Bundle Trust Board Public 8 January 2026

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
November SOX of the month – Yvonne Browning and Vikki Kennard & Pre Op Assessment Team
November Patient Centred SOX – Paul Jones, Audiology
December SOX of the month –
December Patient Centred SOX –

1.2 10:10 - Patient Story
Presented by Helen Rynne

1.3 Welcome and Apologies

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes Public Trust Board Meeting held on 6th November 2025
For approval
1.5 Draft Public Board mins 6 November 2025

1.6 10:35 - Matters Arising and Action Log
1.6 Action Log

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:40 - Chair's Business
Presented by Eiri Jones

2.2 10:45 - Chief Executive/ Managing Director Report
Presented

2.3 10:55 - Integrated Performance Report
Presented by Niall Prosser
For assurance
2.3a IPR Cover Sheet - Trust Board 2026-01
2.3b Integrated Performance Report - January 2026

2.4 11:20 - Audit Committee - December
Presented by Richard Holmes
For assurance
2.4 December Audit Committee Escalation Report

2.5 11:25 - Finance and Performance – November and December
Presented By Richard Holmes
For assurance

2.6 11:35 - Clinical Governance Committee - November
Presented by Anne Stebbing
For assurance
2.6 November 2025 CGC Escalation report to Board

2.7 11:40 - People and Culture - November

3 PEOPLE AND CULTURE

3.1 Health and Safety Quarterly Report – deferred to March

3.2 11:45 - Medical Education Annual Performance Report
Presented by Duncan Murray
For assurance
3.2a Medical education cover sheet jan 26
3.2b Annual Medical Education Report 2024-2025

3.3 11:55 - BREAK

4 QUALITY AND RISK

4.1 12:25 - In-Patient Survey Results
Presented by Judy Dyos
For assurance
4.1a National patient survey 2024 cover sheet - Trust Board January 2026

4.1b National Inpatient Survey 2025 - results report slide deck updated version

4.2 12:35 - Patient Experience Report Q2
Presented by Judy Dyos
For assurance

4.2 Patient Experience - Patient Feedback Report Q2 Annual Engagement Report 25-26 v2.1 Trust Board version

4.3 12:45 - Learning from Deaths Report Q2
Presented by Duncan Murray
For assurance

4.3 Learning From Deaths Report Q2 v1.2

4.4 12:55 - Director of Infection Prevention and Control Report
Presented by Judy Dyos
For assurance

4.4a DIPC front sheet dipc 6 month
4.4b DIPC Report 6 Monthly Update 2025-26

4.5 Annual Maternity Survey – deferred to March

4.6 13:05 - Maternity & Neonatal Quality and Safety Report Quarter 2
Presented by Judy Dyos
For assurance

4.6a Front sheet Q and S report Q2 25 26
4.6b Maternity and Neonatal Q&S Report Q2 July-Sept 2025
4.6c APPENDIX 1 - PMRT Report Q2 Jul-Sept 25
4.6d APPENDIX 2 - Training Report Q2 Jul-Sept 25
4.6e APPENDIX 3 - Patient and Staff Experience Report Q2 Jul-Sept 25
4.6f APPENDIX 4 - Saving Babies Lives Report Q2 Jul-Sept 25
4.6g APPENDIX 5 - Workforce Report Q2 Jul-Sept 25
4.6h APPENDIX 6 - ATAIN and TC Report Q2 Jul-Sept 25

4.7 13:15 - Perinatal Quality Surveillance Report November 2025 (October data)
Presented by Judy Dyos
For assurance

4.7a Front sheet Perinatal Quality Surveillance Report - November (October data)
4.7b FINAL Perinatal Quality Surveillance November 2025 Slides (Oct data)

4.8 13:20 - Rapid Review of Maternity & Neonatal Safety Investigation (MNSI) cases January to September 2025
Presented by Judy Dyos
For assurance

4.8a Rapid Review of MNSI Cases front sheet
4.8b Rapid Review Mat-Neo Safety Investigation (MNSI) cases report

5 STRATEGY AND DEVELOPMENT

5.1 13:25 - Digital Plan Update (Nov F&P)
Presented by Jonathan Hinchliffe
For assurance

5.1 Annual Digital Plan Update

5.2 13:35 - Improving Together Update Report
Presented by Alex Talbott
For assurance

5.2a Cover sheet Improving Together Trust Board Report Jan 26
5.2b Improving Together Triannual Roadmap Progress Report – January 2026

5.3 13:45 - Triannual Strategy Deployment Update
Presented by Alex Talbott
For assurance

5.3a 2026-01-08_Triannual-Strategy-Deployment-Update_CoverSheet
5.3b 2026-01-08_Triannual-Strategy-Deployment-Update

6 ITEMS FOR CONSENT

6.1 Register of Seals
Presented by Tapiwa Songore
For information

6.1 Register of Seals

7 CLOSING BUSINESS

7.1 Agreement of Principal Actions and Items for Escalation

7.2 13:55 - Any Other Business

7.3 14:00 - Public Questions

7.4 Date next meeting

8 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 6th November 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Eiri Jones (EJ)	Chair
Rakhee Aggarwal (RA)	Non-Executive Director
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Mark Ellis (ME)	Chief Finance Officer
Nick Johnson (NJ)	Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Ali Lynne-Smith (ALS)	Interim Chief People Officer
Jonathan Hinchcliffe (JH)	Interim Chief Transformation and Innovation Officer
Judy Dyos (JD)	Chief Nursing Officer
Cara Charles Barks (CCB)	Group Chief Executive
Duncan Murray (DM)	Chief Medical Officer
Jude Gray (JG)	Chief People Officer
Andrew Hollowood (AH)	Group Strategic Clinical Transformation officer

In Attendance:

Alex Talbott (AT)	Director of Improvement
Tapiwa Songore (TS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (item 5.5, 5.6, 5.7, 5.8, 5.9 and 5.10)
Michelle Boucher (MB)	Nurse (Item 1.2)

Apologies

Simon Wade	Group Chief Finance Officer
Richard Holmes	Non-Executive Director

Observers

Jayne Sheppard	Governor
Jane Podkolinski	Governor
Frances Owen	Governor (MS Teams)
Mark Wareham	Unison (MS Teams)
Gillian Rennison	Care Quality Commission (MS Teams)
Victoria Insull	Staff (MS Teams)

ACTION

TB1 6/11/1 **OPENING BUSINESS**

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

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

TB1 6/11/1.1 **Presentation of SOX Certificates**

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

- September SOX of the month – Amanda Harris, Medical Records
- September Patient Centred SOX – Julia Shelly and Clare Lewis, Dietetic and Nutrition
- October SOX of the month – Clinical Site Team.
- October Patient Centred SOX – Suzie Dukes, Stoma Care

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

TB1 6/11/1.2 **Staff Story**

JD introduced the staff story, and the Board welcomed MB to the meeting. MB described her research in colostomy for spinal injury patients as part of her PhD program. The research identified a unique trend of spinal injury patients requesting early colostomy and found through patient interviews that the procedure improved patient understanding, streamlined care pathways significantly improved quality of life, independence, and return to work. MB narrated some of the challenges that she had encountered with the research program.

Discussion

The Board noted the professional resistance and stigma around colostomy, noting that national guidelines were beginning to shift, partly due to MB's published work, and highlighted the need for listening to patient preferences

The Board also discussed the value of qualitative research, recognising the impact on clinical practice, patient outcomes, and committed to supporting ongoing and future nurse-led research initiatives. The Board noted the importance of establishing patient panels to gather qualitative feedback.

The Board congratulated MB on attaining the PhD and thanked her for the inspiring story.

TB1 6/11/1.3 **Welcome and Apologies**

EJ welcomed everyone to the meeting, in particular Jude Gray and Andrew Hollowood who had been appointed as Group Chief People Officer and Group Strategic Clinical Transformation Officer respectively and were attending the Board meeting for the first time.

Apologies had been received from Richard Homes and Simon Wade.

The Board noted that this was ALS last Board meeting and thanked her for the sterling efforts for the period that she was leading the People Directorate.

TB1 6/11/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

TB1 6/11/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 4th September and 15th October 2025**

EJ presented the minutes from the Public Board meetings held on 4th September and 15th October 2025.

Decision:

The Board **APPROVED** the minutes of the meetings held on 4th September and 15th October 2025 as a true and correct record, subject to minor amendments suggested at the meeting

TB1 6/11/1.6 **Matters Arising and Action Log**

TS presented the action log, and it was noted that the two actions on the action had been completed. The Board approved the closure of both actions.

TB1 6/11/1.7 **Register of Attendance**

The Board noted the register of attendance.

TB1 6/11/1.8 **Chair's Business**

EJ reported on the following activities:

- Group activities
  - Attendance at the Board workshop, the Governor's workshops and Joint Committee meeting.
  - Attendance at the Association of Groups Day in London with Liam Coleman, Chair at RUH and GWH
  - Meeting with Sir Jim Mackey, CEO at NHSE and Elizabeth O'Mahony, NHSE Chief Financial Officer
  - System and regional meetings both for group and trust, mainly with the focus around money and quality.
  - Group Executive interviews.
- SFT activities
  - Flu vaccination to encourage staff.
  - Attendance at the Charity thank you evening
  - Meetings with Lead Governor and Deputy Lead Governor
  - Attendance at the quality team Macmillan Coffee Morning.
  - Attendance at the Governor's Development Day
  - Meeting with the local MP

The Board noted the Chair's report.

TB1 6/11/1.9 **Chief Executive/Managing Director Report**

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

- The financial deficit across the BSW Hospitals Group which was at £35.5m deficit at Month 6 and the need for break-even with the region
- The challenge of making difficult decisions while maintaining quality and the focus on developing a new group strategy centred on people and sustainability.
- The establishment of a single Executive Team across the BSW Group and the importance of developing the risk-based governance model.

- Trust Performance league tables had been announced nationally and SFT was 57 out of 132 trusts, and was in Segment 3 of the Oversight Framework, due to the financial challenges.
- The resident doctors planned industrial action and the plans to mitigate.

NJ presented the Managing Directors report and reported on the following.

- UEC demand the Increase in NCTR which was higher than planned.
- Operational and Financial Recovery Plan trajectories were achieved in month 6, after the financial trajectory was missed in M5.
- An unannounced CQC inspection of surgery services took place in September. The CQC inspection team noted the patient centred care which was delivered and identified some areas of good practice and areas for improvement. No immediate safety issues were identified which needed urgent rectification. The Trust was awaiting the inspection report.
- The Trust had implemented the new LIMS system in Pathology in September
- A visit from the Wessex Deanery to review SFT Plastic Services training took place in October. A report would be provided in the coming weeks.
- NJ formally thanked Fiona McNeight, the former Director of Integrated Corporate Governance who retired on 31 October 2025 after 40 years in the NHS.

Discussion

The Board enquired on the level of autonomy that the Trust had to make operational decisions independently and CCB reported that the planning guidance provided clear requirements on the performance and delivery metrics. No new investment was planned, and the delivery would be driven by improved productivity. Work was underway develop a roadmap and to identify priorities and the associated risks.

The Board sought assurance on the delivery of the turnaround work, and it was noted that turnaround work and the appointment of a Turnaround Director was mainly to support RUH and to provide additional capacity and bandwidth to ensure delivery on the current schemes.

The Board noted the report.

TB1 6/11/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 6/11/2.1 **Integrated Performance Report (IPR) (M6 September)**

DM presented the Integrated Performance Report for September 2025 and highlighted the following key points on the Performance Metrics and Improvements:

- September was particularly busy with significant increase in demand and congestion in the emergency department, increased urgent care attendances, ambulance presentations, and corridor care which was the impacting on dignity, privacy and safety of care of patients.

- No Criteria to Reside (NCTR) reduced from 87 to 78 average against a plan of 44, and this was an improved position compared to the average of the last 12 months.
- Time to First Outpatient Appointment reduced from 129 to 127 days against the target of 90 although continued an improved trend compared to 2024 and baseline of 139 days in April 2023.
- Improvements in diagnostics and outpatient wait times, and ongoing challenges in cancer pathways, particularly dermatology.
- Staff Retention increased slightly from 16.2% to 16.7% although this remained close to the 15% target and improved from the baseline of 20.4% in April 2024.

Discussion:

The Board noted that there was no significant deterioration in quality but acknowledged that there were worrying clusters of incidents and requested further assurance that the Trust was providing safe care. JD assured the Board that apart from corridor care, the key performance indicators for safety and quality were stable. The Chair requested that a review of quality come to the Board Development Session in December.

Clarity was sought on the progress with dermatology and NP reported that that there had been a significant amount of demand. NHSE were providing support, and the expectation was that the backlog would be cleared by end of the month, and service back on track by December 2025.

Concerns were raised about increasing sickness absence and declining appraisal rates and the Board acknowledged the importance of accurately assessing morale. It was agreed that this required ongoing monitoring.

The Board noted the report

TB1 6/11/2.2 **Audit Committee – 18th September**

The Board noted the report from the Audit Committee meeting on the 18th of September 2025

TB1 6/11/2.3 **Finance and Performance Committee – 30th September**

The Board noted the report from Finance and Performance Committee meeting on 30th September 2025.

TB1 6/11/2.4 **Clinical Governance Committee – 30th September and 28th October**

AS presented the reports from the Clinical Governance Committee meetings on 30th September and 28th October, and highlighted the challenges being experienced in various services due to staffing issues. Concern had been raised a concern at the end of CGC discussions as to whether the collective issues being presented could be indicating a deteriorating position for safety and quality of care at SFT

Discussion

The Board discussed the unwarranted clinical variation and agreed to be vigilant to early warning signs requiring investigation. AT highlighted the need for effective communication and escalation between Committees, ensuring that both clinical and non-clinical risks, including staff morale and engagement, were monitored and addressed.

The Board noted the report

TB1 6/11/2.5 **Trust Management Committee – 24th September and 29th October**

NJ presented the report from the TMC meeting on 24th September and 29th October and the Board requested the Executive to explore a new model for the aseptic service if current challenges persisted. The Board noted the improvements made in the service.

The Board noted the reports.

TB1 6/11/2.6 **People and Culture Committee – 25th September and 30th October**

RA and EJ presented the report 25th September and 30th October and highlighted the following;

- The Corporate Services Redesign and the impact on staff morale and productivity.
- The reduced administrative support and impact on clinical productivity.
- Winter planning and the importance of fatigue monitoring as suggested by DHSC
- The impact of immigration law changes.
- Changes to the administration and support for the Guardian of safe working role and the current pressure which was not sustainable.
- Sickness absence going up and appraisals going down, and the concern on morale and engagement

Discussion

The Board noted that 20 staff members at SFT were affected by the new immigration thresholds and agreed to develop a consistent group-wide approach to support affected staff and ensure compliance with legal requirements. A report would be provided to the three Board Committee on immigration issues and thresholds.

NJ raised the issues of racism faced by nurses and frontline staff as indicated by the NMC Report and the Board noted the various ways in which issues were raised within the trust. It was agreed this would be discussed further at the People and Culture Committee.

The Board discussed the impact of reduced administrative support on clinical productivity, and JG provided an update on the corporate services redesign. The Board noted that progress had been made, however the pace could be accelerated to minimise anxiety . The Board acknowledged the need to balance technology with adequate staffing.

The Board noted the report.

TB1 6/11/3 **GOVERNANCE**

TB1 6/11/3.1 **Provider Capability Framework**

NJ presented the report and informed the Board that the Provider Capability Framework had been submitted to the SW Region on 22 October .

The Board had agreed at the Extra-Ordinary Private Trust Board meeting held on15 October 2025 to confirm, that it met the requirements in the following domains;

- Strategy, leadership and planning.
- Quality of Care.
- People and culture
- Access and delivery of services.
- Productivity and value for money.

It had also agreed that the Financial performance and oversight domain would be marked as Partially confirmed. Any changes required notification to NHSE via the established private Teams channel.

The Board to **Ratified** the Trust's self-assessment as agreed on15 October 2025.

TB1 6/11/3.2 **Annual Review of Board and Committee Effectiveness**

NJ reported that the Annual Review of Board and Committee Effectiveness had been completed, and the Board noted the improved engagement, and the main themes from the exercise. Plans were to adapt processes as group governance structures evolved.

The Board noted the report.

TB1 6/11/3.3 **Annual Report and Accounts**

The Board noted that the Annual Report and Accounts had been laid before Parliament and had been uploaded on the website. A summary had been provided at the Annual General Meeting.

The Board noted the report.

TB1 6/11/3.4 **Register of Seals Q2**

The Board received the Register of Seal. Assurance was provided that there were no conflicts of interest in any of the signatories.

The Board noted the report.

TB1 6/11/4 **PEOPLE AND CULTURE**

TB1 6/11/4.1 **Nursing Safer Staffing Review**

JD presented the report from the mid yearly safe staffing review, providing a detailed analysis of current nurse staffing levels.

The review had identified the need for additional staff in the spinal unit and emergency department. However, it had been recommended to wait for the outcome of an external group-wide review before implementing changes.

Discussion

The Board sought clarity on the risk from the understaffing in the spinal unit and emergency department and JD outlined the mitigatory processes in place and the Board noted that the service was resourced to Commissioned level rather that the 'gold' standard.

The Board noted the report.

TB1 6/11/4.2 **Guardian of Safe Working Annual Report**

DM presented the Guardian of Safe Working Annual Report and reported the changes in exception reporting, and the impact on the team.

The Board noted that the guardian of safe working was available to receive reports and to work with clinical teams to facilitate a culture of exceptional reporting. All specialties were reporting as required.

The Board noted the report.

TB1 6/11/5 **QUALITY AND RISK**

TB1 6/11/5.1 **Board Assurance Framework and Corporate Risk Register**

JD presented the Board Assurance Framework and the Corporate Risk Register.

The Board noted the 12 BAF risks had not changed in score from the previous quarter. The Board acknowledged the prior work done by the retired Director of Integrated Governance, and it was noted that the identified risks align with those found in other organisations, as referenced by the KPMG report.

The Board noted that there were 22 Risks on the corporate risk register and three new had been added to reflect the financial and operational challenges.

Plans were underway to review and strengthen the corporate risk register to support the evolution of the risk framework across BSW Hospitals Group.

Discussion

The Board reviewed each of the BAF Risk and the appropriateness of risk scores. Concerns were raised on whether certain risks were understated eg EPR deployment, cybersecurity, the impact of workforce capacity and the ability to attract and retain high-quality staff.

It was agreed to potentially increase the risk score for workforce-related risks in the next review.

The Board considered whether more time should be allocated in Committee agendas to discuss specific risks in detail, with a suggestion to move towards a risk-based approach that would focus Committee discussions on the most significant risks

The Board also agreed to review risk appetites and tolerances in the next iteration of the BAF, ensuring that risks remained visible and were appropriately managed during the transition to new governance structures. The importance of not normalising risks outside tolerance was emphasised.

The Board noted the report.

TB1 6/11/5.2 **Patient Experience Report Q1**

JD presented a report on the Patient Experience Report in Q1, providing a summary and insights drawn from the various methods by which our patients feedback on our services, including an analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported .

Discussion

The Board expressed concern that that complaints were not being addressed in a timely manner, and it was noted that this was due to the absence of a patient experience lead. A new lead was expected to start in January.

The Board noted the report.

TB1 6/11/5.3 **Learning from Deaths Report Q1**

DM presented the Learning from Deaths Report Q1. The Board noted the favourable trend in SHMI (Summary Hospital-level Mortality Indicator)

The Board also noted the 12-week pilot of AI-enabled coding to improve data quality and learning which would start soon, with the trust acting as an incubator site for the region.

Discussion

The Board discussed the importance of learning from reports and triangulating with other areas ensuring that learning was disseminated through appropriate groups.

The Board noted the report.

TB1 6/11/5.4 **Incident Reporting and Risk Report**

JD presented report the Q1 Incident Reporting and Risk Report. The Board noted the one Never Event in July involving an Insulin administration in a non-insulin syringe (paediatrics).

Discussion

The Board inquired whether there was any harm from the Never Event and JD confirmed that there was no harm.

The Board noted the report

TB1 6/11/5.5 **Maternity and Neonatal Services Quality and Safety Report Q1**

VM presented the Maternity and Neonatal Services Quality and Safety Report Q1. The Board noted the appendices which included reference and description of triangulation between outcomes, feedback and litigation claims with a focus on improvements.

The Board noted the report

TB1 6/11/5.6 **Maternity and Neonatal Bi-Annual Staffing Report**

VM presented the report and highlighted the ongoing staffing challenges in perinatal services, with recent recruitment of midwives but continued non-compliance with staffing standards.

Some poor outcomes that have included x 1 stillbirths and a cluster of cases when brain injuries have been identified are being reviewed and causes for these are being considered. Staffing and acuity are amongst one avenue of consideration, but this is not proven and will form part of a review to look at outcomes, which will be fed back to board when complete with focus on learning and improved care where changes are indicated.

The Board noted compliance to 1:1 care in labour and Supernumerary status of labour ward coordinator despite staffing challenges.

Discussion

The Board discussed the impact of adverse outcomes on staff well-being, particularly among junior and internationally recruited staff and JD reported the support mechanisms in place, such as advocacy roles and training.

The Board noted the report.

TB1 6/11/5.7 **Perinatal Quality and Surveillance Report – August (July data)**

The Board received the Perinatal Quality and Surveillance Report

Discussion

The Board noted the disparity in outcomes for mothers from global majority and military families, particularly in the Tidworth area. JD highlighted some of the innovations being trialled to close the disproportionate care and to support patients with language barriers, along with the support for cultural sensitivity and compassion. The initiatives included face-to-face antenatal education, the use of translation technology (Pocket Talk), and collaboration with community and military networks to address these inequalities.

The Board noted the report.

TB1 6/11/5.8 **Perinatal Quality and Surveillance Report – September (August data)**

The Board received and noted the Perinatal Quality and Surveillance Report – September (August data)

TB1 6/11/5.9 **Perinatal Quality Surveillance Report – October (September Data)**

The Board received and noted the Perinatal Quality and Surveillance Report – October (September Data).

TB1 6/11/5.10 **SFT Review of Stillbirths 1st November to 30th September**

The Board received and noted the report from the report from the thematic review has been undertaken in response to the increased stillbirths.

The Board noted the report

TB1 6/11/5.11 **In-Patient Survey Results**

The Board noted that the In-Patient Survey Results had been deferred to January.

TB1 6/11/6 **FINANCIAL AND OPERATIONAL PERFORMANCE**

SIRO Annual Data Security and Protection Assurance Report

JH presented the SIRO Annual Data Security and Protection Assurance Report and confirmed that the trust met statutory requirements for data security. The Board noted that governance was in place, statutory roles were covered and a positive internal audit outcome from KPMG, achieving significant assurance with minor improvements.

JH highlighted the ongoing cyber security threats, and the importance of Care Cert compliance, patching, and regular penetration testing to defend against threats. JH also informed the Board on the successful migration to Windows 11 across all three trusts, achieving 99% compliance by the national deadline, with some operational disruptions noted during the transition.

Discussion

The Board noted the drop in compliance with Information Governance training which was below the 85% threshold and urged staff to complete mandatory training on time. Asset management and high-severity alert reporting were identified as areas for further improvement.

The Board noted the report

TB1 6/11/7 **CLOSING BUSINESS**

TB1 6/11/7.1 **Any Other Business**

None

TB1 6/11/7.2 **Agreement of Principle Actions and Meeting Reflection**

- The importance of being curious.
- Although some concerns had been raised there was a lot of good practice happening.
- The unwarranted variation identified in the reports.
- The challenge of balancing costs versus quality.
- The importance of using the BAF and risk-based model.
- Use of the Improving Together

TB1 6/11/7.3 **Public Questions**

None

TB1 6/11/7.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 8th January 2026.

TB1 6/11/8 **RESOLUTION**

TB1 6/11/8.1 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 6/11/2.1Integrated Performance Report (IPR) (M6 September)	04/12/2025	Judy Dyos	The Chair requested that quality be discussed at the Board Development Session in December	Completed - discussed at the Board Development day	Y	3
Trust Board Public	Tapiwa Songore	TB1 6/11/5.1Board Assurance Framework and Corporate Risk Register	05/03/2026	Alex Talbott	Risk appetite and tolerances to be reviwed in the next iteration of the BAF	In progress	N	4

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	2.3
Date of meeting:	08th January 2026		

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)	Niall Prosser, Chief Operating Officer			
Appendices				

Recommendation:
The Trust Board is asked to note the Trust's operational performance for Month 8 (November 2025).

Executive Summary:

Breakthrough Objectives

- *Reducing Pressure Injury* increased from 2.9 to 3.4 total in *Pressure Ulcer categories 1-4 (excluding specialist areas)* against the target of 1.5 and baseline of 3.08.
- *Time to First Outpatient Appointment* reduced from 121 to 120 days against the target of 90 and furthers the lowest point since measuring and baseline of 139 days in April 2023. This remains the key determinate of the Trusts Referral to Treatment (RTT) position.
- *Reducing Staff Unavailability* dropped from 22.8% to 18.4% total and lowest point since April 2025 against the target of 16% and baseline of 22.7%.
- *Productivity* increased slightly from -12.6% to -13% against the target of -5.33% and the baseline of -14.97% in April 2024.

Alert

- *Income* reported an in-month position as a deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

Advise

- *Attendances* into the Emergency Department (ED) increased from 6,786 to 6,822 and remain circa 4% higher than 2024 although performance in month was exemplary:
  - *4-hour Performance* increased again from 68.2% to 75.1% against plan of 71%. Fastest in month recovery within NHS, and best performance for the Trust since March 2024.

- *Ambulance Handover* time reduced again from 23 to 19 minutes average against plan of 20.
- *Ambulance Handovers >60 minutes* reduced further from 33 to 15.
- *ED 12-hour Breaches (arrival to departure)* reduced from 557 to 384.

- Cancer performance began to recover although remains challenged (reporting October data as cancer reporting timeframes one month behind this report):
  - *28-day Faster Diagnosis Standard (FDS)* increased again from 73.9% to 76% against the plan of 80% with Colorectal and Urology lowest, Breast and Skin leading.
  - *62-day Standard* also increased from 57.9% to 65.8% against the plan of 80% with Skin and Head and Neck lowest, Breast and Upper GI leading.
  - *62-day Backlog* increased from 269 to 282 patients at month-end with Skin the top contributor (173) although has additional capacity in place to support and recover, so expect to see improvement in November.
- *Falls resulting in High Harm* and *Total Patient Falls* both reduced to 1 and 7.9 respectively.
- *Staff Absence* reduced from 4.4% to 4% in a welcome drop after previous growth and ahead of winter.
- *Bed Occupancy* reduced from 97% to 96.3% and is also a welcome drop after successive increases.
- *Staff Vacancies* increased from -5.2% to -5% continuing the net Trust position of over-establishment.
- *Stroke Care* measure of *Motor Minutes* increased again from 33 to 38 minutes although continues below the local target of 120 with Latest SSNAP score for the Trust remaining at E.

Assure

- *Referral to Treatment (RTT)* waiting list metrics were positive overall:
  - *RTT Performance* improved again from 67.8% to 68.2% and remains ahead of the March 2026 target of 65%. Highest performance since May 2022
  - *RTT Waiting List* increased from 29,135 to 29,203.
  - Patients waiting *>52 weeks* increased slightly from 161 to 170 although accounts for only 0.58% of the total waiting list ahead of the March 2026 target of 1%.
  - Patients waiting *>65 weeks* remained static at 2 against the rolling target of 0 and resulting from ongoing consultant sickness.
- Diagnostics *DM01 Standard* increased from 87.3% to 88.5% and continues above the plan of 87% with Urodynamics and Audiology lowest, Cystoscopy and Ultrasound leading. Continued sustained improvement in Endoscopy, going from circa 47.4% in February to 84.9% in November 2025.
- *Infection Control* measures of *E.Coli* and *C.Dificile* both reduced to 0 instances of each in month.

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

January 2026

(November 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

NHS Salisbury NHS Foundation Trust

November was a challenging month for the Trust, set against periods of Industrial Action and maximum escalation resulting in critical incidents, although despite and considering this, performance was overwhelmingly positive.

Performance in Emergency Department (ED) had a significant recovery in month, as the *4-hour Standard* increased to 75.1% - which is the most improved in the country and the highest the Trust has performed since March 2024. The ED saw an increase in *Attendances* to 6,822 patients in month and remain circa 4% higher than in 2024. *Ambulance Handover* time reduced further to 19 minutes average, with both metrics in their best positions in almost 2 years. Wider metrics reinforced the strong performance, as *ED 12-hour Breaches* reduced to 384 and *Ambulance Handovers longer than 60 minutes* continued reduction to 15 total.

The Trust continues to drive at improvements with the number of patients with *No Criteria to Reside (NCTR)* and consequently *Bed Occupancy* levels, in the month both decreased to an average of 76 and 96.3% respectively. Aligned with this, the use of *ED Attendances in Temporary Escalation* also reduced significantly to 186 and *Inpatients in Temporary Escalation* was static at 10 total across the month, which is positive although masks pinch-points that contributed to critical incident declaration.

Cancer performance - reporting October data - continued its recovery although challenges in the Skin pathway persist, affecting the overall position and particularly the backlog. The *28-day Faster Diagnosis Standard (FDS)* increased to 76% and the *62-day Standard* also increased to 65.8%. However, the *62-day Backlog* increased to 282 patients at month end, with Skin the top contributor accounting for 173 patients and additional capacity is underway to support and recover. It is likely that the Trust will continue to experience performance challenges in some tumor sites for the next couple of months, as the focus is on clearing the over *62-day backlog*. The Trust continues to work towards reducing the backlog in November.

Diagnostics *DM01 Standard* - the percentage of patients waiting less than 6 weeks - performance improved to 88.5% and highest point in 2 years, remaining above the plan of 87%. Stroke care measure of *Motor Minutes per Patient per Day* increased again to 38 minutes on average although it remains below the local target of 120 as ongoing vacancies in the Therapy team are preventing improvement.

The quality breakthrough objective has changed to measure *Pressure Ulcers (PUs)* and is measured through *Hospital Acquired PUs Categories 1-4 (excluding specialist areas)* which increased to 3.4 total for the month against a target of 1.5. Wider quality metrics were positive, as *Infection Control* reduced to 0 instances of both *E.Coli* and *C.Dificile* in month, *Falls resulting in High Harm* and *Total Patient Falls per 1,000 Bed Days* both reduced to 1 and 7.9 respectively, and the number of *Mixed Sex Accommodation Breaches* halved to 6.

The access related breakthrough objective of *Wait Time to 1st Appointment* continued reduction to 120 days and new lowest point since measuring. Wait time performance improved overall despite the total *Referral to Treatment (RTT) Waiting List* increasing to 29,203 resulting in the *RTT level* - percentage of patients waiting less than 18 weeks from RTT - increasing further to 68.2% and ahead of the March 2026 target of 65%. The number of patients waiting *Longer than 52 weeks* increased to 170, although only accounts for 0.58% of total waiting list - against a March 2026 target of 1% - and the number of patients waiting *Longer than 65 weeks* remained static at 2 - against rolling target of 0 - due to ongoing consultant sickness.

The workforce breakthrough objective has changed to measure *Staff Unavailability* - combined Sickness with all leave types - began with a reduction to 18.4% against a target of 16%. *Staff Sickness Absence* specifically dropped to 4% overall and *Staff Vacancies* increased marginally to -5% and continues to indicate that the Trust remains above establishment overall.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* increased fractionally to -13% against the target of -5.33%. The Trust reported an in-month deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan year-to-date (YTD), the Trust cannot access the national element of the deficit support funding.

Strategic Planning Framework: 2025-26

NHS Salisbury NHS Foundation Trust

Vision

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

People working for us

Population our patients and their families

Partnerships working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing health inequalities
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 12-24 months

- Reducing pressure injury
- Reducing patients' wait time to first outpatient appointment
- Reducing staff unavailability
- Creating value for our patients

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

Salisbury NHS Foundation Trust

Our Priorities

People

Population

Partnerships

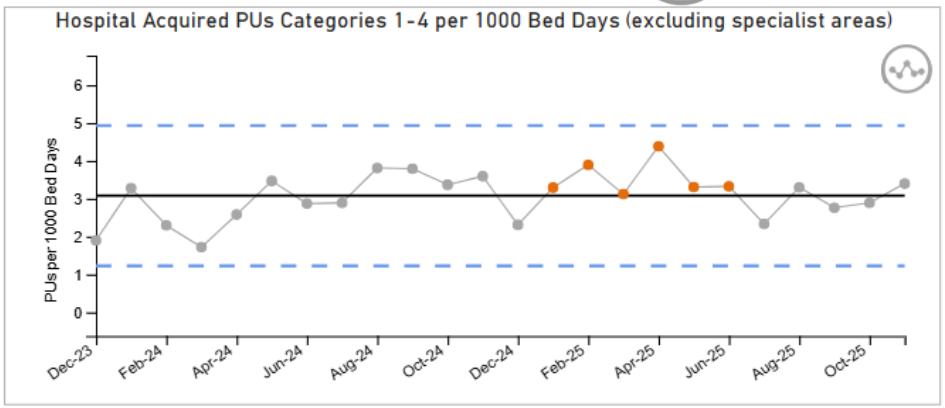
Reducing Pressure Injury

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 3.08 (November 2025)**	The prevention of pressure ulcers remains a clinical priority across healthcare settings due to their impact on patient wellbeing and healthcare resources. Pressure ulcers are listed among NHS England's top 10 harms and among the top harms reported at SFT. Pressure ulcers have significant implications for patients and healthcare providers in terms of mobility, pain management, infections, wellbeing and financial pressures. It is recognised that each pressure ulcer extends a patient length of stay by approximately 5 to 10 days. The Trust is committed to implementing the National pressure ulcer prevention and management strategy, allowing for review of local systems, processes, and pathways to reduce pressure ulcer incidence.

