6	0	0	0	0	0	0	0	1	1

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

2. Learning and Actions

Q4 Figures

The figures below have been obtained from the Trust's online mortality recording tool (MaMR module in AMaT IT system*) for Quarter 4 of the 2024-25 financial year:

Total deaths:242

Total reviewed (ME):238 (98%)

Number of primary reviews (SJRs) requested by the ME:8

Total number of primary reviews undertaken: 119

Number of further reviews requested (e.g., another speciality asked to review): 26

Number of secondary reviews (higher level reviews) requested: 1

9 actions have been logged in the period, three good. In 8 of the 9 the actions have been completed with feed back at departmental clinical governance meetings. Communication and documentation issues predominate

**There may be minor discrepancies when comparing these figures to those directly reported by the Medical Examiners, e.g. due to duplicate entries, recording delays, or other IT issues being rectified at source.*

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ANNUAL OVERVIEW

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.

	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 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.

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.

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.

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Learning Points (LPs) and Actions

- **403 LPs** were recorded on our mortality system in the last 12-months, the majority from Medical specialties: particularly Elderly Medicine, Respiratory, also multiple entries from Palliative Medicine and Stroke
- Some were also added by surgical specialties such as General Surgery, Trauma and Orthopaedics, Burns and Plastic surgery, and ENT.
- The majority were positive points, approximately twice as many of these compared to areas identified for improvement.
- Most of the positive LPs related to good Communications with relatives and carers, assessment/investigation/diagnosis, clinical monitoring and EoLC.
- Regarding areas for improvement, most related to communication with relatives/carers and with colleagues. There were also several LPs related to patient transfers (both internal within the Trust and also external).
- Out of the 403 LPs there were 49 with specific documented actions: 35/49 had arisen from LPs where potential improvements had been identified and 9/49 where good LPs had been reported.
- 35 Actions had been completed, 10 were new ones and 4 were overdue. The clinical divisions are each reviewing their processes to ensure that these actions are routinely discussed at governance meetings.

Some specific examples relate to Communication and Documentation and were as follows:

- ✓ e-Mail Communications with other Trusts being added to the Electronic Patient Record.
- ✓ Action to be taken to improve the recording of ReSpECT form discussions, the date/time/location of falls, the results of scans and the time/date and name of the individual leading ward rounds. These were actioned via individual teams' Morbidity and Mortality Meetings and in newly starting (FY1 doctor) teaching and induction.
- Additional discussion of LPs and actions takes place as a fixed Agenda item at the Trust's bi-monthly Mortality Surveillance Group meetings where representatives from the Divisions are present and who are able to highlight areas of concern themselves or cascade recommendations to the relevant specialties.

Regional Mortality Group Meetings: BSW System Mortality Group

- This group now meets monthly with representation from the three Acute Trusts (RUH, GWH and SFT) along with Public Health and senior ICB individuals along with NHSE Quality leads.
- Issues discussed range from effects of deprivation on the health of the population through to specific components of acute care delivery such as the care of patients with fractured neck of femur.
- Opportunities are being explored to adopt the same methods of analysis of mortality data so that learning and actions can be shared. In order to achieve this in as efficient manner as possible it has been proposed that the three Acute Trusts should as far as possible use the same methodology.This could be approaches for reviewing a specific alert (which could be generated by one of the systems used for benchmarking, SHMI or HSMR) or following SFT's policy to complete all Mortality reviews in the AMaT MaMR platform, thereby ensuring that all data points are consistent and comparable across the different specialties.
- SHMI figures are already shared for all three Trusts at the BSW system mortality group meetings and further collaborations can be facilitated by sharing methodology for reviewing alerts (Pneumonia and Septicaemia as recent examples, or adherence to Sepsis 6 (the six key actions to take within the first hour when a patient with suspected sepsis is identified).

Other Updates

As mentioned previously in this report, the data shows that the Trust's SHMI position has continued to improve. The improvements are likely to be multifactorial and may be attributed to the phased introduction of standardised paper mortality review proformas for all specialties in late 2022, the gradual rollout of the online MaMR platform (early 2024) and the subsequent steady increase in the numbers of standardised format Mortality reviews being performed.

When specific diagnosis groups are examined, *Pneumonia, Acute renal failure* and *Septicaemia* cases, which had generated alerts previously using statistical modelling (higher observed verses expected deaths), are now within the expected range.

Although the Coding team remain under pressure in the Trust, they still manage to code a higher percentage of cases for Comorbidities (which feed into the benchmarking figures) than regional peers (only 13% of cases were uncoded in the year up to December 2024 compared to 17% and 18.7% for regional peers). SFT had 34.4% of cases with zero Comorbidities compared to the National average of 25.8%, which affects the calculation of Expected deaths. This calculation is also affected by the proportion of cases with 20+ Comorbidity score (the highest scores representing the most unwell patients) for which SFT coded 22.2% of cases compared to a National average of 30.4%.

These Comorbidity scores result in lower figures for Expected deaths than other Trusts, so an equivalent crude mortality rate at the other Trusts is more likely to lead to classification as an outlier. This makes it even more important to ensure that coding of Comorbidities is correct and is often the first port of call when investigating Alerts arising from benchmarking analyses.

3. End of Life care

3.1. From 1st April 2024 the NACEL survey replaced the Trust's Your Views Matter (YVM) survey for 12-months to allow for national benchmarking to take place during this period. This report focuses on the quality survey measures for Q4 2024/25. It should be noted that there is limited comparison for the Trust's YVM survey results for 2023/24 because of this change in collection method.

3.2. The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales, and Jersey. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. NACEL is featured on NHS England's Quality Accounts list for 2024/25.

NACEL collects data from four sources:

Quality Survey: This is an online survey completed by relatives, carers and those important to the person who died in hospital, to report their experiences of the care and support received at the end of life.

Case Note Review: This is data collected from patient notes about the care they received during their final admission to hospital. It focusses on 10 indicators of care, including recognition of dying, timely review of the dying and deceased patient, etc.

Hospital/ Site Overview: questions focus on the specialist palliative care workforce, staff training, anticipatory prescribing and quality and outcomes within the hospital/site.

Staff Reported Measure: this survey is completed by staff who are most likely to come into contact with dying patients and their loved ones. The survey asks questions about staff confidence and experience in delivering care at the end of life, the support they receive and the culture of their workplace. This is not a staff satisfaction survey such as the NHS staff survey. About NACEL — National Audit of Care at the End of Life

The NACEL bereavement survey focuses on the insights taken from the Quality Survey.

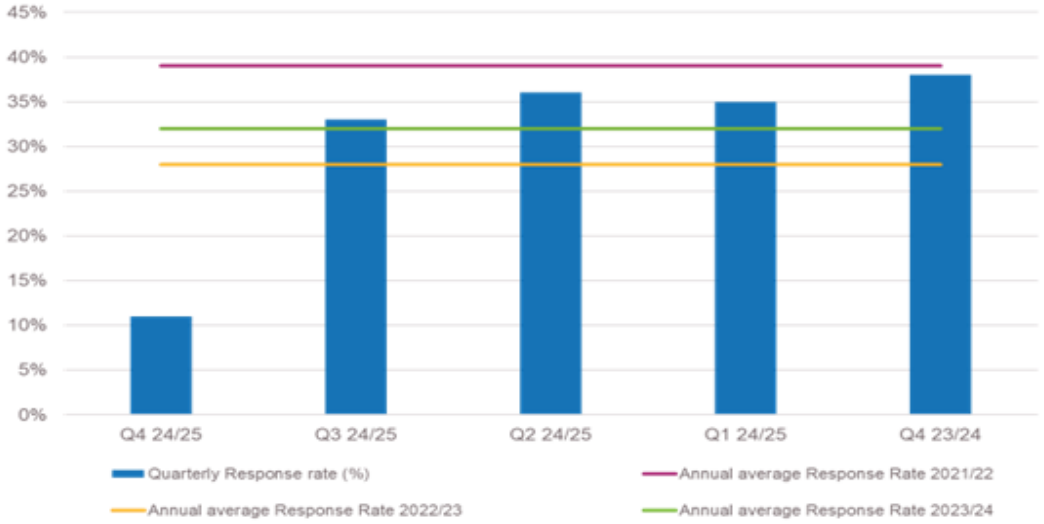
3.3. There was a total of 64 surveys sent during this period (Q4), 53 of these were sent in March when the system changed from paper to an emailed link, which is sent by the Medical Examiner's Office[1*]

[1]Surveys are sent with the consent of the family, the Medical Examiners endeavour to ask every family to participate in this survey, however there is a judgement made on the appropriateness of this at the time the call is made, as a result some discretion is applied and not all families may be offered this survey.

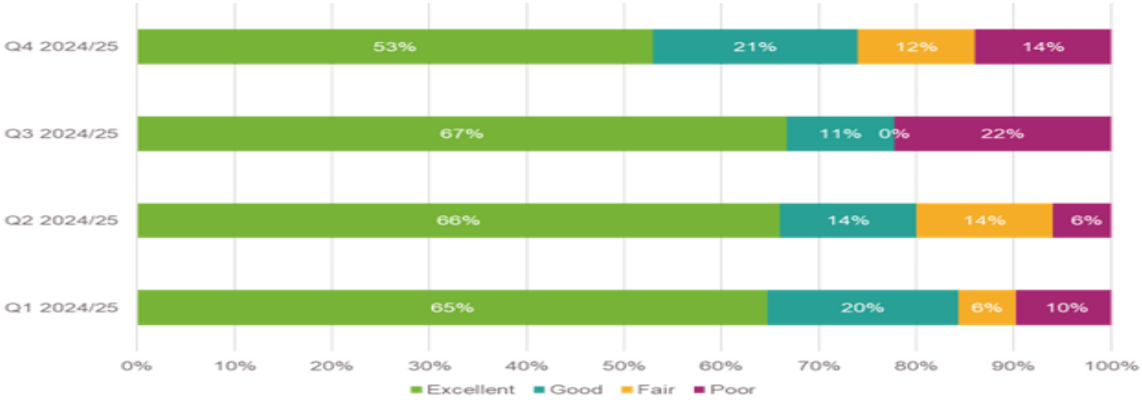
3.4. The survey response rate has significantly reduced this quarter (11% from 33% in Q3), despite an increase in the number of surveys being sent (38% compared to 23% in Q3).This has resulted in an overall sampling of just 4% of bereaved families, compared to 22% (which was the highest sampling recorded back in Q2).

3.5. There were a total of **7** completed surveys received in Q4. NACEL have also advised that this number may reduce further, as one or more surveys have been identified as outside of the scope, with the death occurring outside of this reporting period.

NACEL Survey Quarterly Response Rates for SFT (Compared to National Average)

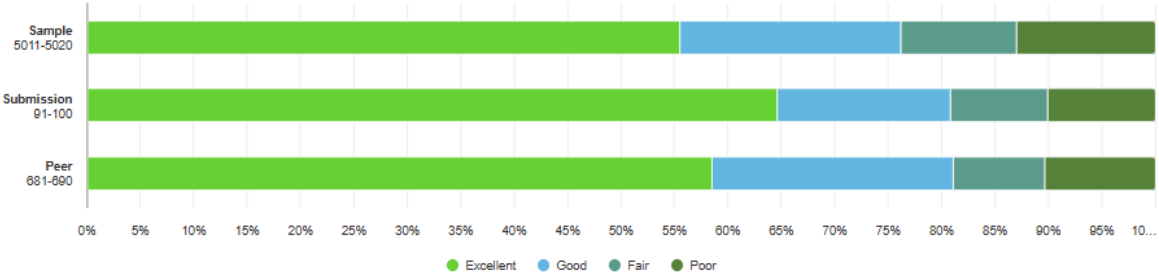


3.6. During Q4 53% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 14% who described this as "Poor". This is noted to be a decline in performance on the excellent rating for Q3 (67%) however a noted decrease in the poor rating (going from 22% to 14%)



3.7. The figure below shows the overall experience ratings for 2024/2025. As a comparison, in 2023/24, the combined rating for good and very good experience ratings was 76%. 2024/25 shows improvement on this overall measure, however, it should be noted that this question was phrased slightly different and ratings used were also slightly different, so difficult to make direct correlations.

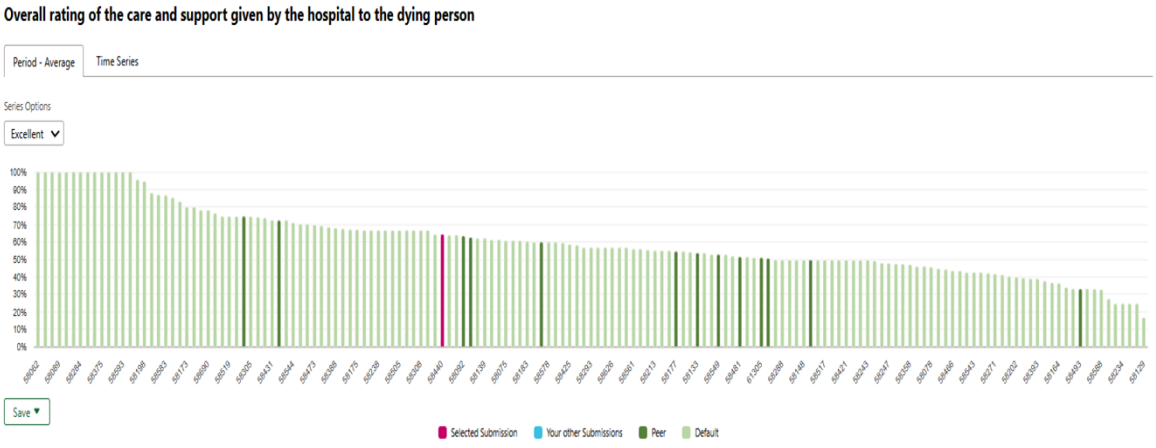
3.8. The figure below shows how SFT (*submission*) compares with the national Sample (England and Wales) and with our Peers in the Southwest. These are the collective ratings for 2024/25, demonstrating SFT as an overall positive comparative outlier.



3.9. The graph below shows how SFT ranks overall in comparison to peers across the Southwest (SW) (shown in dark green) in overall rating of care.

3.10. The Trust's overall ranking after 12-months is third within our Southwest peers and this is in response to the question of overall rating of care and support given to the dying person, where this was described as "excellent".

SFT is depicted in pink below with Southwest Acute Trusts highlighted in dark green.



3.11. Overall, there is a positive response consistently each quarter to the following question.

SFT was noted to have overall performed positively in relation to all these keys areas of patient experience, performing better both nationally and against our Southwest peers on NACEL comparison.

However, the Trust has noted an area for improvement in relation to pain management and manage of other symptoms (excluding pain). This area is considered as an outlier when compared nationally.

Figures 4.1 to 4.4 show the overall ratings in the key areas of patient experience.

Figure 4.1 The person had enough relief of symptoms other than pain (such as nausea, breathlessness or restlessness) - (SFT quarterly comparison)

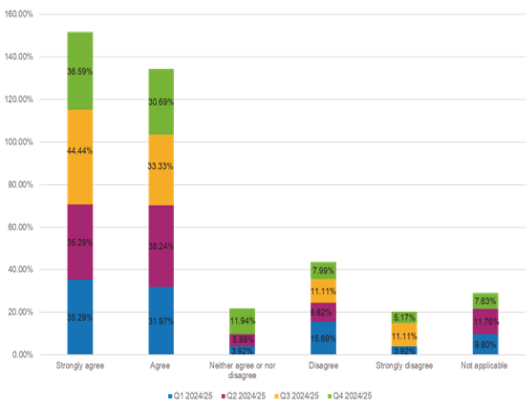


Figure 4.1a The person was given enough pain relief (SFT quarterly comparison)

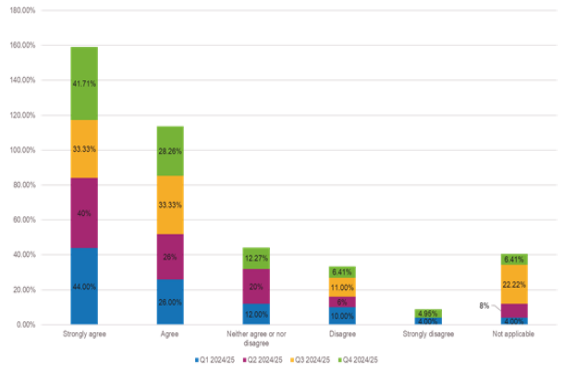


Figure 4.2 Families and others were kept updated and had enough opportunity to discuss the person's condition and treatment with staff (SFT quarterly comparison)

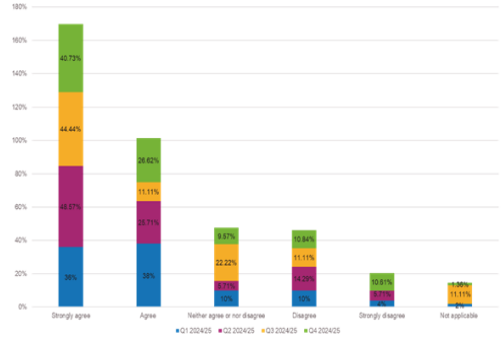


Figure 4.3 Staff looking after the person treated them with dignity – (SFT quarterly comparison)

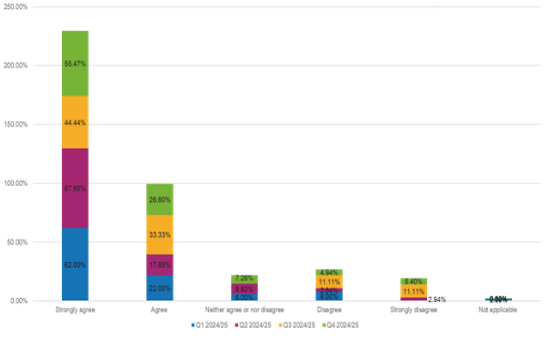
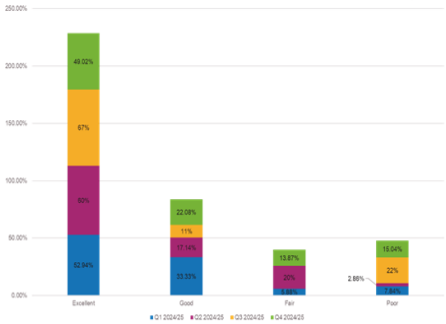


Figure 4.4 Overall rating of the care and support given by the hospital to those important to the dying person (SFT quarterly comparison)



3.12. Participation in the NACEL bereavement survey over the past year has helped the Trust identify key areas for improvement, including decision-making involvement, communication, symptom relief, and support for diverse needs. However, limitations such as lack of ward-specific data has made it difficult to target improvements or align with other feedback sources like FFT or complaints. Feedback on services like chaplaincy and bereavement support were also missed.