Target: 1.5 Performance: 3.4 Position: Common Cause



Understanding the Performance

In November, the total number of Pressure Ulcers (PUs) increased from 25 to 31 which equates to an increase from 2.9 to 3.4 per 1,000 occupied bed days (OBDs), against a baseline of 3.08 and a target of 1.5 per 1,000 OBDs.

The increase is largely attributable to a rise in category 3 PUs with a recognised contributory factor of patients being moved between wards more than once.

This performance relates to inpatient areas, excluding specialist areas of Spinal and Hospice which are recorded separately as a watch metric.

Moisture Associated Skin Damage (MASD) is also monitored as a watch metric.

Countermeasure Actions

	Due Date
• The Tissue Viability (TV) team identified key areas to focus on and set up a working group to look at data collection as a starting point. The aim is to have PU data in one place which is easily accessible for all appropriate staff to measure against their own performance.	Jan 2026
• The Trust participated in worldwide 'Stop the Pressure Ulcer' week and took the 'Red Bed' around the Hospital using visual pressure mapping equipment to demonstrate how quickly injury occurs. A training video will be produced for wider viewing.	Mar 2026
• Improving Together A3 is in development, with the counter measures and root cause analysis available next month.	Jan 2026

Risks and Mitigations

- Nursing and Midwifery forum - Staff have been advised to reduce the usage of procedure pads for managing patient incontinence (a risk factor for skin/pressure injury) as they have minimal wicking abilities and continue to use the available continence products.
- Increase of staff sickness absence.
- Increased waits in ED and bed occupancy raises the risks of pressure ulcers occurring.

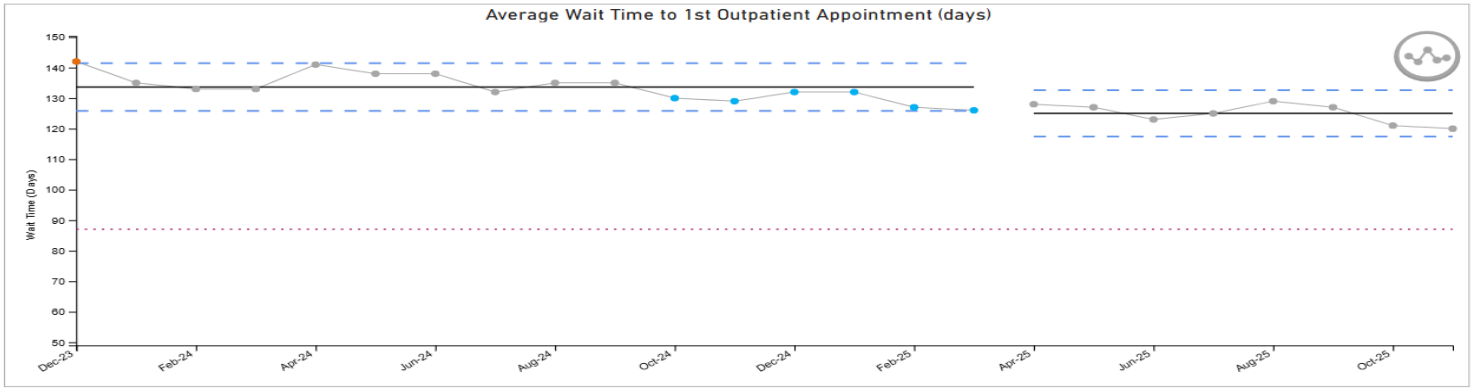
Reducing Patients' Time to First Outpatient Appointment

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: 120 days Position: Common Cause



Understanding the Performance

Time to First Outpatient Appointment (TT1OPA) shows a decrease from last month of 1 day, down to 120 and lowest point since measuring.

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

- Rheumatology - 160 (decrease 5 days)
- Gynaecology - 154 (increase 4)
- Respiratory - 151 (increase 2)
- Trauma and Orthopaedics - 143 (decrease 4)

All have seen a relatively static Referral to Treatment (RTT) waiting list size compared to last month. However, the number of patients waiting over 52 weeks fluctuated, with increases seen in Gynaecology, Respiratory and T&O, whereas Rheumatology saw a decrease.

Countermeasure Actions	Due Date
• Rheumatology, Respiratory and T&O continue to be part of the focused specialties within Outpatient Operational Group (OOG). Gynaecology will be part of Phase 3 (Jan to Mar 2026) alongside Cardiology and ENT.	Mar 2026
• Central Booking have continued with their RTT focus weeks and this has now become BAU from Jan 2026 onwards.	Jan 2026

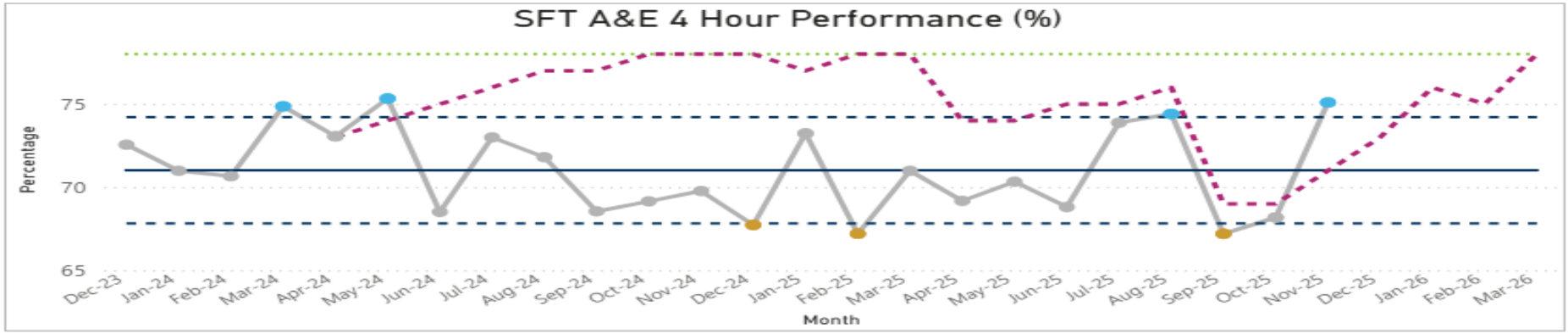
Risks and Mitigations

- Continued risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties. Mitigation: The programme strategy includes monitoring and specific focus on top contributing areas.
- Staffing levels within Central Booking remain challenged due to vacancies and sickness. Continuing to explore overtime options and cross-team working as opposed to just cross-portfolio working as mitigating support.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 75.1% Position: Special Cause Improvement



Month	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Proportion of patients spending more than 12 hours in an emergency department	7.1	7.8	10.5	8.7	8.9	9.1	6.6	4.8	5.3	10.9	11.4	8.1

Understanding the Performance

The Emergency Department (ED) performance continues to demonstrate positive momentum, with overall 4-hour performance of 75.1% in month against the national target of 78% and trajectory target of 71%. Type 1 attendances specifically achieved 62.4%. This represents special cause improvement above the trajectory target, underpinned by 45% of patients being seen by a clinician within 60 minutes, a key driver of enhanced flow and reduced breaches.

The Trust is seeing sustained improvement despite stable attendance volumes, highlighting the effectiveness of operational changes as a result of the introduction of the Clinical Decision Unit, additional AMU consultant cover, 7 day a week SDEC, introduction of send away clinic for minor patients and new ED medical rota to match demand. All of which are supporting delivery of the 4-hour standard. Further improvements are anticipated as the Trust aims to deliver further flow improvements.

Countermeasure Actions	Due Date
• UTC programme of works continues through board, clinical and operational working groups.	April 2026
• Twice daily huddles continue to have a positive impact on patient flow and create problem-solving opportunities with good engagement from assessment areas.	Dec 2025
• Expanded Early Supported Discharge service goes live in December, anticipated this will support reducing NC2R and support flow improvements.	Dec 2025
• MADE Event being launched in December to support trying to improve flow new ways of working including through front-door integration, triage, and streaming in line with SWAST pathways	Dec 2025

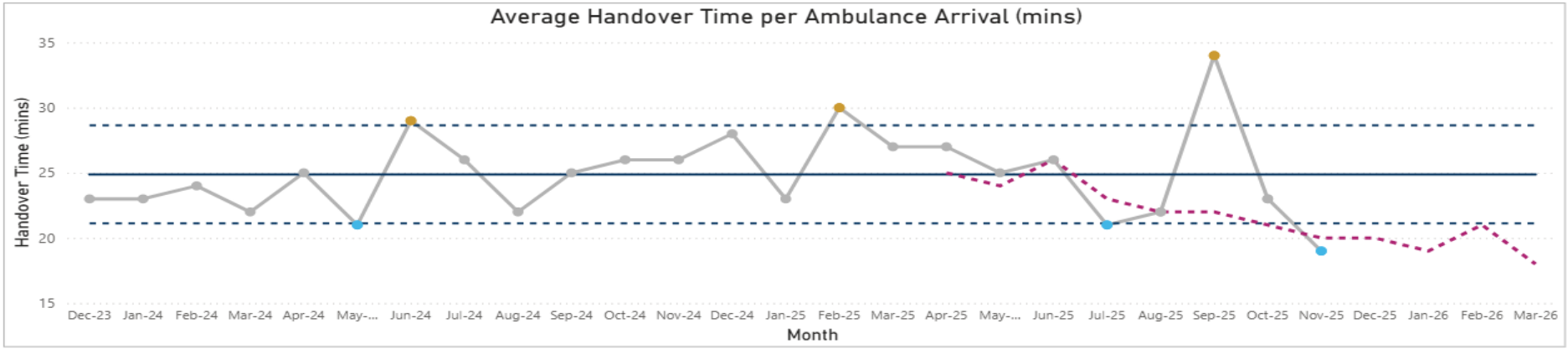
Risks and Mitigations

- During December 25 there is an anticipated spike in flu cases nationally. This is anticipated to have an impact on flow.
- Further industrial action has been declared by the BMA for resident doctors. This is will impact on the normal running of the hospital. This also impacts on the Trusts leadership time to undertake improvement.
- The Trusts flow is heavily impacted on urgent care demand and community supported discharges. Whilst improvement work is in place, there is a risk that this might not deliver as planned.

Ambulance Handover Delays

Salisbury NHS Foundation Trust

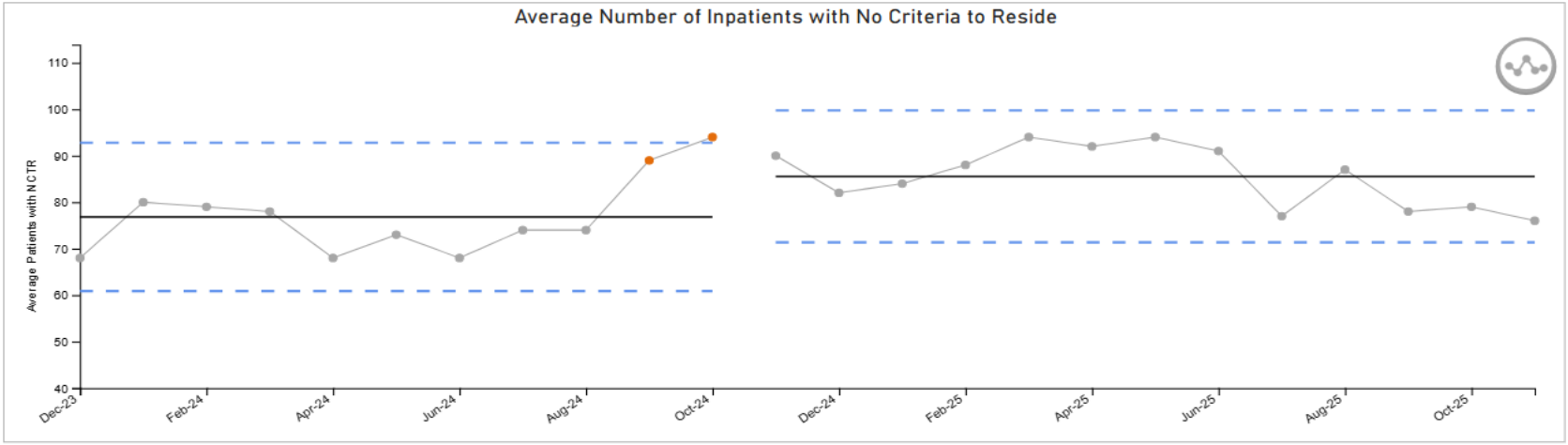
Target: <24 mins Performance: 19 mins Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Ambulance handover performance in M8 achieved 19 minutes which represents special cause improvement as well as delivery of the target trajectory. Except for a variance in September, the performance in ambulance handover continues a consistent downward trajectory in line with the target, underscoring the effectiveness of operational interventions. The enforcement of W45 - policy whereby handover does not exceed 45 minutes - has proven to be a critical lever in driving compliance and accelerating progress, though this has necessitated trade-offs in patient experience, with escalation and corridor care remaining a persistent feature of service delivery. Notably, the Clinical Decision Unit (CDU) has emerged as a key enabler of strategic capacity management in M8, releasing acute assessment space and strengthening offload capability. Industrial action during the month aided flow across the organisation, releasing pressure on the Emergency Department. The team have continued to utilise the ECIST RATT model to deliver rapid handover and have worked to maintain flow through this area despite escalation elsewhere in the department.	• CDU inclusion and exclusion criteria are under review, with proposed expansion to speciality-referred patients meeting pathway requirements. This will optimise CDU utilisation, release acute assessment space, and strengthen offload capacity. • A review is underway into the measurement of 'time to first assessment' in the Emergency Department. This covers both time to streaming for self-presenting patients and the documented 'time to first clinician' contact for those arriving by ambulance. Inconsistencies in documentation practices may risk inaccurately capturing performance times. Addressing this will be key to ensuring accurate monitoring and meaningful service improvement.	Dec 2025 Jan 2026	• The recent escalations to OPEL 4 status and the proximity to critical incident thresholds has necessitated a recalibration of departmental priorities, with strategic reconfiguration initiatives temporarily deferred to maintain operational stability. Current focus remains firmly on demand and capacity management, ensuring resilience in frontline delivery while safeguarding patient safety. This measured approach reflects a commitment to executing any future internal moves at a time that optimises service continuity and mitigates undue pressure on staff, thereby balancing immediate operational imperatives with longer-term transformation objectives.

Optimising Beds

Target: ≤25 (5%) Performance: 76 Position: Common Cause



Understanding the Performance

The November position continues to show that the Trust is holding the improvements delivered since the summer where there are circa 20 less No Criteria to Reside (NCTR) patients. This is supporting improvements in:

- Patients in pathway 1 have reduced in delayed Length of Stay (LoS) from 9.7 days in October to 7.8 days in November. This supports the work ongoing in Discharge Assessment and Action (DANA) - now BAU - and expanded Early Supported Discharge (ESD) services.
- Pathway 2 performance has dropped and seen an increase in bed days from 11.7 Days in October to 20 days in November. This has been recognised system-wide as a point of pressure. Commissioning conversations are continuing to review the P2 bed availability.
- Pathway 3 performance has increased from October. The delayed LoS has dropped by nearly 3 days (26.5 days in October to 24.6 days in November).

The countermeasures and actions are supported by the system recovery plan to bring NCTR back to 9% of bed base.

Countermeasure Actions	Due Date
• Focus on progress against NCTR trajectories within the system. Data still being worked through with ICB.	Dec 2025
• Redesign of Wiltshire Flow Hub (where duplication has been seen).	Dec 2025
• Expansion of ESD team to support delivery of 48-hour target for Pathway 1 discharges - funded by the ICB until end of Q4.	Mar 2026
• ICB led 'Home is Best' programme focused on redesign in Wiltshire to reduce NCTR Pathway 1 delays and length of stay.	Dec 2025
• Review of the Wiltshire P2 bed care home beds.	Dec 2025
• Reduction of length of stay within SFT and early discharge - Ward processes working group in place.	Mar 2026

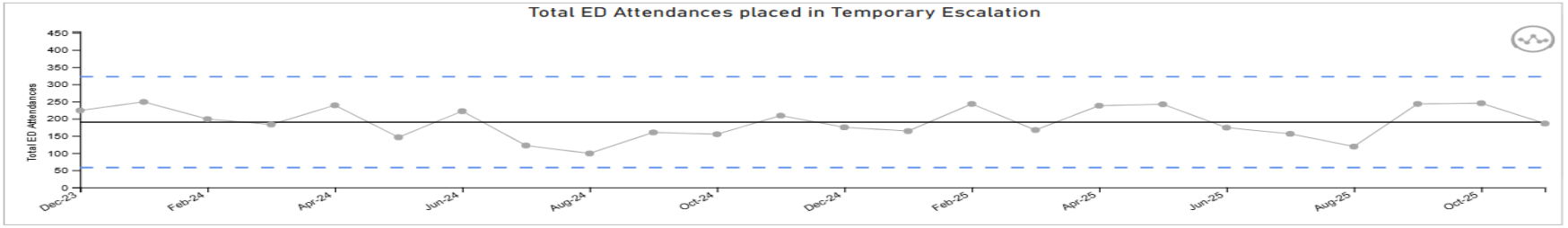
Risks and Mitigations

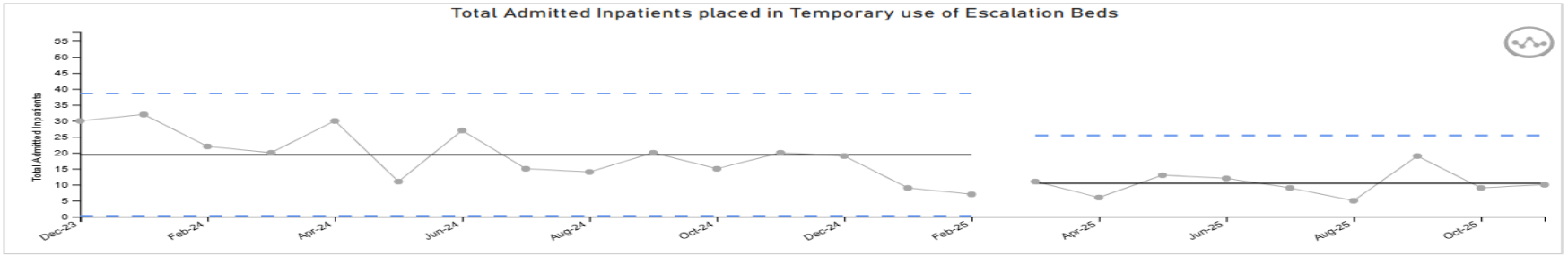
- Inability of the system to meet the NCTR trajectories for discharge. HCRG (Community Services Provider) changes to Hospital at Home (H@H) proposals which caused a pause to the project.
- External conflicts such as reduction in capacity in local authority social care teams and financial constraints.
- Changes to community models could be a risk.
- Clinical capacity and demand conflicts.
- Continued increased in ED and Non-elective admissions increasing NCTR demand.
- Seasonal respiratory virus peaks in demand.
- BMA Industrial action and inability to control when this will happen.

Use of Temporary Escalation Beds & ED Escalation

Salisbury NHS Foundation Trust

Target: 0 Performance: 186 Position: Common Cause





Understanding the Performance

ED escalation saw 186 patients in M8 from a total of 243 in M7, which demonstrates a reduction in month, however, remains consistent with the mean of 189 and therefore common cause variation.

The ED corridor (or Escalation 2) has been utilised for the third consecutive month following the enforcement of W45. Despite the increased flexibility to flow in and out of these additional escalation spaces, the performance this month demonstrates a sustained picture.

Temporary escalation beds have remained in use throughout M8 and the period of industrial action, which provided additional flexibility during this period, but the overall average has not reduced.

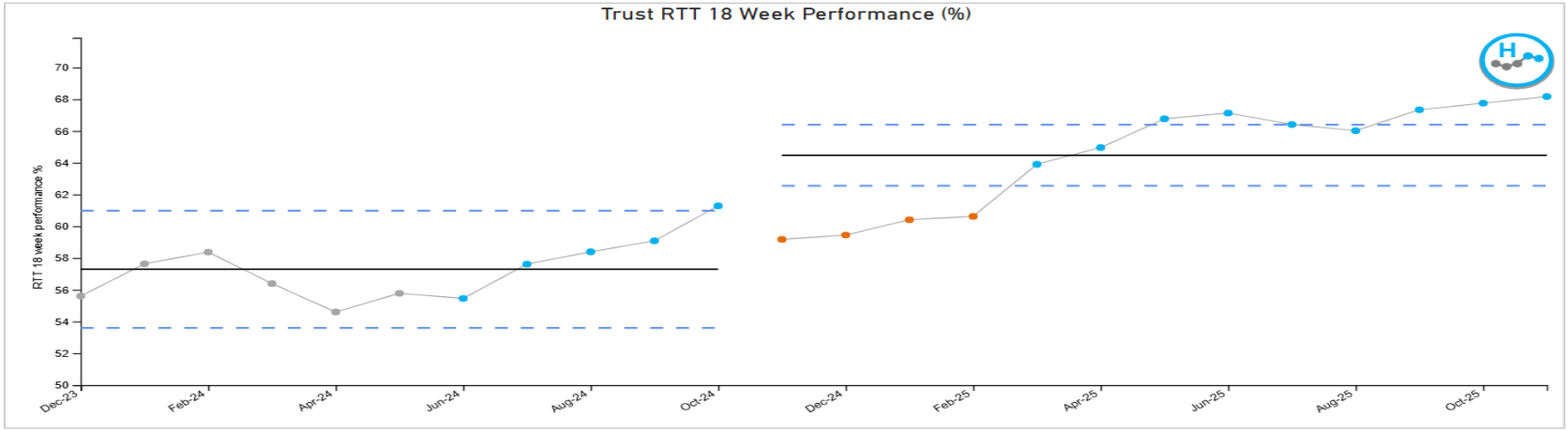
Countermeasure Actions	Due Date
• Review of the efficiency of Clinical Decision unit (CDU) remains ongoing, it attempts to release acute assessment space within the department.	Dec 2025
• Explore sustainable alternatives to ED escalation care and reliance on temporary escalation beds, with quarterly review.	Dec 2025

Risks and Mitigations

- The use of ED corridor care in addition to Trust-wide escalation spaces continues to pose risk to patients, due to the persistent overcrowding, limited visibility, and lack of appropriate clinical facilities in these areas. Patients cared for in corridors often experience delayed assessments, reduced monitoring, and compromised privacy, which can lead to missed signs of deterioration and increased anxiety. The environment is not designed for safe care delivery, meaning vital equipment and infection control measures are harder to maintain, further heightening the risk. This practice, while a response to system pressures, undermines both patient safety and dignity, and highlights the urgent need for more sustainable solutions to address capacity challenges across the Trust.

Elective Referral to Treatment

Target: ≥61% Performance: 68.2% Position: Special Cause Improvement



Balancing Metric	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Longest waiting patient	74	78	71	74	78	64	64	68	71	76	80	84	89	93

Understanding the Performance

Referral to Treatment (RTT) performance continued improvement, rising to 68.2% and its highest point since May 2022. Performance exceeds the plan of 63.5% and improvement aligns with the reduction in time to first outpatient appointment.

Highlight specialties with performance above the plan:
- Urology - 83.3%
- Ophthalmology - 75%
- General Surgery - 68.6%

The number of patients waiting more than 52 weeks increased to 170 although this accounts for only 0.58% of the total RTT waiting list - against March 2026 target of 1% - which also increased to 29,203 patients.

The number of patients waiting more than 65 weeks remained static at 2 due to ongoing consultant sickness.

Countermeasure Actions	Due Date
• Waiting list validation using direct contact with patients via Patient Led Validation (PLV) software planning to go-live in January to ensure accuracy of RTT waiting list and to ensure patients are waiting well.	Jan 2026
• Continued improvement and focus on the time to first outpatient work is driving further improvements in RTT.	April 2026
• Targeted RTT training being planned for 2026 Clinical Governance sessions.	Jan 2026
• Existing digital software for waiting list management (CCS) is being enhanced and expanded to improve the process overall.	Jan 2026

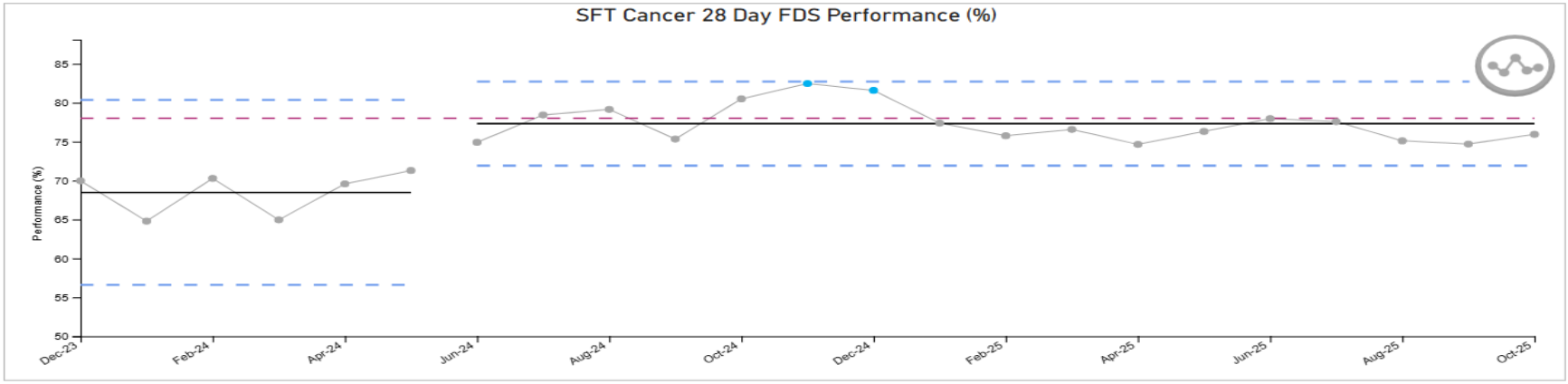
Risks and Mitigations

- Industrial Action will present a risk to all elements of the RTT waiting list.
- 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

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 76.0% Position: Common Cause



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

Understanding the Performance

28-day performance standard not achieved for M7, with month-end reported position of 76.0% (improvement from 73.9%).

Specialties not delivering the standard in month include:

- Lower GI - 56.9% (from 48.6%)
- Haematology - 38.5% (from 38.5%)
- Lung - 62.5% (from 75.9%)
- Non-Site Specific (NSS) - 40% (from 26.2%)
- Upper GI - 67.7% (from 68.5%)
- Urology - 61.5% (from 56.7%)

Breaches are driven by patient choice, insufficient diagnostic capacity and pathway complexity. Bowel Cancer Screening Colonoscopy capacity across BSW and associated patient choice remain a factor.
Operating capacity and differential diagnosis post-histology are drivers for Skin position whilst the backlog is cleared. There remains an ongoing risk to performance through M8 as a result.

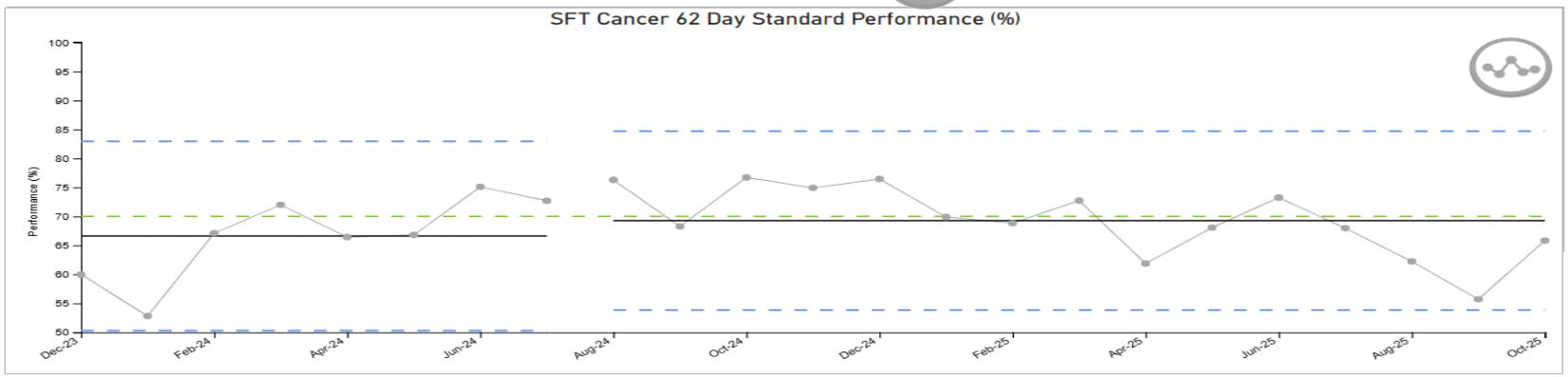
Countermeasure Actions	Due Date
• Implementation of insourcing agreement to support Skin first appointment and theatre capacity over M7 to support clearance of backlog. Additional theatre lists and clinics established across remainder of the financial year to maintain capacity.	Nov 2025
• Faster diagnosis touchpoint meetings in place, which includes specific focus on increasing template biopsy capacity to support waiting times within Urology.	Jan 2026
• Automation of processes via Blueprism software has now commenced in pilot sites, which alongside procurement of SCR modules will support efficiency within MDT function. FDP Cancer 360 PTL management tool to be in place from M10 onwards. Revisions made to existing PTL process to support easier identification of next steps within divisional teams. Escalation protocol under review with action plan collation based on recommendations of external review.	Jan 2026

Risks and Mitigations

- High referral volume across all pathways has significantly impacted capacity, particularly within skin. Insourcing in place, with daily huddles with booking teams to ensure patients are identified and actioned in a timely manner.
- Resource within MDT cancer services remains high risk, resulting in increased cross-cover and therefore detrimental impact on tracking and escalation of delays. Further gap anticipated within Breast services; service has not been at full establishment for >12 months.
- Impact of Industrial Action anticipated on waiting times for Urology biopsy. Demand and capacity modelling to be undertaken to reduce waiting time in template biopsy to 9 days as per best practice.

Cancer 62 Day Standard

Target: ≥70% Performance: 65.8% Position: Common Cause



Patients waiting over 62 days for treatment	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
	78	68	55	84	84	69	66	70	85	82	98	131	214	230

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

Understanding the Performance

Improvement in 62-day performance in M7, with submitted position of 65.8%. A total of 180 patients were treated against the standard with 61.5 patients breaching.

Specialties not delivering the standard in month include:

- Lower GI - 57.5% (8.5 of 20)
- Gynaecology - 57.9% (4 of 9.5)
- Haematology - 46.2% (7 of 13)
- Skin - 50% (13.5 of 27)
- Urology - 71.4% (17 of 59.5)

Breach reasons include complex diagnostic pathways, clinical delays, insufficient diagnostic, oncology and theatre capacity (including impact of Aseptics), as well as patient choice and engagement. Deterioration in performance anticipated over M8 whilst clearing waiting list backlog.

Countermeasure Actions	Due Date
• External review conducted in to existing PTL processes; positive feedback received, though recommendations are being collated into an action plan to support improve ownership of cancer within Divisions.	Nov 2025
• Revisions to existing process standard working to be supported by SWAG cancer alliance alongside clarification of roles and responsibilities.	Dec 2025
• Facilitation of FDP Cancer 360 PTL management tool in conjunction with BSW.	Jan 2026
• Confirmation that the Trust will enter NHS England 'tiering' because of deterioration in performance.	Dec 2025

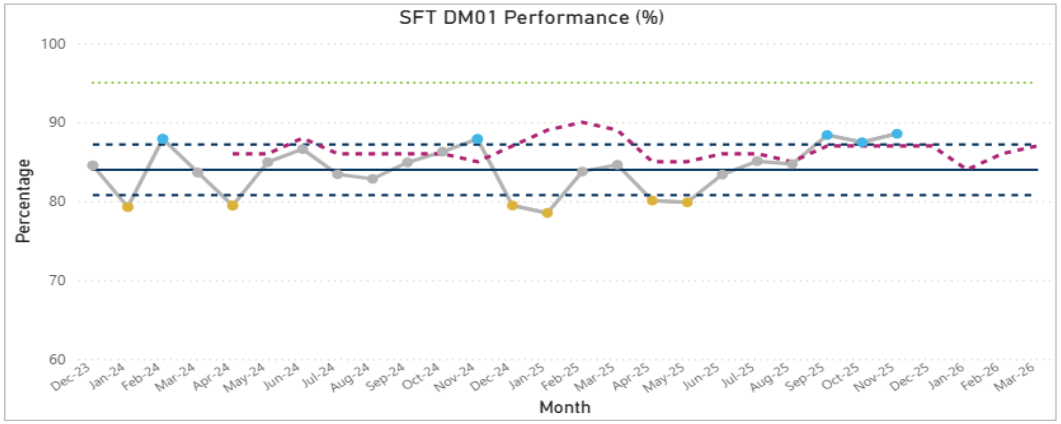
Risks and Mitigations

- Resource within MDT cancer services remains high risk, resulting in increased cross-cover and therefore detrimental impact on tracking and escalation of delays. Further gap anticipated within Breast services; service has not been at full establishment for >12 months.
- Variable ownership of cancer pathways within Divisional teams; action plan to be collated from external review to agree next steps. Session held with divisional teams in relation to roles and responsibilities.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 88.5% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	82.1%	168	Dexa	100%	0	Colonoscopy	83.8%	41	Urodynamics	58.7%	31
CT	81.1%	115	Neurophysiology	100%	0	Gastroscopy	83.6%	51	Cystoscopy	96.2%	2
Ultrasound	98.5%	22	Echo	90.2%	25	Flexi Sigmoid	86.9%	8	Audiology	79.9%	113

Understanding the Performance

Performance against the 6-week standard increased in month to 88.5% from 87.5% last month and 1.25% above the plan position.

Modalities **below plan** are:

- MRI - 82.1% (plan of 84.7%)
- Audiology - 79.9% (plan of 85%)
- CT - 81.1% (plan of 93.1%)
- Cystoscopy - 96.2% (plan of 98.3%)
- Urodynamics - 58.7% (plan 75%)

Ultrasound has maintained a strong position for November and is driving the overall DM01 improvement. Urodynamics continue to be challenged, the variance is more extreme this month due to a planned increase in the M9 performance trajectory. Cystoscopy, although behind plan, have seen an improved performance from 83.75% to 96.2% due to additional weekend capacity. Extensive work is underway to improve Echo performance with CDC and CIU capacity expanded. New reporting is in place for individual Echo modalities and Respiratory will soon be added to reporting to ensure all tests are captured in the data.

Countermeasure Actions	Due Date
• Discussion with Nuffield re outsourcing for Cardiac CT, long term business case being written to include an additional (3rd) CTCA list at SFT.	Dec 2025
• Insourcing continues in all imaging modalities with quarterly review.	Mar 2026
• Urodynamics - Referral pathway to be reviewed and redesign of referral pro-forma. CNS lists to be stood up in December. Functional Reconstructive and Neuro-urology Consultant Business case approved and awaiting recruitment.	Dec 2025
• Continued focus on Audiology administration processes and digital optimisation.	Dec 2025

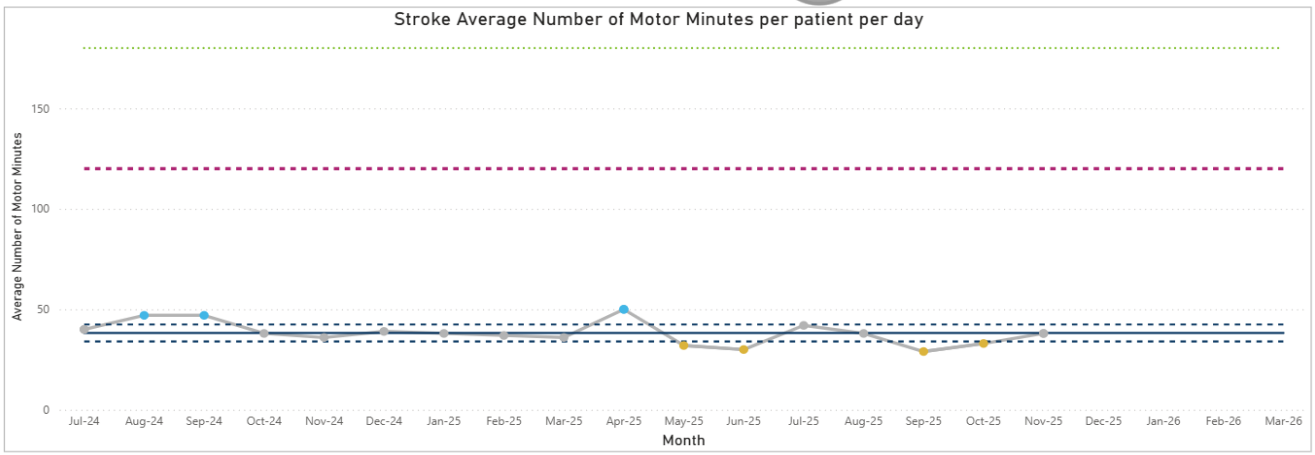
Risks and Mitigations

- Weekly delivery group tracking performance across all modalities.
- Capacity remains reliant on in house overtime / bank to meet demand for Radiology.
- Specialist Audiology capacity to include some weekend working and locum extension.
- Urodynamics - Intensive support to urodynamics booking team and CNS led lists to commence December.
- Tracking Ultrasound performance as DM01 total performance is reliant on maintaining a strong position.

Stroke Care

Salisbury NHS Foundation Trust

Target: ≥180 mins Performance: 38 mins Position: Common Cause



	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2024/25 Q2	2025/26 Q3
SSNAP score	C	C	C	C	D	E	E	E

Understanding the Performance

In M8, provision of motor minutes for patients on the Stroke pathway was 38 minutes which represents common cause variation, although is an improvement of 4 minutes from M7. This is against a target of 180 minutes which is set nationally.

Slight improvement has been challenged by a gap of 4.74 WTE in the therapy team against the required level to meet the target. The reduction in motor minute performance has subsequently resulted in the Trust's SSNAP score declining from D to E in the last quarter. The performance reduction matches a national reduction as refreshed metrics have been published.

4-hour stroke performance declined to 46% in M8 compared to 60% in M7. Largely due to the ward being in escalation. The Specialty along with the Medicine Division are currently refreshing the A3 and mitigations.

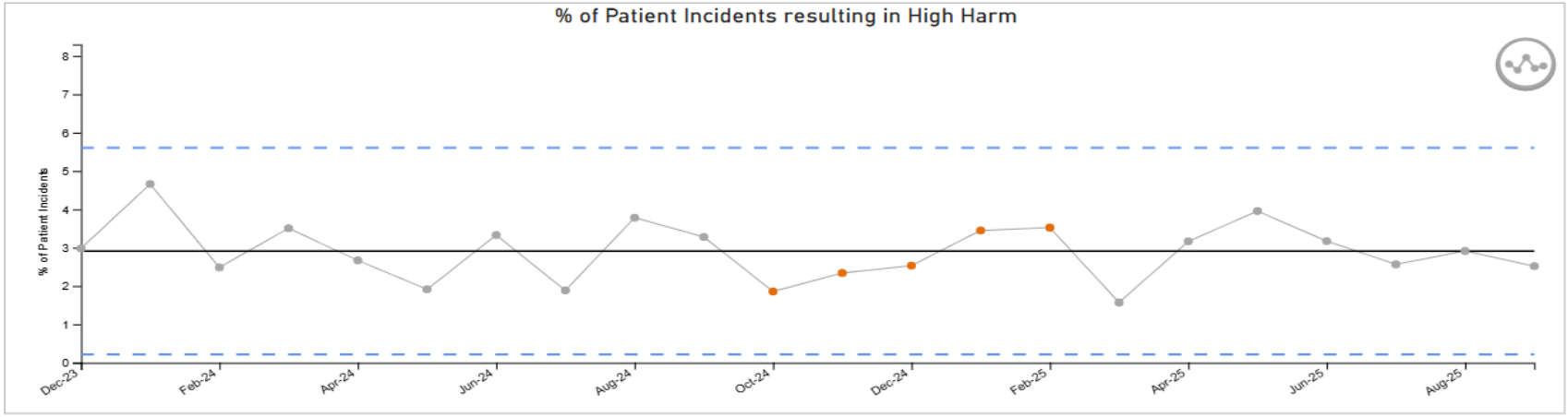
Countermeasure Actions	Due Date
• An A3 review is being be undertaken to encompass workforce and technology requirements within the Stroke Unit and understand the drivers of current performance.	Mar 2026
• To arrange 'Go and See' to other comparable Stroke Units to increase shared learning and practices.	Feb 2026
• MDT Stroke Study day to be arranged to include all new SNAPP targets and thrombolysis.	Feb 2026
• Development of Stroke dashboard ongoing, to capture performance in real time and therefore give opportunity to recognise where performance is being impacted, to enable earlier interception.	Dec 2025

Countermeasure Actions

- Key development areas include addressing workforce gaps in Therapy and Psychology to boost Motor Minutes and SSNAP scores. Workforce focus will remain a priority in the Business Service review.
- Winter pressures, especially out-of-hours and consistently being in escalation may affect timely stroke referrals and CT scanning, impacting Stroke target achievement. Ongoing review of stroke bleep holder redeployment.
- CT Perfusion Radiologists recruitment is ongoing with FASS and once established will enhance diagnostic imaging.

Incidents

Target: ≤2.5% Performance: 2.5% Position: Common Cause

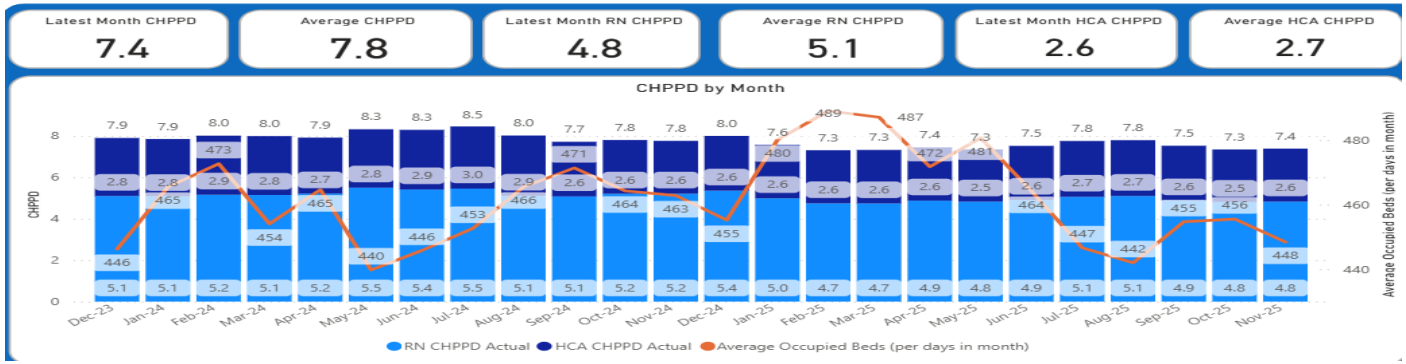


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
In September, a total of 996 incidents were reported, representing an increase of 39 incidents compared to the previous month, with 2.3% resulting in moderate or above harm. Of the 996 incidents reported in September, 816 were related to patient safety. Within this subset, 17 were reported as causing moderate harm, 1 major incident and 2 catastrophic incidents. There were 0 patient safety incidents that resulted in a patient safety incident investigation (PSII). Total number of patient safety incidents across the clinical divisions: • Medicine - 397 (318 no harm, 77 minor, 1 major, 1 catastrophic). • Surgery - 223 (174 no harm, 47 minor, 2 moderates). • FASS - 173 (129 no harm, 37 minor, 6 mod, 1 catastrophic).	The primary themes associated with reported harm in September were in relation to infection control and Maternity related incidents, therefore: • A Post Infection Review (PIR) to be carried out and reviewed at the infection, prevention and control working group. • Maternity team to undertake Patient Safety Reviews (PSR) and present at the weekly Patient Safety Summit following an MDT review and identification of appropriate learning and relevant actions.	Nov 2025 Oct 2025	During the month of September, the patient Safety Summit (PSS) addressed the following: • A total of 26 Patient Safety Reviews (PSR) were conducted with 17 cases closed with assurance and 2 cases requiring further review (mitigation). • All clinical incidents are reviewed at the morning huddle (mitigation).

Care Hours per Patient per Day (CHPPD)

NHS Salisbury NHS Foundation Trust

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



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

Understanding the Performance

CHPPD for November is 7.4 and a slight increase compared to last month as shown in the chart above. This is a direct result of less patients in admitted beds at midnight and more shifts filled.

RMN usage this month has increased significantly with 1477.3 registered hours provided over the month (161 at bank and the remaining 1316.3 hours from agency). There were also 103.5 RMN hours which were not filled.

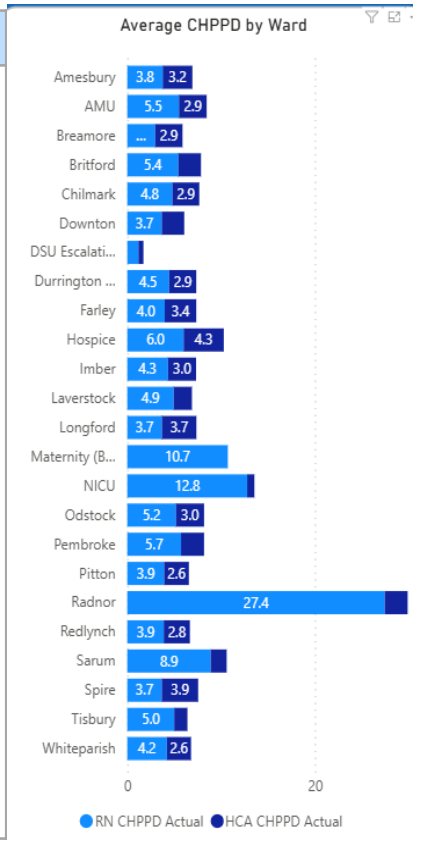
HCAs providing enhanced therapeutic observations and care (ETOC) have increased significantly also - a jump from 242 hours last month up to 1,067 hours in November. There were also 201 unfilled hours of requests for HCA 1:1 care. The increase has been due to a rise in the number of patients with specific needs which require enhanced support. There were also a substantial amount of security hours used to further support patients and staff.

There were no shifts above agency cap in November.

Countermeasure Actions	Due Date
• Additional 1:1 shifts requiring RMN or HCA can only be created by Matrons and above to ensure appropriate levels of restrictive practice, with quarterly process review.	Dec 2025
• All inpatient wards, including ICU and ED, now require Deputy Divisional Director of Nursing second-level approval for bank shifts to ensure all factors are considered before requesting temporary staff, with quarterly process review.	Dec 2025

Risks and Mitigations

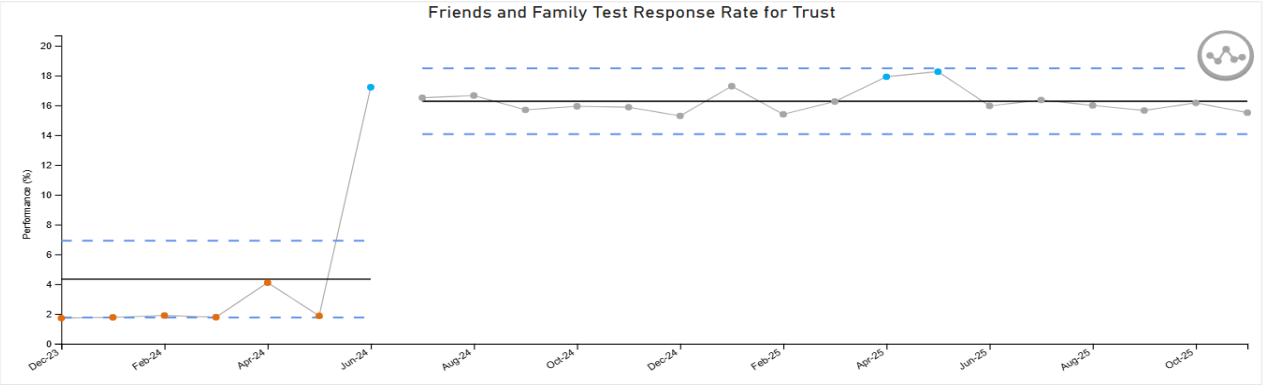
- Continued use of agency RMNs remains a financial pressure. SFT is part of NHSE's ETOC Collaborative, with an internal working group launching its first meeting later this month. The collaborative will include an NHSE site visit and a review of all policies and processes.
- HCA vacancy remain but are mitigated by the over templated numbers of RNs.
- Sickness rates remain high across most wards, with multiple daily absence calls. Increased scrutiny of backfilling shifts is ongoing, mitigated by using supernumerary and supervisory staff. This will impact completion of some managerial tasks and reduce practice educator availability.



Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥18% Performance: 15.5% Position: Common Cause



Response Rate by Area	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
FFT Response Rate - A&E	21.7%	21.8%	20.0%	19.5%	21.1%	21.1%	20.2%	21.2%	20.3%	18.8%	22.2%	20.4%
FFT Response Rate - Day Case	10.1%	12.3%	9.6%	23.0%	17.0%	20.5%	14.3%	15.9%	13.9%	16.9%	18.3%	15.8%
FFT Response Rate - Inpatient	27.2%	30.2%	19.9%	34.6%	46.2%	39.3%	23.7%	30.2%	27.9%	24.5%	28.5%	21.9%
FFT Response Rate - Maternity	10.4%	10.3%	8.9%	3.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FFT Response Rate - Outpatient	14.5%	16.8%	15.4%	14.5%	15.5%	16.4%	15.3%	15.2%	15.0%	14.8%	14.9%	14.7%

Understanding the Performance

Our response rate in November was slightly decreased to 15.5% although with a slightly higher satisfaction rate of 95%. We fell ever so slightly short of our response rate target of 18% but met satisfaction rate target of 95%.

The top three themes for dissatisfaction are staff attitude, environment and waiting times. This data is reported to individual wards with an expectation that areas take these themes forward for improvements potentially as part of their Improving Together work. Reports are presented quarterly at divisional meetings ensuring senior management oversight.

It is to be noted that due to the BadgertNet upgrade we are still not surveying all Maternity patients until we have the data transferred correctly. Text messages can't be sent but manual feedback can still be captured although will be low numbers.

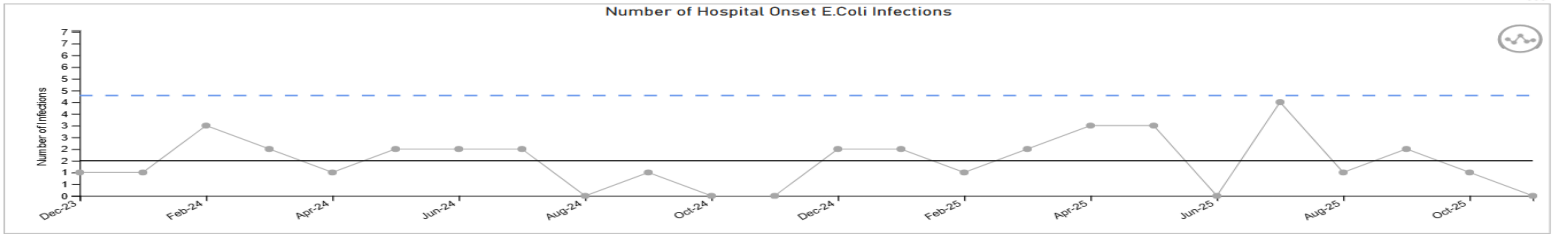
Countermeasure Actions	Due Date
• We understand that work has now commenced with Estates and that the FFT boards will be put up when they have capacity.	Mar 2026
• A new system will now need to be procured or provided internally as the currently company are ceasing their FFT product	Aug 2026
• Working with IT to resolve the issue with BadgerNet data to ensure we can capture feedback from all maternity patients.	Dec 2025

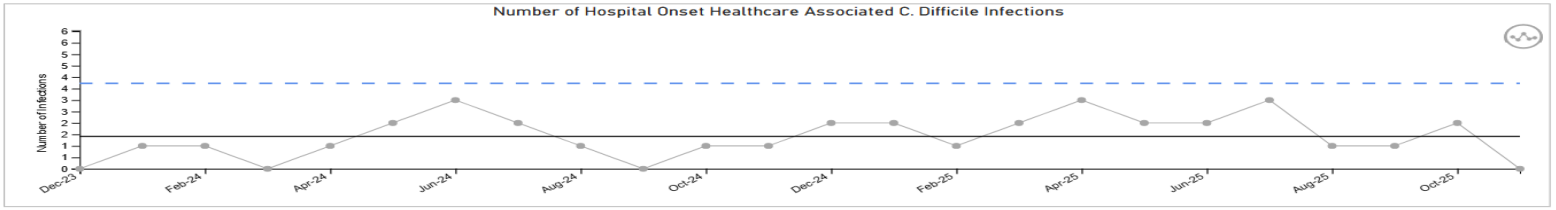
Risks and Mitigations

- Unfortunately, the future of our online system and gathering of feedback via SMS is currently being reviewed as we consider moving to a group wide process. We are still awaiting confirmation of our position moving forward given the company we are currently with (Envoy) will not be hosting an FFT platform past August 2026. Work is ongoing to ensure this risk is mitigated and replacement system sourced.

Infection Control

Target: 0 and 0 Performance: 0 and 0 Position: Common Cause





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

Understanding the Performance

There has been no Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bacteraemia infections, compared with one last month. For HOHA reportable *C.difficile* cases, there has been no cases, compared with two last month. For Community Onset Healthcare Associated (COHA) reportable *C.difficile* cases, there has been one case, compared with two last month.

For *Pseudomonas aeruginosa* bloodstream infections (BSIs) the Trust has exceeded the threshold level for HA cases. The threshold is set at 7 cases, with 13 reported to date. For *Klebsiella sp.* bloodstream infections (BSIs) the Trust has also exceeded the threshold level for HA cases. The threshold is set at 9 cases, with 10 reported to date.

The period of increased incidence (PII) of *C.difficile* declared for Spire Ward in October was retrospectively declared as an outbreak on 10.11.25 following review of ribotyping results.

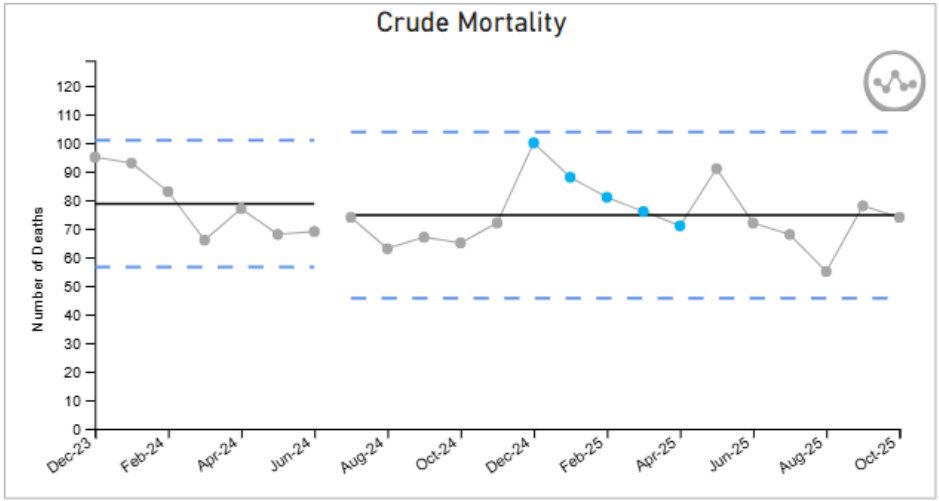
Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas / teams to identify good practice and any new learning continues with identified timeframes and quarterly review.	Dec 2025
• From reviews completed for *C.difficile,* lapses in care continue to be identified with ongoing themes. The divisions monitor those areas that have produced action plans and are required to provide updates to the IP&CWG, with quarterly process review.	Dec 2025
• Completion of Tendable inspections and specific IPC related audit work by the divisions, including commencement of peer auditing.	Dec 2025
• Review of IPC practice policies to further support staff.	

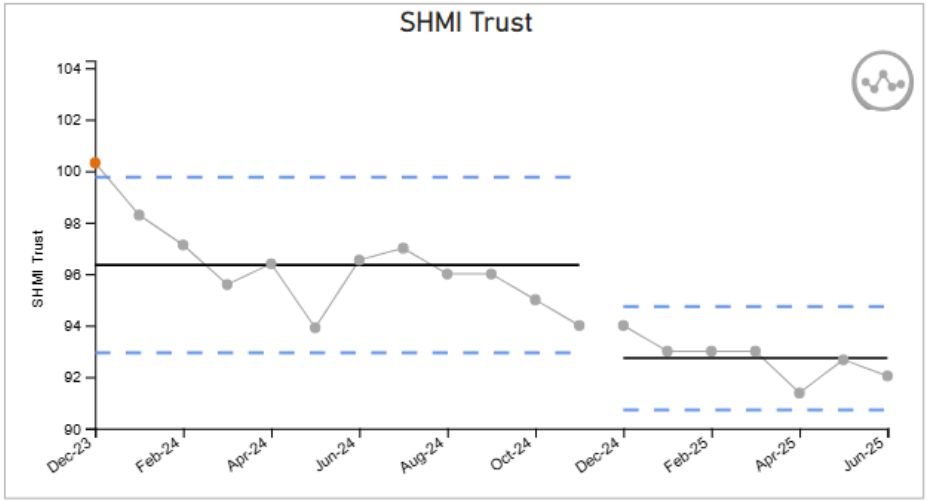
Risks and Mitigations

- Recruitment plan for Band 6 vacancy position has progressed, with the advert now authorised. Leave commitments and unexpected absence in November continues to impact IPC service provision.
- Underlying risk continues of potential increase in reportable HCAI with poor patient outcomes.
- Delays in completion of investigations and action plans by divisions to identify learning has impacted improvements in patient care outcomes.
- New WinPath system for results reporting (replacing T-Path system) continues to increase workload when processing alerts in a timely manner.
- Exceeding the NHS Standard Contract 2025/26 threshold levels set for SFT - currently for reportable *C.difficile*, the threshold is set at 21 HA cases, with 26 reported to date (14 HOHA and 12 COHA).

Mortality

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





Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in June 2025 is 0.9204 and remains statistically within the expected range. The Trust withdrew from their contract with Telstra Health U.K at the end of September 2025, and the Hospital Standardised Mortality Ratio (HSMR) is no longer being used by the Trust for monitoring mortality insights. Several improvements have been made to Trust mortality processes and reporting to mitigate any risks from the contract withdrawal, and a Power-Bi dashboard is being modified and updated to improve how mortality data is being reported across the Trust (see countermeasure actions).	• The online mortality system to support learning from deaths was launched in March last year, and activity has continued to be focused on improving reporting input / outputs from mortality reviews. • The Trust are working closely with mortality leads at RUH and GWH to improve how mortality data is being viewed and reported. Development work recently commenced to align our Power-Bi reporting across the 3 acutes. By using the same methodology, this will enable us to further improve our learning and understanding of the data.	Nov 2025 Dec 2025	• 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	161	33	15		0		Special Cause Improving - Below Lower Control Limit	X	60
Beds Occupied %	96.3%	97.0%	96.3%	96.0%	92%		Common Cause Variation	X	3
Cancer 31 Day Performance Overall	87.6%	82.4%	90.1%		96%		Common Cause Variation	X	5
Complaints Closed within agreed timescale %	50.0%	46.0%	39.0%	85.0%			Common Cause Variation	X	60
ED 12 Hour Breaches (Arrival to Departure)	541	557	384		0		Common Cause Variation	X	60
Inpatients Undergoing VTE Risk Assessment within 14hrs %	16.5%	17.9%	18.6%		95%		Special Cause Improving - Above Upper Control Limit	X	60
Mixed Sex Accommodation Breaches	13	12	6	0	0		Special Cause Improving - Below Lower Control Limit	X	60
NEWS2 Compliance with Escalations	50.2%	48.5%	51.7%	60.0%			Special Cause Improving - Above Upper Control Limit	X	60
Number of High Harm Falls in Hospital	3	5	1	0	0		Common Cause Variation	X	18
RTT Incomplete Pathways: Total 65 week waits	3	2	2	0	0		Special Cause Improving - Below Lower Control Limit	X	7
Stroke patients receiving a CT scan within one hour of arrival	53.0%	55.0%	46.0%		50%		Special Cause Concerning - Below Lower Control Limit	X	1
Total Incidents (All Grading) per 1000 Bed Days	69	67	68				Special Cause Concerning - Above Upper Control Limit		
Total Number of Complaints Received	19	22	32				Special Cause Concerning - Above Upper Control Limit		
Total Number of Compliments Received	38	11	28				Special Cause Concerning - Run Below Mean		
Total Patient Falls per 1000 Bed Days	6.84	8.72	7.93	7			Special Cause Concerning - Above Upper Control Limit	X	2

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Performance in the Emergency Department (ED) was incredibly strong in November as noted, with watch metrics of Ambulance Handovers more than 60 minutes continuing its reduction to 15 in month and alerting positively. The number of patients waiting more than 12 hours also improved again to 384 as service model changes implemented in month - a Clinical Decision Unit (CDU) to support flow - and one implemented in October - a Send-Away clinic for evening arrival minor injuries - contributed to significant performance positions.

Patient Falls reduced to 7.93 although remains alerting negatively as above the upper control limit. Whereas the number of High Harm falls reduced significantly to 1 in month.

Cancer 31-Day performance - reporting October data - despite remaining below national target aligned with overall service recovery, increasing to 90.1% as additional capacity in the high-volume Skin tumour site positively impacted.

Bed Occupancy remains higher than national and trajectory targets at 96.3% and some way higher than November 2024 when 92.3% was reported.

Countermeasure Actions

- Reducing Pressure Injury and Reducing Staff Unavailability have become Trust Breakthrough Objectives from November, replacing Managing Patient Deterioration and Staff Retention, respectively.
- Monitoring of ED service model changes to track if improvements seen in performance are directly influenced and if they can be sustained.
- Caffeine project commenced, falls care plan and postural hypotension education delivered throughout wards in October. Review contribution to November improvements and how to maintain.
- Early Supported Discharge (ESD) team expansion will support targeted patient discharges with the aim of ensuring beds are available for those who need it most in line with Right Patient, Right Place policy and potentially improving Bed Occupancy and No Criteria to Reside levels.

Risk and Mitigations

- Critical incident / staff shortages / Industrial Action result in some areas being unable to provide 1:1 supervision for patients who need it. Poor compliance with Baywatch and falls care plans.
- Continued high attendances into ED circa 4% more than last year present an ongoing challenge.
- Suspected Skin cancer referrals are 20% above levels seen last year - seasonal pattern suggests this will reduce over Q3, but reduction not yet being seen.
- ESD team expansion only funded by the ICB until the end of Q4 so potentially need financial succession plan if proposed benefits realised.

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	10795	10552	8865	8658			Special Cause Improving - Above Upper Control Limit	✓	0
ED Attendances	7006	6786	6822				Common Cause Variation		
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	58.3%	82.8%	83.7%				Special Cause Improving - Above Upper Control Limit		
RTT % of patients waiting less than 18 weeks for 1st Appointment	63.5%	65.3%	66.1%				Special Cause Improving - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	159	161	170	200	0		Special Cause Improving - Below Lower Control Limit	✓	0
Trust 30 day Emergency Readmission Rate	13.1%	11.5%	8.9%				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

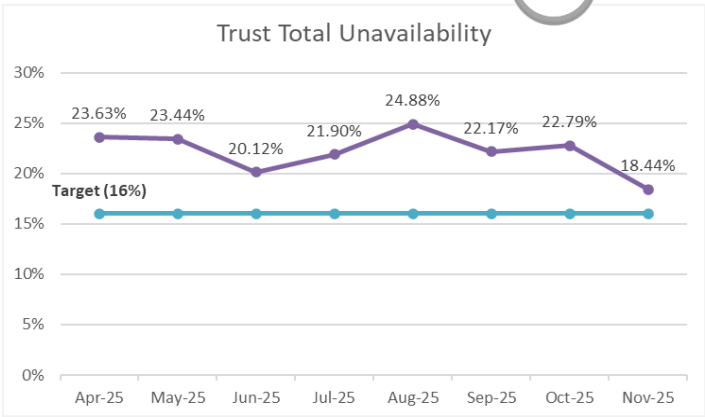
Reducing Staff Unavailability

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because…	Staff unavailability reduces the number of substantive staff able to safely deliver operational outputs, requiring unplanned use of Bank and Agency staff, as well as increased work for those staff who remain in work. This makes the workforce element of the budget unaffordable against plan, reduces performance attainment and increases the risk of poorer patient outcomes.
Baseline: 22.7% (November 2025)	Using an Improving Together A3 approach and measuring all types of leave, we are defining the areas of focus which will result in higher staffing availability and less reliance on temporary staff cover. This focus will deepen our understanding of our staffing picture across all professions.