From 1st April 2025, the Trust will return to using its local survey, "Your Views Matter (YVM)", to better address these gaps. Bespoke YVM versions will also be developed to include feedback from deaths in ED and the Hospice, which NACEL had previously excluded.

The Trust plans to participate in NACEL again in 2028 for a year-long benchmarking exercise, ideally in coordination with RUH and GWH.

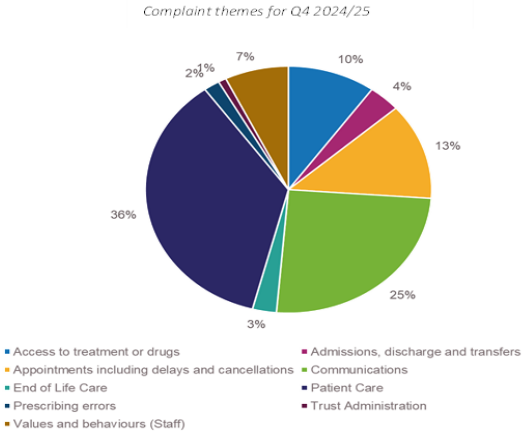
EOL Care – Correlation with Complaints

3.13. The chart adjacent shows the themes for complaints during Q4.

3.14. There were a total of 111 complaints/concerns logged during this period, of which less than 3% (n~3) were related to end-of-life care.

3.15. There were no clear themes from these complaints, each concerning a different aspect (poor communication, privacy and dignity and staff attitude).

3.16. The NACEL survey format means that the Trust is unable to reliably correlate complaint themes by location with this feedback, this is a recognised limitation of this survey.



4. Medical Examiners (MEs)

Please refer to the mortality overview table in section 1 for the full breakdown of data

The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

9 Structured Judgement Reviews were requested by the Medical Examiners during Q4 in which opportunities for learning were identified.

Overall, 98% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q4 (a similar percentage was consistently reported throughout the whole of 2024/25).

- There were no maternal deaths, neonatal deaths, or deaths in patients with a learning disability/autism* reported during Q4.
- There were 3 deaths in patients with serious mental illness reported during Q4 (January 2025).
- There was 1 stillbirth death reported in Q4 (February 2025)

*As per standard practice these patients would be subjected to a mortality review (using the validated SJR method) and a review by our learning disability/autism nurse for a specialist input of potential learning. These cases are also usually submitted to the national LeDer programme to support further learning (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)).

5. Litigation

New Enquiries from the Coroner During Q4

- During this reporting period, there were 5 new enquiries from the coroner concerning the deaths of patients known to SFT.
- Statements have been requested in all 4 of those cases. In the final case the Coroner is awaiting the outcome of the internal investigation.
- 3 of those 5 cases are subject to PSII or internal review.

Inquests Concluded in Q4 from Previous Reporting Periods

- 3 inquests were concluded in this quarter. Statements were provided by SFT in all 3 cases. SFT was an interested party in 2 of those cases. No witnesses from SFT were called in the final case where SFT was not an interested party.
- There were no jury cases and no Prevention of Future Deaths reports.

- One case related to a death following several inpatient falls. Coroners verdict: Narrative and Accident. Unfortunately 1:1 observation was not in place at the time of the last falls due to staffing shortages at the time.

- Another case related to a cardiac case. Coroners verdict: Narrative and Natural Causes.

6. National Audits

- **National Bowel Cancer Audit**

  Referencing the National Bowel Cancer Audit (38,604 new diagnoses) SFT benchmarking

  - SFT was the lowest in 90-day mortality rate (1.3%) and within the expected range for 2-year survival rate (83.3%)

- **National Hip Fracture Database**

  Case mix adjusted mortality in Q3 was within control limits (Q4 data not yet available)

- **National Heart Failure Audit**

  Mortality rate was lower (SMR for 2021-2022; 1.07, 2023-24; 0.97) and was within expected range for Q4. Survival for patients admitted with heart failure was also within the expected range. Likewise, outcomes for cardiac arrest also are all within the expected range compared to national data.

- **Sentinel Stroke National Audit**

  Above national average in implementing 72-hour care bundle: SFT 65.5 % (national 60.4%). There has been a modest increase in palliative care decisions for patients presenting with acute stroke.

- **Care at the End of Life**

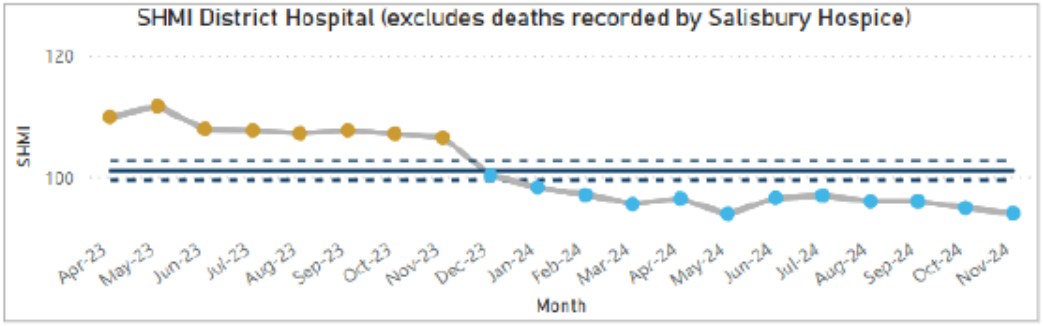
  The possibility that the patient may die within the next few hours or days was recognised in 96% of SFT cases; this is higher than 2022 (87%) and higher than the national average.

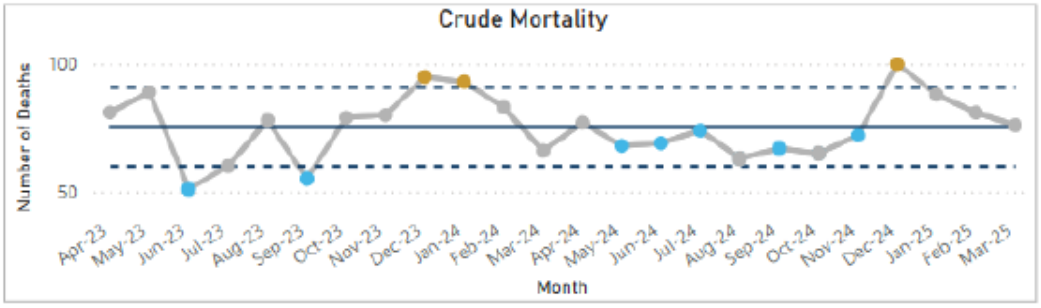
  However, it is worth nothing that although there was recognition that the patient is sick enough to die, the non-recognition of dying for SFT is higher (80%) compared to our peers in Southwest region and similar Trusts (63%). This correlates with SFT's mean average time between admission, recognition of dying and death (SFT - 94 hrs) compared to other service providers in the Southwest region and all acute trusts (GWH 139 hrs & RUH 106 hrs)

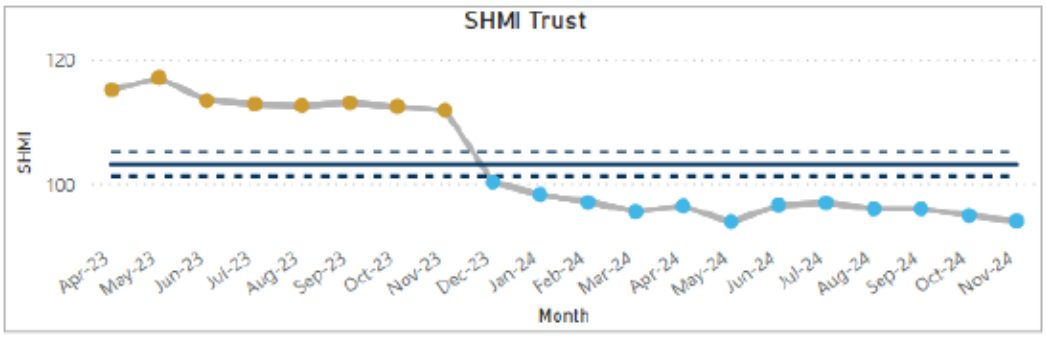
APPENDICES – Supplementary Data

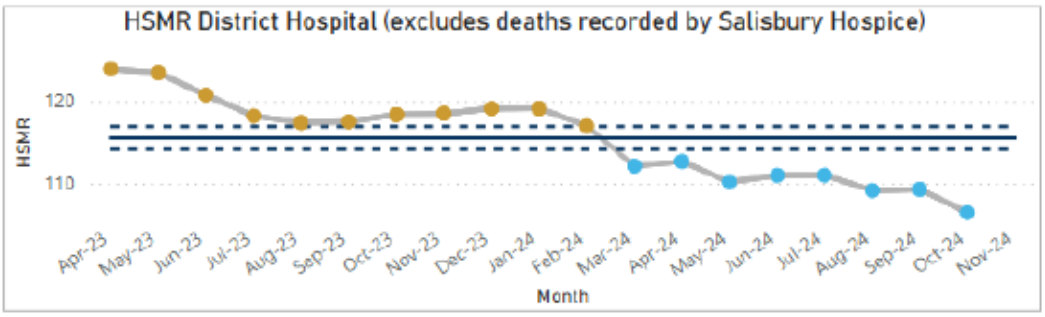
HSMR and SHMI Rolling 12-month Trends – Latest data as reported in the Trust's Integrated Performance Report

A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Both the HSMR and SHMI have continued to see an overall decline. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards, resulting in no distinction between the Trust and District SHMI figures beyond this time.

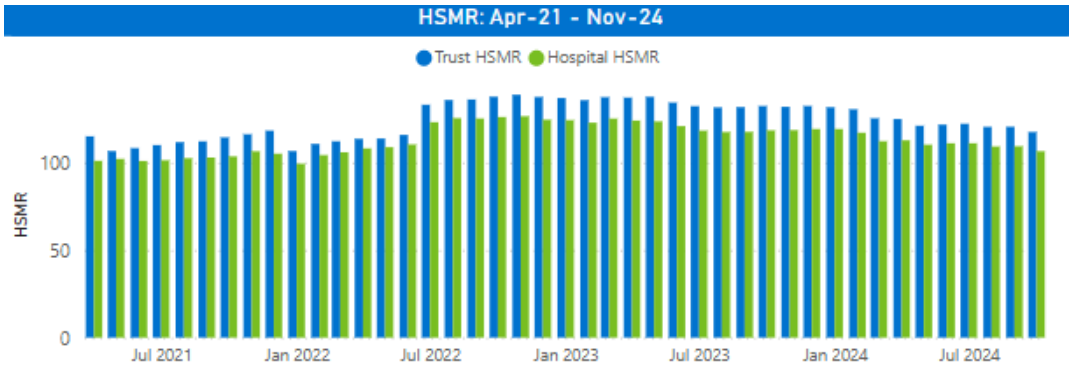


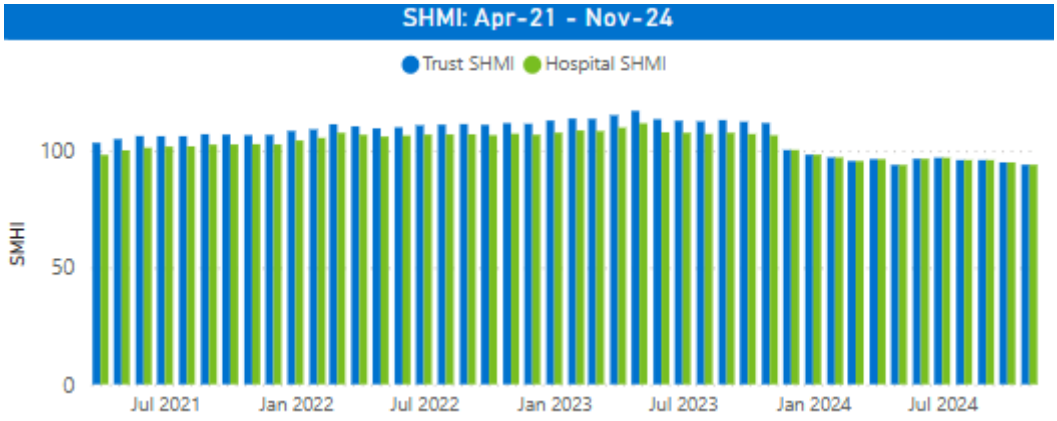






HSMR and SHMI Represented as Bar Charts





Salisbury NHS Foundation Trust

6.3. Latest SHMI data supplied by Telstra U.K. (Dr Foster)

SHMI - Summary Hospital Mortality Indicator

Period: Dec 23 - Nov 24

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

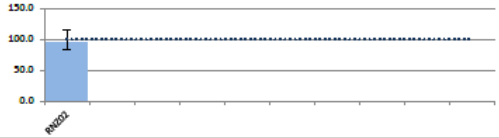
☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter, click header title to clear*

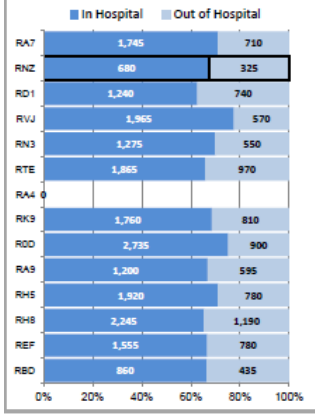
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	34,445	1,295	1,215	80	106.52	86.48	115.64
REF	Royal Cornwall Hospitals NHS Trust	66,170	2,335	2,260	75	103.34	86.92	115.05
RH8	Royal Devon University Healthcare NHS Foundation Trust	100,345	3,435	3,570	-135	96.23	87.12	114.79
RH5	Somerset NHS Foundation Trust	71,710	2,700	2,610	90	103.49	86.99	114.95
RA9	Torbay And South Devon NHS Foundation Trust	43,245	1,795	1,885	-90	95.26	86.82	115.18
R0D	University Hospitals Dorset NHS Foundation Trust	100,530	3,635	4,160	-525	87.39	87.17	114.72
RK9	University Hospitals Plymouth NHS Trust	82,780	2,570	2,200	370	116.72	86.91	115.06
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	104,095	2,835	2,495	340	113.65	86.97	114.98
RN3	Great Western Hospitals NHS Foundation Trust	65,120	1,820	1,745	75	104.56	86.77	115.25
RVJ	North Bristol NHS Trust	97,260	2,535	2,605	-70	97.25	86.99	114.95
RD1	Royal United Hospitals Bath NHS Foundation Trust	63,835	1,980	2,015	-35	98.08	86.86	115.13
RNZ	Salisbury NHS Foundation Trust	35,010	1,005	1,070	-65	93.61	86.35	115.80
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	115,535	2,455	2,755	-300	89.07	87.02	114.92
Group		980,080	30,395	30,585	-190	99.38		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	35,005	1,005	1,070	93.62	85.36	117.15

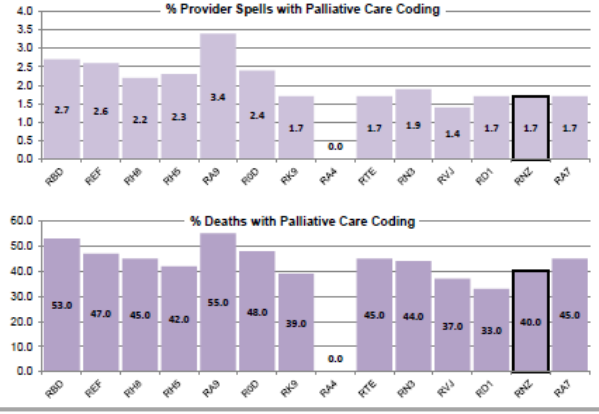


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	40	45.00	85.84	73.81 135.49
Cancer of bronchus, lung	20	20.00	111.37	64.34 155.42
Secondary malignancies	20	30.00	64.82	70.27 142.31
Fluid and electrolyte disorders	15	20.00	69.49	61.40 162.88
Acute myocardial infarction	15	25.00	58.31	67.03 149.18
Pneumonia	170	155.00	107.84	80.89 123.62
Acute bronchitis	10	15.00	57.79	59.91 166.92
Gastrointestinal haemorrhage	15	10.00	126.78	54.22 184.43
Urinary tract infections	30	25.00	121.23	61.72 162.01
Fracture of neck of femur (hip)	20	25.00	73.32	66.79 149.72