Target: <16% Performance: 18.4% Position Common Cause



Understanding the Performance

Performance of 18.44% M8 (23.63% M1) continuing above the 16% target. Data is developing.

Temporary staffing YTD shows a variance of c£4.9M above plan, much of this variance is due to cover for staff unavailability. Highest contributor to Temporary staff spend is Medicine Division with £988,101 in month.

Staff turnover down to 12.17% from 12.38% in M7 against target of 12%. Corporate are the highest division at 13.54% and Medicine account for 136.1 WTE rolling 12 months by headcount.

Sickness rates reduced to 4% with highest division Surgery at 4.8% and highlight areas: GI Unit 7.23%, Plastics 6.96%, Surgery Management 6.9%, ICU 5%, General Surgery 5.1% and Theatres 4.92%.

Countermeasure Actions	Due Date
• Develop case study of well deployed team-based rostering.	Mar 2026
• Teams with high turnover identified work to triangulate with vacancy, temp staff usage and absence data.	Feb 2026
• Work to identify stratified data at divisional level to enable divisional support to the Breakthrough Objective (BTO).	Jan 2026

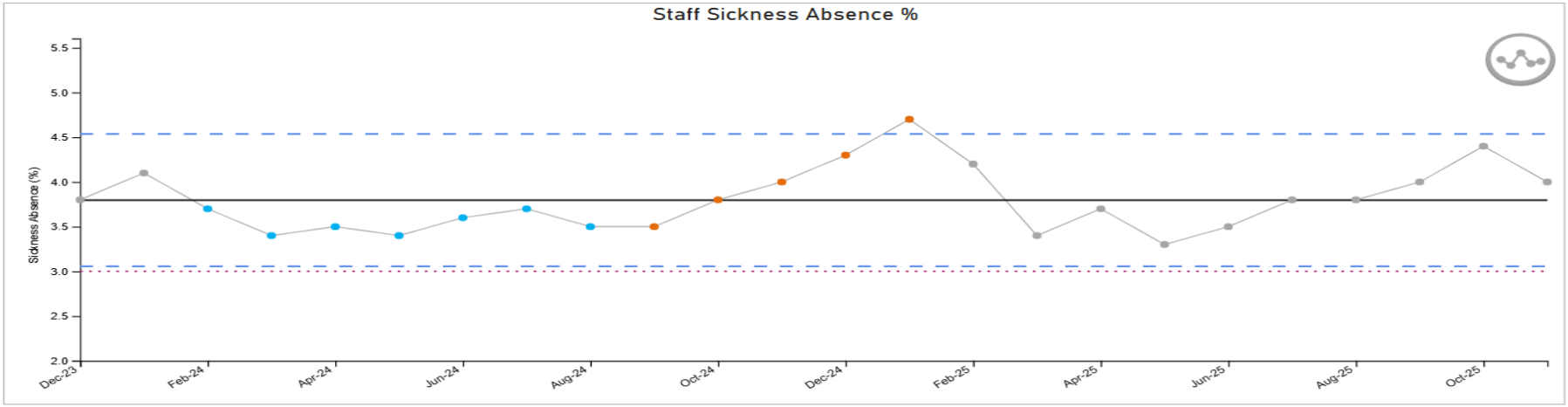
Risks and Mitigations

- An increase in national living wage from April 2026 will present further issues relating to the NHS salary awarded to Band 2 & 3 roles.
- Risks around high turnover in Corporate functions during period of redesign (and potentially lower job security).
- Operational issues of patient flow and acuity of patient condition both contribute to drive increased pressure on staff.
- This will now be the BTO tracked at the monthly Retention Steering Group.

Sickness Absence

NHS Salisbury NHS Foundation Trust

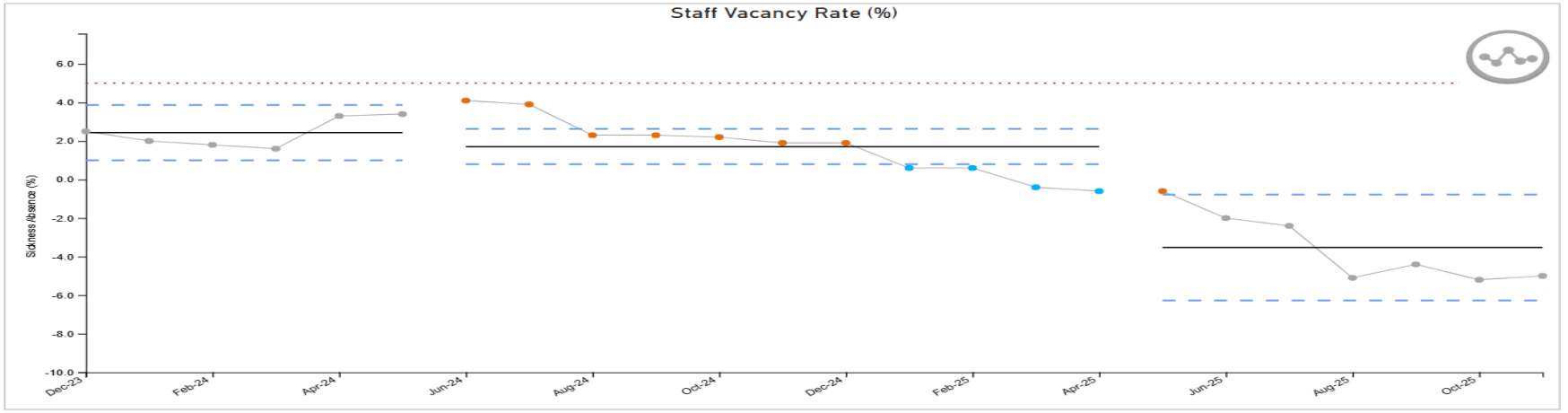
Target: ≤3% Performance: 4% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Absence has dropped to 4% (4.41% in October). This is the lowest since August. Surgery has the highest divisional absence of 4.82% (5.43% M7). Only Corporate division is below the 3% target. ACS are the highest by staff group at 6.34%. Only Medical and Dental and AHPs are below 3%. There were 930 occurrences (1170 M7). One employee has had 41 absences in 12 months, with 20 having 12 or more absences in 12 months. 5,000 WTE days taken in M8 (down 800+ from M7) with 1,307 WTE days due to anxiety / stress / depression & 863 WTE days due to cold / cough / flu. Regional absence average in Q1 is 4.5%.	• Delivery of bite size attendance management training by HR started w/c 08/12/2025. Sessions offered up until 24/12/2025. More sessions will be offered in January 2026.	Jan 2026	• Risk of inconsistency of policy application and attendance management processes due to range of management experience and training. • Risk of lack of availability of managers to attend training. • Limited number of HR advisors to support high demands of high-volume attendance cases. • Mitigation is via targeted approach to highest absence (individuals and teams) should provide most benefits to reducing overall absence levels. • Restorative approach to attendance management is hoped to enable higher attendance due to tailored support and reasonable adjustments.

Vacancies

Target: ≤5% Performance: -5% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Vacancy position continues to show a negative net figure and now -4.98% from -5.23% in M7. This is NET figure: SFT funded WTE is reducing each month to hit the year-end position as per workforce plan, however the contracted WTE remains higher than the funded hence the NET figure; this number is also including a figure set aside as 'In year management'. This potentially masks where actual vacancy numbers sit at department level. Based on the above however Nursing, Admin, Medical, ACS and AHP Staff Groups report Contracted WTE being above Funded WTE. M4 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 134 WTE M5 (240 WTE M4), a vacancy rate of 2.9%. Vacancy rate for South-West region is 5.5% in Q1.	• Proposed review of current vacancy control process after 3 months.	Jan 2026	• Recruitment pipeline is under external scrutiny from NHSE / Region / ICB. • New process being bedded in and resulting in longer approval timescales, this in turn may apply pressure to service provision particularly to support replacement of leavers from lower banded roles that have shorter notice periods. • Impact of Group People services review may reduce operational performance in resourcing and associated people roles during periods of consultancy and restructure likely to happen in Q4 current year and through 2026/27.

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 %	80.5%	80.5%	80.4%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	60
Medical Appraisal Rate %	86.9%	86.8%	89.9%	90.0%			Common Cause Variation	X	4
Non-Medical Appraisal Rate %	73.8%	72.6%	71.4%		90%		Special Cause Concerning - Below Lower Control Limit	X	60

Watch Metrics: Alerting Narrative

People

Understanding the Performance

Mandatory training for M8 is almost 10% below target at 80.4% completion rate across the Trust (80.5% M7) .
The best performing area remains Facilities with 93% completion. The lowest contributors are Corporate at 74% and Surgery at 80%.
The 90% target has not been met since January 2023.

Work is continuing to update MLE records relating to Safeguarding Levels 1-3 which are currently ranging between 43-50%.

Medical appraisals rose to 89.9%. This is the highest since July, and just under 90% target. The number of out-of-date appraisals has decreased from 91 to 87, the number out of date by more than 3 months decreasing from 49 to 38.

Non-medical appraisals rates have dropped to 71.4% (72.6% M7). This is 1.6% higher than the previous September, but the lowest since February. This equates to 951/3322 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 61.7% (219 / 572 out of date) and Surgery at 66.9% (263 / 795 out of date).

Countermeasure Actions

- Education team is working to manually check/update compliance records on MLE with focus on safeguarding courses. This is planned to be completed by 24/12/2025.
- Reliance on management to undertake appraisals and complete ESR. Part of this process requires managers to sign off that employees are up to date with stat/man training.
- Non-medical appraisals are also now declining and so focus on these is required to correct the position and recover to the 90% completion rate.

Risk and Mitigations

- Inability to release staff to enable MLE completion is frequently cited as the main blocker to success.
- Completion of appraisals remains off target. OD&P delivered a new form, which improved the rate from April 2025, but this improvement has stalled despite further work to improve training and oversight of appraisals for line managers.

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
Staff Turnover (Trust overall)	12.4%	12.4%	12.2%	13.0%			Special Cause Improving - Below Lower Control Limit	✓	0
Staffing Availability	3.1%	3.2%	2.8%	3.7%			Common Cause Variation	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

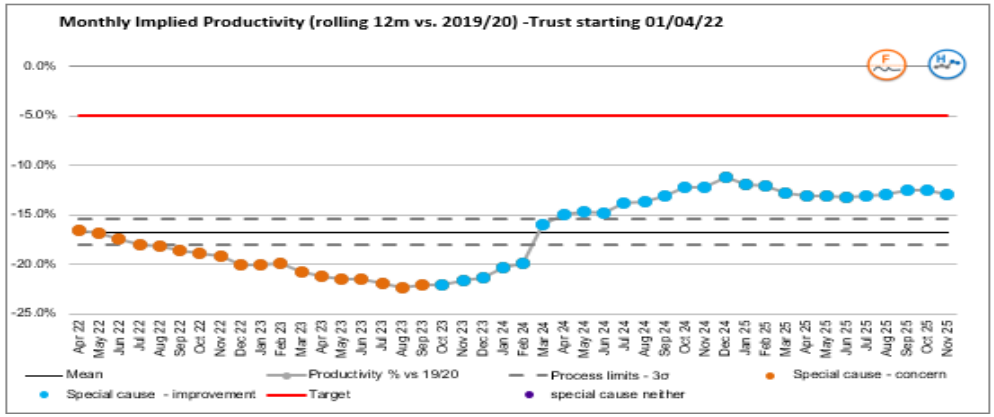
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -14.97% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services can 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: -12.98% Position H Special Cause Improvement



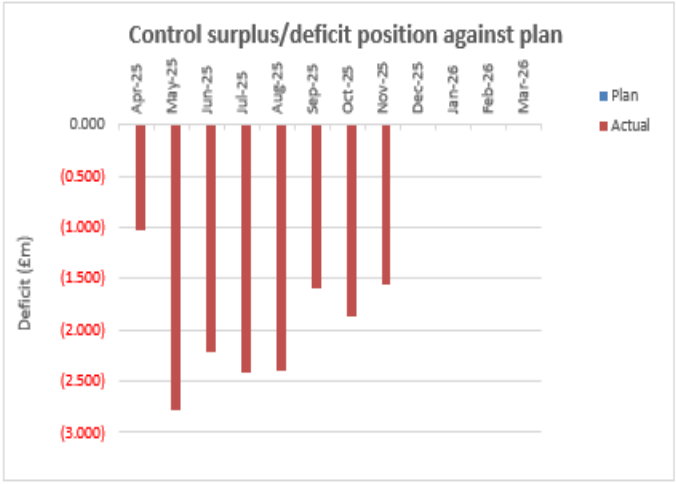
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Performance has slightly reduced in Month 8 to -12.98% from -12.56% in Month 7. High levels of inpatient activity in month but lower levels of day case and outpatient activity, alongside increased pay costs (both substantive and temporary staffing) have driven the deterioration in month. There is an improvement of 1.99% from April 2024 due to cost increases being mitigated by activity improvements across A&E, Elective inpatients and Non-Elective Inpatients 0 days. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• Detailed actions on the response to Division's productivity drivers are detailed within the A3 Productivity countermeasures and discussed at Divisional Performance Reviews.	Dec 2025	• The Finance Recovery Group and Delivery group supports the savings programme and Elective points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

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

	November '25 In Month			November '25 YTD			25-26 Plan
Operating Income							
NHS Clinical income	27,829	28,473	644	224,894	225,559	665	331,367
Other Clinical Income	1,487	1,928	441	11,327	12,033	706	21,586
Other Income (excl Donations)	3,152	3,078	(74)	26,573	25,107	(1,466)	39,984
Total income	**32,468**	**33,480**	**1,012**	**262,794**	**262,698**	**(96)**	**392,937**
Operating Expenditure							
Pay	(21,783)	(22,940)	(1,157)	(176,268)	(180,701)	(4,433)	(263,725)
Non Pay	(10,471)	(9,820)	651	(84,802)	(86,644)	(1,842)	(126,633)
Total Expenditure	**(32,254)**	**(32,759)**	**(505)**	**(261,070)**	**(267,345)**	**(6,275)**	**(390,358)**
EBITDA	**214**	**720**	**506**	**1,724**	**(4,647)**	**(6,371)**	**2,579**
Financing Costs (incl Depreciation)	(1,881)	(2,106)	(225)	(15,057)	(14,649)	408	(22,579)
NHSI Control Total	**(1,667)**	**(1,386)**	**281**	**(13,333)**	**(19,296)**	**(5,963)**	**(20,000)**
Deficit Support Funding - local	515	515		4,121	4,121		6,182
Deficit Support Funding - national	1,152		(1,152)	9,212		(9,212)	13,818
Reported Position		**(871)**	**(871)**		**(15,175)**	**(15,175)**	



Understanding the Performance

The financial plan submitted to NHS England on 7 May 2025 showed a breakeven position for the year and included an efficiency requirement of £20.9m. The plan assumes deficit support funding of £20m phased equally throughout the year. Identified efficiency schemes assumed significant length of stay reductions which will rely on effective system working.

The in-month position was a deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

The adverse month 8 position has been mainly driven by pay pressures due to Industrial action and staff unavailability with high levels of sickness and leave absences.

Countermeasure Actions

- Trust financial recovery plan resubmitted August 25 with actions for Trust wide departments and efficiency programmes.

Due Date

Mar 2026

Risks and Mitigations

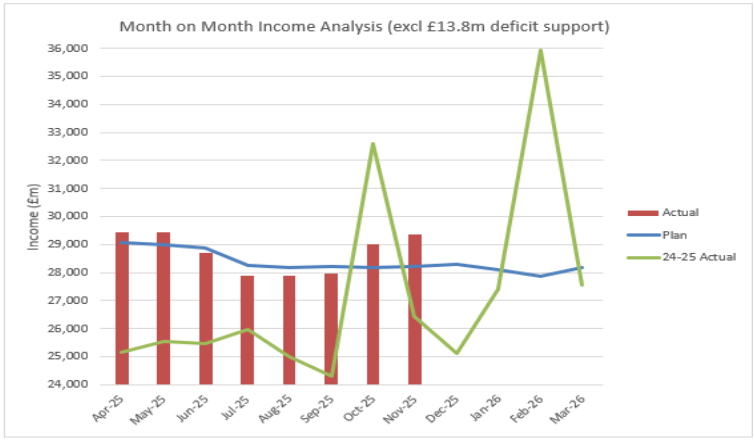
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and system working.

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	October Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	10,680	10,785	105
Day Case	19,393	19,165	(228)
Elective inpatients	13,122	12,192	(930)
Excluded Drugs & Devices (inc Lucentis)	20,325	22,096	1,771
Non Elective inpatients	62,291	63,559	1,268
Other	69,056	69,214	158
Outpatients	34,148	32,669	(1,479)
TOTAL	229,015	229,680	665

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	141,023	141,685	662
Dorset ICB	20,698	20,559	(139)
Hampshire, Southampton & IOW ICB	19,152	18,754	(398)
Specialist Services	32,083	31,663	(420)
Other	16,059	17,019	960
TOTAL	229,015	229,680	665



	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	53,413	54,073	660	52,787	1,286
Day case	19,170	18,726	(444)	18,462	264
Elective	2,657	2,507	(150)	2,446	61
Non Elective	20,611	21,290	679	20,654	636
Outpatients	218,076	209,640	(8,436)	200,267	9,373

Understanding the Performance

The Trust level performance is driven by lower Outpatient First attendances, Elective Inpatients and Day cases impacting on the ERF income offset by overperformance on High-cost drugs and Devices and Other points of delivery.

There is underperformance across all main commissioners, except for BSW, and overperformance on Provider-to-Provider contracts, Cross border, Channel Islands and Local authorities. Activity across the main points of delivery was lower in November than October for A&E, Day cases and Outpatients with A&E attendances on average 4 below plan per day and SWIC attendances on average 8 per day higher than October.

Countermeasure Actions

- Agreements with Dorset and HIOW ICBs are being finalised following formal dispute resolution.

Due Date

Jan 2026

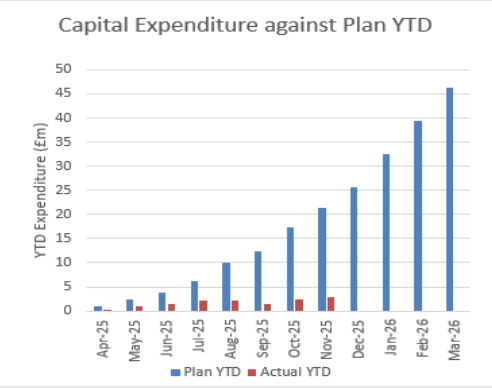
Risks and Mitigations

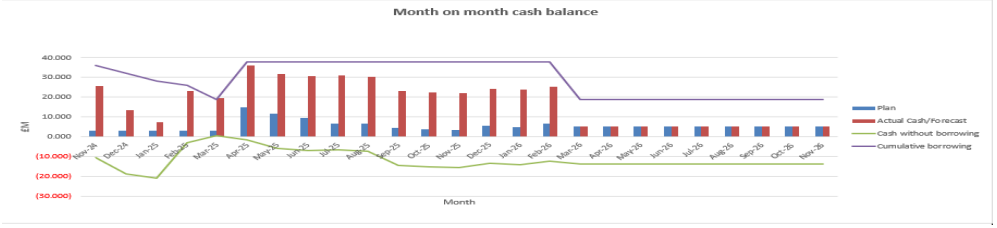
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements as outlined within the Trust recovery plan.

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	8,326	806
Debtors	19,291	31,880	12,589
Cash	22,530	29,749	7,219
TOTAL CURRENT ASSETS	**49,341**	**69,955**	**20,614**
Creditors	(49,082)	(65,160)	(16,078)
Borrowings	(1,391)	(19,845)	(18,454)
Provisions	(590)	(553)	37
TOTAL CURRENT LIABILITIES	**(51,063)**	**(85,558)**	**(34,495)**
TOTAL WORKING CAPITAL	**(1,722)**	**(15,603)**	**(13,881)**





Schemes	Annual Plan £000s	November '25 YTD Plan £000s	November '25 YTD Actual £000s	November '25 YTD Variance £000s
Position				
CDEL Schemes				
Building schemes CIR	2,915	1,166	621	(545)
Building projects	1,392	554	426	(128)
Fire schemes	608	242	34	(208)
IM&T	5,370	1,852	1,016	(836)
Medical Equipment	3,000	1,200	225	(975)
Leases	750	750	593	(157)
Total CDEL schemes	**14,035**	**5,764**	**2,915**	**(2,849)**
National Funding				
Shared EPR - Nationally funded element	3,199	3,199	2,114	(1,085)
Estates Safety Funding Phase I	5,254	2,476	552	(1,924)
Estates Safety Funding Phase II	2,105	165	165	
25/26 Community Diagnostic Centre	12,160	3,025	137	(2,888)
25/26 Seed Funding for Elective Care Centre	5,400	4,100	396	(3,704)
25/26 Procedure room	300	200	35	(165)
25/26 Urgent Treatment Centre	7,000	2,666	2,242	(424)
Diagnostics Physiological Equipment - Audiology	200			
Diagnostics Physiological Equipment - Cardiology	40			
25-26 Reach Programme for LIMS	332			
GB Energy Solar	366		1	1
Fibroscan	150		150	150
LIMS set up costs	210			
Total National Funding	**36,716**	**15,831**	**5,792**	**(10,039)**
GRAND TOTAL	**50,751**	**21,595**	**8,707**	**(12,888)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £8.7m in Month 8. This is mainly driven by UTC, EPR and building projects. Nationally funded schemes are dependent on the successful submission of business cases, except for Shared EPR which has already been approved, and the Estates Safety Funding which has already received NHSE approval.

The cash balance at the end of Month 8 was £29.7m. The position excludes non recurrent deficit support funding but includes an additional month's contractual payment from BSW of £18.7m. BSW ICB paid 2 month's contract payments in April to mitigate the requirements for PDC support in 25/26.

Countermeasure Actions

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

Due Date

Dec 2025

Risks and Mitigations

- The ageing estate, medical equipment and digital modernisation means that the Trust's capital requirements are in excess of resources. The Trust seeks to mitigate the constraint of available system capital by proactively bidding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.
- Deficit support funding in 25/26 is contingent on the system financial plan delivery which was not achieved at Month 7. The funding will be achieved if the system can recover the position by the end of the financial year. Financial recovery is of paramount importance.

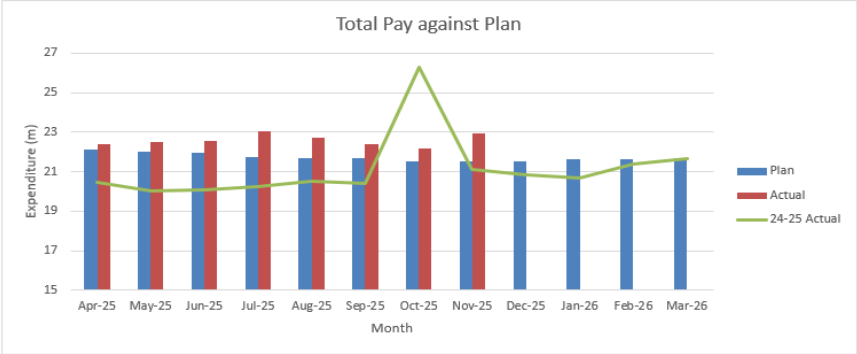
Workforce and Agency Spend

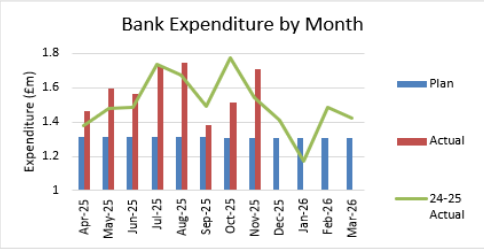
NHS Salisbury NHS Foundation Trust

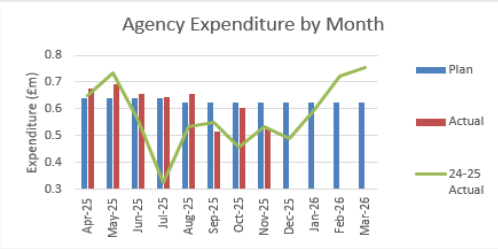
Target: N/A Performance: N/A Position: N/A

	November '25 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	162,887	162,324	563
Pay - Bank	10,428	12,711	(2,283)
Pay - Agency	2,381	4,967	(2,586)
Other (eg apprenticeship levy)	572	699	(127)
TOTAL	**176,268**	**180,701**	**(4,433)**
Medical Staff	45,738	51,954	(6,216)
Nursing	48,223	47,920	303
Support to Nursing	13,457	14,101	(644)
Other Clinical Staff	25,813	24,310	1,503
Infrastructure staff	42,465	41,716	749
Other (eg apprenticeship levy)	572	699	(127)
TOTAL	**176,268**	**180,701**	**(4,433)**

	November '25 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	571.5	608.14	36.7
Nursing	1,239.0	1,322.44	83.4
Support to Nursing	528.2	560.82	32.6
Other Clinical Staff	650.0	696.86	46.9
Infrastructure staff	1,359.8	1,368.17	8.4
TOTAL	**4,348.4**	**4,556.4**	**208.0**







Understanding the Performance

In November pay costs were £22.9m against a plan of £21.8m, an in-month variance of £1.1m leading to an adverse YTD variance of £4.4m.

The pay expenditure run rate increased by £0.8m mainly due to Industrial action costs and operational pressures related to urgent and emergency care pathways. Unavailability of staff remained high across all leave and sickness categories excluding any absences related to Industrial Action.

The WTE trajectory is a reduction from the funded establishment of 4,509 WTE in month 1 to 4,349 WTE in month 12: a reduction of 160 WTE. At month 8 there is an over establishment of 208 WTE.

Countermeasure Actions

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

Due Date

Dec 2025

Risks and Mitigations

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

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

Change	Date	Metric	Description of Change
1	01/04/2025	Elective Referral to Treatment	Revised from measuring Total Elective Waiting List in 2024/25 to Referral to Treatment (RTT) Performance % in line with national target for 2025/26
2	01/04/2025	Productivity	Revised target from -8% to -5.33%
3	01/04/2025	Elective Referral to Treatment	Watch metric of '78+ week waits' removed and '% of patients waiting less than 18 weeks for first appointment' added as a Watch metric
4	01/04/2025	Urgent and Emergency Care	Metric added for '% of ED attendances over 12 hours'
5	01/04/2025	Cancer	Cancer 31-day performance slide removed and now reported as a Watch metric
6	01/04/2025	Friends and Family Response Test Rate	Target increased from 15% to 18%
7	01/10/2025	Mortality	HSMR no longer used for reporting as contract with Telstra ended, amending metrics to only those not reported within that system: Crude Mortality and SHMI
8	01/12/2025	SPC Charts Re-based	Metrics had their SPC charts re-based due to months of continuous special cause improvement: Reducing Time to First Outpatient Appointment, Optimising Beds, Use of Temporary Escalation Beds and ED Escalation, Elective Referral to Treatment, Cancer 28-Day Standard, Cancer 62-Day Standard, Mortality, Vacancies

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

Change	Date	Metric	Description of Change
9	01/12/2025	Breakthrough Objectives Revised	Revised in quality from *Managing Patient Deterioration* to *Reducing Presure Injury* and in people from *Increasing Staff Retention* to *Reducing Staff Unavailability* as both previous objectives have seen common cause variation in performance close to targets since launch in April 2024 and April 2025 respectively, redirecting focus to other key drivers.

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

NHS Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

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

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

Appendix

Reading a Statistical Process Control (SPC) Chart

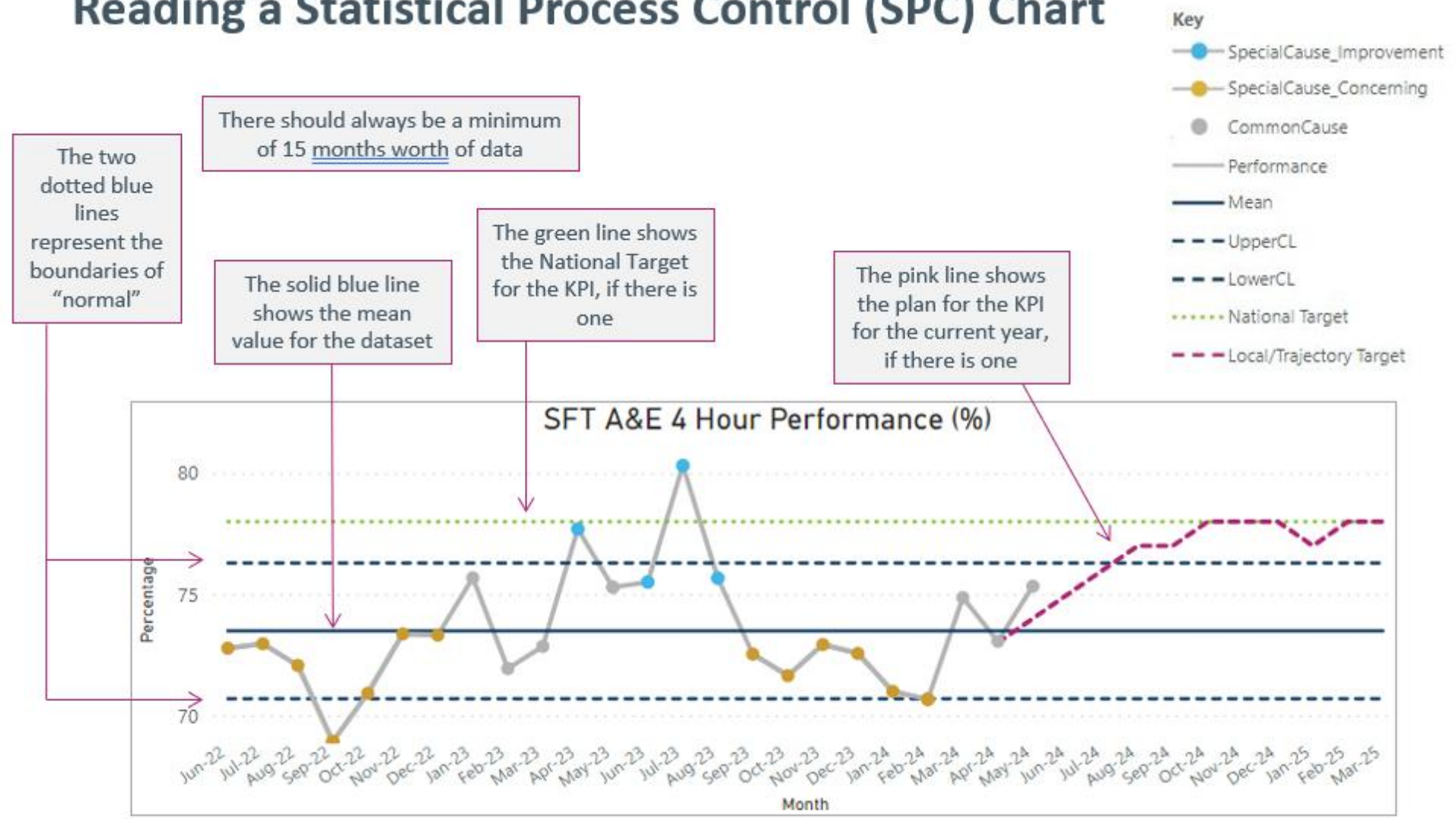
There should always be a minimum of 15 months worth of data

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:	2.4
Date of meeting:	8 January 2026		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	11 December 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 Report reviewing Management of IT Applications, a joint report covering both SFT and GWH, which was rated 'Partial Assurance with improvements required', the third in four tier rating system, and in line with management expectations. The principal findings rated as High relate to the oversight of and communication with system suppliers, and the implementation of multi-factor authentication of a number of legacy IT systems. Management Actions have been agreed to address these issues by the end of the financial year.