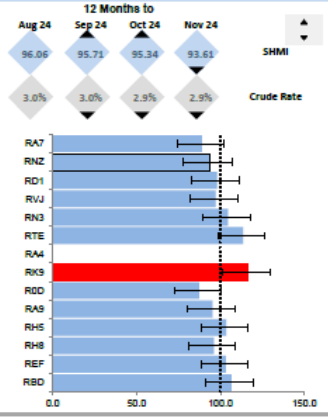
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(42) Mental retardation, Senility and organic mental disorders	25	15	166.67	107.83 246.04
(63) Congestive heart failure, nonhypertensive	40	35	114.29	81.64 155.63
(77) Aspiration pneumonitis, food/vomitus	30	30	100.00	67.46 142.76
(66) Acute cerebrovascular disease	60	70	85.71	65.41 110.33
(123) Joint disorders and dislocations, trauma-related, Spinal cord injury, Skull and face fractures,	15	15	100.00	55.93 164.95
(78) Pleurisy, pneumothorax, pulmonary collapse	15	15	100.00	55.93 164.95
(75) Chronic obstructive pulmonary disease and bronchiectasis	25	30	83.33	53.91 123.02
(130) Superficial injury, contusion	10	10	100.00	47.87 183.92

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's*

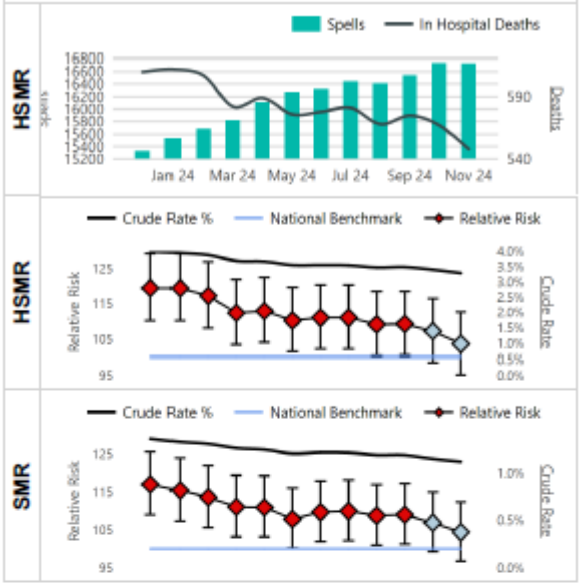
6.4. HSMR for the 12 Month Period Ending in November 2024 for Salisbury District Hospital [Excludes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Nov-2024 as at 13/05/2025

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Regional enteritis and ulcerative colitis	0	4	0.6	662.9	178.3	
Senility and organic mental disorders	1	15	8.1	185.3	103.6	

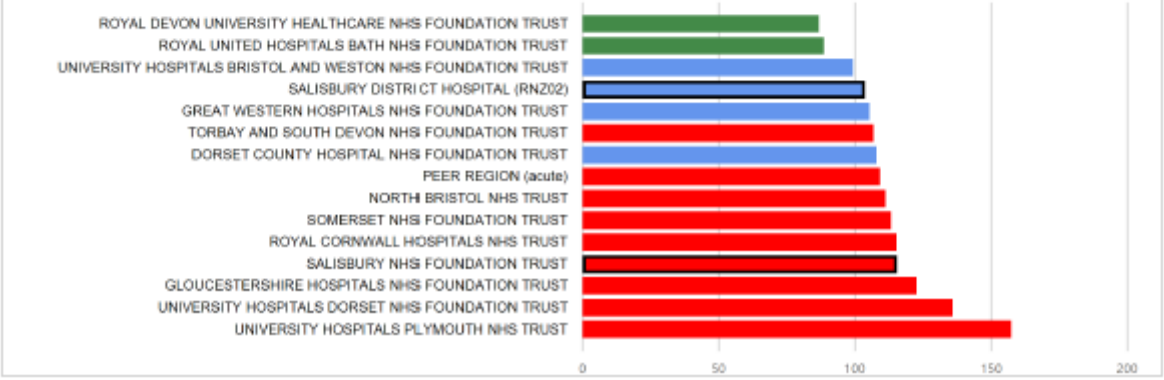
CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	15	8.1	185.3	103.6	
Cancer of kidney and renal pelvis	1	4	1.1	365.2	98.3	
Other connective tissue disease	1	7	4.3	162.1	65.0	
Bacterial infection, unspecified site	1	3	1.7	175.9	35.4	
Allergic reactions	1	1	0.1	893.8	11.7	
Other ear and sense organ disorders	1	1	0.2	663.1	8.5	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	15	8.1	185.3	103.6	
Other connective tissue disease	1	7	4.3	162.1	65.0	

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	103.5	115.4	109.2	99.9
SMR	104.4	121.9	109.0	99.5
Non-elective (HSMR)	103.6	114.9	109.3	99.7
Weekday, emergency (HSMR)	103.4	116.1	106.8	98.3
Weekend, emergency (HSMR)	105.2	112.1	116.8	104.3
Saturday, emergency (HSMR)	102.1	105.7	116.7	103.5
Sunday, emergency (HSMR)	107.9	118.5	117.4	105.1
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	46.7%	53.3%	46.9%	45.9%
% Non-elective spells with palliative care (HSMR)	3.6%	4.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.2%	6.2%	9.0%	7.0%
% Non-elective spells with Elixhauser comorbidity score = 0 OR less than 0 (HSMR)	34.0%	33.7%	27.9%	26.0%
% Non-elective spells with Elixhauser comorbidity score = 20+ (HSMR)	22.3%	22.6%	26.7%	30.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)	86.2%	85.8%	83.4%	81.3%
Average frailty score		6	6	6

HSMR Peer Comparison



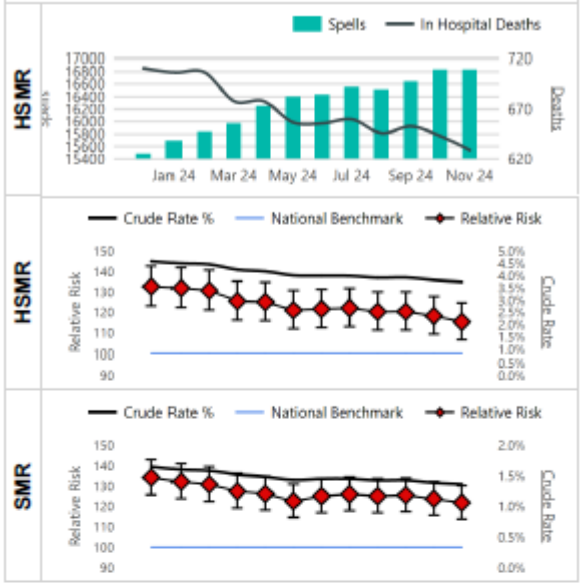
6.5. HSMR for the 12 Month Period Ending in November 2024 for SFT [Includes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Nov-2024 as at 13/05/2025

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Regional enteritis and ulcerative colitis	0	4	0.6	662.9	178.3	
Other hereditary and degenerative nervous system conditions	1	7	2.0	362.6	141.2	
Cancer of other GI organs, peritoneum	1	7	2.1	337.4	135.2	
Chronic renal failure	1	4	1.0	417.2	112.2	
Senility and organic mental disorders	1	16	8.3	192.0	109.7	
Cardiac dysrhythmias	1	10	4.4	227.2	108.8	
Pneumonia	0	131	109.2	119.9	100.3	

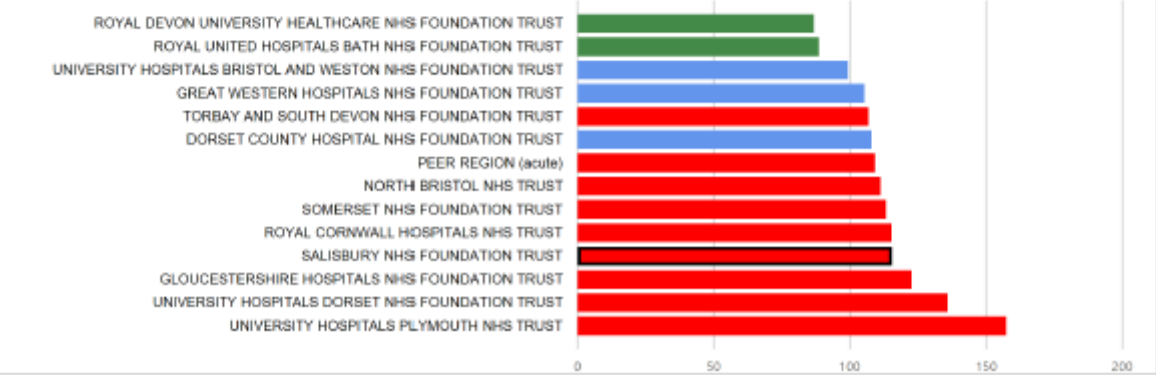
CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Other hereditary and degenerative nervous system conditions	1	7	2.0	362.6	141.2	
Cancer of other GI organs, peritoneum	1	7	2.1	337.4	135.2	
Senility and organic mental disorders	1	16	8.3	192.0	109.7	
Cardiac dysrhythmias	1	10	4.4	227.2	108.8	
Cancer of prostate	1	8	3.5	227.5	98.0	
Cancer of bronchus, lung	1	24	16.0	149.6	95.8	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	16	8.3	192.0	109.7	
Cancer of prostate	1	8	3.5	227.5	98.0	
Cancer of bronchus, lung	1	24	16.0	149.6	95.8	
Cancer of oesophagus	1	8	3.9	203.9	87.8	
Secondary malignancies	1	20	14.1	141.4	86.3	
Intestinal obstruction without hernia	1	17	12.6	134.4	78.3	

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		115.4	109.2	99.9
SMR		121.9	109.0	99.5
Non-elective (HSMR)		114.9	109.3	99.7
Weekday, emergency (HSMR)		116.1	106.8	98.3
Weekend, emergency (HSMR)		112.1	116.8	104.3
Saturday, emergency (HSMR)		105.7	116.7	103.5
Sunday, emergency (HSMR)		118.5	117.4	105.1
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		53.3%	46.9%	45.9%
% Non-elective spells with palliative care (HSMR)		4.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		6.2%	9.0%	7.0%
% Non-elective spells with Elixhauser comorbidity score = 0 OR less than 0 (HSMR)		33.7%	27.9%	26.0%
% Non-elective spells with Elixhauser comorbidity score = 20+ (HSMR)		22.6%	26.7%	30.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)		85.8%	83.4%	81.3%
Average frailty score		3	3	3

HSMR Peer Comparison



NHS
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NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.8
Date of meeting:	3rd July 2025		

Report title:	Director of Infection Prevention and Control (DIPC) Annual Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Infection prevention and control Committee			
Prepared by:	Jayne Sheppard – Deputy Chief Nursing Officer			
Executive Sponsor : (presenting)	Judy Dyos – Chief Nursing Officer			
Appendices (if necessary)				

Recommendation:

This report is for assurance and noting by the committee

Executive Summary:

This report provides an overview of the work undertaken at Salisbury NHS Foundation to provide assurance to the Trust Board that prevention and control of infection risks are being managed effectively.
It includes progress made against the 2024/25 Annual Action Plan to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

For the reported period, the Trust has experienced a challenging twelve months for infection prevention and control, which included national UKHSA alerts and NHSE guidance released relating to Measles, Monkey Pox (Mpox) and the appropriate management of a suspected Middle East respiratory syndrome (MERS) case – negative following tests.
During 2024/25 the Trust reported :

- One Human Metapneumovirus (HMPV) outbreak, one Influenza A outbreak, and one *Bordetella pertussis* period of increased incidence (PII) in medicine.
- Five *Clostridioides difficile (C.difficile)* PIIs, in medicine and clinical support and family services. For 2024/25, the *C.difficile* case threshold objective set for the Trust by NHSE was no more than 21 healthcare associated reportable cases. It is noted that the Trust exceeded this threshold with 32 healthcare associated reportable cases identified and reported to the UKHSA.

Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

The reportable HCAI's detailed below are reviewed against national and local benchmarking, the trust data demonstrates a positive position in the bench marking data against the group hospitals show in tables 1-8. Additionally, the BSW group benchmark well nationally.

Mandatory surveillance included :
Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias - During quarter 1 of 2024/25, there have been two unrelated community onset MRSA bacteraemia cases. The Trust's MRSA hospital onset case target for 2024/25 was zero.

Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias - During 2024/25, there have been 15 unrelated healthcare associated MSSA bacteraemia cases, of which all 10 cases were hospital onset, and 5 cases were community onset.

Escherichia coli (E.coli) - During 2024/25, there have been 25 unrelated healthcare associated *E.coli* bacteraemia cases, of which 10 cases were community onset, and 15 cases were hospital onset.
Klebsiella spp. and Pseudomonas aeruginosa - During 2024/25, there have been 13 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 4 cases were community onset, and 9 cases were hospital onset. There have been 13 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which one case was community onset and 12 cases were hospital onset. To note, the Trust exceeded the threshold for *Pseudomonas aeruginosa* bacteraemia cases.

UKHSA Audit of HCAI DCS entries completed by the Trust - During quarter 4 of 2024/25, following the completion of an audit, the UKHSA raised queries relating to 22 historical DCS entries, this was investigated by the ICNs, with the outcome that 8 cases were identified for retrospective submission onto the DCS during quarter 1 of 2025/26.

Surgical Site Infection Surveillance (SSIS) - Final data collection for quarter 1 and 2 of 2024/25 - no infections identified. For quarter 3 - one deep incisional infection identified. Quarter 4 data to be entered 30th June 2025.

MRSA screening - For 2024/25, the Trust compliance rates for MRSA emergency screening ranged from 87.31% - 96.58%. For MRSA elective screening, the Trust compliance rates ranged from 67.5% - 84.1%.

Hand hygiene - The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. For the internal hand hygiene audits completed, the overall average compliance rate for 2024/25 ranges from 60% - 100%.

Antibiotic stewardship (AMS) - AMS ward rounds with a Consultant Microbiologist, antimicrobial pharmacist, and antimicrobial technician are taking place twice weekly. There will be a focus during 2025/26 on aligning our guidelines with those of our BSW partners in preparation for implementation of the Cerner patient management and Electronic Prescribing Medication Administration (EPMA) system.

Audit - For 2024/25, the overall average IPC compliance scores reported have ranged from 88% - 94% for those audits completed by HoNs and Matrons.

Education and training activities - Mean compliance scores for 2024/25 were 75.28% for staff completion of hand hygiene assessments and 89.6% for staff completion for IPC computer-based learning (CBL) package. The low hand hygiene assessment compliance remains an ongoing concern. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment.

Decontamination - Policies rewritten and ratified, new laboratory autoclaves installed and refurbishment of SSL due for completion end of quarter 4.

Cleaning services - Internal and National PLACE audits completed alongside the Deep clean programme. Housekeeping is working towards the new national cleaning standards.

Water safety management - Water safety review meetings continue including six monthly pseudomonas sampling, with live counts identified, and remedial works and resampling completed. One live count is currently being managed, with the next round of sampling due to commence in May 2025. Pool water quality failure recorded during quarters 1and 2 2024/25 The pool was backwashed and resampled, and a clear result was obtained and no failures since.

Specialist ventilation systems management - Annual planned preventive maintenance completed as planned. Ventilation Safety Group (VSG) supported by an operational group which focuses on the delivery of KPIs related the management and maintenance of critical ventilation.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes

Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

DIRECTOR OF INFECTION PREVENTION AND CONTROL

Annual Report

April 2024 – March 2025

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

April 2025 (Final draft v.1)

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1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control (IPC) is delegated to the Director of Infection Prevention & Control (DIPC) who is the Chief Nursing Officer (CNO).

The DIPC Reports together with the IPC Board Assurance Framework (BAF) and monthly Integrated Performance Reports (IPR), are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this annual DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust (SFT) and inform the Trust Board of the progress made against the 2024/25 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised December 2022),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced a challenging twelve months for infection prevention and control, which has involved:

- One Human Metapneumovirus (HMPV) outbreak, one Influenza A outbreak, and one *Bordetella pertussis* period of increased incidence (PII) in medicine
- Five *Clostridioides difficile (C.difficile)* PIIs, in medicine and clinical support and family services
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2024/25 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements.

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control (IPC) team provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven-day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks and other clinical activity exceptions.