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 no Internal Audits reports; the report on Research Governance due at the meeting was submitted to Management but the departure of the Head of Research in October has impacted on the timeliness of Management's response. It will be brought to a subsequent meeting.
- The Internal Audit Progress Report has for the first time indicated that a very small number of management actions from prior Internal Audit Reports have passed their deadline delivery dates, without prior approval for an extension. The Committee expressed its concern that this behaviour should be nipped in the bud and not represent the start of a slippery slope towards a future loss of focus on delivery of actions to mitigate risk.
- Deloitte LLP presented their proposed fee for the 2025/2026 year end audit as a straight 10% fee uplift on their 2024/2025 fee. The Committee did not approve the fee as presented and sought additional assurance from the CFO that this increase is reasonable in all the circumstances.
- The Committee noted that the CEO was requested by NHS England to confirm any post balance sheet events for the period ending 31 March 2025. The Trust submitted three events, covering the liquidation of Wiltshire Health and Care on 31 December 2025, a possible review of the valuation of the car park asset owned by the Charity, and the potential impact of the supreme court ruling re Northumbria Healthcare NHS Trust v HMRC which will have a £0.6m adverse impact on recoverable VAT.

NHS Salisbury NHS Foundation Trust

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

- The Committee received a deep dive into the continuing project to improve the effectiveness and controls of the Starters and Leavers process. The project commenced in November 2024 following an Internal Audit Report. The project has completed the delivery phase and is now in the project review phase. Processes have been streamlined and enhanced, management training has been delivered and a single point online access has been delivered, all of which reduce the risk of incomplete or inaccurate information, improving data quality and accuracy.
- The Committee welcomed Michelle Hopton from Deloitte LLP, the Trust's statutory Auditor who is replacing Chris Randall as Audit Partner who has moved overseas with the firm. Michelle presented the External Audit Plan for the year end 2025/26 in conjunction with the CFO. The Committee commended the plan.
- The Committee received its regular Counter Fraud Progress Report which highlighted no items for concern.
- The Committee received an enlightening summary report from the Internal Auditors demonstrating the potential for use of AI within the Trust. This is taken from their benchmark of the approaches to deploying AI across their NHS internal audit client base, with responses from 22 Trusts, and gave illustrated examples of both Clinical and Administrative examples of AI Implementations. The Committee recommended that this report be circulated to all members of the Trust Board, and that representatives from the Internal Auditors might be invited to support the future Board Development Session covering AI.

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

- None.

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:	2.6
Date of meeting:	8th January 2026		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25/11/25
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing, Chair, Clinical Governance Committee			
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.

- Further to CGC report last month, CMB escalation report informs CGC that Aseptic Unit remains high risk following QA inspection in June. Immedate actions have been taken to maintain service continuity while modelling / business case are being developed for possible future investment.
- CGC remains very concerned that safeguarding training data is still unavailable, (see below), and is having to be collated manually. This has been escalated again to People and Culture Committee.

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.

- Draft CQC report following visit to medicine has been received for checking, but SFT is awaiting response from CQC regarding the representations made by SFT after receipt of concerns raised about NEWS2 recording and VTW risk assessments.
- CGC further discussed results of the 2024 inpatient survey and discussed these alongside the results from the staff survey. CGC welcomed the approach to triangulating the results and noted that overall, the results were similar to previous years, but for 5 questions the trust had performed significantly worse than in previous years. For 3 questions SFT scored worse than other trusts, including being able to get a member of staff when you needed attention, which may link to staff reporting increased pressure.
- CGC noted the assurance provided by both the Perinatal Surveillance report (October data), and the Maternity Quality and Safety report for Q2.
- In addition CGC received a rapid review of 5 cases reported to MNSI in August and September which has identified the following themes: non- English speaking service users; military families; and foetal monitoring and clinical escalation. The full report from MNSI will be received in due course. CGC also noted (in CMB upward report), that the Badgernet Phase 2 CTG central monitoring had gone live in November 2025.
- CGC were informed that the Safeguarding Children's team are concerned that not all concerns are being identified, particularly in the emergency department. In the absence of reliable data on training compliance this is very concerning. The team are working with colleagues in ED to increase awareness, and to "think family". CGC asked that the executive consider a further deep dive into safeguarding if there is no improvement by next reports to CGC.

• The Surgery division report highlighted challenges in specific services due to vacant posts and slightly longer recruitment timetables due to the tight scrutiny of all posts. Assurance was provided regarding laser services. • CGC discussed an update on GIRFT noting that this advice is actively considered by divisions, alongside other initiatives. SFT and Group use "Improving Together" for improvement and CGC agreed that it would be more appropriate for updates from GIRFT, and any potential actions required to be considered at divisional performance review alongside updates on Improvement. CGC also requested that the Group Clinical Transformation Director incorporates GIRFT in the Group Clinical Strategy.
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• CGC noted good assurance provided by the 6 monthly IPC report and IPC BAF, noting also that clostridium difficile infection rates have increased both in and outside of the hospital setting. • CGC noted continued assurance from the Learning from Deaths report, but that also that there had been a rise in deaths in patients with a serious mental illness, which is receiving further review. • CGC noted the Internal Audit report into discharge processes which had previously been reviewed at FPC and Audit Committees.

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:	3.2
Date of meeting:	8 January 2025		

Report title:	Medical education annual performance report			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	People and Culture Committee, November 2025			
Prepared by:	Emma Halliwell, Director of Medical Education			
Executive Sponsor: (presenting)	Duncan Murray, CMO			
Appendices	Appendix A: GMC Survey 2024/2025 Appendix B: Educational supervisor courses Appendix C: Staff and associate specialist doctor courses Appendix D: Induction feedback Appendix E: F1 shadow week and induction feedback			
BAF Risk link				

Recommendation:

This report is for assurance for the Trust Board on the quality of medical education and training provision

Executive Summary:

Executive summary

The 2024–2025 reporting year has been one of significant transition and growth for Medical Education at Salisbury NHS Foundation Trust. Despite workforce pressures, space constraints, and increasing trainee numbers, the Trust continues to deliver a high-quality educational environment, reflected in outstanding GMC survey results and strong trainee recruitment.

This is the final report from Dr Emma Halliwell as Director of Medical Education, marking the end of a six-year tenure during which the Trust has strengthened its educational culture, expanded training capacity, and enhanced support for trainees, SAS doctors, and locally employed doctors.

Key achievements include becoming the highest-ranking acute Trust in Wessex for overall trainee satisfaction, successful expansion of Foundation and specialty training posts, and the introduction of new undergraduate and postgraduate teaching initiatives. Challenges remain around medical education administrative team capacity, education space, and supporting expanding cohorts of IMGs, LEDs and SAS doctors.

Key points

1. Workforce Expansion and Capacity Pressures

- Foundation Programme numbers have reached to 36 F1s and 33 F2s due to expansion of F1 numbers, with further national expansion expected.
- Specialty trainee numbers have risen to 62, and locally employed doctors remain high at 71.
- Administrative staffing is becoming challenged by the scale of activity.
- Education Centre space is becoming increasingly challenged by expanding educational and other demands.

2. GMC Survey Success and Quality Assurance (Appendix A)

- Salisbury is now the highest-ranking acute Trust in Wessex for overall trainee satisfaction.
- Obstetrics & Gynaecology achieved a significant turnaround, earning recognition from their Royal College.
- Concerns in Plastic Surgery require ongoing work.

3. Leadership Transitions

- Significant flux in leadership roles: DME, Foundation Programme Director (now shared), Associate Clinical Sub-Dean

4. Undergraduate Education Expansion

- First full year hosting 3rd-year medical students in Surgery, supported by a new Surgical Education Fellow.
- Only one outstanding action from the 2022 QAE visit: insufficient education space.

5. SAS, LED, and IMG Support

- Growing SAS/LED cohort with increasing demand for CESR support, with several successful developmental activities delivered and support programmes initiated. (Appendix C)
- SAS Advocate and IMG Lead roles continue to provide essential pastoral and developmental support.

6. Physician Associates

- National PA workforce remains under pressure following national scrutiny and the Leng Report. The Bournemouth University course has become undersubscribed and SFT is now supporting its last cohort of PA students.

7. Wellbeing and Pastoral Support

- Junior Doctors' Mess continues to thrive, with strong engagement and events programme.
- Low levels of Practitioner Support and Wellbeing Unit (PSWU) referrals compared with previous years.
- Enhance Programme uptake remains modest due to conflicting pressures for FY doctors, reflecting national trends.

Risks and issues

- Administrative capacity is stretched and may compromise training quality.

- Education Centre space constraints are inhibiting further expansion of training opportunities.
- Increasing trainee numbers will require proportional investment in infrastructure.

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):	

Salisbury NHS Foundation Trust

Director of Medical Education
Annual Medical Education Report
August 2024 to August 2025

Produced by: **Dr. Emma Halliwell, Director of Medical Education**

October 2025

Acknowledgements

Ms. Rashi Arora, Specialty and Associate Specialist, and Locally Employed Doctor Development Lead

Mrs. Emma Freeman, Medical Education Manger

Dr. Annabel Harris, Outgoing Associate Clinical Sub-Dean

Dr. Georgina Morris, Outgoing Foundation Programme Director

Dr. Ellen Neale, GP Vocational Training Scheme Programme Director

Dr. Gail Ng, Physician Associate Lead

Dr. Julie Onslow, International Medical Graduate Lead

Administrative Staff, Medical Education Department, Education Centre

Members of the Medical Education Training Committee

Distribution List

Mr. Nick Johnson, Managing Director, Salisbury NHS Foundation Trust

Dr. Phil Rushton, Wessex Locality Postgraduate Dean, NHS England

Dr. Duncan Murray, Chief Medical Officer, Salisbury NHS Foundation Trust

All members of the Medical Education Training Committee (METC)

All members of People and Culture Committee

Posted on the Medical Education page of the Trust Intranet

Executive Summary

This will be my last annual report as Director of Medical Education. After almost six years in post, I have decided to step down. I'm delighted to report that Mrs. Karinya Lewis, Consultant Ophthalmologist, has been appointed as my successor and will take up the post from the beginning of November.

It has been a year of changes. Dr. Georgina Morris, Foundation Programme Director, stepped down. She oversaw a 50% expansion in our Foundation Doctor numbers, and her expertise in well-being and professional support has been particularly invaluable. Due to increasing numbers, we have appointed two Co-Foundation Programme Directors – Dr Bhavisha Shah, Consultant Anaesthetist, and Dr. Gail Ng, Consultant in Emergency Medicine – to replace her. In addition, we are delighted that Mrs. Anna Thorne, our Foundation Programme Coordinator, is currently on maternity leave. This flux has been challenging but, as far as the Foundation doctors are concerned, it has been business as usual which as a hue testament to the team's flexibility.

In the summer Dr. Annabel Harris handed over as Associate Clinical Sub-Dean to Dr. Chris Ford, Specialist Doctor in Anaesthesia. Our undergraduate offer has gone from strength to strength with Annabel at the helm, including having third year medical students in surgery for the first time, which has been a huge success. Chris has started well, and his enthusiasm has been infectious. Our surgical education fellow was an asset to the team last year, so we have replicated this by appointing an education fellow in anaesthetics to lead on the fourth-year acute care block, as this is where the 'Covid bulge' year now sits.

Throughout this time of change, the Medical Education Team's priority continues to be to provide an excellent educational and training environment in Salisbury, whilst supporting the well-being and development of both trainees and trainers alike.

The GMC survey results this year (Appendix A) continue to reflect our success in doing so. We are now the highest-ranking acute Trust for 'overall satisfaction' in Wessex, which is huge achievement. This is a testament to the hard work and dedication of all those involved in medical education in the Trust at all levels, and I extend my thanks to them all. I am particularly delighted that, after a difficult survey last year, Obstetrics and Gynaecology have performed exceedingly well and have been recognised for their training by their Royal College. We are fully cognisant that not all issues about the training environment surface through the survey. The Trust and Deanery are currently working together to deal with issues in the plastic surgery department that have been raised by residents through other routes.

Our SAS and LED cohort continues to grow in number. Ms. Rashi Arora, SAS and LED Development Lead, has been building on the foundations she has laid down to improve the educational and developmental offer for this invaluable group of colleagues. We continue to recognise that the portfolio pathway (CESR route) onto the specialist register is proving more popular, and we are anxious to support those wishing to make their career in Salisbury to progress in this way. Throughout her endeavours, Rashi has been ably supported by Dr. Chris Ford in his role as SAS Advocate.

Dr. Julie Onslow, our International Medical Graduate Lead, continues to support and welcome anyone who is new to the NHS. Our local IMG handbook has been an asset in this regard. The challenge remains as to how we capture the start dates for any locally employed IMGs, so we can extend to them the same welcome and support that we now have in place for our rotating doctors, as the information flow from recruitment is not consistently reliable.

Physician Associates have had an exceedingly difficult time over the last two years. The Leng Report has now been published and Dr. Gail Ng, our PA lead, has met with the CMO to discuss how to implement the recommendations for our substantive PAs. We are currently supporting year two PA students from Bournemouth University. After this year, we will not have any more students as, unsurprisingly, the course is proving less popular.

Again, this year, I am pleased that we have been able to offer a wide range of training days to support Educational and Clinical Supervisors in their role. These have been run both 'in house' and by an external provider; the latter also providing some training days for our SAS/LED cohort. These have universally well attended (appendices B and C) and received very good feedback. They have also proven to be an excellent opportunity to spend time together as an educational faculty.

Our medical education administration team has dealt with many challenges this year, mainly because of the Trust's increasing workforce controls. They have had to fight to get maternity cover for our Foundation Programme Coordinator, even though it is a requirement for us to have someone in this role to support our Foundation doctors' training. It is still imperative that we look to expand this team as a matter of urgency, and the money is available from the Deanery to do so, funds which are explicitly meant to be spent on education. However, it seems likely that any increase in administration support will not be authorised due to headcount controls. The increase in trainee and student numbers, and the increasing responsibility the team has for our SAS and LED cohort, means that the team are running at over capacity which is not sustainable. It has also resulted in us being unable to develop other important areas e.g. widening participation, clinical attachments etc. Emma Freeman, Medical Education Manager, and her team have our heartfelt thanks for all their flexibility, hard work and grace that has enabled us to at least keep business going as usual. This is a huge achievement in the circumstances.

The other ongoing challenge is the space available in the Education Centre to support the increasing demand for education and training. It is disappointing that, whilst I have been highlighted this for several years now, no progress has been made in this regard.

I am proud to have been Director of Medical Education in Salisbury over the last six years and to oversee the strengthening of the educational environment. This has only been possible because the wider educational fraternity are continuingly willing to go 'over and above' what is necessary to support, educate and train our residents. I have been extremely grateful for all their expertise and enthusiasm over the years and would like to take this opportunity to thank them all. It is a challenging time in the NHS in general, but I know that they will show the same support to Karinya as she takes over the reins.

Finally, I must finish by extending my immense gratitude to Mrs. Emma Freeman, Medical Education Manager. She has simply been my right-hand man, sounding board, sense checker and coffee maker when I've needed it. Her leadership has been second to none, and working alongside her has been the biggest privilege of my educational career.

Dr. Emma Halliwell
Director of Medical Education

1.0 Introduction

This report gives an overview of medical education in Salisbury NHS Foundation Trust (SFT) for the past 12 months from August 2024 until August 2025. These activities are assessed against our strategic objectives which are as follows:

Objectives

1. Maintain accreditation of training posts
2. Accreditation of Medical student and Physician Associate student placements via universities
3. Maintain a strong educational environment for resident doctors.
4. All Educational and Clinical Supervisors to be accredited in line with GMC requirements and resident doctors only allocated to those supervisors who are fully recognised.
5. Keep the Trust management informed of national policy pertaining to resident doctors and the impact these polices will have on service delivery
6. Feed into the Trust's clinical governance framework to ensure patient safety
7. Provide supportive pastoral care and personal development opportunities, including career guidance information, whilst promoting equality and diversity
8. Ensure Medical Education is incorporated into Directorate Annual Plans
9. Ensure good quality Trust and Departmental Induction with appropriate evaluation of these.
10. Ensure quality of training is maintained in light of ongoing clinical and financial pressures
11. Ensuring resident doctors feel valued and are an integral part of the Trust in line with the national 'well-being agenda.'

All these objectives have proven particularly challenging this year due to the ongoing pressure on service delivery and financial restraints. The Trust has aimed to minimise any negative impact on both training and well-being, but its effects are likely to pertinent for the foreseeable future.

2.0 The Medical Education Department

The Medical Tutors are:

Director of Medical Education (DME)	Dr. Emma Halliwell	
SAS and LED Development Lead	Ms. Rashi Arora	
Associate Clinical Sub-Dean (ACSD)	Dr. Annabel Harris	Until July 2025
	Dr. Christopher Ford	From July 2025
Foundation Programme Director (FPD)	Dr. Georgina Morris	Until July 2025
	Dr. Gail Ng	From July 2025
	Dr. Bhavisha Shah	From July 2025
GP Vocational Training Scheme (GPVTS) Programme Director		
	Dr. Ellen Neale	
Physician Associate (PA) Lead	Dr. Gail Ng	Until July 2025
International Medical Graduate (IMG) Lead	Dr. Julie Onslow	

The Education Centre is based on Level 5 of the hospital. The Medical Education Team is as follows:

Medical Education Manager	Mrs. Emma Freeman
Medical Student and GP VTS Co-ordinator, and PA to the Associate Clinical Sub Dean	Mrs. Rebecca Henderson
Foundation Programme Co-ordinator, and PA to DME and FPD	Mrs. Anna Thorne
Maternity Leave Cover	Mrs. Sam Woodward

3.0 Quality Assurance Methods

The standards and outcomes for postgraduate medical education and training are set by the General Medical Council (GMC).

These standards form the basis for monitoring and implementing education and training of medical staff at Salisbury Foundation NHS Trust. Quality Assurance processes are in place to monitor and support the development of medical education both at a local and regional level. These processes are usually augmented by the annual GMC trainees and trainers' survey, and triggered visits from the various 'schools' to programmes at the Trust when issues arise.

The Director of Medical Education is required to complete an 'annual return' to NHS England Workforce, Training and Education (NHSE WTE) as part of the Quality Assurance process. Medical Education also contribute to the NHSE Education Quality Self-Assessment.

4.0 Accreditation of Medical Training Posts

4.1 Foundation Programme

<u>Recruitment</u>

Salisbury continues to be a popular hospital for doctors to undertake the Foundation Programme. For August 2024, we had 35 new F1s starting with us (compared with 33 in August 2023) - including 3 new posts (3 x 4 months) that were created in response to a request from the Foundation School to cater for doctors on the waiting list. For the first time, we have F1 posts in Trauma and Orthopaedics and in Haematology, in addition to the longstanding F2 posts in these specialties. We also had 2 'out of sync' F1s on extended training post-ARCP (these both became F2s in December 2024).

We were allocated 3 F1s who were International Medical Graduates. These doctors started in August 2024 having not previously had opportunity to sit the Prescribing Skills Assessment (PSA). Two passed at their first sitting in Sept 2024 and have generally been assessed by clinical supervisors as working at the upper end of clinical performance expected for an F1. The third required 3 attempts at PSA and some additional support initially. However, they have now settled in well and are working at the clinical level expected for end of F1. In general, our current F1 cohort have had lower levels of anxiety and additional support requirements than those who joined us in August 2023, and only 2 referrals have been made to Wessex Professional Support and Wellbeing Unit (PSWU) for this cohort to date. All but 1 of our current F1s have now successfully passed through their Gateway ARCPs (June 2025) and are expected to move on to F2 posts in August 2025. The remaining F1 has had significant time out of training for health-related reasons. They are receiving support from PSWU and external specialists and are working 80% less than full time. They are due to have their end of F1 ARCP in October 2025 and have been approved for supernumerary funding for development of bespoke posts for F2.

Regarding F2s, in August 2024 we had 33 in standard rotational posts (having been F1s in Salisbury). One of our F2 posts is in Medical Education (since 2021) and is included within the Specialised Foundation Programme. A doctor will be joining us in Salisbury as a stand-alone F2 in August 2025 to undertake the F2 rotation previously allocated to the F1 who withdrew in July 2024.

At the June 2025 ARCPs, all 33 of our F2s having an 'end of F2' ARCP were successful in exiting the Foundation programme. The two 'out of sync' doctors mentioned above who became F2s from Dec 2024 have recently both resigned from the Foundation programme. One is an International Medical Graduate who plans to work as a doctor in Hong Kong (where his family live and he attended medical school). The second has made the decision to leave medicine for health and well-being reasons.

Around 30% of our current F2s have obtained GPVTS or Specialty training posts for August 2025, which compares favourably with reports from other Trusts in Wessex. For numerous reasons it has become increasingly competitive to obtain training posts in recent years, which is an understandable cause of anxiety for Foundation Doctors and their Educational Supervisors. The majority of F2s will go on to do a clinical fellow or similar job either in the UK or overseas post foundation. I extend very best wishes for a successful and happy career to all our F2 cohort who are moving on.

The Enhance Programme

The Enhance Enable programme was introduced and rolled out nationally as an option for all F1s from August 2023 to support and provide additional evidence of development of non-clinical generalist skills. It covers topics such as complex multimorbidity, social justice and health equity, environmental sustainability and population health. Enhance Enable is entirely optional and self-directed. Completion of all 6 Modules (3 in F1 and 3 in F2) results in a certificate awarded in Contextual Leadership which counts towards evidence of Leadership Development for some (but not all) specialty training applications. During 2023/24, 13 of our 33 F1s started the Enhance Enable programme, with 11/13 completing the initial 3 Modules with the aim of continuing during their F2 year. Of these, 6/11 doctors completed all of the Enhance Enable programme as F2s.

In general, nationally the Enhance Enable programme has not been as successful as originally anticipated. F1s and F2s are facing increasing demands on their time, both clinically and in preparation for applying for GPVTS/Specialty training. Many doctors are choosing to spend time working towards Royal College exams or gaining greater experience and evidence that can be used for their application portfolio rather than undertake Enhance.

Roll out of Enhance Enable was facilitated by a Senior Education Fellow working for Wessex Foundation School who provided tutorials and supported our F2 Education Fellow for advice and in integrating it into our local teaching programme. The Wessex Enhance Fellow post was only funded until April 2025.

From August 2025, our Public Health F1 posts have been incorporated into the Wessex Enhance Explore programme. This is an extension of Enhance Enable which requires completion of an Enhance – themed placement, a longitudinal Quality Improvement Project and attendance at 3 specific study days. The Enhance Explore posts already running in Dorset for the past 2 years have proven to be successful, and applicants are prospectively recruited to these posts.

Well-being

We continue to strive to ensure that our Foundation Doctors are supported pastorally as well as clinically to provide the best care for patients.

The Junior Doctors' kitchen area on Level 5 is now well-utilised, with 24-hour access. Dr. Daniel Rose (Mess President), and his committee team have continued to develop the Mess environment and the programme of Mess Events in 2024/25 was diverse and very well-received. The Fourth Mess Formal Event in July 2025 at the Guildhall was attended by over 80 people.

I am greatly indebted to Dr. Emma Halliwell, Director of Medical Education; Emma Freeman, Medical Education Manager; and all the Foundation Clinical and Educational supervisors. I want to thank them for their hard work and support. I would also like to thank Anna Thorne who is well-established in the Foundation Coordinator role. Anna has recently gone on maternity leave following the birth of her daughter (congratulations Anna!). We have been very lucky to have had the support of Lara Powell who has very ably assisted us in preparing for the ARCPs and the new intake for FY1s, and more recently Sam Woodward has joined our team providing maternity cover for Anna.

I am very sad to say that this will be my last report as FPD. After 5 and a half years in post I am moving on to a different role within the PSWU. I have very much enjoyed supporting the training and well-being of Foundation Doctors and seeing them develop and thrive during their time with us. I am certain that my successors – Dr. Bhavisha Shah and Dr. Gail Ng will continue to ensure we provide a Foundation Programme to be proud of in Salisbury.

Dr. Georgina Morris
Foundation Programme Director

4.2 General Practice Training

I am pleased to report 2024-2025 was again a successful year for GP trainees rotating through Salisbury hospital posts in their ST1 and ST2 years of their GP training programme.

Productive regular meeting between the Trust and the mid Wessex education team continues to allow us to collaboratively support our resident doctors and aid clear lines of communication between our teams. To further develop these close links, the Trust HR Department have been invited to attend the Salisbury Trainee Group meetings.

<u>Teaching</u>

The move to face-to-face teaching provision for the monthly sessions has been met with enthusiasm by the trainees and we have maintained excellent levels of attendance. Due to circumstances beyond our control, the venue for these sessions going forwards into the next academic year has had to be moved. We are committing to continuing to provide face-to-face teaching provision for the trainees as we have observed the benefits of the return to this educational delivery format to be multifactorial for the trainees, especially those in their first year of training.

To align with our culture of open communication, we regularly seek feedback from our resident doctors regarding their posts and all teaching events held. GP residents are invited to submit feedback after each 6-month post. This information is then shared with the respective hospital departments. The feedback received after a teaching event is actively used to evolve the teaching delivery, resources utilised and targeting of trainee learning needs.

<u>Recruitment</u>

Mid Wessex remains a popular choice with trainees. All August 2024 and February 2025 training posts were again successfully filled with trainees enrolling onto the 24:12 GP training programme.

International Medical Graduates continue to form a significant proportion of GP residents in mid Wessex. By continuing to proactively contact all non-UK Medical School graduates who have been successfully accepted into training places in mid Wessex, we are able as a Team of TPDs to explore their past NHS working experience. This information can then be shared with the Trust to help ease their transition into GP training and potentially their first employed role within the NHS.

Less than full time working trainees also form a notable proportion of GP residents. The unique challenges of these residents, as well as the delivery of 24:12 training programme, upon both hospital and GP practice posts remain. Through collaborative teamwork with both the Trust and GP Practices, we are pleased to have been able to continue to succeed in managing these challenges together.

Many thanks to the administration team for their ongoing administration support and assistance with the mid Wessex GPVTS residents.

Dr. E Neale
GP & Mid-Wessex TPD (Salisbury ST1&2)

4.3 Medical Posts within Salisbury NHS Foundation Trust

Trainee posts numbers within SFT for the last few years are as follows:

	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
F1	28	27	33	33	36
F2	29	29	29	33	33
Core Trainees	38	40	33	37	36
GP VTS	18	16	15	15	19
Specialty trainees	50	46	57	52	62
Locally employed doctors	72	54	45	68	71
Total	**215**	**212**	**212**	**238**	**257**

In addition, the Trust currently employs 54 SAS doctors.

The table above clearly shows the expansion in the Foundation Programme, which has been reflected nationally to accommodate the increasing number of medical students. The expectation is that there will be an increasing need for more Foundation posts in the coming years.

Expansion of specialty training is happening nationally, and we are already benefited from extra posts which have been a combination of Tariff-funded and Trust-funded posts. The DME continues to work with CDs to identify LED posts that might be suitable for conversion to training posts, which will ensure cost and headcount neutrality for the Trust.

Expansion at Core level is lagging behind nationally, as reflected in the static numbers here in Salisbury. The issue this is creating is many of our Foundation doctors are struggling to get onto training programmes at the end of their F2 year, as the competition ratios for core posts has rocketed in recent years. Many F2s have to look at locally employed roles or chose to work abroad at least for a period of time.

Our cohort of locally employed doctors remains sizeable and many of them are going down this route as an active career choice. Many look to provide training equivalence to apply for specialty training at a later date or choose the portfolio pathway for entry onto the specialist register. They need excellent support from their Educational Supervisors in order to achieve this. We also aim to support to transfer them onto the SAS contract after the appropriate length of time.

5.0 Accreditation of Student Placements

5.1 Medical student placements

This report pertains to medical students present in Salisbury, mostly from Southampton Medical School, and is covering the academic year 2024-2025.

It has been another successful year for Salisbury NHS Foundation Trust and medical student education. This has been due to the ongoing dedication, flexibility and positive attitude of all staff at all levels. This year has not been without its usual challenges, and I remain hugely thankful for all those that have helped and supported myself and the medical students this last year.

We have addressed all bar one of the recommendations and requirements that we had following the QAE visit from Southampton after their inspection in December 2022. "The Trust team needs to look at education space to ensure that teaching spaces are not compromised by clinical commitments"- this is still an issue which needs to be looked at by the Trust executive team.

Teaching provided

As well as the formal teaching programme that we provide the medical students, the resident doctors' undergraduate education group maintained their high standards this year. Resident doctors provided simulation teaching, a Mock OSCE and evening regional teaching - a collaboration between us and Dorchester. The teaching program, simulation and Mock OSCE were well received by the students and received excellent feedback. They also delivered assistantship teaching sessions and case-based teaching regional sessions which were also well received. Dr. Morris and I delivered our third 'Foundations of Teaching' course which provided foundation teaching skills to more than 24 resident doctors. This ran from September to March and received very positive feedback.

This year was the first year that we had 3rd year medical students in Salisbury. In preparation for having medical students in Surgery all year round we also recruited an education fellow in surgery for the first time. This was a 60-40% split teaching-clinical and Dr. Theo Stylianou was successful in getting this position. He has been fabulous and has created a curriculum and teaching timetable to ensure that the students all had the best experience. I would like to thank Theo, Mr. Ghauri, Mr. Ali Samar, and the rest of the surgical team for embracing the 3rd years and having a very successful year of education in surgery.

Medical student numbers

Through our doors we hosted 12 final year medical students for their 6-month medicine/surgery and student selected unit (SSU) placements. We also had 24 final year students doing their assistantships with us. Throughout the year we also saw 12 x 4th year students in O&G, 8 x 4th years in child health and 19 x 4th year students in acute care modules. In the New Year our 18 x 3rd year students started in surgery. We hosted several SSUs and electives here in more than 14 departments. It was great to see people offer to help with this and I know that the students and the university were happy with these placements.

Staffing

In August the 4th year modules are due to change so in preparation for this we have bolstered these departments this year to support them. Dr. Peta Coulson-Smith has joined Dr. Tayo Gandon in leading the child health module. Mr. Thanos Tsoukas has been given some time for teaching to support Miss. Sophie Moloney-Geany in O&G. We have also successfully created a new Clinical Teaching Fellow in Education and Anaesthetics to help support delivery of the acute care module. Dr. Andy Nash has also joined Dr. Barr in leading the acute care module.

I was privileged to be invited to speak at the university this year and represent Salisbury by speaking at their "Women in Medicine" annual conference. I felt very proud to be part of this.

I would like to thank all the subject leads and administration staff for all they have done for the students this last year. This was my last year in the ACSD role as I am stepping down after more than 5 years in the role. We had a very competitive interview for my replacement and Dr. Chris Ford was successful in being offered the job. Huge congratulations. I know that the medical students are in excellent hands with Chris.

Many thanks to Rebecca Henderson, Emma Freeman, Dr. Georgina Morris, Dr. Emma Halliwell, Claire Brattle, the undergraduate faculty, the teaching block/rotation leads and everyone involved in providing high quality supervision and teaching to the medical students 2024-2025.

Dr. Annabel Harris
Associate Clinical Sub-Dean

5.2 Physician Associate students

Background

SFT had its first cohort of Physician Associate (PA) students from Bournemouth University in November 2021. I took on the role as Physician Associate Lead in SFT in December 2021. As of November 2024, we will have our last cohort of PA students from Bournemouth University for now. We continue to have our four amazing, qualified Physician Associates working in ED and AMU.

Summary report 2024/2025

It has been a very challenging and difficult year for the qualified PA and PA students. There has been a huge amount of media coverage regarding PAs a lot of which has been negative. The result is that we have had PA students drop out of the programme and the overall morale of the PAs is low. The remaining PA students will continue their last year with us with Surgery/ Obstetrics and Gynaecology in November 2025, then Paediatrics in April 2026. They have, however, said that they have had a great time in their acute block (AMU/ED) and two of them had an excellent time with Respiratory (thank you to Dr. Anna Barton) and Gastroenterology (thank you to Dr. Hazel Woodland) teams.

Our qualified PAs are to remain in ED and AMU until I have met with the Trust to discuss the Leng Review that was published on 6th July 2025. Feedback from the Senior ED team is that we want to continue to have our PAs and we are finding ways to use of PAs wisely.

Dr. Gail Ng
Physician Associate Lead

6.0 Strengthen the Education Environment

6.1 Medical Education Training Committee (METC)

This committee includes medical tutors, specialty education leads (College Tutors), staff from Medical Education and Medical Personnel. During the past 12 months the Committee met on 6 occasions and, as in previous years, has been proactive in its approach to sharing information and implementing changes to medical education and training. These meetings also provide a forum for the educational faculty to be made aware of concerns and issues in the various departments with regards to training.

The Medical Education and Training Committee reports to the OD&P Management Board and the minutes of meetings held are therefore submitted here for review and, if necessary, action.

6.2 SAS and Locally Employed Doctors

This report provides an overview of the SAS and LED education initiatives at Salisbury NHS Foundation Trust (SFT) over the past 12 months. All activities have been aligned with our strategic objectives, which focus on promoting development opportunities that meet service needs while supporting individual learning experiences and career progression, with particular emphasis on supporting those pursuing the GMC Specialist Register via the CESR (Certificate of Eligibility for Specialist Registration) or Portfolio pathway.

Group Size

As of February 2025, there are 54 SAS and 71 LEDs at SFT, an increase from 37 SAS doctors and 59 LEDs in 2023. Efforts are continuing to ensure the SAS and LED database remains current, with collaboration between the Medical Education and the OD&P teams.

CESR (Certificate of Eligibility for Specialist Registration) or Portfolio Pathway

SFT continues to recognise and appreciate the vital contributions made by SAS and LED doctors. An increasing number of colleagues are choosing to pursue CESR as a route to specialist registration for a variety of professional and personal reasons. As many of them gain more experience, their interest in the CESR (portfolio) pathway grows.

In October 2023, the Trust formally launched a foundational CESR framework, outlining our vision, objectives, and the practical support available to CESR candidates. This includes new educational and pastoral support streams for non-Deanery doctors and their supervisors. There are currently 11 CESR candidates registered within the Trust and 3 success stories from this registered cohort. While the foundational structure for CESR support has been established, implementation across departments remains variable. Some specialties are leading in their support, while others require further development. This remains a work in progress.

Key initiatives for 2024 include:

1. **Programme launch**: A Trust-wide CESR workshop was held in July to address common queries and provide targeted support. Lecture content has been recorded and archived as part of an introductory resource pack for future candidates.
2. **CESR support group**: A digital peer-support network (WhatsApp group) has been established to encourage mutual support and knowledge-sharing among CESR candidates.
3. **Training opportunities**: Plans are in place to offer regular CESR-focused training in relevant generic areas. All departments are encouraged to create tailored CESR programmes, offering portfolio support through both retrospective and prospective reviews.
4. **Regional collaboration**: For specialties requiring advanced or niche training, partnerships with larger regional hospitals are being explored.
5. **Support for supervisors**: Training for CESR supervisors will be provided to ensure they understand the requirements and can effectively support candidates. The Trust hopes to identify and train at least one consultant or educational supervisor per specialty to support CESR candidates.

SAS Week

SAS Week (14th-18th October) was dedicated to recognising the contributions and expertise of SAS doctors. A highlight of the week was a celebration event on 17th October 2024, hosted at the White Hart Hotel. This high tea event was attended by Dr. Duncan Murray (Chief Medical Officer) and Melanie Whitfield (Chief People Officer). It was a resounding success with an engaging roundtable discussion on key SAS issues and insightful talks from Harjinder Bahra and Dr. Pulkit Gupta (winner of design a study day competition). SAS doctors also had the chance to discuss their issues with Trust Executives.

In addition, the SAS Education Team organized a unique hashtag competition to celebrate the exceptional work of SAS doctors, using #ProudToBeSAS and #ProudToSupportSAS. Doctors in the Trust were invited to share a social media post-photo, video, a unique caption, or a story that highlights pride in being an SAS doctor, or their support for SAS doctors. Dr. Duncan Murray awarded prizes to the winners – Dr. Benita Florence, Dr. Pulkit Gupta and Dr. Mahmoud Eissa and thanked all SAS doctors for their invaluable contributions.

Additional Courses and Activities

SAS and LED Courses Organized at SFT:

- *SAS Doctors' Career Tool Kit Day:* Organised on 14th March 2025. It covered resources available to SAS doctors in the Wessex Deanery, the SAS contract, leave entitlement, pay increments, the role of the LNC, job planning, appraisals, LTFT working, CVs and interview skills, research, opportunities in senior and extended roles.
- *CESR Workshop*: Organized on 17th July 2024 at White Hart Hotel.
- Dr. Pulkit Gupta, Second Prize-winner of "*Design a study day competition*" created a session on "*Use of AI and Exercises to Improve Sensory Focus*" in the SAS week on 17thOctober 2024.

See Appendix C.

Well-being Support

Our commitment to supporting doctors' well-being remains steadfast. An informal well-being event was held at Maul's in Salisbury on 6th February 2025. This included cheese tasting followed by a discussion on Portfolio pathway, specialist contracts, and other SAS-specific challenges. The session also provided a safe space for open conversation, reaffirming the Trust's commitment to both personal and professional wellbeing.

Dr. Chris Ford has also been offering support to the SAS Doctors in his role as SAS Advocate.

Future Direction

Although the Trust was unsuccessful in their bid to secure national SAS/LED development funding, discussions are underway to implement a similar internal model aimed at developing every SAS doctor as an educator.

Plans include:

- **SAS Discovery Days:** These events will promote involvement in extended roles and educational development.
- **SAS Educator Pathway:** Work is in progress to formalise a framework that supports SAS doctors in becoming active educators within the Trust.

Acknowledgements

Sincere thanks to all colleagues who have contributed to these initiatives. Special appreciation goes to Dr. Emma Halliwell and Dr Chris Ford for their unwavering support. My appreciation also goes to Emma Freeman, Sam Woodward, and other colleagues in the Medical Education team for their dedication and contributions.

Ms. Rashi Arora
SAS and LED Training and Development Lead

6.3 International medical graduates

The IMG support within Salisbury District Hospital is developing continuously.

The IMG handbook has been further developed with additional information that helps graduates settle into the NHS and local area.

Every other month there are drop-in sessions held in Springs restaurant at lunchtime. These have been successful with graduates and trainers dropping in with questions. I have been able to offer support to individuals in this forum, with a successful PLAB exam, successful career guidance and sign posting to some regulations as a flavour of activity.

I provide a one-to-one face to face induction/ meet and greet for IMGs in Salisbury.

We have formulated a feedback form for Foundation IMG graduates to complete after the induction with myself.

I have been able to sign post trainers to the Deanery provided half day IMG induction.

I am developing a communications session for IMG doctors and will hope to provide some coaching sessions if needed in the future.

I have planned a new Educational Supervisors' course; this is a half day to run in Salisbury. This is for our Salisbury educators and is in response to a plea from the Trust for more ES provision. It is running in August of this year and there are 40 doctors attending. This is open to our SAS doctor cohort, many of whom were IMGs.

Dr. Julie Onslow

International Medical Graduate Lead

6.4 Quality Assurance Monitoring Data

Local processes to quality assure in addition to the annual GMC survey of resident doctors include:

1. Annual feedback sessions with both the Foundation Year 1 and Foundation Year 2 doctors – summarised and distributed as appropriate by the FPD.
2. Formal feedback from GP VTS trainees at the end of each year - forwarded to the individual departments.
3. Formal evaluation of the main August induction and F1 shadow week – Appendices D & E
4. Regular departmental visits by the DME to meet with trainees and discuss their training experience.

6.5 Educational Supervision

All Educational Supervisors in Wessex are required to have undertaken 'The Essentials' course. This is the 2-day course run by HE Wessex that equips Educational Supervisors for their role. Currently this is running as a combination of E-learning and face-to-face tutorials, and places are very limited. Once accredited, trainers recognised for these roles are now identified on the GMC register.

Due to Wessex struggling to keep up with demand, and the need for Salisbury to train more Educational Supervisors, there is a plan to put on an accreditation course in Salisbury run by the DME and IMG Lead, who is also an Associate Dean in Wessex.

The process for maintaining recognition as a trainer is based upon a requirement to undertake 10 hours of educational CPD (8 hours of which must be face-to-face) within a five-year period. Once all the CPD requirements have been met, an individual's training role is discussed at their appraisal and their educational revalidation submitted to the GMC.

There are many examples of what could be classed as CPD e.g., equality and diversity training, attendance at ARCP panels, career guidance, exam support, supporting trainees through SIIs etc. Several 'Trust Refresher' courses have been facilitated by an increasing number of senior educationalists at SFT, which can form part of the face-to-face element. The two that have been run over the last 12 months had good attendance and received excellent feedback – see Appendix B

During the past year we have continued to use an external company called 'Doctors Training' to run various courses aimed at supporting our Educational Supervisors in their role. These have included 'Career development and medical leadership', 'Unlocking the value of reflective practice and supporting trainees with incidents' and 'Personal and professional effectiveness – managing difficult conversations'. In addition, they ran a 'Senior educators' day' for METC members, which was excellent and very well received by all those who attended.

6.6 Revalidation for Trainees

The GMC revalidation process for secondary care and resident doctors has been in place since 2012, which requires each doctor to revalidate on a 5-yearly cycle. The SE Regional Postgraduate Dean (Dr. Jo Szram) is the Responsible Officer for all doctors in training and SFT's Chief Medical Officer (Dr. Duncan Murray) fulfils this role for locally employed doctors.

Any resident involved in an SII or Clinical Review or named in a Complaint has to self-report this on their Form R, which feeds into the ARCP process. Once any investigation is complete, they are also required to upload a reflection about the incident onto their portfolios.

6.7 Medical Education Budgets

The department is supported by the following budgets:

- Medical Education Director (Infrastructure)
- Specialty Doctors' Training
- Study Leave (held centrally by NHS England Workforce, Training and Education, and reimbursed to SFT)
- Undergraduate Tariff from Southampton University (formerly SIFT)

The responsibility for these budgets lies with the DME.

The annual Undergraduate Tariff business plan, which outlines how around £650,000 will be spent, is drawn up by the DME and then approved by the Chief Medical Officer. This is used to support medical students with accommodation, travel, administrative support, and well-being initiatives. It is also used to develop/train our medical educators. In addition, funds have been allocated for the purchase of the following items of equipment:

- Interactive anatomy table
- Surgery – rectal examiner
- Simulation – teatherless sim baby
- AMU/urology/orthopaedics - butterfly ultrasound probes
- Anaesthetics – nerve simulators
- Ophthalmology – digital eye examiner, ophthalmoscope
- ENT - otoscopes
- Library - Up-to-Date subscription

7.0 Education provision

The restriction in space in the Education Centre is becoming a more acute issue with each passing year. Ensuring that rooms are available to meet our obligatory training commitments is becoming more of a challenge. The ability to organise something 'ad hoc' or with short notice is virtually impossible. The situation is hindering business as usual, never mind our desire to expand educational opportunities

It remains necessary to hire other venues at times, with the associated cost and lack of flexibility, and run courses at the weekend in order to get round this issue. There is also a lack of private space for 1:1 conversation, which goes against the NHS-wide well-being agenda.

As has been said in this report for several years, the Trust needs to look at this as a matter of urgency. We have contractual requirements to provide dedicated teaching for various cohorts of our learners, and this is proving more difficult to achieve. With the political agenda moving towards widening participation in medicine, the situation is only going to get worse. Our non-medical colleagues are also struggling within this limited provision, and so a complete 'rethink' is necessary.

8.0 Inform Trust Management of National Policy

The Medical Education and Training Committee (METC) is a cohesive and functional group as it provides a forum for cascading information out to Departments and resident doctors within SFT via the Educational Leads. The DME reports to the People and Culture Committee in order to continue to highlight the impact of national directives regarding education and training, and recruitment issues on service delivery and safe patient care. Finally, the DME meets every other month with the Chief Medical Officer to discuss issues that have arisen at Deanery, Trust, and resident level.

9.0 Clinical Governance Framework

Salisbury's inter-professional Healthcare Improvement Programme (HImP) is a well-established course to help Foundation Doctors learn basic, non-clinical skills by undertaking service improvement projects. During the last year, this programme has been aligned further with the Trust's 'Improving Together' initiative. It is hoped that this will (amongst other benefits) improve the sustainability of the projects undertaken as this has always been a challenge for HImP.

10.0 Careers Advice and Pastoral Care

Career support and pastoral care from the DME, FPD, and College/Specialty/GP and Tutors continues to ensure that residents receive appropriate and timely assistance and guidance throughout the duration of their time in Salisbury.

Career guidance for Foundation doctors takes place in both years of the Foundation Programme. There are 2 generic career guidance sessions, with additional specific sessions on interview preparation and applying for GPVTS in Foundation Year 2.

With the ongoing clinical pressures, the need for pastoral care and well-being support remains in forefront of everyone's mind.

The DME and FPD continue to provide pastoral care for trainees who require additional support for reasons both within and outside the working environment. As a rule, the FPD mainly supports the Foundation Doctors as issues regarding their welfare are usually escalated in that direction. The DME usually does the same for trainees above Foundation level, but not exclusively so. Both are supported in this regard by an excellent network of departmental educational leads and medical education staff.

Referrals from the Trust to the Wessex PSWU (Professional Support and Well-Being Unit) for the few residents needing higher level of support, are usually made by Educational Supervisors, in discussion with the departmental educational leads. However, they are always done with the knowledge and support of the DME. Many of these have been for diagnosis/support of residents with neurodiversity, which we are seeing in increasing amounts.

A couple of recliners have now been placed in the Nunton Unit staff room which residents can access overnight as a make-shift rest area. It will be necessary to ensure that this area is still available as the footprint of this unit changes, especially as it forms part of the requirements of the 10 point 'Improving Junior Doctors' Working Lives' initiative.

The Mess continues to be a well-used area, and the events held on a regular basis are well-attended. The Mess Committee make a point of attending each induction to make the new residents aware of this provision.

11.0 Trust and Departmental Inductions

The new Foundation Year 1 doctors had a week of shadowing, funded nationally, as usual. This allowed the new doctors to undergo the same level of induction as their more senior colleagues who arrived a week later, whilst addressing areas that were particularly important at the start of their medical careers. They completed an AIM (Acute Illness Management) course and had the opportunity to 'find their feet' on the wards by working alongside the outgoing F1s. It is recognised that a longer shadow week would be preferable, but this is currently not supported by UKFPO. With the revision of curricula that are due at medical school, this may be achieved in the next few years by a longer 'assistantship' attachment, happening at the end of medical school, but at the hospital that the students have been assigned to for their Foundation programme.

Just over 50 new doctors joined the Trust on Wednesday 7th August 2024, all receiving a mandatory induction followed by their departmental inductions. The Medical Education staff are to be commended for all their hard work in ensuring that everything ran smoothly, and we are grateful for the support of Medical HR and the rota coordinators, who played an invaluable role in the process.

Regular monthly inductions (of up to 20 doctors) follow a similar format but are often held in an alternative venue to the Education Centre and are run by Medical HR.

The publication of the national 'Safe Learning Environment Charter' has given us the platform to make improvements in the consistency of departmental induction across the Trust. This work is being led by Emma Freeman, Medical Education Manager, who is actively engaging with the resident doctors to understand the current provision and how well it is received.

12.0 Challenges for 2025/2026

- Embedding the new Medical Education Team – DME, FPD, ACSD and changes within the administration team
- Working alongside the Trust and NHS WTE to support training, education, and well-being of our resident doctor after the challenges of recent years.
- Ensuring the emphasis on well-being is maintained and the 10 point 'Improving Junior Doctors' Working Lives' initiative is fully implemented.
- Continuing to ensure that all Named Clinical and Educational Supervisors who are GMC accredited trainers maintain this accreditation and encourage more consultants to take up these supervisory roles, including by offering training to further their own professional development.
- Support Named Clinical and Educational Supervisors to ensure they have adequate time in their job plans, which is ring-fenced, to support the doctors in training.
- Continuing to work with the Trust so that, even when vacancies in a rota are at the level that the viability of a rota is jeopardised, the impact on the quality of education provided and the time available by senior doctors to train is minimised.
- Ensuring full implementation of the self-development time for residents at all levels and locally employed doctors.
- Working with the GoSW and Trust management to implement the new approach to exception reporting.
- Supporting departments where there have been concerns about training and supervision raised by residents at their ARCPs, via the GMC survey or by other means.
- Support the increasing cohort of Foundation doctors, and their supervisors, to ensure they integrate into teams and become a valuable part of the workforce.
- Looking to continue to develop our SAS and Locally Employed Doctor cohort and, specifically, how we can support and develop these individuals, including those wanting to join the GMC specialist register via the CESR route.
- Continue to develop our support mechanisms for International Medical Graduates starting in the Trust in line with GMC guidance.
- Considering how we widen our remit to meet the challenge of the national 'widening participation,' clinical attachments, work experience etc., and the need to increase administration and education centre space capacity to support this.

13.0 References

The following documentary evidence supporting this report is held in the Medical Education Department:

- Medical Education Strategic Plan: 2024-2025
- Evaluation of locally organised teaching
- Nationally analysed formal assessment of feedback from medical students on placement
- Feedback and analysis from the medical students of the local teaching sessions
- Evaluation forms received from shadowing week and induction August 2024
- Study leave database – Accent.
- METC agenda and minutes
- Junior Doctors Induction and H@NT course programmes
- Website documentation
- Archives retained according to local policy

Appendix A

GMC Survey 2025

Background

The yearly, national GMC trainee and trainer survey has taken place again in 2025 and the results were released in July.

Caveats

Response rate

There was a marked decrease in response rate nationally when compared to 2024:

69% trainee response (76% 2024)

33% trainer response (38% 2024)

Pleasingly, the trainee and trainer response rate in Salisbury was higher than the national and regional averages:

73% Salisbury trainees (66% Wessex trainee response)

51% Salisbury trainers (44% Wessex trainer response)

Locally

Results are not reported if less than three responses to questions, so ability to look at individual departments/training programmes is more limited, especially when looking at the smaller departments.

In additional, if only a few trainees in a department/programme respond the results can easily be skewed (positively or negatively) by an outlier.

This means that the results for a hospital like Salisbury can potentially be less representative of the communal experience of all trainees within a particular area and more difficult to interpret.

Results

Results are benchmarked against other Trusts across the country. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive, but shares a confidence interval with the national average, the box is highlighted pink or light green.

The survey also asked questions about patient safety and undermining behaviour, allowing free text comments.

A trainer survey runs alongside the trainee survey.

Benchmarking results by programme for SFT

There were insufficient trainees in a programme, or responses from those that are, for the results to be reported in the following programmes:

F2 – general practice, intensive care medicine, obstetrics and gynaecology, paediatrics

GP VTS – endocrinology and diabetes, obstetrics and gynaecology, otolaryngology, paediatrics

Specialty – acute internal medicine, cardiology, emergency medicine, endocrinology and diabetes, geriatric medicine, haematology/oncology, histopathology, intensive care medicine, maxillo-facial surgery, obstetrics and gynaecology, ophthalmology, otolaryngology, palliative medicine, plastic surgery, rehabilitation medicine, respiratory medicine, rheumatology, urology

Specialty	**Programme**	**Green flags**	**Red flags**
Anaesthetics	Core	Facilities, handover, teamwork, reporting systems, feedback, supportive environment, local teaching	0
Emergency medicine	F2	Clinical supervision out of hours	0
	GP VTS	Clinical supervision out of hours, regional teaching	Supportive environment
	ACCS	Teamwork	0
Medicine	F1	Reporting systems	0
Paediatrics	Specialty	Overall satisfaction, educational governance, reporting systems, supportive environment, induction, handover	0
Surgery	CST	0	Facilities, regional teaching
	Specialty	Overall satisfaction, educational governance, rota design, reporting systems, supportive environment, facilities, workload	0
Trauma and orthopaedics	Specialty	Induction, local teaching	0
Total		**27**	**3**

The results for other programmes all sat within the national inter-quartile ranges.

Benchmarking results by post for SFT

When the survey is interrogated by post, the responses from trainees of all levels are pooled into the individual specialty results.

Post	Green flags	Red flags
Acute internal medicine	Clinical supervision, teamwork, supportive environment	0
Cardiology	0	Induction
Emergency medicine	Clinical supervision out of hours, regional teaching	0
Gastroenterology	Clinical supervision out of hours	0
Haematology	Supportive environment, reporting systems, handover, teamwork, workload, clinical supervision	0
Intensive care medicine	0	Workload
Obstetrics and gynaecology	Educational governance	0
Otolaryngology	Study leave	0
Paediatrics	Overall satisfaction, supportive environment, facilities	0
Palliative medicine	Workload, clinical supervision out of hours	0
Plastic surgery	0	Local teaching
Respiratory medicine	Educational governance, adequate experience, reporting systems	0
Trauma and orthopaedic surgery	Teamwork, study leave, local teaching	0
Total	**25**	**3**

Overall satisfaction ranking

The survey also provides ranking of hospitals for 'overall satisfaction'. This year Salisbury was ranked 185th of all Trusts, not just acute Trusts, nationally – up from 197th in 2024. In addition, for the first time, we were ranked in first place of all the acute Trusts in Wessex, which is a huge achievement.

Patient safety and undermining behaviour

There were two free text comments about undermining behaviour/bullying.

One was within the Elderly Care department pertaining to a fixed-term consultant who had already had their contract terminated because of such witnessed behaviours.

The other was commenting that they were aware of ongoing investigations within the plastic surgery department, which is being addressed out with of the survey.

Trainer results

These results were only available for a small number of specialties, which is consistent with the last few years.

Specialty	Green flags	Red flags
Anaesthetics	Time to train, support for training, resources for training, handover	0
Emergency medicine	Handover	0
Geriatric medicine	0	Time to train
Paediatrics	Appraisal	0
Respiratory medicine	Rota issues	Time to train
Trauma and orthopaedic surgery	Handover	0
Total	**8**	**2**

All the other responses were either within the inter-quartile range or had an insufficient number of responses to report.

Comments

The GMC survey continues to be regarded as the most valuable tool there is for assessing the quality of training of posts nationally. However, when there are only a small number of respondents in a programme/post, it is relatively easy for the results to be biased by the responses of just one resident in a positive or negative way. This is compounded where there are several 'neutral' or 'average' responses or if the particular programme/post concerned is one of a limited number in the country, due to the way results are analysed and compared. There has been a marked fall in the response rate across the country this year and so it is pleasing that in Salisbury the response rate to both the trainee and trainer survey is above both the national and regional averages. There remains concern at local, regional and national level that some of the questions asked are ambiguous and would be better answered with a 'yes' or 'no' rather than a graded response.

Even though the GMC survey does not always give us the full picture, it does identify areas where there are significant concerns and where training is clearly excellent. The results give a guide as to where work needs to be done to improve the quality of the posts and also where there is good practice that should be shared more widely.

The most pleasing element from this year's GMC survey is that our ranking for overall satisfaction at both a national and regional level continues to improve, such that we are now the top ranked acute Trust in Wessex. In addition, we have not been asked by the Deanery to investigate or respond to any issues/red flags that have been brought up in the survey, which is only the second time this has happened in many years.

Our benchmarking results have shown that we have maintained the improvement we had seen in the trainee survey in last few years – namely 27 green flags (22 in 2024) v 3 red flags (9 in 2024) when looked at by programme. These results are equally as good when looked at by post – 25 green flags and 3 red flags.

The standout results, as highlighted by the Deanery, for this year are:

By programme:	Core Anaesthetics	7 green flags
	General Surgery	7 green flags
	Paediatrics	6 green flags
By post:	Acute Internal Medicine	3 green flags

	Haematology	6 green flags
	Paediatrics	3 green flags
	Respiratory Medicine	3 green flags
	Trauma and Orthopaedics	3 green flags
Trainer survey:	Anaesthetics	4 green flags

All these departments should be proud of what they have achieved. It is rewarding to note that even in some of the most challenging clinical environments, where the workload is high (namely acute internal medicine and respiratory medicine) the training environment is still perceived in an excellent light. Anaesthetics should be congratulated for getting such positive feedback via both the trainee and trainer surveys.

It is always worth highlighting other areas that have improved, which may not be fully reflected in the 'flag count'. Obstetrics and Gynaecology had their worst survey results in 2024 for several years with 4 red flags. It is a real testament to the changes instituted by the educational faculty and clinical lead in the department, that this year they have come away with 1 green flag and no red flags, as well as being recognised for their standard of training by The Royal College of Obstetrics and Gynaecology. The work that has been put in by the Gastroenterology department continues to reap rewards. Last year they had no red flags, which was the first time this had happened for many years, and this year they have had a green flag for the first time during my tenure as DME.

These results have been discussed with educational leads for the various departments in order to facilitate further reflection and discussion.

I must make comment that we are fully aware that not all issues with the training and the educational environment come to light through the GMC survey. We are currently addressing issues within the plastic surgery department that have been highlighted by residents through another route.

My final reflection is that this survey was undertaken at a time when many residents continue to express their disquiet in an industrial dispute with the government. It is satisfying that, despite this undercurrent, the residents feel that their experience of working in Salisbury is still very positive. This is a real testament to the hard work, dedication and enthusiasm of the whole educational faculty, and I am grateful for their continuing support.

Dr Emma Halliwell

Director of Medical Education

Salisbury NHS Foundation Trust

August 2025

Appendix B

Supervisor courses

Date	Event title	Number of attendees
16th October 2024	Career development: Helping Trainees make informed career choices	15
13th November 2024	Education Supervisor ½ day refresher	13
15th January 2025	Personal & Professional Effectiveness / Managing Difficult conversations	23
26th February 2025	Supporting trainees with incidents & Reflective Practice	16
2nd April 2025	Senior educational faculty development day	14
16th April 2025	Education Supervisor refresher ½ day	10
17th June 2025	Understanding and supporting neurodiverse doctors	13

Feedback on these courses was obtained, which was very positive. This is available from Medical Education.

Appendix C

SAS courses

Date	Event title	Number of attendees
6th February 2025	SAS Spring Meeting	10
14th March 2025	SAS doctor career toolkit day	25
17th April 2025	SAS doctors as educators	16

Feedback on these courses was obtained, which was very positive. This is available from Medical Education.

Appendix D

Induction feedback

Overall Satisfaction

- **High satisfaction** was reported by most Foundation and Specialty Trainees, especially in departments like Endocrinology & Diabetes, Elderly Care Medicine, Pathology, and General Surgery.
- **Departments with lower satisfaction** included Respiratory, Plastics, and Acute Internal Medicine, suggesting targeted improvements may be needed.

Departmental Induction Effectiveness

- **Strong agreement** on departmental induction supporting learning needs was most common in Pathology, Endocrinology, and Elderly Care Medicine.
- **Mixed responses** were seen in Plastics and Acute Internal Medicine, where trainees felt less prepared or welcomed.

Team Welcome Experience

- Most respondents felt **welcomed by the wider team**, with strong agreement in Radiology, Cardiology, and Oral & Maxillofacial Surgery.
- A few departments (e.g., Acute Internal Medicine) had feedback indicating a lack of structured welcome or guidance.

Safety Emphasis

- **Majority confirmed** that clinical induction emphasized safety.
- One notable exception was Child Health, where the trainee marked "No," suggesting a review of safety messaging may be beneficial.

Usefulness of Day 1 Information Pack

- The **Day 1 pack was widely appreciated**, with only a few respondents unsure or finding it unhelpful (e.g. Respiratory and Child Health).

Qualitative Feedback Themes

- **Positive highlights**:
  - "Excellent induction, key points covered well." (Oral & Maxillofacial Surgery)
  - "Very well organised… issues easily rectified." (Pathology)
- **Constructive suggestions**:
  - Include referral and trauma clinic booking guidance (Plastics).
  - Avoid assigning night on-calls as first shifts; consider buddy systems (Cardiology).
  - Provide clearer scan vetting protocols and specialty review processes (Acute Internal Medicine).
  - SHO-led walkthroughs to reduce stress during first on-call (T&O).

Appendix E

F1 shadow week and induction feedback

What Went Well

- **Practical and clinically relevant content**: Pain management, ECG interpretation, and VTE prophylaxis were consistently praised.
- **Interactive and scenario-based teaching**: Example cases and real-world applications helped reinforce learning.
- **Specialty variety**: Sessions covered multiple disciplines, including ENT and cardiology.
- **Clear medication guidance**: Dosing and indications were well explained.
- **Holistic structure**: Timely sessions with space for questions and feedback.

Areas for Improvement

- **Session length**: Several participants noted that 3-hour blocks were too long and impacted ward coverage.
- **Printed materials**: Requests for handouts and annotated slides to support learning.
- **Practical focus**: Some lectures were seen as too theoretical and not sufficiently job focused.
- **Environmental comfort**: Comments included air conditioning and seating duration.
- **Timing and scheduling**: Suggestions to better communicate end times and avoid clustering multiple sessions.

Representative Quotes

"Really good revision for pain management, VTE prophylaxis and ECGs."
"Going through examples of cases related to VTE and ECG findings, pain management scenarios. Practical tips and also of working with Lorenzo."
"Some lectures did not focus enough on practical aspects of the job but were more of an overview of how the specialty works."
"A teaching session on fluids would be great."
"Too long a session. Problems with ward cover while we were away for 3 hours."

Recommendations for Future Sessions

- Introduce shorter, modular teaching blocks to reduce disruption.
- Provide printed or digital handouts for key sessions.
- Increase emphasis on practical, job-relevant content.
- Consider additional topics such as fluid management and analgesia dosing.
- Improve environmental comfort and scheduling transparency.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	8th January 2026		

Report title:	National Inpatient Survey Results 2024			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee - 25th November 2025 Patient Experience Steering Group - 29th October 2025			
Prepared by:	Jayne Sheppard – Deputy Chief Nursing Officer			
Executive Sponsor : (presenting)	Judy Dyos – Chief Nursing Officer			
Appendices (if necessary)	National Inpatient Survey Results (2024) – Results Report Slide Deck updated version			

Recommendation:

This report is for assurance and noting by the Trust Board.

Executive Summary:

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51.49%.

The Trust scored worse than expected for 3 questions compared with all other Trusts:

- During your time in hospital, did you get enough to drink?
- When you asked nurses questions, did you get answers you could understand?
- Were you able to get a member of staff to help you when you needed attention?

All other 43 questions were scored comparatively the same with all other Trusts.

Our results this year were significantly worse than our 2023 survey results, for 5 questions:

- Getting enough to drink
- Able to get the answers you could understand, from nurses
- Ability to get medical staff to help when attention was needed
- Overall feeling of being treated with kindness and compassion
- Overall experience whilst in hospital

“Significantly worse” means a hospital’s score is statistically lower than what would normally be expected when compared with other trusts and the difference is unlikely to be due to random sampling variability given the number of responses.

Positive themes from comments in relation to:

- Care and general treatment
- Staff

- Hospital / ward stay

Negative themes from comments in relation to:
- Communication / information giving by staff
- Insufficient staff
- Discharge process / information
- Noise and disruption

These themes were noted to have some correlations with the Trust's **Real-Time Feedback** themes captured over the past year. Particularly in relation to noise at night, discharge process and communication.

Correlation of staff and inpatient survey data reveals strong links between workforce experience and patient outcomes. Communication shows improvement but gaps remains, with miscommunication impacting patient experience. Environment and facilities are a concern, with low staff morale mirrored by 72% negative patient feedback on ward conditions. Clinical teamwork stands out positively, correlating with patient praise for kindness, compassion and coordinated care. Recognition remains a cultural challenge—internal staff recognition has improved compared to previous years but remains outside top tier despite high external patient appreciation. Staffing pressures reported as unrealistic time by staff that is reflected in patient survey which reports delays and reduced presence, strongly aligned with patient dissatisfaction.

National Cancer Patient Experience Survey 2024 report painted a more positive picture with 9.1 rating for overall care compared to a national average of 8.9.

Children and Young People's Survey 2024 reported that SFT are scoring as the highest trust in our region for overall experience.

Focused work has already commenced by Matrons and operational teams to address the inpatient survey results with action plans shared at Nursing and midwifery forum.

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

National Inpatient Survey Results (2024)

Results Report - Oct 2025

Salisbury NHS Foundation Trust National Inpatient Survey 2024

Sample: Patients aged 16years+ who had spent at least one night in hospital and discharged during November 2024

Scoring: Each question in the survey that can be scored are converted into scores on a scale of 0 to 10. Scores of 10 are assigned to the most positive and scores of 0 are assigned to the least positive.