The IPC team currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Deputy ICD and one of whom is the Trust Antimicrobial Stewardship Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the IPC team

- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on *Legionellosis* and *Pseudomonas* water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Ventilation Safety Group (VSG)
- Receive regular reports from the Facilities Division regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally. An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Integrated Care System (ICS) and other regulatory bodies, e.g., NHS England (NHSE).

The Trust is also required to record these incidents in line with the *Public Health England (PHE) HCAI: Operational Guidance & Standards for Health Protection Units (HPUs) (July 2012),* PHE now UK Health Security Agency (UKHSA) from 1st October 2021.

In January 2024, the Trust implemented the *Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022),* which replaces the *Serious Incident Framework: Supporting learning to prevent recurrence (NHSE, 2015)* and makes no distinction between 'patient safety incidents' and Serious Incidents'.

During 2024/25, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant *Acinetobacter baumannii* (MDRAB)
- Carbapenemase Producing Enterobacterales (CPE)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- SARS-CoV (COVID-19)
- *Bordetella pertussis* (Whooping cough)
- Respiratory Syncytial Virus (RSV)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the UKHSA website:
UK Health Security Agency - GOV.UK (www.gov.uk)

The ICNs provide clinical teams with infection control advice, support, and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk-based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms to prioritise high risk patients. Information and guidance are communicated to and discussed with, the ward nursing and medical teams, including the Clinical Site

Team (as necessary). Additional written documentation is provided to support staff in the ongoing management of these patients.

5.1 Respiratory Illnesses

5.1.1 SARS-CoV (COVID-19)

During 2024/25, the Trust continued to experience COVID-19 activity, and the ICNs worked closely with the divisions and Clinical Site Team around COVID-19 management. All newly identified COVID-19 positive cases for inpatients continued to be discussed at the Virtual Board Round (VBR) meetings which were held until mid-August 2024, then disbanded. It was agreed that the VBR group members would continue to have oversight of the positive lists circulated by Informatics, with responsibilities to escalate any exceptions or concerns via the IPCWG and Operational Working Group (OWG) accordingly. Where clusters of any respiratory illness cases were identified, the divisions are required to implement additional monitoring measures; increased auditing of practices and environmental cleaning. It was also identified that if required, the VBR meetings would be reconvened.

No new COVID-19 outbreaks were declared for the Trust during 2024/25 across inpatient areas. COVID-19 positive cohort bays have been created at different times on Breamore, Imber and Spire Wards (medical division).

Of note, the Trust was notified during quarter 4 of 2024/25 that the national COVID-19 outbreak portal application, utilised to report COVID-19 outbreaks, would be decommissioned from 31.03.25.

5.1.2 Influenza and Respiratory Syncytial Virus (RSV)

During quarters 1 and 2 of 2024/25, there were cases of Influenza A and B and Respiratory Syncytial Virus (RSV) identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified. The IPCWG reviewed the Respiratory Illness Guide (previously called the Seasonal Illness Plan), to ensure that this reflects the updated management agreed for the various aspects covered by the document. Following final approval by the IPCC, the Respiratory Illness Guide was cascaded and made available centrally for all staff to access.

During quarters 3 and 4 of 2024/25, the numbers of respiratory illnesses experienced in the Trust were at a continued level until December 2024, when there was a significant increase in activity and the numbers of patients being admitted with symptoms, testing positive for a respiratory illness and requiring admission. This was similar to the activity experienced across other local Acute Trusts at the same time, and included for COVID-19, Influenza, and RSV. The patients were appropriately nursed under isolation precautions, with the increased Influenza A activity resulting in positive cohort bays being created on Downton Ward (1 bay), Imber Ward (1 bay, resolved within 24 hours) and on Spire Ward (ranged from 1 bay to all 5 bays at different times). Additional control measures were implemented on Spire Ward, and included requesting the wearing of fluid resistant surgical facemasks (FRSM) on entry to the ward, the introduction of essential visiting, and increased frequency of environmental cleaning.

During quarter 4 of 2024/25, one outbreak of Influenza A was declared for Tisbury Ward (medical division), with seven cases included in the outbreak cohort and respiratory illness symptoms also reported for staff. Review meetings were held and attended by the required personnel, with the control measures implemented following established processes and the Trust Outbreak Management policy. The positive patients were appropriately isolated, with monitoring of the identified contact patients. As increased Influenza A activity was also experienced for the adjacent Whiteparish Ward (medical division), this was included within discussions at the meetings and for the measures implemented. No bed closures were required as a result of the outbreak, and there was no impact on cardiac service provision. The Integrated Care Bureau (ICB) were notified and updated of the situation.

5.1.3 Human Metapneumovirus (HMPV) and *Bordetella pertussis* (Whooping cough)

During quarter 1 of 2024/25, the Trust declared a period of increased incidence (PII) of *pertussis* (a total of two cases, both patients were also identified to have HMPV), coupled with a simultaneous outbreak of HMPV (total of five cases) on Farley Ward (medical division). Review meetings were held and attended by the

relevant personnel, to ensure that the required actions were identified and implemented. The positive patients were appropriately isolated, with monitoring of the identified contact patients and staff.

A number of control measures were instigated, including essential visiting only; mask wearing (FRSM) for all needing to enter the ward; ensuring the required follow up of contact patients already discharged; consideration of vaccination requirements and implementation; additional environmental cleaning; increased practice assurance checks, and wider communications as needed. Farley Ward remained open to admissions throughout, with no impact on the service delivery for acute stroke management and care. The ICB and local UKHSA were notified and updated of the situation.

Throughout 2024/25, when notified of new HMPV and/or pertussis cases, the ICD/Consultant Microbiologists and ICNs reviewed all available information including recent care episodes at the Trust to ensure the completion of any required follow up actions.

5.1.4 Pulmonary Tuberculosis (TB)
When informed of a patient with a suspected diagnosis of Pulmonary TB, management advice for isolation precautions and the wearing of personal protective equipment (PPE) has been provided by the ICNs. During 2024/25, when patients were admitted with a new or known diagnosis of pulmonary TB, additional support was provided to the relevant teams (all were unrelated cases). This included instructions provided by the ICD to the Respiratory team, with follow up undertaken by the ICNs and input from the Trust Fit Testing team.

5.2 Carbapenemase Producing Enterobacterales (CPE)
When notified of new CPE cases, the Consultant Microbiologist and ICNs review all available information including recent care episodes at the Trust to ensure the completion of any required actions. The ICD and ICNs have provided ongoing advice and support to the medical and surgical divisions, around risk assessment, the management of specific patients, the wearing of PPE and environmental decontamination requirements. There have been no outbreaks of CPE declared for the Trust during 2024/25.

5.3 *Clostridioides difficile (C.difficile)* periods of increased incidence (PII)
During 2024/25, five unrelated PIIs of *C.difficile* were declared for the Trust for clinical support and family services, and medical divisions *(see section 6.4 for details).*

5.4 Norovirus (viral gastroenteritis)
During 2024/25, the Trust has experienced a continued level of activity associated with patients experiencing diarrhoea and/or vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period. It was necessary to close bays at different times within the medical, surgical, and clinical support and family services divisions.

During June 2024, three medical wards (Durrington Acute Frailty Unit (AFU); Pitton and Breamore Wards) were closed with symptoms of diarrhoea and/or vomiting reported for patients, staff members and visitors. Separate review meetings were held with the DIPC and Deputy DIPC, divisional and ward team representatives to review and progress resolution. This aided discussions for overall management decisions and monitoring and consideration of service provision.

During quarters 3 and 4 of 2024/25, two wards were closed with symptoms of diarrhoea and/or vomiting reported for patients and staff members. This was Amesbury Suite (December 2024, surgical division) and Laverstock Ward (February 2025, medical division). During both ward closures, there was discussion and meetings involving the DIPC and Deputy DIPC, divisional and ward team representatives to review options and progress resolution. This included monitoring and reviewing service provision for orthopaedic elective and trauma admissions in the surgical division, and acute respiratory admissions within medicine (alternative admissions plan agreed by the Respiratory Consultant team). With an increased number of empty beds on Laverstock Ward and operational challenges being experienced by the Trust at the time, a risk based assessment decision was made to facilitate patient movements and progress cleaning. This allowed access to beds in one bay on the ward, to enable the transfer of respiratory patients due to their clinical need, who

were being nursed elsewhere in the hospital. This decision involved the Respiratory team and the medical division, and was supported by the DIPC, with a DATIX report completed to capture the details.

5.5 Varicella Zoster (Chickenpox)
During quarter 1 of 2024/25, a staff member was admitted as an inpatient and isolated within a sideroom facility on a medical ward prior to confirmation of the positive Varicella Zoster result. A review meeting was held to assess the staff member's working pattern and management as a patient from admission. Actions were identified following contact tracing of patients and staff, with additional learning for the ward team relating to the wearing of PPE. Completion of the actions involved the Occupational Health and medical division teams.

5.6 Measles
In response to national UKHSA alerts and NHSE guidance released during quarter 4 of 2023/24, the Trust formed a Measles Preparedness Group with the membership of key personnel. Response action cards were developed to ensure the appropriate measures implemented for a suspected or confirmed case attending SFT. Internal messaging continues to raise awareness for staff. There have been no inpatient cases identified during 2024/25.

5.7 Additional patient screening requirements
During quarter 2 of 2024/25, following information notified to the Consultant Microbiologists, the Trust instigated additional screening for identified patients:

- Screening for *Candida auris* of all patient transfers to SFT from identified units within University Hospitals Southampton NHS Foundation Trust.
- Screening for CPE of all patient transfers to SFT from Dorset County Hospital NHS Foundation Trust.

The Consultant Microbiologists were made aware of outbreak management information by both Trusts, and the implications for SFT were reviewed. The resulting screening requirements were communicated to key staff groups and operational teams, with detailed advice for the screening and management of relevant patients provided. Following the publication of national guidance, the ICD is developing a *Candidozyma auris (C. auris)* policy for the Trust, and will share with BSE colleagues. This will be completed during quarter 1 of 2025/26.

5.8 High Consequence Infectious Diseases (HCID) Preparedness
During quarter 2 of 2024/25, in response to national UKHSA alerts and updated NHSE guidance relating to Monkeypox (Mpox), the Trust formed an Mpox Touchpoint Group with the membership of key personnel. Action cards were reviewed to ensure the appropriate measures are implemented for a suspected or confirmed case. Part of this work has included review of updated HCID guidance. A decision was made to include all HCIDs within one policy document which the ICD has written, with this document for approval via the Emergency Planning Resilience and Response (EPRR) route.

During quarters 3 and 4 of 2024/25, further assistance was provided by the ICNs to the EPRR team with the review of existing and future HCID PPE stock requirements. This work remains ongoing.

During quarter 4 of 2024/25, a UKHSA notification issued in March 2025 stated that Mpox Clade I was no longer classed as a HCID. The public health message clarified that Mpox (both Clade I and Clade II) would no longer be managed as a HCID within healthcare settings. As a result, the ICD instructed the EPRR team to remove Mpox from the Trust HCID Plan.

5.9 Middle East Respiratory Syndrome (MERS) – suspected case
During quarter 4 of 2024/25, the Emergency Department team were notified of a patient being transported via ambulance to the Trust with a suspected diagnosis of MERS. Following the established process, the patient was appropriately managed in the Decontamination Room, with the PPE requirements reviewed by the ICD as further details about the patient was available. The initial onsite respiratory testing was negative, and testing completed at the UKHSA Laboratory was negative for MERS. The patient had been moved to a sideroom facility for ongoing isolation precautions, with the ICD advising the clinical team regarding the management of the patient.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by UKHSA (*Mandatory enhanced MRSA, MSSA and Gram negative bacteraemia, and Clostridioides difficile infection surveillance Protocol (version 4.4) updated December 2021).*

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarter 1 of 2024/25, there have been two unrelated community onset MRSA bacteraemia cases reported from inpatient blood culture samples by the Trust (in May and June 2024). The Trust's MRSA hospital onset case target for 2024/25 was zero. *(Of note: one of these cases was classified as community onset; healthcare associated (COHA)).*

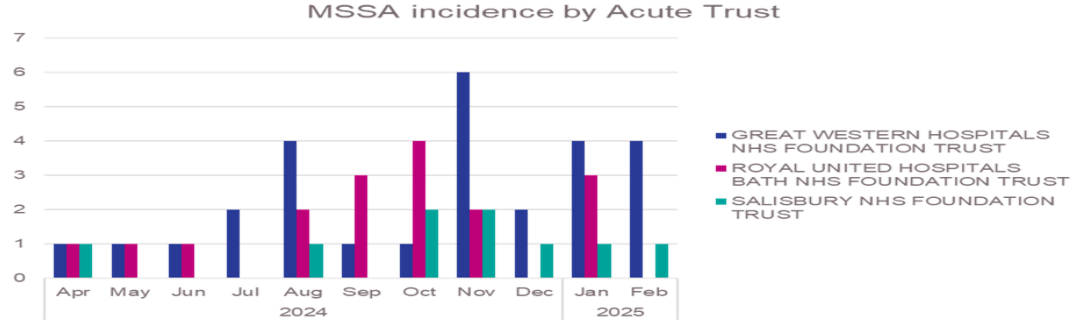
Post Infection Review (PIR) meetings were held to discuss the cases and support the completion of the required documentation. Action plans were developed by the medical and surgical divisions to capture the identified learning within the Trust with improving compliance with established policies for MRSA screening and commencing treatment, care of vascular devices and appropriate escalation (when needed). Progress with these actions and identified learning were monitored by the IPCWG. There were no MRSA bacteraemia cases identified during quarters 2, 3 or 4 of 2024/25.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

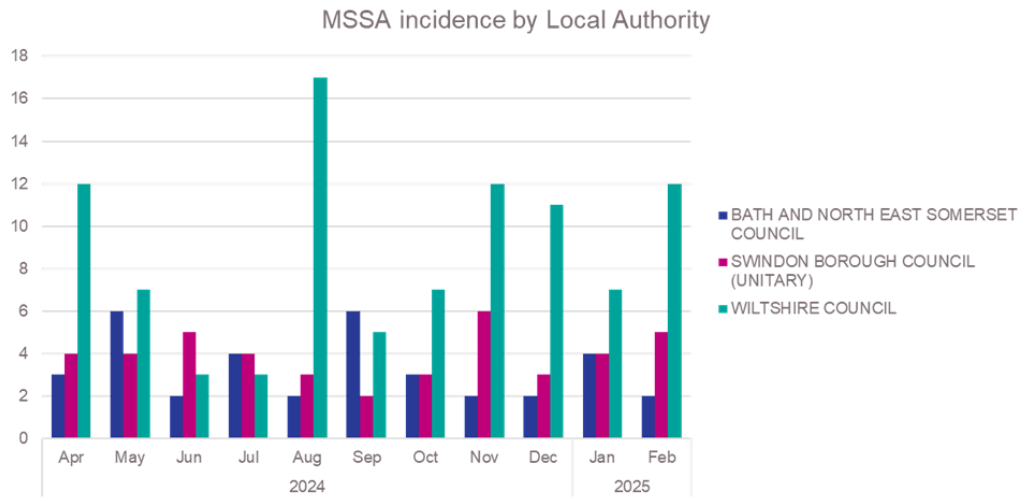
During 2024/25, there have been 15 unrelated healthcare associated MSSA bacteraemia cases, of which all 10 cases were hospital onset and 5 cases were community onset. For these hospital onset cases, the sources of infection were identified as:

- Skin/soft tissue infection (5 cases)
- Unknown/unclear source (2 cases)
- PVC related (2 cases)
- Pneumonia (2 cases)
- Surgical site infection (1 case)
- Septic arthritis (1 case), with associated clinical infection determined as endocarditis
- No underlying focus of infection (2 cases), with associated clinical infection determined as a leg ulcer for one of the cases, and gastroenterology related for the other case.

Post infection reviews were requested to be completed by the ward teams for the hospital onset cases. For those reviews completed, key learning identified the requirement for continued monitoring of all invasive devices by staff, adherence to the relevant IPC Trust policies and practices, including with the taking of blood cultures and skin disinfection/decontamination, and maintaining the required care documentation. *(Of note: the Trust Medical Devices Safety Officer (MDSO) is coordinating training related to care of peripheral vascular devices (PVD) to have 'line leaders' in areas. This will be a key person within each clinical team to ensure a best practice approach, and will be ongoing work for 2025/26).*



(Table 1)



(Table 2)

Table1 demonstrate good benchmarking on MSSA for SFT against the hospitals within the group. Table 2 demonstrates the local prevalence.

(Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for reduction targets to be set. UKHSA are collating data which may function as a baseline for trajectory setting in the future. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset).

6.3 Gram-negative organism bloodstream infections (GNBSIs)
The increase in gram negative organism bacteraemia infections remains a national concern and mandatory surveillance of *Escherichia coli (E.coli), Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias continues. This reporting at the Trust now requires enhanced investigation and data entry onto the UKHSA DCS website. This work is undertaken by the ICNs.