Full CQC Benchmark Report:

FINAL_RNZ_Salisbury NHS Foundation Trust (1).pdf

Summary of comparisons with other Trusts

Salisbury NHS Foundation Trust

131 NHS Acute Trusts involved
(131 last year)

62, 444 Total responses received average return rate of 41%
(63,573 responses and a return rate of 41.7% last year)

621 Total responses received for SFT (624 last year)

51.49%* Response rate *same as last year

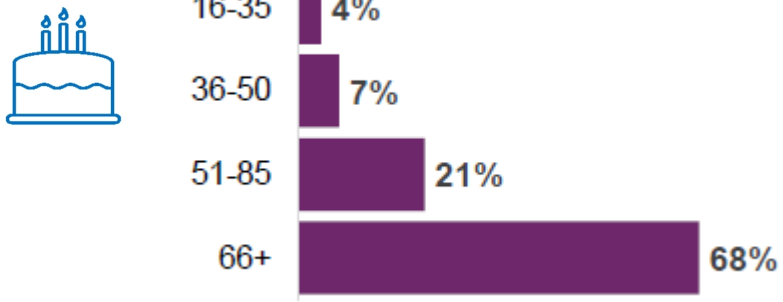
No. of questions where SFT scored better than other Trusts = 0

No. of questions where SFT scored about the same as other Trusts = 43

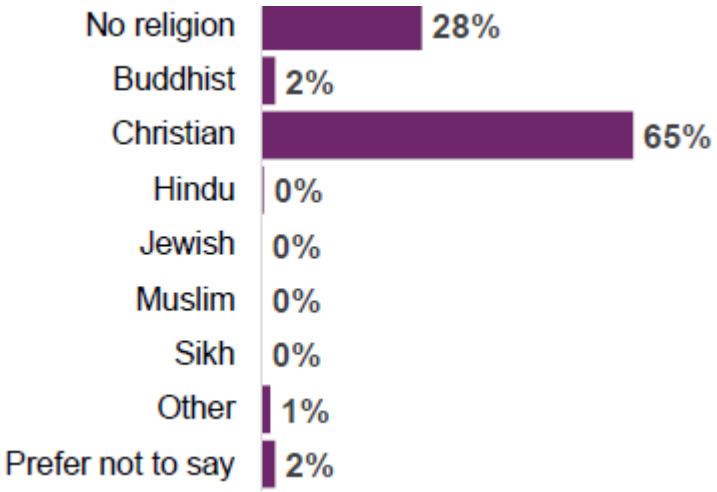
No. of questions where SFT scored worse or somewhat worse than other Trusts = 3

Demographic breakdown

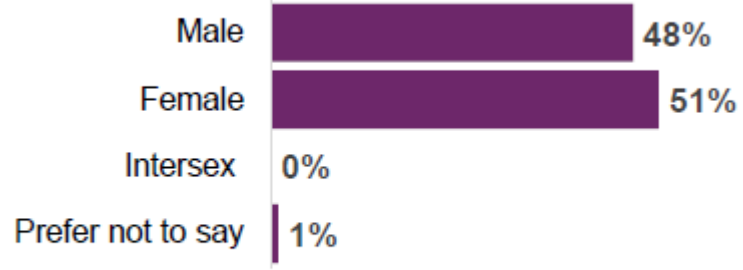
Age



Religion

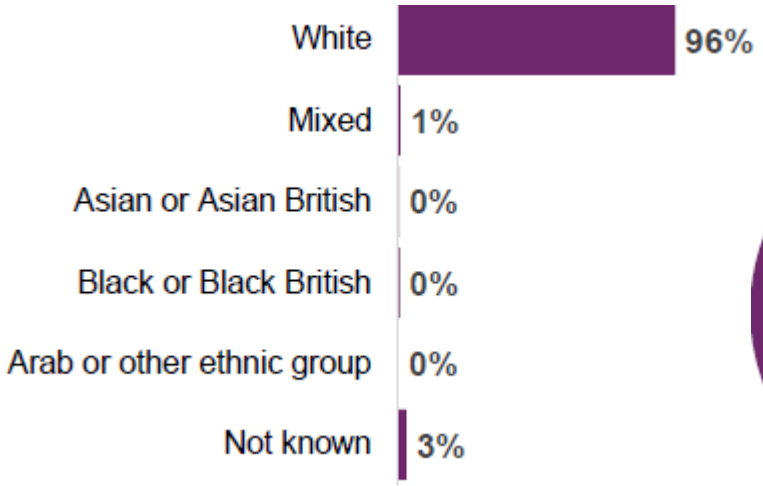


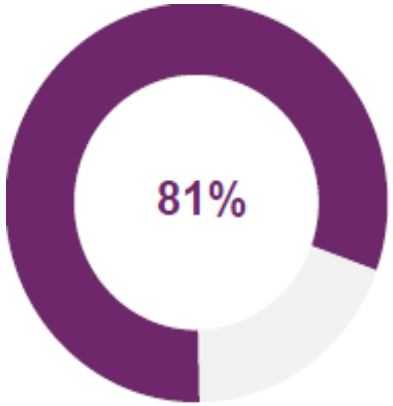
Sex



0% of patients said their **gender is different from the sex they were assigned with at birth.**

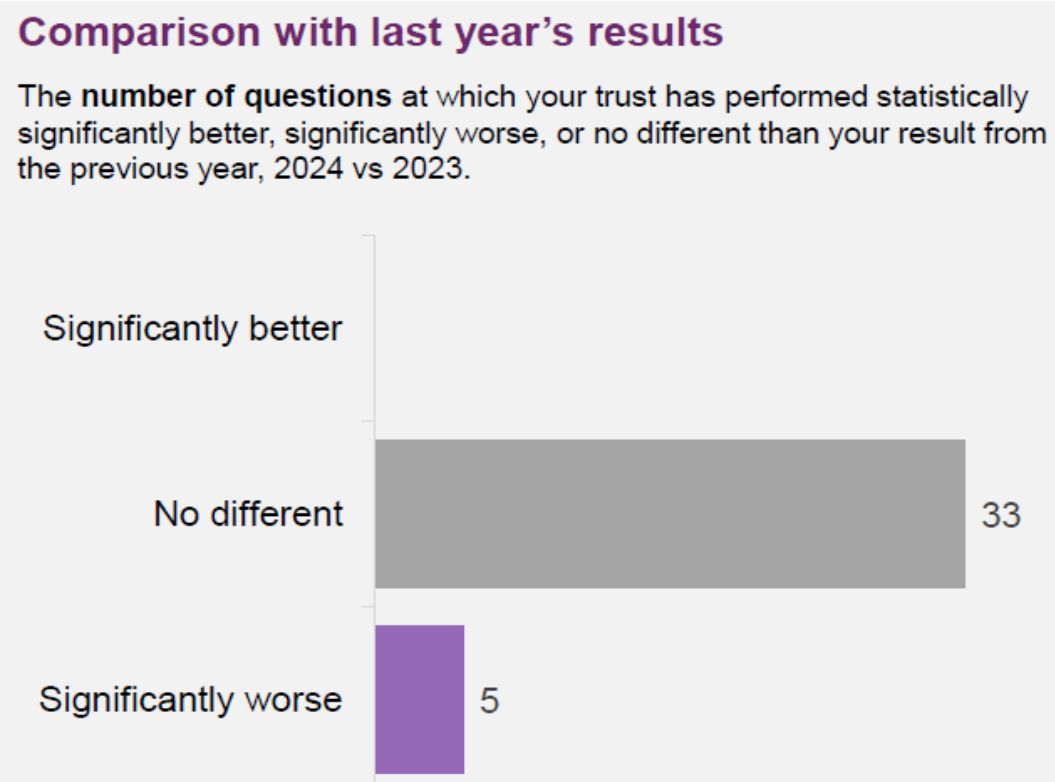
Ethnicity





of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

Comparison with SFT's 2023's survey results



5 results were significantly worse than last year

- Q 16. During your time in hospital, did you get enough to drink?
- Q20. When you asked nurses questions, did you get answers you could understand?
- Q30. Were you able to get a member of staff to help you when you needed attention?
- Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?
- Q48. Overall, how was your experience while you were in the hospital

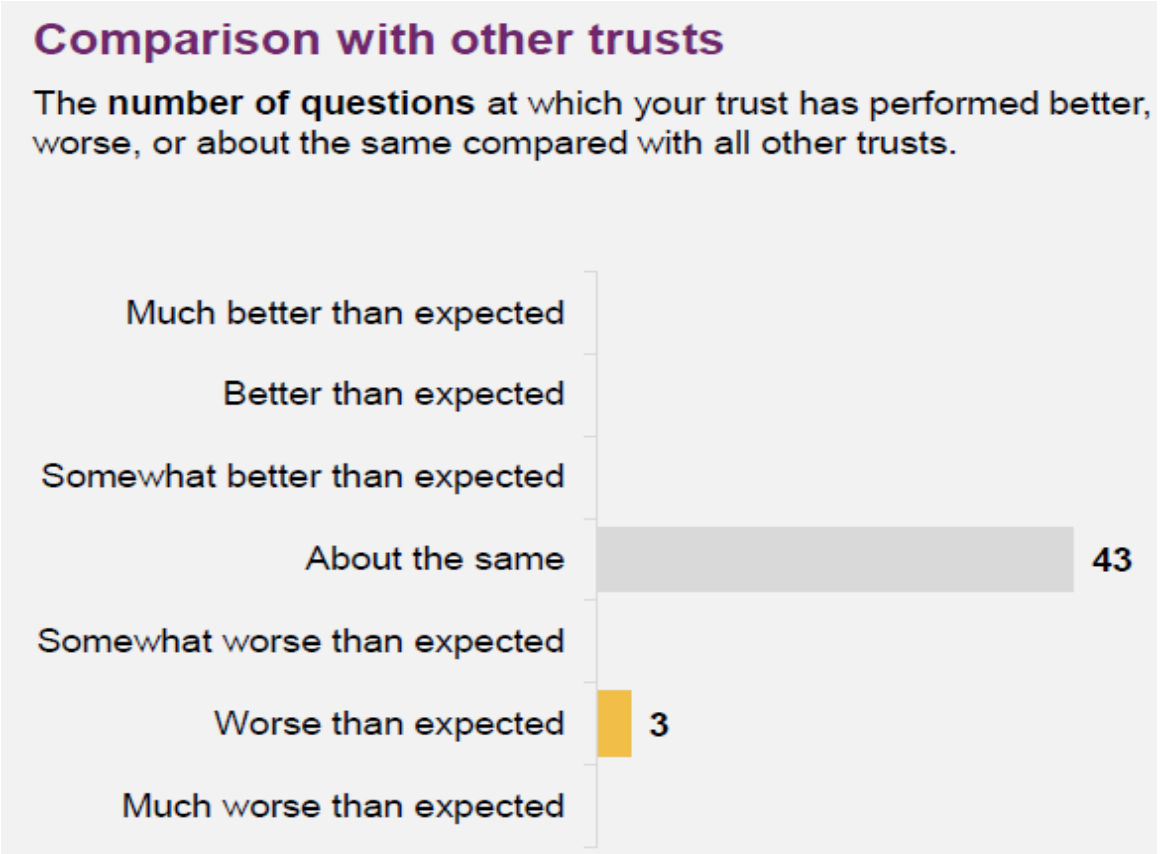
In the NHS National Adult Inpatient Survey, "significantly worse" means a hospital's score is statistically lower than what would normally be expected when compared with other trusts. It isn't just a small difference — it means the score falls outside the expected statistical range, so the lower performance is unlikely to be due to chance. It shows a trust is genuinely underperforming in that area compared with others

Comparison with other Trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

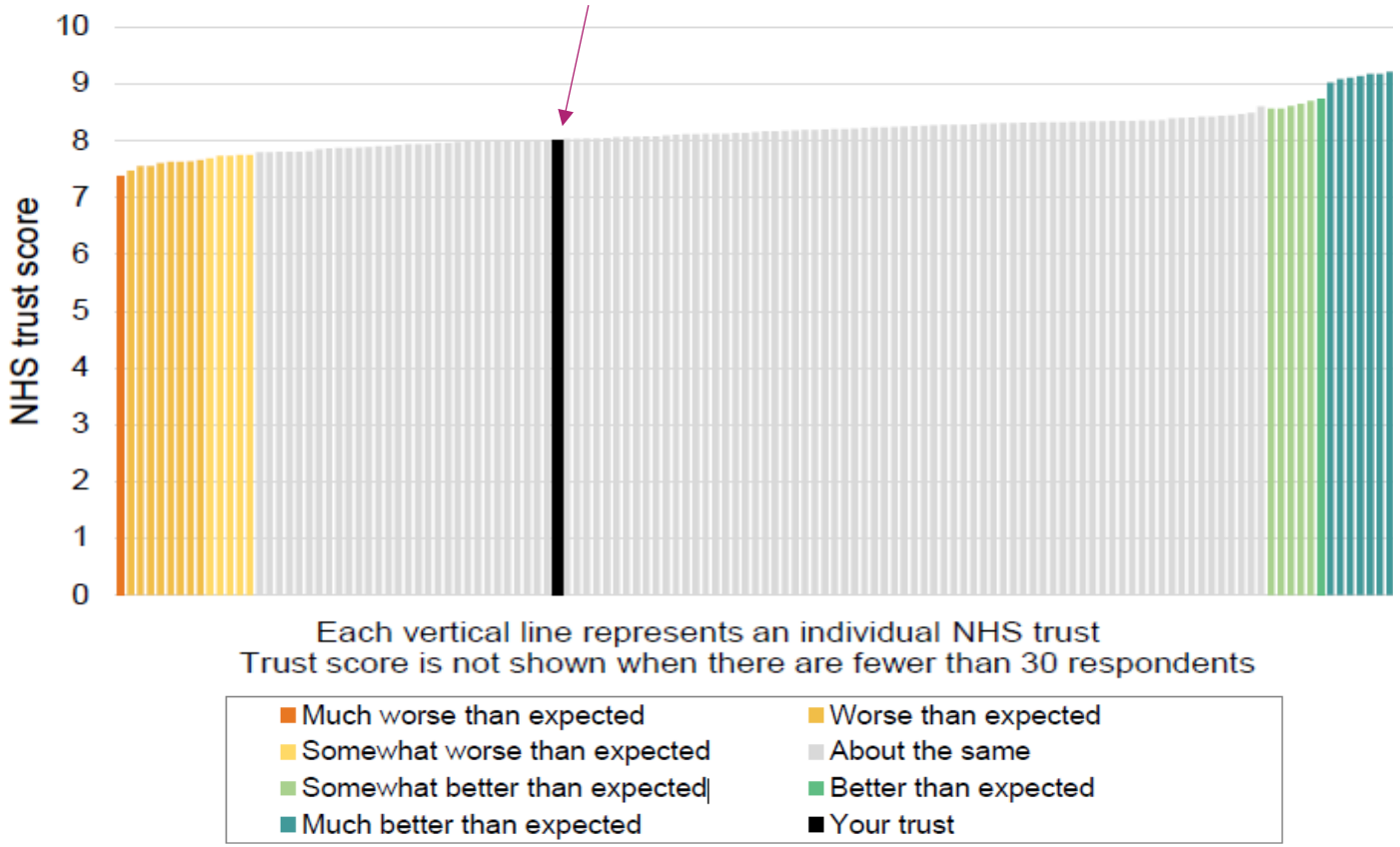
- Q16. During your time in hospital, did you get enough to drink?
- Q20. When you asked nurses questions, did you get answers you could understand?
- Q30. Were you able to get a member of staff to help you when you needed attention?



	2024	2023	2022
Overall Experience	Patient Response 8.0	Patient Response 8.3	Patient Response 8.0

NHS Salisbury NHS Foundation Trust

*SFT's position is indicated by the black line below



Comparison with other trusts within your region

Trusts with the highest scores

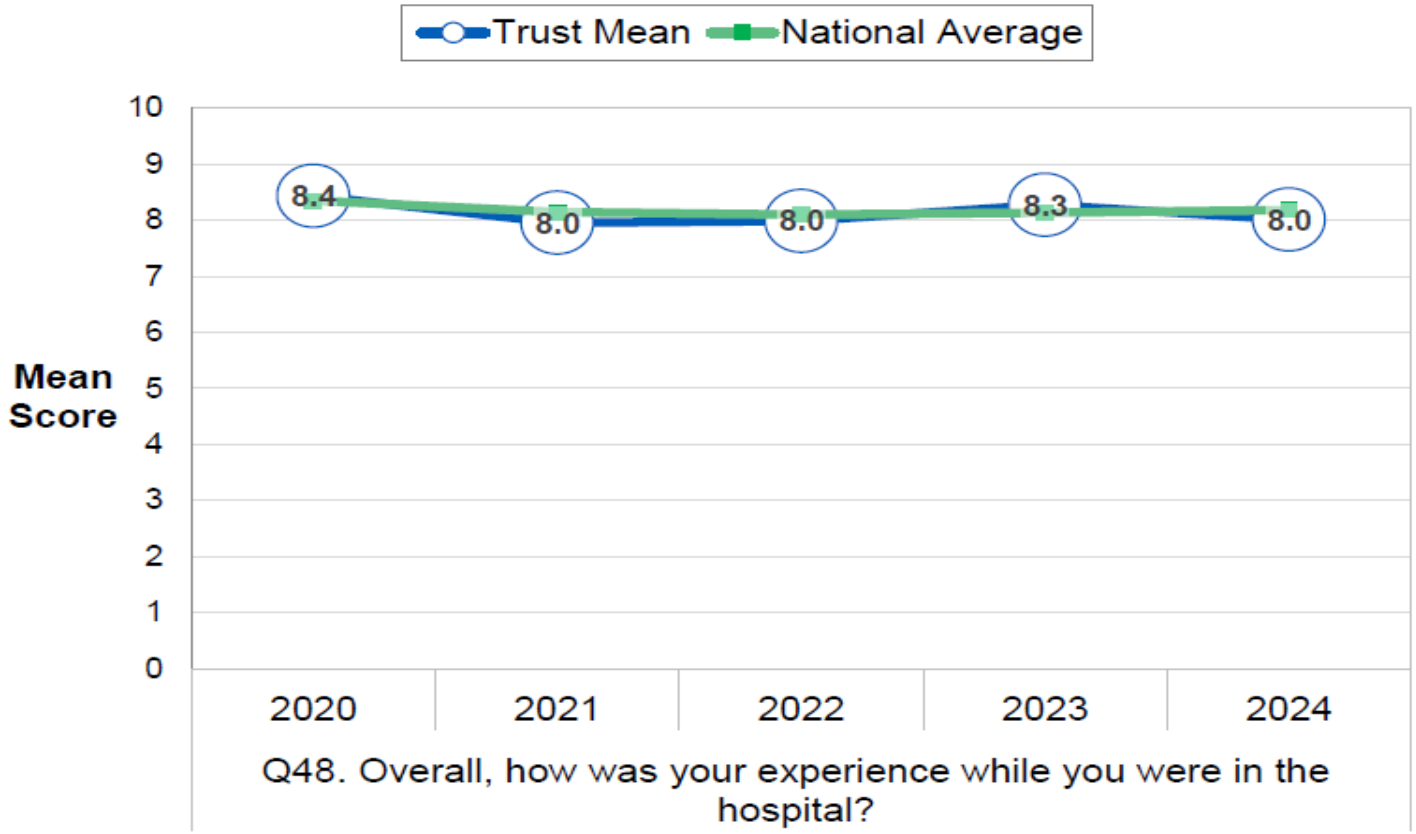
Royal Devon University Healthcare NHS Foundation Trust	8.6
University Hospitals Dorset NHS Foundation Trust	8.3
Gloucestershire Hospitals NHS Foundation Trust	8.3
University Hospitals Plymouth NHS Trust	8.3
Royal Cornwall Hospitals NHS Trust	8.3

Trusts with the lowest scores

Great Western Hospitals NHS Foundation Trust	7.9
Salisbury NHS Foundation Trust	8.0
Somerset NHS Foundation Trust	8.2
North Bristol NHS Trust	8.2
Torbay and South Devon NHS Foundation Trust	8.2

Overall Experience

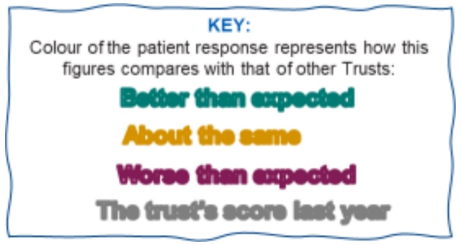
Salisbury NHS Foundation Trust



Significant change 2024 vs 2023	Decrease
Significant change 2024 vs 2022	No change

Answered by all.
Number of respondents: 2020: 680; 2021: 577; 2022: 610; 2023: 615; 2024: 615

Comparison with 2023



Salisbury NHS Foundation Trust

	2024	2023
Admission to hospital	Patient Response 6.6	Patient Response 7.5
Hospital and Ward	Patient Response 7.2	Patient Response 7.7
Doctors	Patient Response 8.9	Patient Response 9.0
Nurses	Patient Response 8.2	Patient Response 8.4
Care and treatment	Patient Response 8.1	Patient Response 8.3
Virtual Wards	Patient Response 6.6	Patient Response 7.1
Leaving hospital	Patient Response 7.1	Patient Response 7.1
Basic needs	Patient Response 7.8	Patient Response *No data available*
Kindness and Compassion	Patient Response 8.9	Patient Response 9.2
Respect and dignity	Patient Response 9.2	Patient Response 9.3

Results for Salisbury NHS Foundation Trust
NHS Adult Inpatient Survey 2024

Salisbury NHS Foundation Trust

Where patient experience is best

- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ✓ **Leaving hospital:** Staff telling patients who to contact if worried about condition/treatment after leaving hospital
- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival

Where patient experience could improve

- **Information while on virtual wards:** Patients feeling they were given enough information about care and treatment on virtual ward
- **Waiting list:** Length of time on waiting list before hospital admission
- **Information while on waiting list:** Quality of information given while on waiting list
- **Drink:** Patients getting enough to drink
- **Help when needing attention:** Patients being able to get help from staff when they need attention

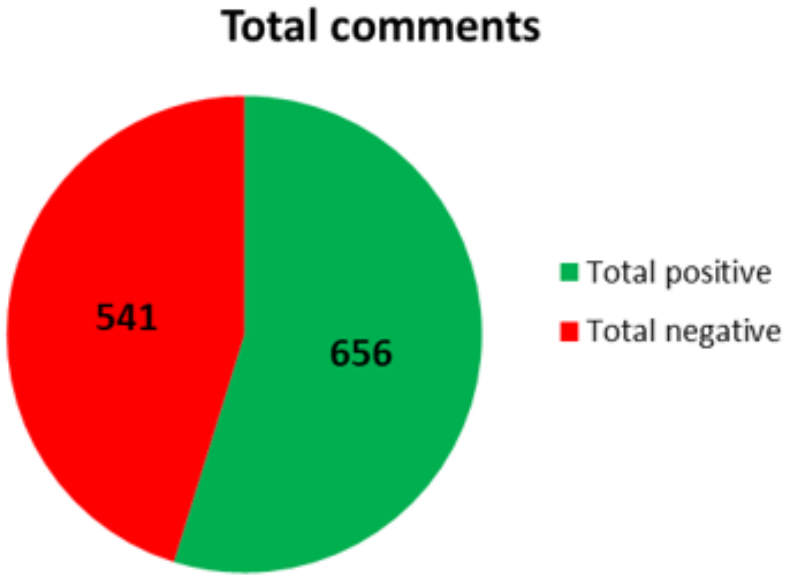
These questions are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.

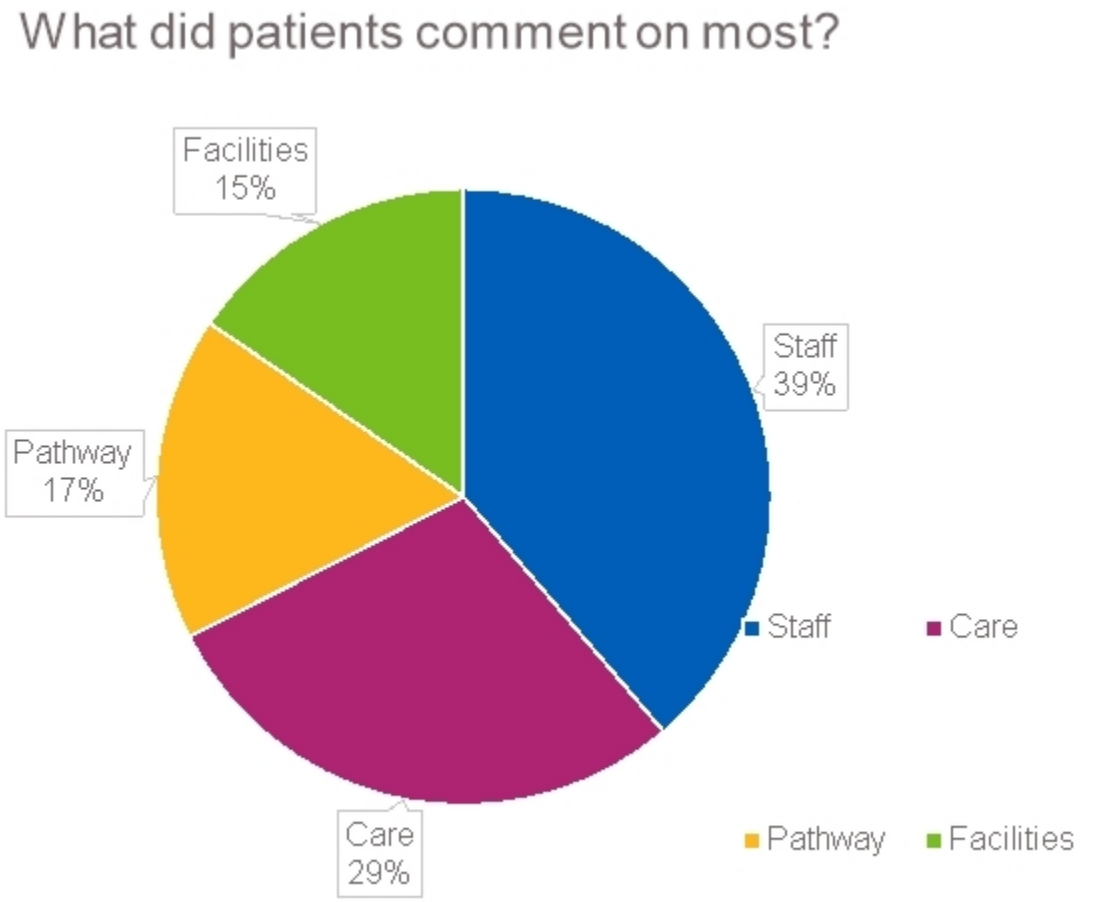
Themes from comments

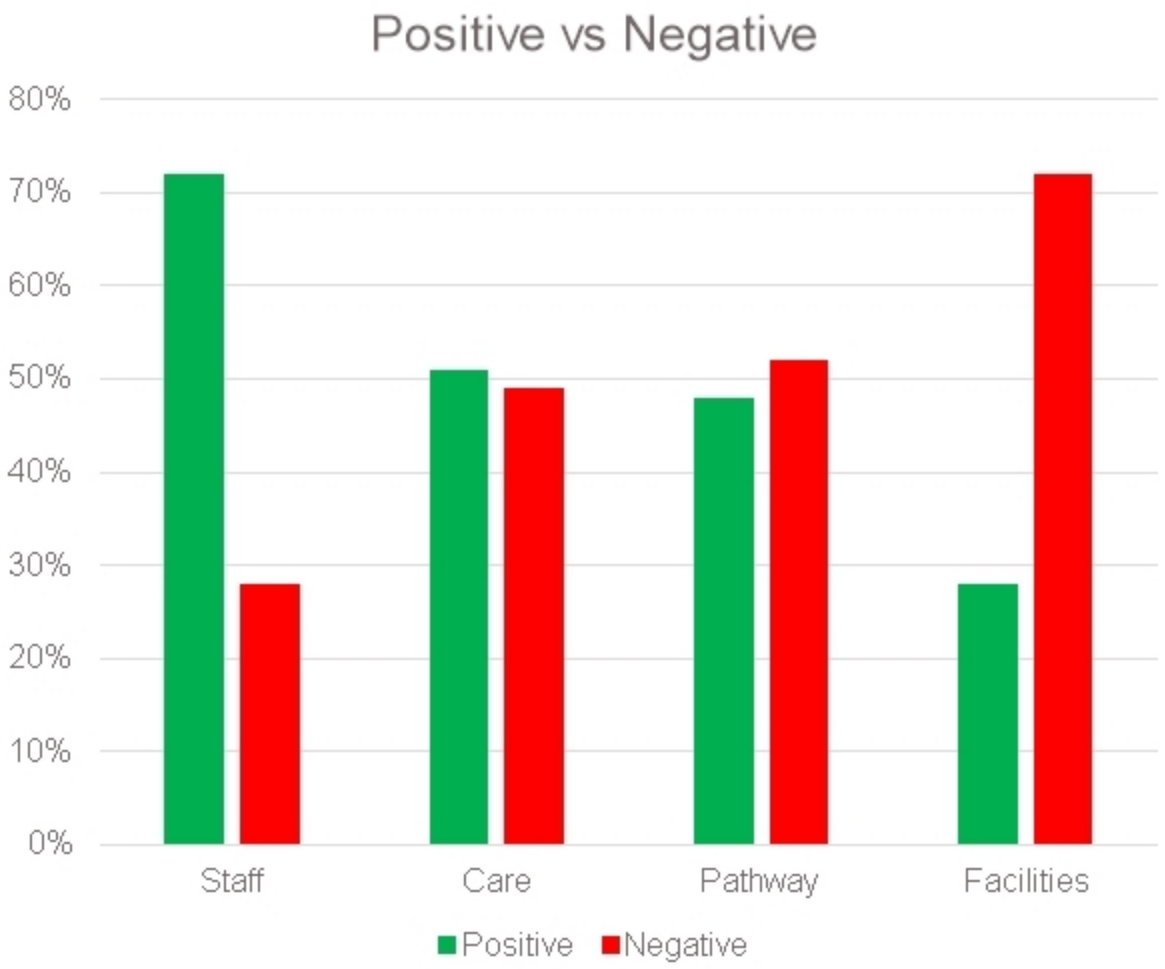
Salisbury NHS Foundation Trust

Total comments received: 1,197
(1,277 last year)

Overall positive: 55%
(56% last year)







While 72% of comments about staff and 51% of comments about care and treatment were positive, 52% of comments about the pathway of care and 72% of comments on hospital environment & facilities were negative.

Themes from comments

NHS
Salisbury
NHS Foundation Trust

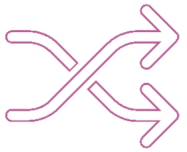
Positives

Care and general treatment

Staff (nurses and doctors and generally)

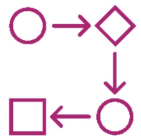
Hospital / ward stay

Negatives



Communication / information giving by staff

Insufficient staff / staff shortages



Discharge process and/ or information

Noise and disruption

Correlations with Real-Time Feedback (RTF)

Salisbury NHS Foundation Trust

Real-Time Feedback is a face-to-face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This is usually undertaken by volunteers or governors.

The aim of the feedback to give a "real-time" view of a patient's perspective of their care.

Real-time feedback is currently undertaken in all inpatient areas with the exception of maternity inpatient areas or on Sarum ward.