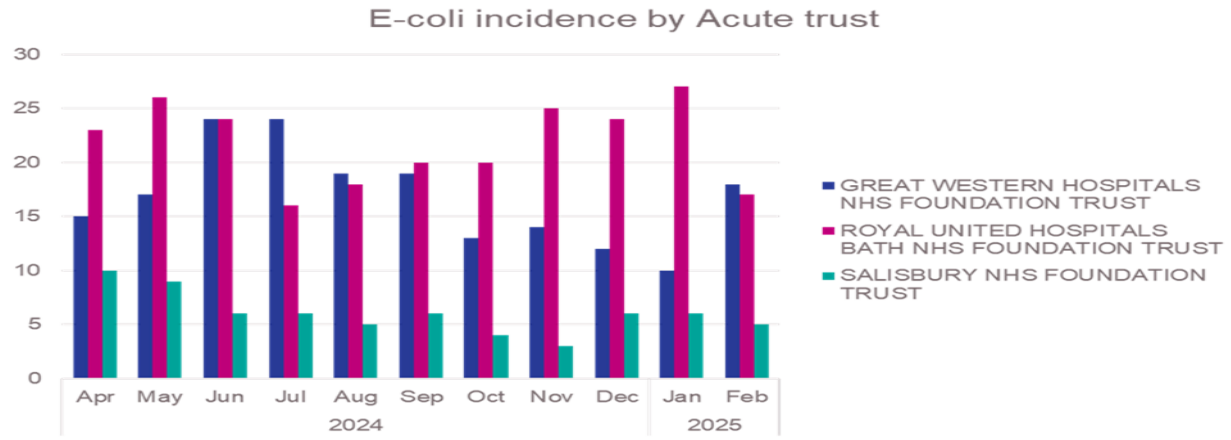
The UK Government has developed a new 5-year action plan for antimicrobial resistance – 'Confronting antimicrobial resistance 2024 to 2029', which builds on the achievements and lessons from the first national action plan *'Tackling antimicrobial resistance 2019 – 2024' (published January 2019).* The overall aims are to optimise the use of antimicrobials; reduce the need for, and unintentional exposure to, antibiotics, and support the development of new antimicrobials.

6.3.1 *Escherichia coli (E.coli)*
Following the identification of a positive blood culture result for *E.coli,* a Consultant Microbiologist completes a UKHSA mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

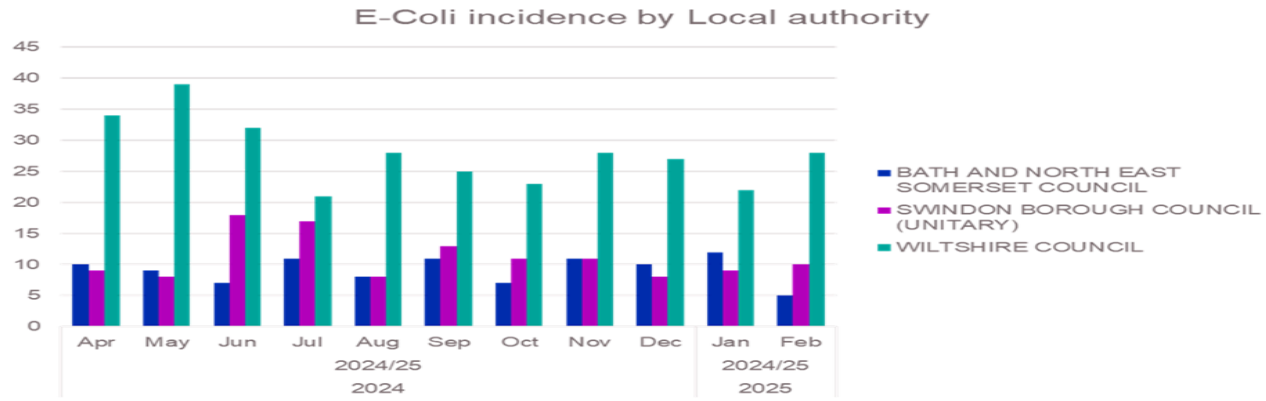
During 2024/25, there have been 25 unrelated healthcare associated *E.coli* bacteraemia cases, of which 10 cases were community onset, and 15 cases were hospital onset. Of the 15 hospital onset cases identified, an unknown or no underlying focus of infection was identified for four cases, and the remaining 11 cases had a source of infection identified. Of these unrelated 11 cases, the sources of infection were:

- Lower urinary tract (4 cases)
- Hepatobiliary (3 cases)
- Gastrointestinal or intraabdominal collection (2 cases)
- Intravascular device (1 case)
- Lower respiratory tract (1 case).

The Trust will continue to collaborate closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, the ICNs will continue to work collaboratively with the relevant ICBs who are leading on achieving this Quality Premium guidance. Table 4 and 5 demonstrate the trust position against the other hospitals in the group and additionally against the community levels. This demonstrates positive assurance regarding our IPC measure



(Table 3)



(Table 4)

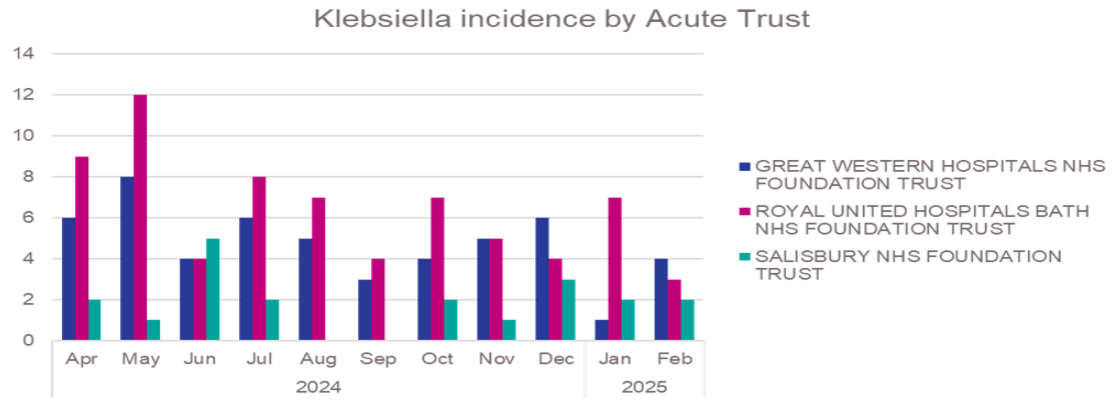
The Trust's *E.coli* case threshold for 2024/25 was no more than 39 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 2) updated June 2024).*
NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*
During 2024/25, there have been 13 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 4 cases were community onset and 9 cases were hospital onset. There have been 13 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which one case was community onset and 12 cases were hospital onset. To note, the Trust exceeded the threshold for *Pseudomonas aeruginosa* bacteraemia cases. The IPC working group are going to have a focus on measures related to gram negative bacterium. Table 6 and 7 demonstrate trust activity against local prevalence.

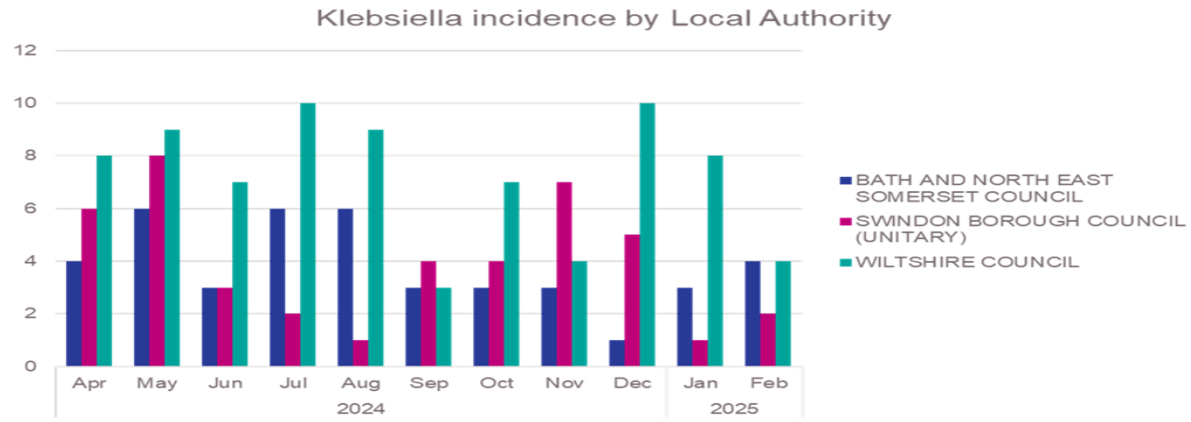
The Trust's *Klebsiella spp.* case threshold for 2024/25 was no more than 13 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 7 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 2) updated June 2024).*

NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections

Further information relating to official statistics and benchmarking of performance can be found at:
Statistics at UKHSA - UK Health Security Agency - GOV.UK (www.gov.uk)



(Table 5)



(Table 6)

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply Department of Health (DH) guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to UKHSA. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

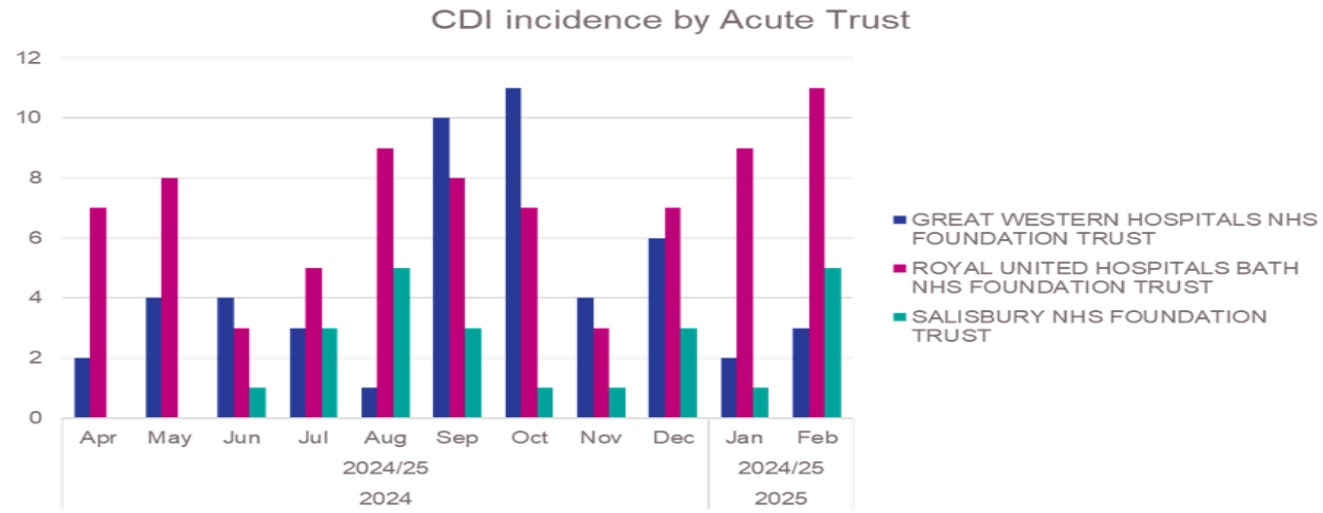
For 2024/25, the *C.difficile* case threshold objective set for the Trust by NHSE was no more than 21 healthcare associated reportable cases. It is noted that the Trust exceeded this threshold with 32 healthcare associated reportable cases identified and reported to the UKHSA. Guidance for testing and reporting *C.difficile* cases has remained unchanged, and the safety and care of patients remains our concern and priority.

Of the 32 healthcare associated *C.difficile* cases reported during 2024/25, 14 cases were community onset, and 18 cases were hospital onset. Incident investigations are conducted for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant clinical leader and divisional

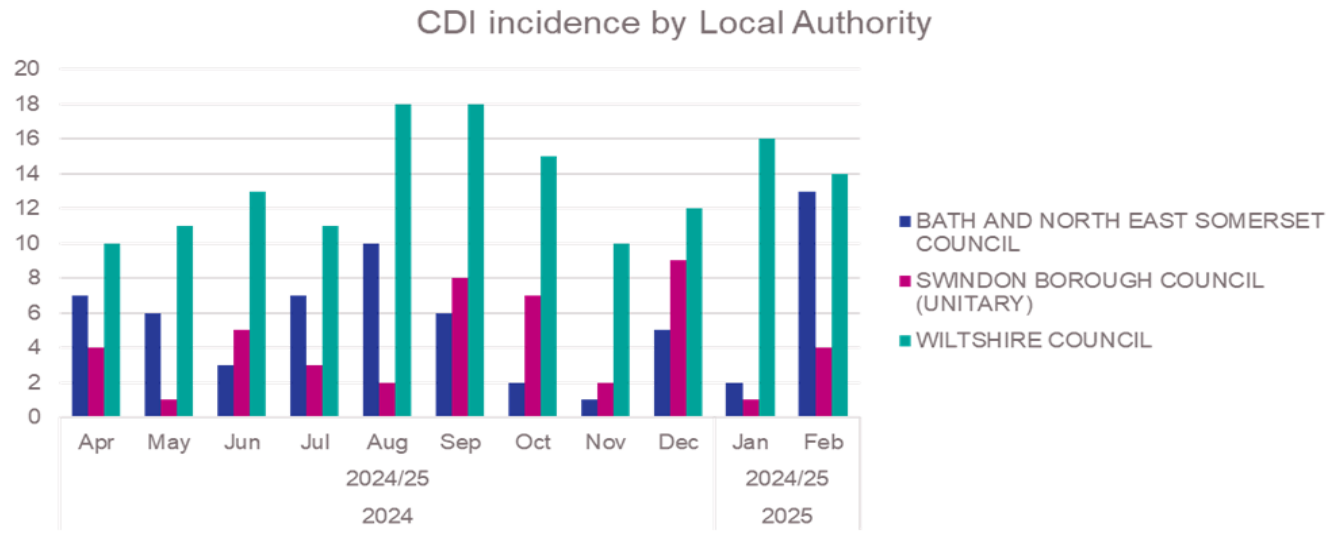
Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs review the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning has included improvements required for the use of the Diarrhoea Pathway, documentation and escalation of symptoms, instigation of isolation nursing and closure of bays, timeliness of sampling symptomatic patients, and timeliness of clinical reviews for these patients. (*Of note: From an ICB perspective, the appeals process is not in place anymore and the fines associated are no longer in existence and third-party arbitration not in place. Apportion categories are being reviewed nationally and may change or disappear next year 2024/25).*

The data provided in tables 8 and 9 provided benchmarking data against the hospitals in the group. Table 2 indicates the higher prevalence now seen in the Wilshire area and this is then leading to higher prevalence in the hospital.



(Table 7)



(Table 8)

In addition, the ICNs have completed extra investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

6.4.1 Periods of increased incidence (PII) of *C.difficile*

During 2024/25, there were five unrelated PIIs of *C.difficile* declared for the Trust for the clinical support and family services, and medical divisions (detailed in Table 1 below).

Date PII declared	**Area** *(number of positive cases in brackets)*	**Ribotyping results**	**Final outcome**
01.05.24	Sarum Ward (3 cases)	1 case = 014 1 case = 015 1 case = sample not available to send to Reference Laboratory for ribotyping	Remained a PII
03.06.24	Pitton Ward (3 cases)	1 case = 002 1 case = 015 1 case = 054	Remained a PII
23.07.24	Durrington AFU (3 initial cases) (*further 2 cases where patients had received a period of care on AFU)*	1 case = 014 1 case = 005 1 case = *C.difficile* not able to be grown from sample sent to Reference Laboratory 1 case = 002 1 case = 023	Remained a PII
07.01.25	Retrospective declaration for Q3 – Redlynch Ward (3 initial cases) (*further 2 cases where patients had received a period of care on Redlynch Ward)*	1 case = 015 1 case = 020 1 case = 023 1 case = 002 1 case = 087	Remained a PII
05.02.25	Durrington AFU & Imber Ward *– one PII declared across the 2 areas* (3 cases)	1 case = 014 1 case = 015 1 case = *C.difficile* not able to be grown from sample sent to Reference Laboratory	Remained a PII

*(*Table 9)

In response to each of the declarations, measures were instigated, and included increased monitoring of practices and checks; completion of an antibiotic stewardship audit; ribotyping of identified positive stool samples (completed at the External Reference Laboratory); and additional daily enhanced environmental cleaning of the areas by Housekeeping. A DATIX report was generated for each PII to ensure escalation to the Patient Safety Summit Group (PSSG). Each PII of *C.difficile* was monitored by the IPCWG, with the divisions required to feedback and provide updates to this group.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for 2024/25 for further detail of HCAI data.

6.5 UKHSA Audit of HCAI DCS entries completed by the Trust

During quarter 4 of 2024/25, the UKHSA contacted the Trust following the completion of an audit reviewing DCS entries made by the Trust for reportable healthcare infections. The audit also reviewed the quarterly sign off of Laboratory Returns on the DCS (completed by the Microbiology Laboratory Team). The UKHSA

raised queries relating to 22 historical entries. This was investigated by the ICNs, with the outcome that 8 cases were identified for retrospective submission onto the DCS. These cases had not been notified by Microbiology Laboratory staff to the ICNs at the time that they were identified and dated from 2017 to 2022.

The cases comprised MSSA BSI (1 case); *E.coli* BSI (1 case); *Pseudomonas aeruginosa* BSI (1 case); and *Klebsiella spp.* BSI (5 cases). It was established for the relevant cases, management advice was provided to the appropriate clinical teams by a Consultant Microbiologist, and no concerns relating to the provision of patient care was identified. Information was also provided to the UKHSA for the other 14 entries, which the UKHSA confirmed they updated, with no further action required by the Trust.

The Lead ICN and ICD met with the Microbiology Laboratory Manager to feedback the findings and agree corrective measures for Microbiology, and a DATIX report was completed. The retrospective submission of the 8 cases onto the DCS will be completed during quarter 1 of 2025/26, with an update provided to the IPCWG.

6.6 BSW Collaboratives

During quarters 1 and 2 of 2024/25, representatives from the Trust attended a newly formed BSW ICS HCAI and Infection Prevention Management (IPM) collaborative. These partnership meetings are held quarterly and enable a system wide approach to monitor and improve IPC for the populations of BSW. The meetings provide an opportunity for thematic reviews of HCAI data and shared learning from communicable disease incidents, with outcomes fedback to the IPCWG (the meeting scheduled for quarter 3 was cancelled).

During quarters 3 and 4 of 2024/25, there was IPC team representation from the Trust at other BSW IPC meetings including for HCID/Mpox and Winter Planning. In addition, the ICNs and ICD have ensured engagement with the various BSW Electronic Patient Record (EPR) workstreams, with this significant work continuing into 2025/26.

6.7 NHS Standard Contract 2024/25

Table 2 below summarises the threshold levels for the Trust's count of healthcare associated (i.e., hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA)) cases for 2024/25 (*as detailed in the Official NHS Standard Contract 2024/25 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 2) updated June 2024).*

Organisation code	Name	Case thresholds for 2024/25			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	21 ↓	39 ↑	7 ↓	13 ↑

*(*Table 10)

6.8 Surgical Site Infection Surveillance (SSIS)

The ICNs and IPC team secretary coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS. Active data collection for the category of repair of neck of femur (NOF) surgery has continued during 2024/25.

- Final data collection for quarter 1 of 2024/25 was reconciled within the required timeframe. A total of 44 cases were entered onto the national database, with no infections identified.
- Final data collection for quarter 2 of 2024/25 was reconciled within the required timeframe. A total of 54 cases were entered onto the national database, with no infections identified.
- Final data collection for quarter 3 of 2024/25 was reconciled within the required timeframe. A total of 57 cases were entered onto the national database, with one deep incisional infection identified.

- Data collection has continued in quarter 4 of 2024/25, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 1 of 2025/26 (30th June 2025).

Throughout 2024/25, the IPC team secretary continued to link with the Trust Clinical Coding team to clarify coding queries and discuss the coding process for this surveillance category to ensure the inclusion of all required cases in the relevant quarter.

Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

(Of note: It has been noted that on reconciliation of data, the number of patients included within the reporting periods, have reduced from those first identified. This is a result of the clinical code allocated to the operation, being different from those being included within this category of surveillance, as set out by UKHSA).

6.9 PreciSSIon

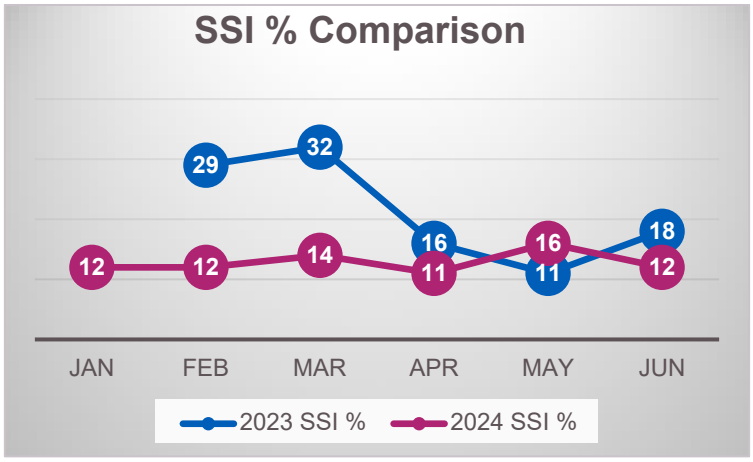
A new national PreciSSIon project, focussed on reducing the incidence of SSI after caesarean birth launched in October 2022. A care bundle was developed by reviewing literature for interventions that showed reduction by up to 50% of SSI in colorectal surgery and consists of:

- 2% chlorhexidine skin preparation for all cases
- Use of dual ring wound protector
- Repeat antibiotic therapy after 4 hours operating time
- Antibacterial suture for mass closure and skin.

This has been adapted for maternity patients to see if the results can be replicated for caesarean sections:

- 2% chlorhexidine skin preparation for all cases
- 2 minutes drying time
- Repeat dose of antibiotic therapy after >1.5 L blood loss
- Wound protector used if booking BMI >40
- Antimicrobial sutures for sheath and skin
- Surgical glove change after delivery of placenta.

Following the implementation of the PreciSSIon bundle in July 2023, there is clear evidence of a reduction in surgical site infection rates within the Maternity Unit following birth by caesarean section. Ongoing compliance for the bundle is currently at 98% with individual cases being reviewed to understand further why the bundle was unable to be used. The ongoing theme at present is omission of 2nd dose of IV antibiotics after identification of blood loss above 1500mls. This is addressed on a case-by-case basis.



(Table 11)

The graph above (Table 3) in blue shows the baseline data for 2023 which showed an approximate SSI rate of 16.9%. The red line represents the 2024 baseline data following the implementation of PreciSSIon which has shown a reduction to 13.2%.

There are ongoing reviews with the PreciSSIon elements and looking more closely at SSI rates within women with raised BMI, smoking and diabetes to identify potential improvement in outcome and patient satisfaction. One element being considered is the introduction of negative pressure dressings and PreciSSIon have decided to proceed with PiCO dressings in the raised BMI category. This is currently in early stages at SFT, a business case has been submitted to the DMT and was not initially successful and more data has been requested and resubmission highlighting stating the clinical benefit and financial impact.

During quarter 4 of 2024/25, the division fedback to the IPCC that the DMT had decided not to progress with use of the PiCO dressings further, however they would be available for patients in the raised BMI category.

6.10 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a quality performance indicator. The IPC team secretary undertakes a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2024/25, the Trust compliance rates for MRSA emergency screening ranged from 87.31% - 96.58%. For MRSA elective screening, the Trust compliance rates ranged from 67.5% - 84.1%.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health guidance published in 2015 and continues following further review by the Trust.

6.11 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). The Unit Leads/Matrons are responsible for completing data submission onto the national database within the required timeframes. From the data submitted so far, report updates have been provided by UKHSA and cascaded to the area leads.

6.12 Private Healthcare Information Network (PHIN)
The Trust continues to complete mandatory reporting externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the IPC team secretary undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data provided to the IPC team for review, there have been no externally reportable infection alert organisms identified for this patient group during 2024/25.

7. HAND HYGIENE
Fifty-eight areas (including wards and departments) across the four clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action. The clinical divisions have been undertaking some peer cross auditing within their areas and specialities to further validate audit processes.

Key areas of non-compliance identified were predominantly staff missing moment number 1, handwashing before patient contact and moment number 5, handwashing after contact with patient surroundings and following removal of gloves. Additional education and support have been provided by the ICNs to staff groups focusing on audit findings.

For the internal hand hygiene audits completed, the overall average compliance rate for 2024/25 ranges from 60% - 100%. It should be noted that completion of these audits remains variable across all divisions, which the divisions have reported as being due to reduced staffing levels and/or ongoing operational/bed capacity challenges.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating has been revised, and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group. *(Of note: during 2024/25, there have been 8 PLACE Steering Group meetings held (April, May, July, August, September, January, February and March).*

7.1 Provision of hand hygiene products

During quarter 1 of 2024/25, the ICNs have been actively involved with other teams including the EPRR team, Procurement and Housekeeping Department, in accessing an alternative supplier for GOJO Industries hand hygiene products following the company ceasing trading/production from April 2024. Part of this work has involved review of alternative products and identifying key critical areas for phase 1 of the product change over. This work continued into quarter 2 of 2024/25 with further rollout phases identified across the Trust site. This has created an opportunity for the IPC team to review the number/location and placement of wall mounted alcohol hand rub (AHR) gel dispensers in all areas.

During quarter 2 of 2024/25, the IPC team worked closely with other departments to ensure the installation of new hand wash soap and gel dispensers throughout the hospital. This collaboration aimed to enhance hand hygiene standards and contribute to the overall well-being of the patient, staff and visitors. This work continued into quarter 3 of 2024/25 with further rollout across the Trust site with replacement of hand moisturisers dispensers. The replacement of end of bed AHR gel holders (point of care) with the new product continued through quarters 3 and 4 of 2024/25.

8. ANTIBIOTIC STEWARDSHIP

8.1 Key successes

Antimicrobial stewardship (AMS) ward rounds

AMS ward rounds with a Consultant Microbiologist, antimicrobial pharmacist and antimicrobial technician are taking place twice weekly. The regularity and frequency of visits has, created its own demand for the service. *Of note: Dr Flanagan retired in January 2025 and as a result, AMS ward rounds were less frequent during February and March, with the other Microbiologists making themselves available to participate in the AMS ward rounds whenever possible. Dr Lam joined the team in March 2025 and the rounds have restarted on a regular basis.* A full round now takes place on a Tuesday and a second round is undertaken on a Thursday or Friday where staffing levels allow. Between 20 and 40 patients are reviewed on a ward round and antimicrobial stewardship recommendations are made to prescribing teams. Furthermore, non-medical/independent prescribers and Biomedical Scientists (BMS) are also attending AMS ward rounds as part of their own training and development.

Subjectively, most interventions made, involved stopping Intravenous (IV) antibiotics, prompt IV-to-Oral (PO) antibiotic switches, and reviewing antibiotics due to treatment efficacy.

Commissioning for Quality and Innovations (CQUIN)

The successful completion of 2023/24 IVOS CQUIN led to further encouragement within the AMS community to continue this data gathering as a non-mandatory CQUIN for the 2024/25 year, which was completed at the end of March 2025.The results below reflect our compliance and the ongoing impact of the antimicrobial stewardship ward round.

Patients still receiving IV antibiotics past the point at which they meet switching criteria

Division	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
CSFS		0% (0/2)	0% (0/2)	0% (0/4)	**0%** (0/8)
Medicine	20% (10/50)	15.22% (7/46)	8.93% (5/56)	6.15% (4/65)	**11.98%** (26/217)
Surgery	7.14% (2/28)	18.37% (9/49)	4.88% (2/41)	9.68% (3/31)	**10.74%** (16/149)
Women & Newborn		0% (0/3)	100% (1/1)		**25%** (1/4)
Total	**15.39% (12/78)**	**16.00% (16/100)**	**8% (8/100)**	**7% (7/100)**	**11.38% (43/378)**

(Table 12)

From the results shown above (Table 4), the Trust is achieving the CQUIN aims and objectives. A lower percentage reflects improved compliance with the CQUIN. Threshold for CQUIN compliance is minimum of 25% and maximum of 15%. There are no new CQUINs schemes currently scheduled for 2025/26.

8.2 Guidance Development

A full review of all policies in the antimicrobial section of Microguide (now Eolas Medical) has now been completed and segregated into body systems since quarter 4 of 2023/24. Furthermore, all guidance now contains review and expiry dates to aid with future updating. Outstanding guidance that still requires review and expiry dates are the Neutropenic Sepsis guidelines. The Antibiotic Reference Group (ARG) have been informed that there are larger pieces of work ongoing within Haematology/Oncology and that in time this will be part of a larger update.

During quarters 3 and 4 of 2024/25, the only guideline that has been updated was the Keratitis guidelines. Further guidance work was paused (as was the ARG meetings) whilst Microbiology was short staffed. There are a number of guidelines due for review in quarter 1 of 2025/26. The action plan for guideline review will be considered at the ARG meeting scheduled for April 2025.

There will be a focus during 2025/26 on aligning our guidelines with those of our BSW partners in preparation for implementation of the Cerner patient management and Electronic Prescribing Medication Administration (EPMA) system. The first guideline that has been identified to work on is Teicoplanin prescribing with a possible move to dose banding which will aid more accurate prescribing and simplify administration by the use of whole vials wherever possible. During quarters 3 and 4 of 2024/25, guidelines on Microguide were successfully migrated over to Eolas Medical and the requisite updates/expiry dates have all been aligned in the antimicrobial section.

8.3 Electronic Patient Medication Administration (EPMA)

The antimicrobial team feed into the EPMA team any issues identified relating to the prescribing of antimicrobials. The antimicrobial team have also been involved in a number of workshops relating to the implementation of Cerner EPMA.

8.4 Risk Management

For quarters 1 and 2 of 2024/25, there have been 65 DATIX reports directly relating to antibiotics with one DATIX listed as minor harm and two DATIXs listed as moderate harm. A review of the DATIXs, indicated issues with delayed/dose omissions (23), incorrect dosing (7), prescribing of antimicrobials listed as an allergy (5), interactions with regular medication (2) and excessive antimicrobial duration (2). Other themes include, information governance issues, incorrect administration of antimicrobial doses, incorrect route of administration used, incorrect prescribing and incorrect formulation issues.

For quarters 3 and 4 of 2024/25, there have been 63 DATIX reports directly relating to antibiotics with four DATIXs listed as minor harm, and the remaining reports were categorised as no harm. A review of the minor

DATIXs, indicated issues with double dosing (1), incorrect dosing (1), drug availability and process for obtaining a dose of critical medicine not followed (2).

Ongoing themes in the reports categorised as no harm included:

- Poor handover/communication about whether a dose of antibiotic had been administered resulting in duplication/omission of dose.
- Allergy status (penicillin allergy): Penicillin allergic patient given a penicillin (no reaction so categorised as no harm).
- Wrong antibiotic given/dispensed (confusion with cephalosporins).
- Missed doses of antibiotics: process for obtaining a dose of a critical medicine not followed.

8.5 Staff resources

A new Lead Pharmacist for Antimicrobials & HIV commenced their new role on 18th November 2024, working 3 days a week (Monday, Tuesday & Thursday) which may limit staffing resources in the foreseeable future. Additionally, our Antimicrobial Consultant Microbiologist retired in January 2025 *(see Section 8.1)*.

8.6 Antibiotic Reference Group (ARG) Action plan for 2024

- ARG to review total antibiotic consumption and to create a stepwise plan for its reduction. AMS team to review data collection on treatment information and undertake an audit of total antibiotic consumption within SDH.
- The Microguide application is currently switching publishers to a company called Eolas Medical and at present no updates are possible during this switch. Once this is completed, the AMS team will update and publish some approved Drugs and Therapeutics Committee (DTC) guidance.
- Resolution and management of several current and future stock supply issues.

8.6.1 Antibiotic Reference Group (ARG) Action plan for 2025/26

The action plan is to be agreed at the ARG meeting in April 2025:

- Aligning our antimicrobial policies with BSW partners.
- Focus attention on a general reduction of consumption of daily defined doses (DDDs) of antibiotics, with particular focus on “AWARE” category of antibiotics (as per the national action plan).

8.7 Challenges

- There have been several antibiotic stock supply issues that have made an impact on current clinical practice. Furthermore, this situation remains fluid as further supply issues might impact the Trust in the future.
- There has been increased rogue prescribing of antimicrobials especially in quarter 1 of 2024/25. This has reduced in quarter 2 of 2024/25. The AMS team will be monitoring specific wards and prescribers to provide targeted education especially with the introduction of new junior doctors. However, risk reduction relating to antibiotic use is an ongoing challenge.
- The AMS service will be facing significant staff changes in the coming months and a reduction of staff hours dedicated to antimicrobial stewardship.

8.8 Summary

As outlined in the sections above, this is the current work undertaken by the ARG in relation to AMS and issues affecting this, guidance creation, development and reviews and supporting national improvement frameworks.

8.9 Recommendations

Continuation of action plan above and resolution/mitigation of ongoing challenges. Additionally, to continue advising the IPCC of work being undertaken by the ARG.

9. AUDIT

The ICNs have not undertaken any formal policy audit due to ongoing clinical workload but have been involved in supporting identified clinical areas to complete the Tendable inspections for infection prevention

and control. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. (*Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group. (*Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during clinical visits to ward areas*).

When required, the HoNs and Matrons have completed additional Tendable IPC inspections within identified clinical areas. The ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For 2024/25, the overall average IPC compliance scores reported have ranged from 88% - 94% for those audits completed.

Of note, the ICNs have met with the Tendable team and reviewed the IPC inspection questions. Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPC team. Mean compliance scores for 2024/25 were 75.28% for staff completion of hand hygiene assessments and 89.6% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 01.04.25).*

The low hand hygiene assessment compliance remains an ongoing concern. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through their divisional areas and departments. In addition, the ICNs continue to work with the Education Department to improve compliance for staff completing these mandatory training modules.

As requested by the DIPC, the hand hygiene assessment trial (previously discussed in 2022/23), has been slowly progressed by the divisions within inpatient areas. This is an alternative to using the UV light box to assess hand hygiene technique, where the clinical leader (Band 7) assesses staff members washing their hands using soap and water. Progress with this work has been reported to the IPCWG, by the medical and surgical divisions.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the clinical visits undertaken by the ICNs.

For the Infection Control Link Professionals (ICLPs) group, a mix of formal 'virtual' and 'face-to-face' meetings have been during 2024/25. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non-clinical areas have continued. Details of education opportunities provided are available from the ICNs.

10.1 NHS England Infection Prevention and Control (IPC) Education Framework

This national framework outlines the behaviours, knowledge and skills required by the health and social care workforce to improve the quality of IPC practice and thereby improve patient outcomes. The document was considered by the IPCWG to agree the way forward for the Trust.

During quarters 3 and 4 of 2024/25, there have been discussions with the Education team regarding the ongoing provision for IPC CBL, and how this fits with the IPC Education Framework. Currently, all staff are required to complete the existing IPC CBL package every 2 years. Following a meeting with the Deputy DIPC and Head of Education and Apprenticeships to review the Framework, information has been provided to the Education team, with agreement to move to the national programme. This follows a two tier approach; with all staff completing Level 1 every 3 years, with the completion of Level 2 required annually by all healthcare staff who are involved in direct patient care.

The IPC Education Framework (March 2023) can be accessed via:
NHS England » Infection prevention and control education framework

11. DECONTAMINATION

11.1 Key success stories in quarters 1 and 2 of 2024/25

- The Creutzfeldt-Jacob Disease (CJD) policy re-write was led by the Deputy ICD/Consultant Microbiologist, with the support of the Decontamination Lead. Flow-chart style appendices have been added to improve ease of use for clinical staff. The final policy was approved at the IPCC prior to ratification at CMB on 18th September 2024. The policy has been uploaded onto Eolas Medical.
- The Decontamination Policy has been re-written and presented to IPCC (in October 2024) for approval, prior to ratification at CMB during quarter 3 of 2024/25. The policy has been split into two sections; one section covering the regulatory and governance requirements and a separate section for clinical aspects. Having a separate clinical section will offer more user-friendly information for staff to refer to.

11.2 Key Success stories in quarters 3 and 4 of 2024/25

- The Decontamination Policy was ratified at CMB and is available on Eolas Medical.
- New Laboratory autoclaves installed in quarter 4 of 2022/23 had been unreliable causing operational challenges for the Laboratory teams. Following a lengthy review, larger water softener tanks have been installed which appear to have resolved the issues.
- A new flexible endoscope washer disinfector has been installed in Sterile Services Limited (SSL) to replace a machine which, despite steps to resolve, had been returning persistent high total viable counts (TVC) since January 2024. The new machine is now operational and returning TVC counts within acceptable limits.
- During quarter 4, focussed training for specialist staff who undertake high level disinfection of invasive ultrasound probes using both automated and manual processes was completed. The Clinical Trainer for the automated system (Trophon) attended site twice, visiting high use areas and identified some learning opportunities due to updated manufacturers recommendations. These visits are valuable to support our staff, ensuring their processes reflect Best Practice for patients, and are standardised across the Trust.
- The refurbishment of SSL approached formal completion at the end of quarter 4 of 2024/25. This heralds the end of a particularly challenging time both within SSL and for the clinical teams. New contractual arrangements commence from 1st April 2025.

11.3 Progress on actions during quarters 1 and 2 of 2024/25

- New Laboratory autoclaves, installed in quarter 4 of 2022/23, continue to be unreliable and ongoing work to resolve the situation has so far been unsuccessful. The working group are now being supported by the Deputy Director of Procurement, who is keen to make the discussions with the manufacturer more formalised, with specific references to the contract, to facilitate resolution.
- Ongoing refurbishment of Sterile Services Limited (SSL) continues to be a challenge. Quarters 1 and 2 has been a critical phase where operational capacity was reduced whilst work focused on the instrument washers, clean room (where instrument trays are laid out and wrapped) and autoclaves. Mitigations to keep the impact on production to a minimum were put in place, and no significant events occurred. The final phase of the refurbishment is due to be completed in quarter 3 of 2024/25 and will be associated with handover of decontamination equipment. Clarity between SFT and SSL relating to future responsibility for services and maintenance of decontamination equipment is still required.

11.4 Progress on actions during quarters 3 and 4 of 2024/25

- Flexible endoscope storage arrangements have progressed, with the new scopestore cabinet in Urology being commissioned at the end of quarter 4 of 2024/25. It is anticipated that once the commissioning reports and validation results are received, the cabinet will be brought into use during quarter 1 of 2025/26. This will reduce the requirement for vac-packed scope storage which has many benefits.
- Discussions continue to identify a suitable new location of a scopestore cabinet removed from Endoscopy Unit following a Joint Advisory Group (JAG) action. The new location needs to meet both clinical and regulatory requirements which is proving a challenge.
- Unfortunately, there has been minimal progress on the action to improve accessibility of information by introducing a new section within Eolas Medical. It is anticipated that this will house quick reference guides, posters for display and any generic SOPs alongside the main policy. This will be a focus for quarters 1 and 2 of 2025/26.

11.5 Key challenges for quarters 1 and 2 of 2025/26

Develop a more robust auditing method to capture any gaps in knowledge or practice and enable focussed education to support staff and evidence good practice. Opportunities to undertake audits via Tendable continue to be explored.

Monitoring the transition to the new contractual arrangements between SFT and SSL. Two important aspects are the financial implications associated with changes in charging, and decontamination equipment implications due to the refurbishment project team leaving and responsibilities for ongoing service and maintenance still need confirming.

12. CLEANING SERVICES

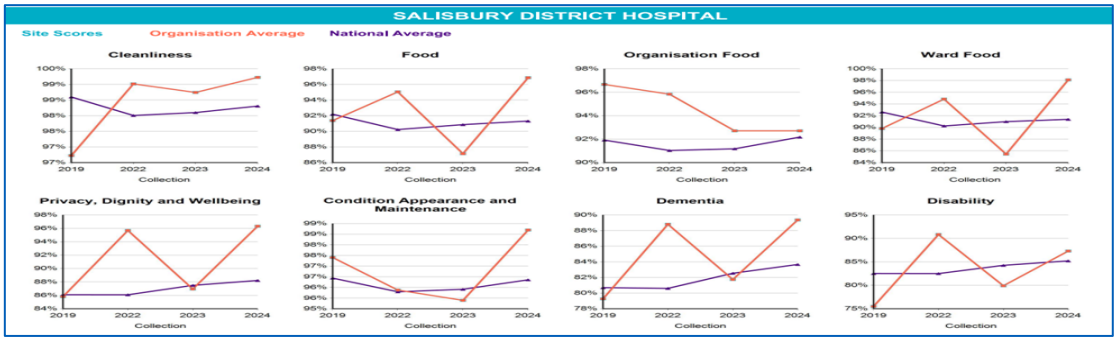
This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities Division.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust has undertaken a programme of internal PLACE audits which commenced in February 2025. A total of 11 audits have been completed, with a further 15 planned during the next quarter. The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly PLACE Steering Group.

12.2 National PLACE

The National PLACE inspection was undertaken on the 7th November 2024 with results being available from February 2025 (see below):



(Table 13)

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in April 2024 and was completed ahead of schedule in March 2025, with all areas completed. The Deep Clean Programme for 2025/26 has commenced.

12.4 Improvement Work Over the past 12 months

Recruitment drives of group interviews, working alongside Human Resources (HR) to attract new Cleaning Assistants.

12.5 Successes from the past 12 months

- Reached 99% or above each month for our KPIs linked to the operational response times in starting an environmental clean within 3 hours.
- Successfully recruited 17 new Cleaning Assistants (vacancies and new standards).
- Capital secured for the purchase of 3 new hydrogen peroxide vapour (HPV) disinfection systems.

12.6 Challenges for the coming 6 months

Housekeeping Department are working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased implementation period. Terminal (post infection) cleans remain high (above pre-COVID levels). See Table 6 below.

2024/25 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
TERMINAL (POST INFECTION) CLEANS	766	1007	1201	1079	994	902	1065	1092	1319	1256	929	1053	**12663**
ENHANCED HRS	87.25	51.75	73.5	80	55	55.75	57.75	49.25	64.75	68.75	59.25	52	**686.25**
DOUBLE CLEANS HRS	73.75	77	92.75	74	85.75	37.5	13.75	8.25	24.75	51	41.25	70	**649.75**
BIOQUELL (HPV disinfection)	52	74	92	91	50	43	45	33	36	33	30	41	**620**
2023/24 MONTH	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTALS**
TERMINAL (POST INFECTION)	882	850	735	656	666	810	934	884	1055	995	988	785	**10240**
ENHANCED HRS	95.50	104	53.5	57.75	64	83.25	69	81.25	117.75	108.75	108.75	83.5	**1027**
DOUBLE CLEANS HRS	10	33	61.5	70.25	49.25	59.25	54	67.75	56.25	98	72	103	**735.25**
BIOQUELL (HPV disinfection)	0	31	37	54	59	45	56	74	62	59	113	66	**656**

(Table 14)

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken during 2024/25. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) *Pseudomonas* (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and deputy RP (dRP) water) from Estates Technical Services (ETS) and FES Ltd (PFI maintenance contractor) are held monthly, to review progress with planned preventative maintenance (PPMs) and actions in respect of water safety.

13.1 *Legionella*

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore, the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see Tables 7 & 8 below – *Legionella,* listing counts reported >1000 cfu/l) have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mails as events occur, and as regular reports

to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

***Legionella* sampling results for Quarters 1 and 2 of 2024/25**						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 25/09/2024	
					Pre	Post
1	Chilmark Suite	PFI	4.10.08	1st clear sample, further samples required	ND	ND
2	Chilmark Suite	PFI	4.10.105	1st clear sample, further samples required	ND	ND
3	Dermatology	PFI	2.11.33	1st clear sample, further samples required	ND	ND
4	Dermatology	PFI	2.11.45	1st clear sample, further samples required	ND	ND
5	Dermatology	PFI	2.11.40	1st clear sample, further samples required	ND	ND
6	Amesbury Suite	PFI	4.10.236	1st clear sample, further samples required	ND	ND
7	Plastics	PFI	3.10.09			
8	ENT	416102	3.04.24	POU fitted, investigate temperature/circulation issues	4200	
9	Pembroke Ward	416117	3.04.50	POU fitted, investigate temperature and circulation issues	600	
10	Sarum Ward	416064	4.05.17	Clean, disinfect outlet and resample	380	

(Table 15)

***Legionella* sampling results for Quarters 3 and 4 of 2024/25**						
	Ward / Department	LG Ref	Location	Action plan	Test result as of 19/03/2025	
					Pre	Post
1	Chilmark Suite	PFI	4.10.08	3rd clear sample	ND	ND
2	Chilmark Suite	PFI	4.10.105	3rd clear sample	ND	ND
3	Dermatology	PFI	2.11.33	3rd clear sample	ND	ND
4	Dermatology	PFI	2.11.45	3rd clear sample	ND	ND
5	Dermatology	PFI	2.11.40	3rd clear sample	ND	ND
6	Amesbury Suite	PFI	4.10.236	3rd clear sample	ND	ND
7	Plastics	PFI	3.10.09	3rd clear sample		
8	ENT	416102	3.04.24	POU fitted, investigate temp / circ. issues	4200	
9	Pembroke Ward	416117	3.04.50	POU fitted, investigate temp / circ. issues	600	
10	Sarum Ward	416064	4.05.17	Clean, disinfect outlet and resample	380	

(Table 16)

13.2 *Pseudomonas*

Six monthly sampling has been completed, with some live counts identified, and remedial works and resampling completed. One live count is currently being managed, with the next round of sampling due to commence in May 2025. See Table 9 below for results *(no live counts were being managed at the time of the previous DIPC Report for quarters 1 and 2 of 2024/25)*.

***Pseudomonas* sampling results for Quarters 3 and 4 of 2024/25**						
	Ward / Department	PS Ref	Location	Action plan	Test result as of 18/03/2025	
					Pre	Post
1	Odstock Ward	-	Rm 6 SHW	3rd clear sample, remove POUF.	ND	
2	Odstock Ward	-	Rm 8 Bath	3rd clear sample, remove POUF.	ND	
3	Odstock Ward	-	SHW 4.11.09	3rd clear sample, remove POUF.	ND	
4	Odstock Ward	-	WHB 4.11.06	3rd clear sample, remove POUF.	ND	
5	Neonatal Unit	29	WHB 77.09	POUF fitted, need to follow up with ProEconomy	>100	

(Table 17)

13.3 Pool Water Quality

One failure was recorded during quarters 1 and 2 of 2024/25, a test completed on the learner pool at the Leisure Centre failed a test in May 2024 and the pool was out of use on the 14th May. The pool was backwashed and resampled, and a clear result was obtained on the 15th May. There were no failures of pool water quality recorded for quarters 3 and 4 of 2024/25.

13.4 Achievements for 2024/25

- Managed service for water sampling has been introduced, this is more cost effective and releases the inhouse team from this task to enable them to focus on the maintenance of the hot and cold-water systems.
- Completion of six monthly *Pseudomonas* testing and associated actions where applicable following high counts.
- Completion of actions from the site water risk assessment (RA), these include the fitting of flow through valves, cleaning/inspection of hot water tanks and plate heat exchanges. The % of completion of actions has risen from 40% (quarters 1 and 2) to 70%.
- Regular meetings of the WSG. This group focus on the delivery of PPMs, actions related to any 'live' counts and tasks for the sites water RA.
- With the engagement and support of the IPC team, risk assessments have been completed in line with BS 8580-2 for all augmented care wards at SFT. These RA's will be reviewed, and the associated action plans will be progressed via the WSG.

13.5 Key focus for quarters 1 and 2 of 2025/26

- Further works on the risk assessment, currently at 70% of completion, most of the outstanding actions require funding (revenue/capital) to deliver as they relate to increased temperature monitoring of the hot and cold water systems.
- Completion of actions from the *Pseudomonas* risk assessments that were completed in quarter 4 of 2024/25, there are actions that need to be progressed by the wards and the WSG.
- Improvements in key areas of maintenance e.g., TMV maintenance.

- Introduction of a new process for the flushing of clinical areas, with the support of the WSG this new process will save water, energy and in turn release some additional resource for the Estates team to focus on the delivery of Water Safety PPM.
- The completion of the six monthly *Pseudomonas* testing.
- The recruitment of a Band 5 lead for Water Safety to assist with the management and delivery of PPM, routine sampling and monitoring in line with the Trusts Water Safety Plan.

14. SPECIALIST VENTILATION SYSTEMS MANAGEMENT

This section summarises the actions/precautions that the Trust has taken during 2024/25 in relation to the critical ventilation systems. The Trust manages the safety of ventilation systems in line with the Health Technical Memorandum (HTM) 03-01 and operates a permit to work system to ensure that approval has been sought by the key stakeholders (e.g. Theatres, Pharmacy and Laboratories) of the system prior to its isolation.

14.1 Achievements for 2024/25

- Annual PPM completed in Main Theatres and Day Surgery Unit (DSU) Theatres.
- Annual PPM completed on Pathology Laboratories, Cardiac Outpatients, Radnor Ward, Longford Ward, Britford Ward, Downton Ward, Pembroke Ward and Laverstock Ward.
- Annual Local Extract Ventilation (LEV) testing completed on systems located in Medical Engineering, Orthotics, Estates and Wessex Rehabilitation.
- Laverstock Ward ventilation duct cleaning completed, and ventilation re-balanced due to issue with air flow/temperatures in some of the bays on the ward, in particular the bay that was previously utilised as a COVID-19 cohort bay for Radnor Ward during the pandemic.
- Progression of remedial works on the fire dampers by Rock Compliance.
- Ventilation duct cleaning completed for all main theatres (1-8) and including core areas.
- Main kitchen extract hoods and ducts cleaned in line with TR19.
- Two Estates team members completed a course on the maintenance of critical ventilation systems with a view to a formal appointment at competent persons (CPs), in line with the roles and responsibilities as defined in HTM 03-01.
- Ventilation Safety Group (VSG) meeting regularly. This is now also supported by an operational group which focuses on the delivery of KPIs related the management and maintenance of critical ventilation systems.

14.2 Key focus for quarters 1 and 2 of 2025/26

- Completion of PPMs to include 40-point check for critical systems as per the guidance in HTM 03-01.
- Progression of fire damper remedial works and fire damper testing.
- Plan and deliver the replacement of the faulty pressure stabilisers in DSU.
- Complete a full review of the ventilation systems within the main Laboratories, as it has been established that some areas within the Laboratories do not have sufficient air changes. This is a potential hazard to health as well as a comfort issue.
- Progression to the formal CPs appointment in line with the roles and responsibilities within the HTM 03-01 (following the training completed in 2024/25).

15. CONCLUSION

This annual DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2024/25 in reducing HCAI rates for the Trust.

For quarters 1 and 2 of 2025/26, the key ambitions for the Trust will include:

- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided.
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship

- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water and ventilation safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

16. ACKNOWLEDGEMENTS

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- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2024/25

Please note: The numbering **does not** depict the order of priority for the Trust but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	CEO	In place
Lead infection prevention & control in the Trust and provide a six-monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPC team	In place
Continue contribution to implementation of the Bed Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	Deputy CNO	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/ICD/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPC team	In place
Review implementation of 'alert organism' & 'alert condition' system	ICD/Microbiologists	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	ICD/Microbiologists	In place
Promote liaison with UK Health Security Agency (UKHSA) for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the PLACE Steering Group meetings.	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Bed Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPC team	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies:		
Standard infection control precautions (incorporated within National IPC Manual (NIPCM))	ICNs	In place
Outbreak Management	ICNs	In place
Isolation of patients	ICD	In place
Safe handling and disposal of sharps	H&S Lead	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	H&S & OH Lead	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	IPC team	In place
Disinfection policy	Facilities GM	In place
Antimicrobial prescribing	ICD/Lead Pharmacist	In place
Mandatory reporting HCAIs to Public health England (PHE)	ICD	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	ICD/IPC team	In place
Additional policies:		
CJD & Transmissible Spongiform Encephalitis (TSE)	Deputy ICD/Decon. Lead	In place
Glycopeptide Resistant Enterococcus (GRE)	ICD	Included in
Acinetobacter species	ICD	Isolation
Viral Haemorrhagic fever (VHF) – being incorporated into Trust HCID Plan (EPRR team)	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	NNU Lead	In place
Infection control measures for ventilated patients	ITU Lead/Matrons	In place
Tuberculosis IPC	ICD	In place
Legionellosis risk management policy and procedures, including pseudomonas	Head of Estates	In place
Strategic Cleaning Plan & Operational Policy	Facilities GM	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	Head of Estates	In place
Waste Management Policy	Waste Manager	In place
Linen Management Policy (incorporated within NIPCM)	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	Decon. Lead	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & Safety Services (OHSS)	Head of OD&P & OH Lead	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	OH Lead	Continuous
Continue the provision of infection prevention and control education at induction	IPC team	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPC team	Continuous
Continue recording and maintaining training records for all staff via the LEARN (previously MLE)	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	Continuous

NHS Salisbury NHS Foundation Trust

APPENDIX B (2024/2025)

Clinical Divisions	Inpatient areas/wards	*Clostridioides difficile* - all cases (reportable and not reportable)		Bacteraemias - all cases are reportable to UK Health Security Agency (UKHSA)														Outbreak declared	PII declared	Hand Hygiene (mean %)	
				MRSA			*MSSA*			*E.coli*			*Pseudomonas aeruginosa*			*Klebsiella sp.*						
		Hospital onset healthcare associated	Community onset healthcare associated	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	See main repot for details			
Clinical Support & Family Services	Sarum Ward (inc. Children DAU)	1 + 2*	1 + 1									1								Q1 C.difficile	↓97.5%	
	Hospice Unit																				→100%	
	Longford Ward	1								2			1								↑86.88%	
	CS&FS Totals:	**1 + 3***	**1 + 1**							**2**		**1**	**1**									
Women & Newborn	Labour Ward		1 + 1																		↑98%	
	Neonatal Unit																				↓89.94%	
	Post-natal Ward											1									↑96%	
	W&N Totals:		**1 + 1**									**1**										
Medicine	AMU (inc. SDEC)	2	3 + 1			1		2	4	1	2	6				1	1	1			↓82.03%	
	Breamore Ward																				↓89.87%	
	Durrington AFU	1 + 1	1 + 1						3	1		1	1					1		Q2 & Q4^ C.difficile	↓83.33%	
	ED (inc. SSEU)		1		1			3	22		8	59		1	7		3	17			↓63.32%	
	Farley Ward	1					1			1			1						Q1 HMPV	Q1 Pertussis	↓80.83%	
	Imber Ward	2 + 4	1										2							Q4^ C.difficile	↑88.25%	
	Laverstock Ward	1					1														↓80.31%	
	Pembroke Ward	2					1			2						2					↑97.5%	
	Pembroke Suite																				↑100%	
	Pitton Ward	3 + 4														1				Q1 C.difficile	↓78.33%	
	Redlynch Ward	1 + 2	2				2			1			3			1					↓86.88%	

	Spire Ward	1 + 2	1				1														↑81.67%	
	Tisbury CCU	1							1	1						1			Q4 Flu A		↑89.32%	
	Whiteparish Ward	1 + 1					1														↓88.75%	
	Nunton Unit																				→100%	
	Medicine Totals:	**13 + 17**	**5 + 6**		**1**	**1**	**7**	**5**	**30**	**7**	**10**	**66**	**7**	**1**	**7**	**6**	**4**	**19**				
Surgery	Amesbury Suite									2			1								↑91.72%	
	Britford Ward (inc. SAU)	1 + 1							1				1								↓81.67%	
	Chilmark Suite	1 + 1																			↑83.33%	
	Day Surgery Unit																				↑86.67%	
	Downton Ward	2								3											↑71.51%	
	Odstock Ward	2					1														↑93.33%	
	Radnor Ward		1				2			1			2			3					↑99.29%	
	Surgery Totals:	**4 + 4**	**1**				**3**		**1**	**6**			**4**			**3**						
Additional info: Other *C.difficile* samples, e.g. GP, other Emergency Assessment, OPD, Mortuary, Private or Community Hospitals			**6 + 2**																			

***C.difficile*: All SFT samples including inpatient and outpatient areas, GP and other e.g., Emergency Assessment** *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

- *There was an additional paediatric case (not reportable) tested in the Laboratory where the child was under 2 years of age, which was followed up at the time by the Consultant Microbiologist
- ^This PII of C.difficile was declared across Durrington AFU and Imber Ward during quarter 4

Bacteraemia classification codes:

- Hospital onset healthcare associated, is shown as Hospital onset HA
- Community onset healthcare associated, is shown as Community onset HA
- Community onset community associated, is shown as Community onset CA

Hand hygiene scoring: ↑ = improved compliance score; ↓ = reduced compliance score; → no change to compliance score; when compared to DIPC Report for quarters 1 and 2 of 2024/25

	Score 85% and above
	Score 61% - 84%
	Score 60% and below

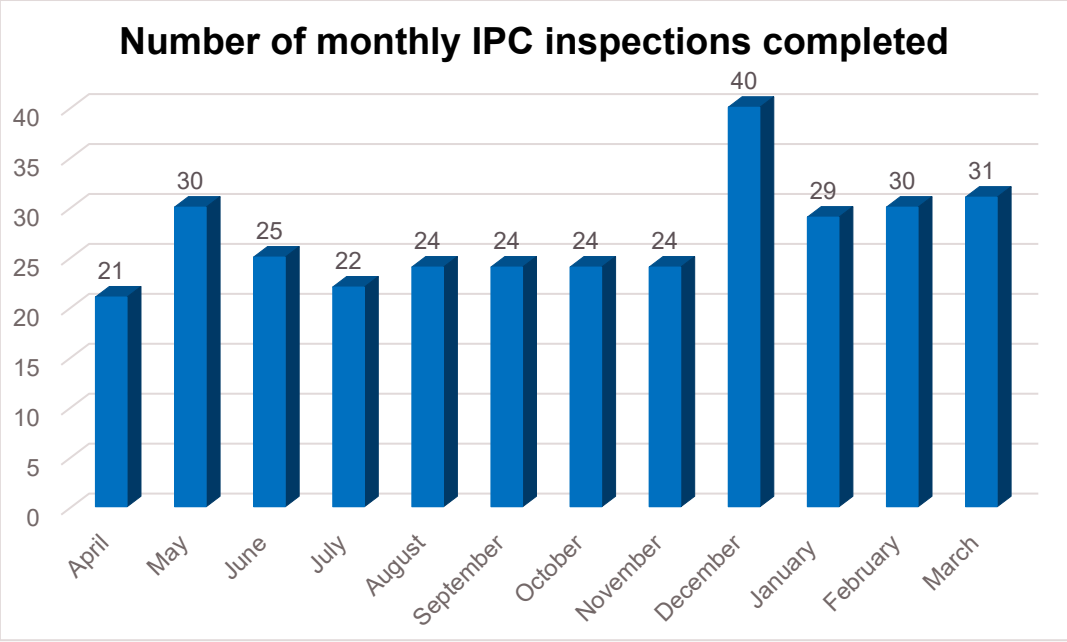
(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

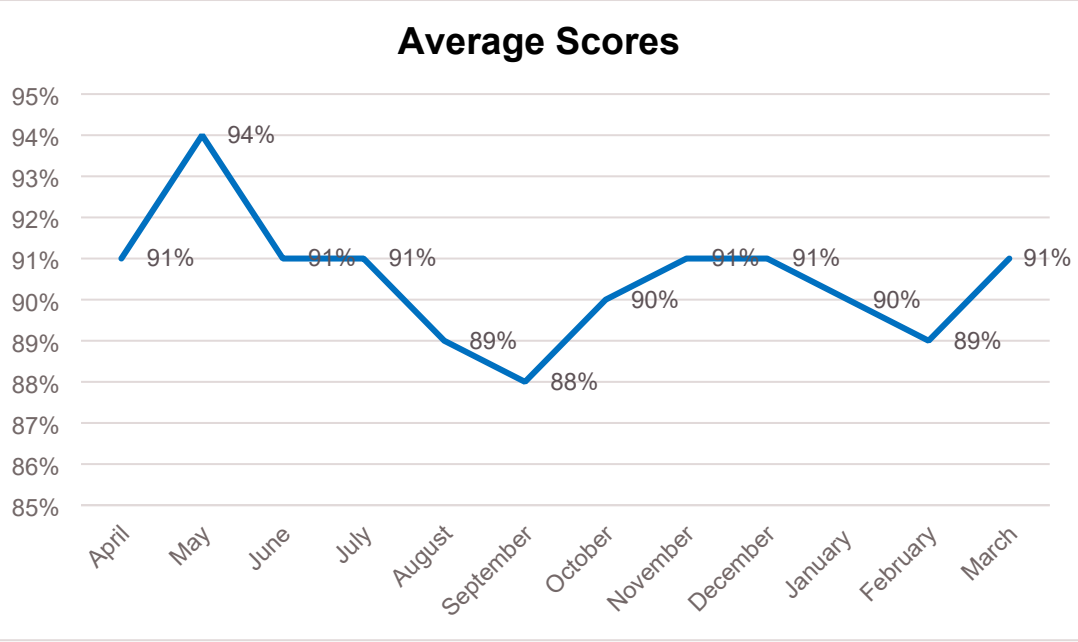
Salisbury NHS Foundation Trust

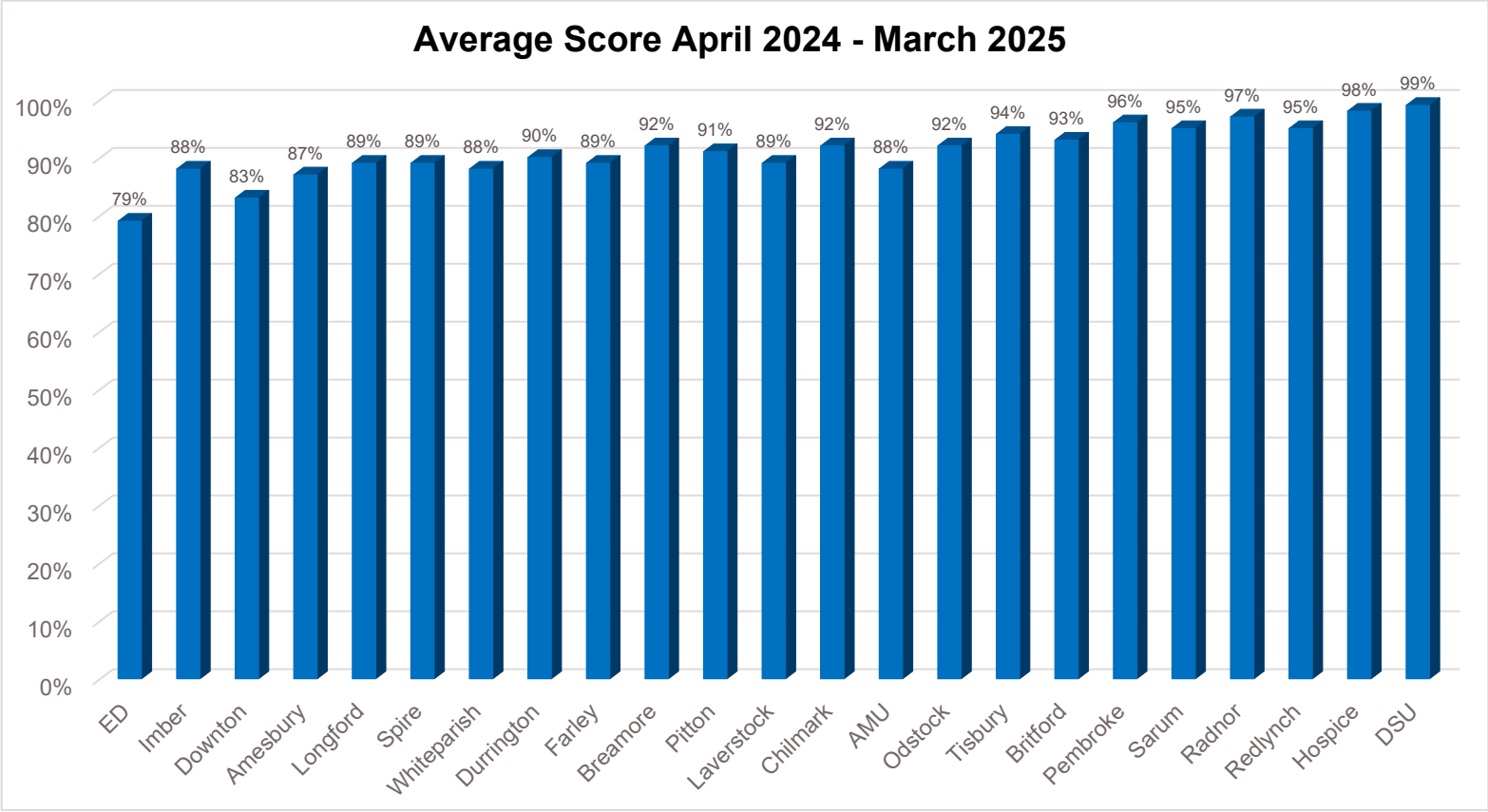
APPENDIX C

Tendable Infection Prevention & Control (IPC) Audit Inspection Summary for 2024/25

Overall







(Information provided by Tendable Review Team at SFT)

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.9
Date of meeting:	03/07/2025		

Report title:	Q4 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board 22/05/2025 Clinical Governance Committee 24/06/2025			
Prepared by:	Louise Jones- Head of Risk Management			
Executive Sponsor: (presenting)	Judy Dyos- Chief Nursing Officer			
BAF Risk link				

Recommendation:

The report aims to provide an overview of risk management activity in Quarter 4.

Executive Summary:

- **LFPSE**

In Q4, efforts have been made with Datix and NHSE to investigate the LFPSE discrepancies. A Datix upgrade is being pursued to help address some of the ongoing issues, while NHSE continues to review our data for further insights

- **Risk Facilitation**

Face-to-face support and facilitation are being offered five days a week to the Matrons and ward leads in the Medicine Division. This support aims to ensure the timely completion of Datix incidents, assist with patient safety reviews, provide guidance on Duty of Candour, and oversee and review risk registers.

- **Risk Registers**

  There has been an ongoing focus on mitigating risks that lack action plans. Compliance improved in Q4, rising to 84% from 72% in Q3.

Risks escalated to Divisional risk registers

Medicine – 1

Reports of abnormal test results requested in an AMU consultants name not regularly seen or acted on

Surgery – 1

Lack of Short Term Paediatric Orthopaedic Provision for a minimum of 3 months

CSFS/FASS – 3
Risk of injury to staff and closure of mortuary due to inadequate equipment
Unable to meet national guidance for staffing ratios in colposcopy
Insufficient diagnostic test/colonoscopy capacity across all 3 sites resulting in delay in seeing patients

- There have been 0 risks escalated from Divisional Risk Register to Corporate Risk Register in Q4.
- The number of incidents where major or catastrophic harm has occurred has significantly reduced over the past 12 months (39 in 2023/24, 24 in 2024/25). All patient safety incidents, where harm has occurred, are discussed and reviewed through the patient safety summit (PSS).
- The overall harm, for all incidents, over the last 12 months has reduced from 3.08% in Q1 to 2.99% in Q4.
- In Q4 there have been 117 Patient Safety Reviews (PSR 1) undertaken, of these 41 have proceeded to a further PSR 2 review in line with the PSIRF policy and plan.
- The recent KPMG audit provided an overall assessment of 'Significant assurance with minor improvement opportunities' in comparison with the previous audit Jan 2024. The audit focused on corporate risks and reviewed adherence with the risk management and corporate risk escalation process, risk reporting structures and quality of information reported, and used their 'NHS Risk Management bot' to assess trends in risk register completeness from the prior year.
- RLDatix has provided feedback that our incident reporting form utilizes all available functionalities within datix to make it as user-friendly and streamlined for our staff, which contributes to our strong reporting culture. They also recommended our form design as an exemplary model for other Trusts nationally. Additionally, they noted that any limitations are due to the system itself or the mandatory additions from LFPSE.
- In Q4 there were 108 actual hospital acquired pressure ulcers and 177 pressure ulcers that were present on admission.

Medicine , Surgery and FASS Risk Register Divisional Deep Dives have been completed with the CNO and CMO.

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