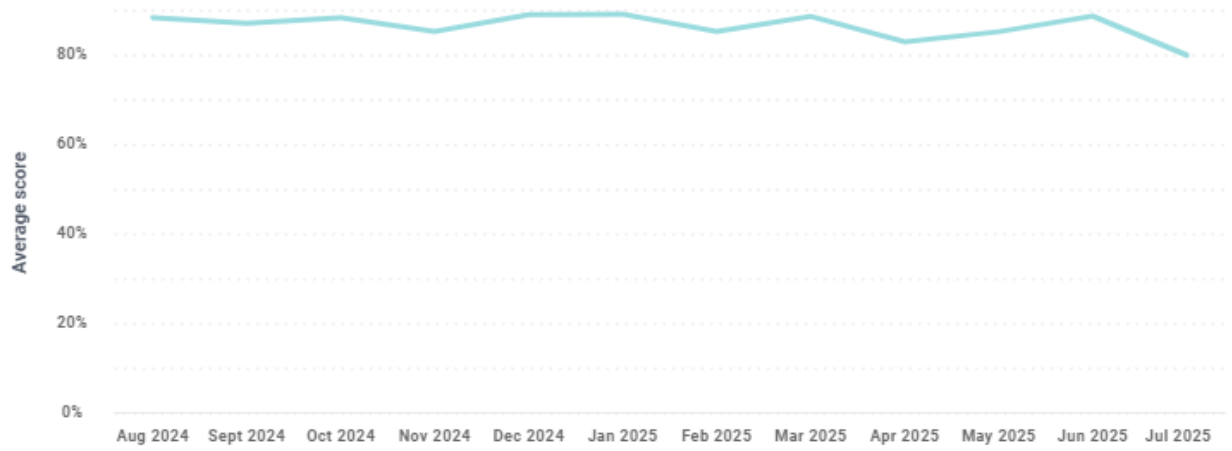
The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

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

Aug 2024 – Jul 2025

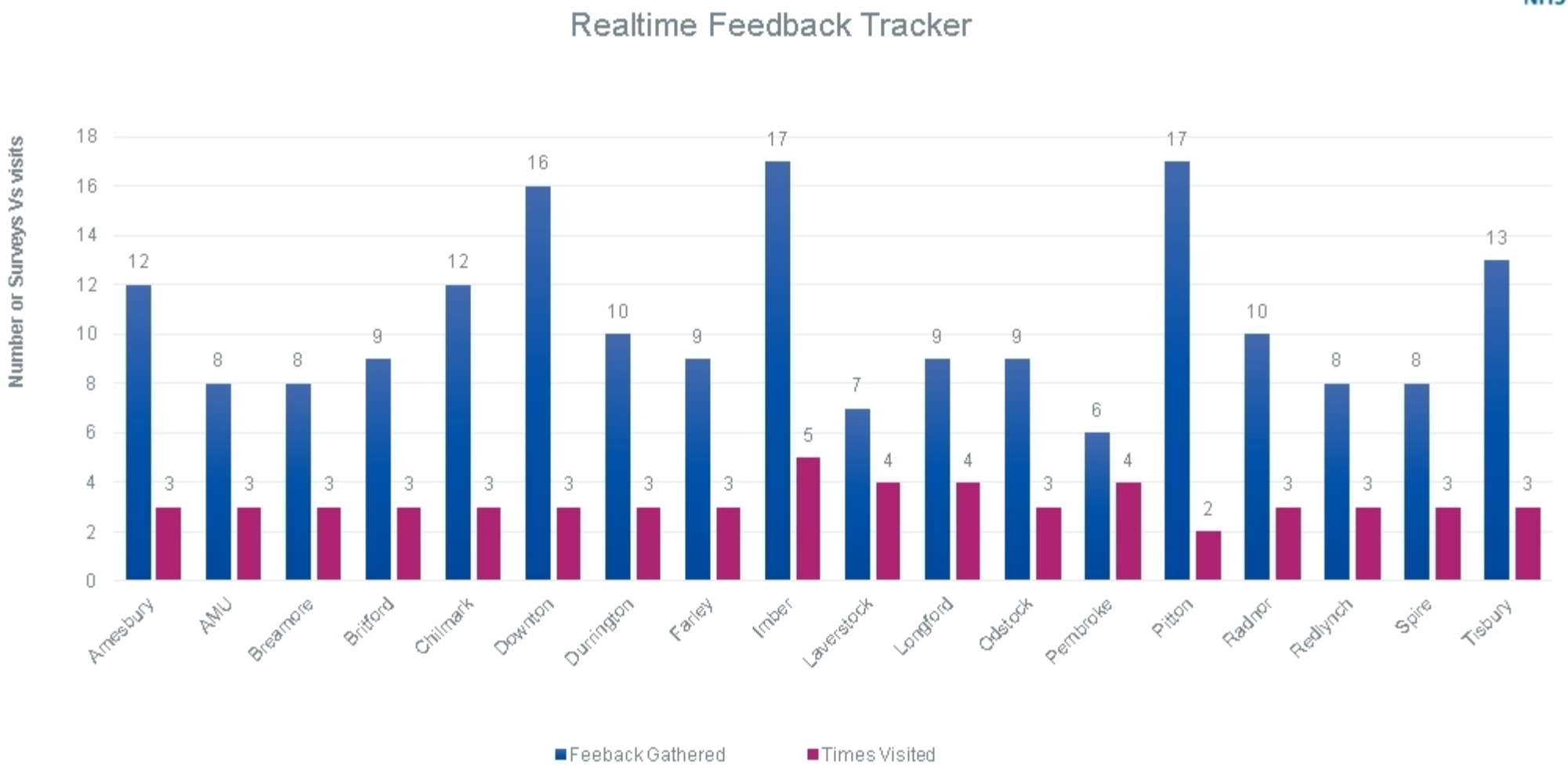
Total surveys undertaken: 415

Average satisfaction rating: 87%



Activity Tracker

NHS Salisbury NHS Foundation Trust



Themes from Real-time Feedback

NHS
Salisbury
NHS Foundation Trust

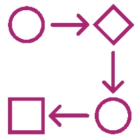
Positives

Cleanliness of the wards, toilets and wash facilities

Levels of assistance for basic care such as eating drinking and washing

Trust and confidence in those involved in their care

Negatives

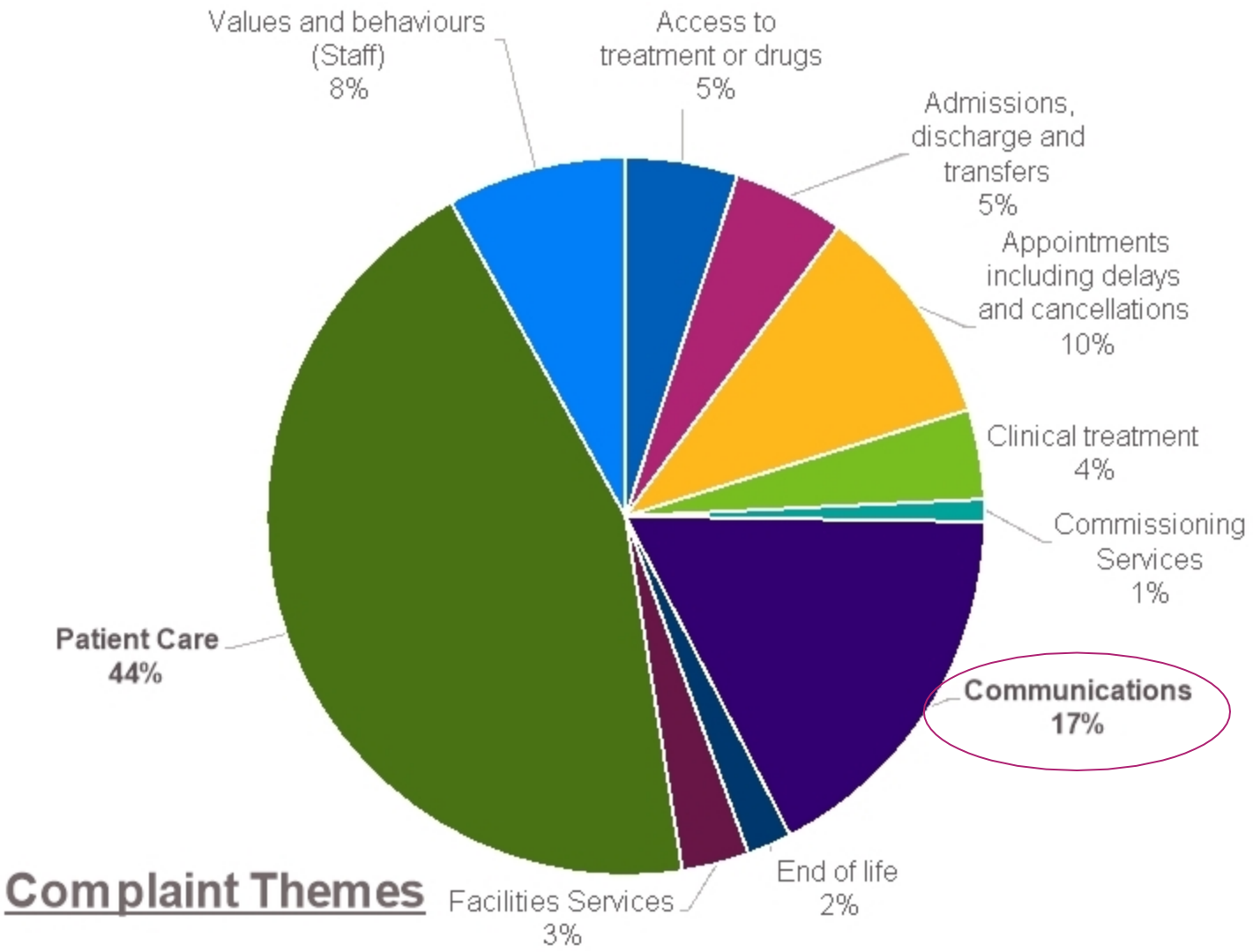


Understanding and involvement with discharge planning

How well medical staff are explaining things

How well staff explain how you might feel after an operation or procedure

Themes from Complaints



Data from RTF during the survey period demonstrated low scoring questions in relation to communication

It was noted to have correlated with themes from complaints seen in Q3 (of which 17% of complaints were noted to be in relation to insensitive and lack of communication which was the highest causes for complaints under the Communications category)

Complaints and concerns during the survey reporting period were small when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This represents the proportion of good or very good experiences (as rated by the service users) and how vast this is in comparison to the number who have raised a complaint or concern.

Correlation of Inpatient survey with Staff survey 2024

Salisbury NHS Foundation Trust

Theme	Staff Survey	Inpatient Survey	Correlation
Communication	'Voice that counts' trending upwards but still a gap compared to other trusts, especially on raising concerns	Complaints about miscommunication	High alignment
Environment & Facilities	Low morale in Estates & Facilities. However no dedicated facilities condition metric in staff survey. Reasonable satisfaction with health, safety and resource provision	72% negative comments on ward conditions	Some alignment
Clinical Teamwork	High 'We are a Team' scores; staff feel part of a cohesive team and have good management relationships.	Positive patient narratives, Praise for kindness	Positive correlation
Recognition	Internal recognition improved compared to previous years but remains outside top tier of excellent recognition	High external praise from both in patient and Realtime feedback	Inverse pattern
Staffing levels	Unrealistic time pressures	Reports of delays and lack of staff presence	Strong alignment

Staff experience can be a leading indicator of patient experience, Patients often describe consequences whilst staff describe cause.

Key Department Correlations

NHS
Salisbury
NHS Foundation Trust

Emergency Department

Emergency department staff survey reports low scores for staff morale, recognition and ‘we are safe and healthy. Patient complaints about long waits and pain management. The system pressures within ED are experienced by both patient and staff

Surgery

Surgical areas have mixed staff survey feedback, strong teamwork but low flexibility. There is fragmentation across surgical flow pathways contributing to frequent patient complaints about cancellations and communication. Praise for surgical technical skills and clinical quality but focus required to enhance pathway coordination.

Facilities and Estates

Facilities departments report low morale and recognition, linked to patient dissatisfaction with ward conditions and amenities. Operational staffing constraints within estate services are felt by patients.

There were several high performing teams across the trust with high scores from both staff and patient feedback “unfailingly kind, compassion, professionalism and excellent teamwork” was praised.

Next Steps

Salisbury NHS Foundation Trust

Enough to Drink

Patient Hydration Challenges
Patients reported insufficient access to drinks, affecting comfort and recovery during hospital stays.

Improvement Actions
Leads introduced hydration rounds and ensured water accessibility to improve patient hydration.

Monitoring and Feedback
Patient feedback and spot checks will monitor progress, with updates from Matrons planned for upcoming Nursing and midwifery meeting.

Nurses Answering Questions Clearly

Patient Satisfaction Challenges
Patients reported dissatisfaction with how nurses answered questions clearly, impacting their confidence and safety.

Communication Improvement Initiatives
Nursing Team is focusing on improving bedside communication through training and patient engagement strategies.

Strategies for Clear Communication
Using plain language and verifying patient understanding are key strategies to enhance communication effectiveness.

Ongoing Monitoring and Review
Progress on communication improvements will be monitored improvement with anticipated positive outcomes from recent initiatives. Review planned in December

Staffing levels

Retention focused to the People Plan, including support networks for staff, flexible working, leadership training and line management support. Daily staffing reviews continue to ensure safe staffing levels, triangulation with quality, safety and workforce metrics, skill mix and staffing red flags.

Next Steps

Salisbury NHS Foundation Trust

Getting Staff Attention When Needed

Patient Safety and Satisfaction
Delayed staff response can negatively impact patient safety and satisfaction, especially in critical care areas.

Ward Process Review
Matrons will lead a review focusing on call bell audits, staff allocations, and workflow improvements to enhance response times.

Monitoring and Progress
Progress will be tracked and reported at the Nursing and Midwifery forum and Patient experience steering group.

Discharge process and/ or information

Committed focus remains to enhance discharge and follow-up process led by Chief Operating Officer working with community partners to eliminate inefficiencies and streamline process

Noise at Night

Sources of Nighttime Noise
Common noise sources include bin lids, staff conversations, moving equipment, aprons, and bed transfers disrupting patient rest.

Improvement Strategies
Implementing 'Quiet Hours', fitting soft-close bin lids, relocating noisy equipment, and staff awareness aim to reduce disturbances.
Patient safety partners working with ward-based staff to identify other opportunities to reduce noise
Head of Facilities reviewing curfew for deliveries out of hours.
Linking with colleagues from across Royal United Hospital, Bath and Great Western Hospital, Swindon to implement 'Putting the hospital to bed at night' initiative.

Importance of Quiet Environment
A restful environment is critical for patient recovery and overall experience, requiring immediate and robust interventions.

Monitoring and Feedback
Progress will be reviewed at the Nursing and Midwifery Forum and Patient experience steering group, with feedback from Matrons to ensure continuous improvement.

National Cancer Patient Experience Survey (NCPES) 2024

NHS Salisbury NHS Foundation Trust

- Annual survey, commissioned & managed by NHS England (since 2010)
  - ➢ New design from 2021, now have 4 years of comparable data.

- Picker - responsible for designing, running & analysing the survey

Designed to

- Monitor progress in cancer care
- Provide information to drive local quality improvements
- Assist commissioners and providers of cancer care
- Inform the work various charities and stakeholder groups, supporting cancer patients

NCPES Methodology

NHS Salisbury NHS Foundation Trust

•Provider survey samples

- Adults (16 and over), with a confirmed diagnosis of cancer
- Discharged from SFT (after an inpatient or day-case attendance for cancer related treatment) in April, May and June 2024

•Trusts submitted sample of patients September 2024

•Survey fieldwork Nov. 2024 – Feb. 2025.

•Mixed mode methodology. Questionnaires were sent by post, with two reminders where necessary, but also included an option to complete the questionnaire online.

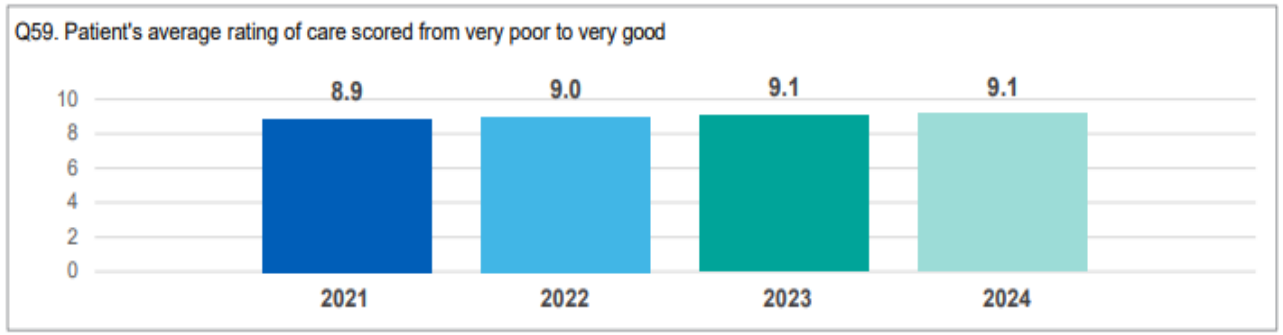
•Reports published July 2025 (National, Alliance, ICS, Trust)

Key Messages

Salisbury NHS Foundation Trust

- The report scores 61 questions at Trust level, which are compared to the national average, expected lower and upper ranges.
- **41** questions were within the **expected range**.
- **20** questions were **positive** outliers compared to **23 in 2023 and 8 in 2022**
- **0** questions were **negative** outliers compared to **0 in 2023** and **0 in 2022**.

- Patients are asked to rate their care from very poor (0) to very good (10). The Trust score was **9.1** compared to a national average of **8.9**, lower expected of 8.7 and upper of 9.1. **Consistent with 2023.**



Link to full CPES presentation report : [My Documents\PESG\CPES 2024 General Presentation.pptx]

Children and Young People's Survey 2024

NHS Salisbury NHS Foundation Trust

SFT scoring as the highest trust in our region for overall experience

Where parents and carers reported experience is best

- ✓ **Hospital food:** Children having access to hospital food outside of mealtimes
- ✓ **Leaving hospital:** Parents / carers receiving written information about care at home
- ✓ **Facilities:** Good facilities being available for parents / carers staying overnight
- ✓ **Facilities:** Parents / carers having good access to hot drinks in hospital
- ✓ **Leaving hospital:** Parents / carers understanding next steps in their child / young person's care

Where parents and carers reported experience could improve

- **The waiting area:** Children being kept informed while in waiting areas
- **The waiting area:** Children experiencing reasonable waiting times in waiting areas
- **Hospital ward:** Children and young people being placed in an age appropriate ward
- **Leaving hospital:** Parents / carers understanding information about care at home
- **The waiting area:** Children not feeling bothered by anything in waiting areas

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	08 January 2026		

Report tile:	Patient Experience Report – Q2 2025/26			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 25th November 2025 Patient Experience Steering Group 26th November 2025			
Prepared by:	Sophie Rolfe – PALS Lead Helen Rynne – Patient Engagement Lead Jayne Sheppard – Deputy Chief Nursing Officer			
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 Q2 of 2025/26.

Patient Experience Feedback – Q2:

To summarise the contents of this section of the report:

Complaints/concerns/compliments and enquiries:

- Overall patient activity across the Trust has increased this quarter to 124,463 from 102,131 in Q1.
- A total of 510 comments/enquiries were logged by the PALS team in Q2, this is slightly more than the previous quarter. The top three locations these related to were Cardiology (12%), Orthopaedics (6%) and Gynaecology (5%). These top locations are the same as Q1.
- The total number of complaints and concerns also increased to 159 logged in Q2, compared to 137 in Q1. The top three most prevalent high-level themes for complaints across the Trust were largely the same as those in previous quarterly reports. Patient Care (37.7%), Communication (23.8%), Appointments (10.7%).
- Timely closure target: 85% – Achieved 52% in Q2 which is an improvement from the 40% in Q1.
- Reopened complaints: Significant increase this quarter, but year-on-year trend improving.

The PALS team and the Divisions continue to focus on early resolution and de-escalation of complaints. 57 complaints/concerns were considered to achieve an earlier resolution than anticipated. The Medicine division accounted for the highest proportion, responding to 51% of these 57 early resolution cases.

- A total of 114 compliments were recorded on Datix for Q2 which is 100 less than Q1 however there is a backlog of compliments which are still to be logged. Formal reporting still being promoted for correlation with complaints and FFT.

.

Friends and Family Test (FFT) :

16,811 responses in Q2, which is 324 less more than in Q1 and equates to an average response rate of 18% (of eligible population) and meets the Trust 18% target . FFT experience ratings have stabilised at 94%, with those surveyed rating their experience of our hospital as Good or Very Good . Waiting times now top concern (previously communication).

Triangulation of data with ICB Acute Trusts:

ICB comparison: Salisbury KPI for response time not at Trust target, currently 52% vs GWH 70%, RUH 76.8%.

Themes for complaints are largely similar, communication and patient care being the top themes across all three Trusts.

FFT response rate Salisbury 16% vs GWH 32%, RUH 24%.

Positive themes for FFT are similar, with staff attitude being top. However, it is also the top negative theme. Amongst the top negative themes, waiting times are common across all three Trusts.

Local Surveys:
Real-time feedback (RTF)
continues to be a standing item for discussion at the PESG. 100 surveys completed in Q2slight reduction from 108 in Q1, average satisfaction 84.48%.

- Highest scores: Cleanliness (95%), Trust in care team (94%).
- Lowest scores: Discharge planning (14%), Staff explanations (52%).

Your Views Matter (YVM) Bereavement survey – Q2

Bereavement Survey: 143 sent, 13 responses (9% return rate). Positive feedback on communication, compassion, dignity.

National Surveys:

Adult Inpatient Survey: Response rate 51.49%; negative themes include drinks not offered, communication, staffing, discharge, noise.

Children & Young People's Survey: SFT highest in region for overall experience.

Cancer Patient Experience Survey: Overall score 9.1 vs national average 8.9; 20 positive outliers, 0 negative.

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

Patient Experience
Patient Feedback Q2 Report

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

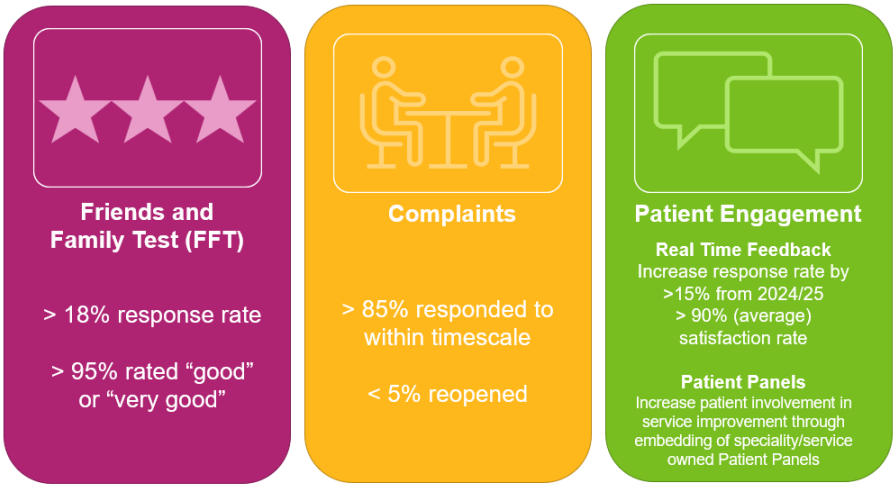
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and 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 2025/26. 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.

Summary of the performance metrics in relation to these areas for 2025/26 is summarised below:



Salisbury NHS Foundation Trust

Contents

Patient Feedback Q2 Report

1. Complaints, Concerns and Compliments - Trust Overview

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 has seen a slightly higher level of patient activity, when compared with the same quarter last year.

Table 1.1 – Patient Activity

Patient Activity by Division / Quarter	FASS	Medicine	Surgery	Total
Q2 2025-26	43,561	38,821	42,081	124,463
Q1 2025 - 26	41,844	39,748	42,318	102,131
Q4 2024 - 25	36,076	36,343	43,856	121,251
Q3 2024 - 25	36,087	37, 514	44,472	123,125
Q2 2024 - 25	36,567	36,800	43,222	121,862

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 shows an overall increase in the total number of both complaints and concerns received for Q2, in comparison with Q1.

FFT feedback continues to maintain high response rates, but we are yet to meet the Trust target again this quarter.

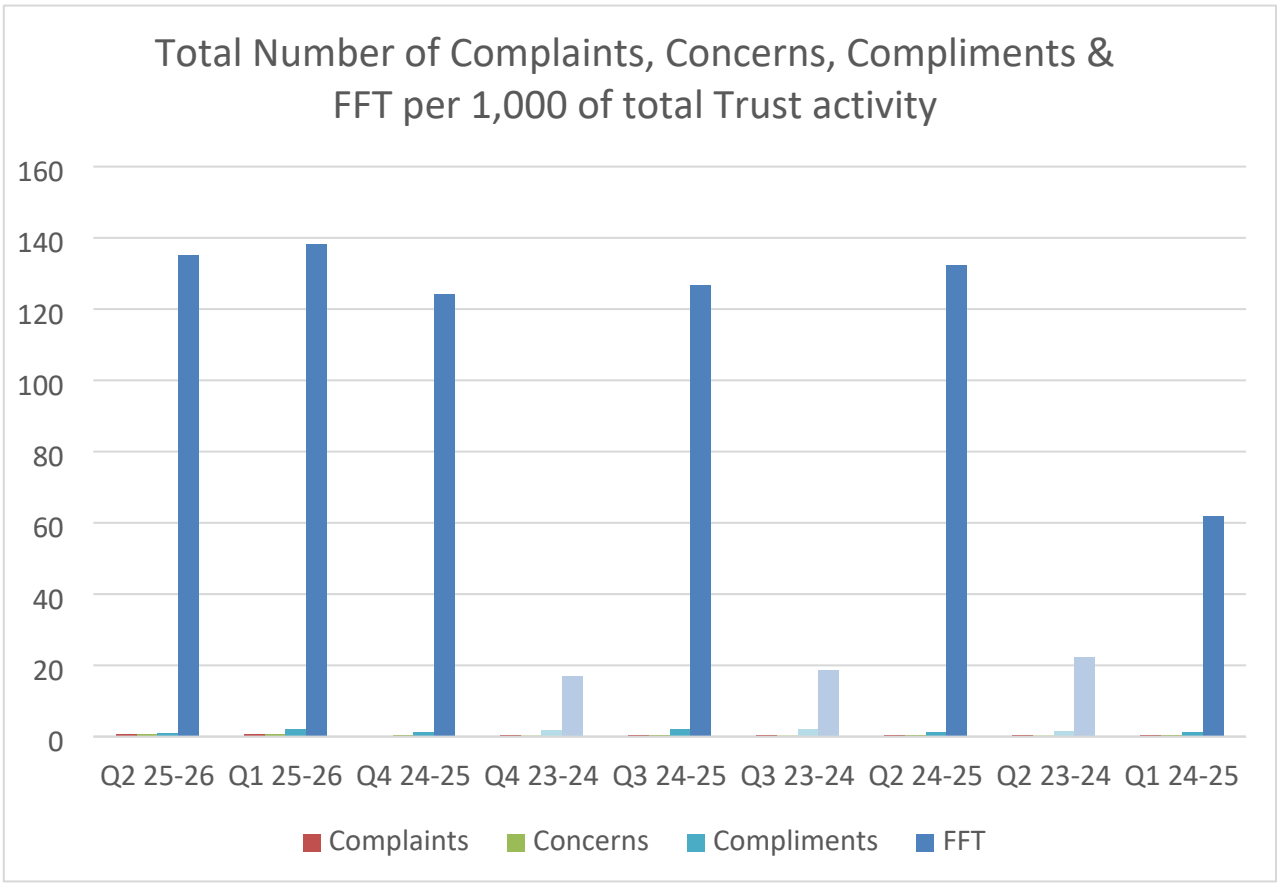
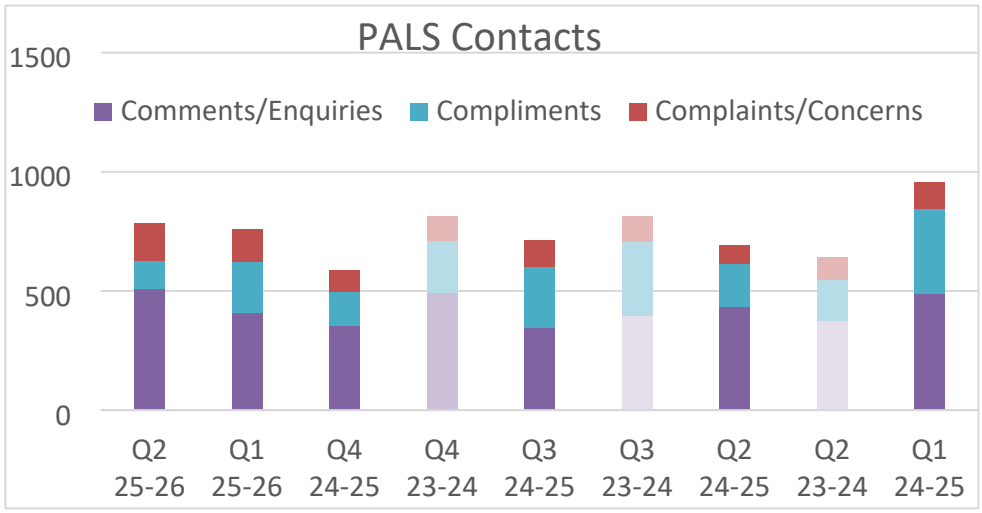


Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

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. A total of **114** compliments were recorded on Datix for Q2 which is 100 less than Q1 however there is a backlog of compliments which are still to be logged. A volunteer is joining the PALs team soon to support with this process.

In Q2, the PALS department logged **510** comments/enquiries – 103 more than Q1 which is a sizeable increase. The top three locations these related to were Cardiology (12%), Orthopaedics (6%) and Gynaecology (5%). These top locations are the same as Q1.

This equates to an average of 4.0 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.



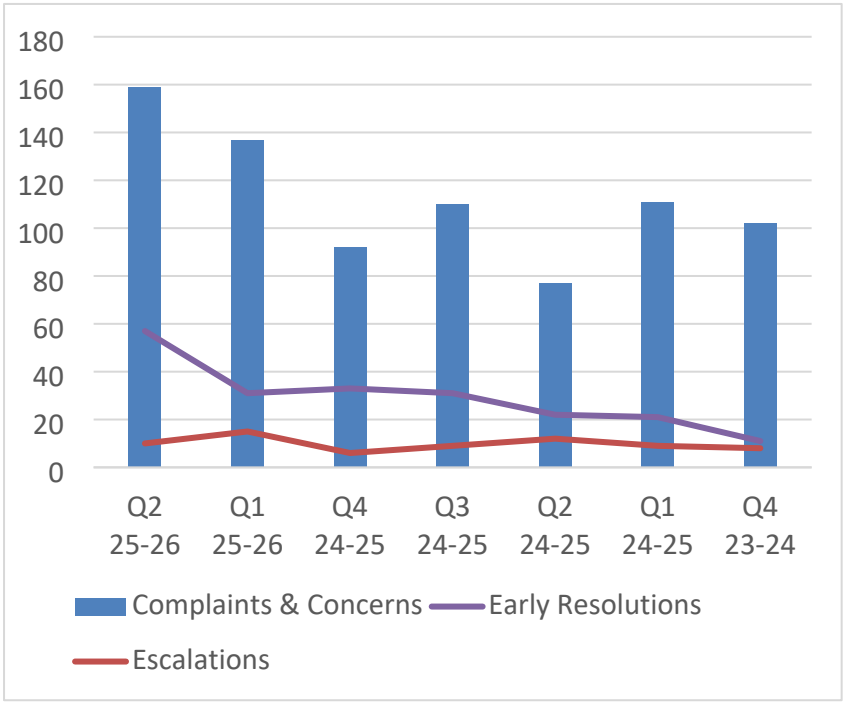
During Q2 there were a total of **159** complaints and concerns logged (137 in Q1).

The Trust has seen an overall increase in contacts this quarter.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2023/24 – 2024/25 – 2025/26

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



57 complaints/concerns were considered to have achieved an earlier resolution than anticipated in Q2.

10 concerns/complaints were noted to have escalated from a comment or enquiry into a concern or complaint, which is 5 less than Q1.

Figure 1.1b shows how this correlates with previous quarters and demonstrates a steady positive trajectory of early achieving earlier resolution.

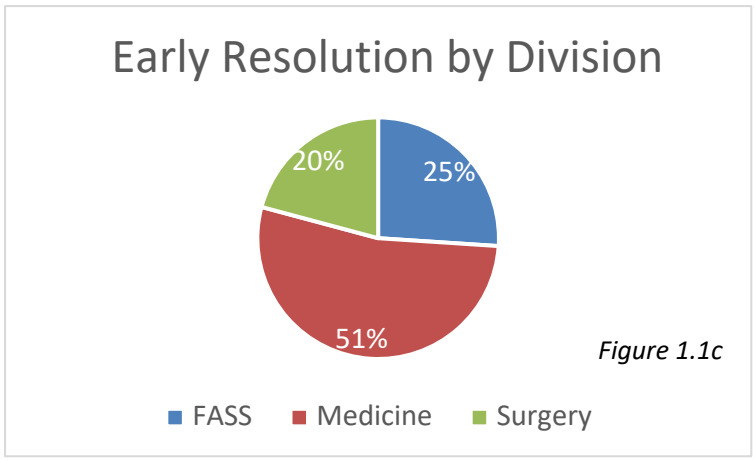


Figure 1.1c

Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.

In Q2, a total of 159 complaints and concerns were recorded, with 57 resolved through early resolution (within the first week of being sent the concern/complaint). The Medicine division accounted for the highest proportion, responding to 51% of these 57 early resolution cases.

Themes from Complaints/Concerns

Table 1.2 below shows the themes for complaints and concerns received in Q2 (Trust-wide).

Highlighted are the top three most prevalent themes: **Patient Care** and **Communication** are consistent themes with the previous quarter, along with **Appointments, including delays and cancellations.**

These top three themes are further broken down into sub-categories for deeper analysis in Table 1.2.

Table 1.2 Raw data - Themes from Q1 Complaints/Concerns

	FASS	Medicine	Surgery	Non-Clinical	Total by theme	% of total by theme
Access to treatment or drugs	1	4	10		15	9.4%
Admissions, discharge and transfers	2	4	2		8	5.0%
Appointments including delays and cancellations	2	4	11		17	**10.7%**
Clinical Treatment			1			0
Commissioning Services						0
Communications	11	15	10	2	38	**23.8%**
End of Life Care						0
Facilities Services		1			1	0.6%
Other		1	1	2	4	2.5%
Patient Care	15	25	20		60	**37.7%**
Prescribing errors		1			1	0.6%
Privacy, dignity & wellbeing	2	1			3	1.8%
Trust Administration						0
Values and behaviours (Staff)	2	4	6		12	7.5%
Waiting times						0
Total by Division	**35**	**60**	**60**	**4**		
Divisions Total	**159**					

Unsatisfactory treatment was again the highest sub-category this quarter under **Patient Care.** This was the same for the last four quarters.

Insensitive and lack of communication was again the highest causes for complaints under the **Communications** category. This was the same for the last four quarters.

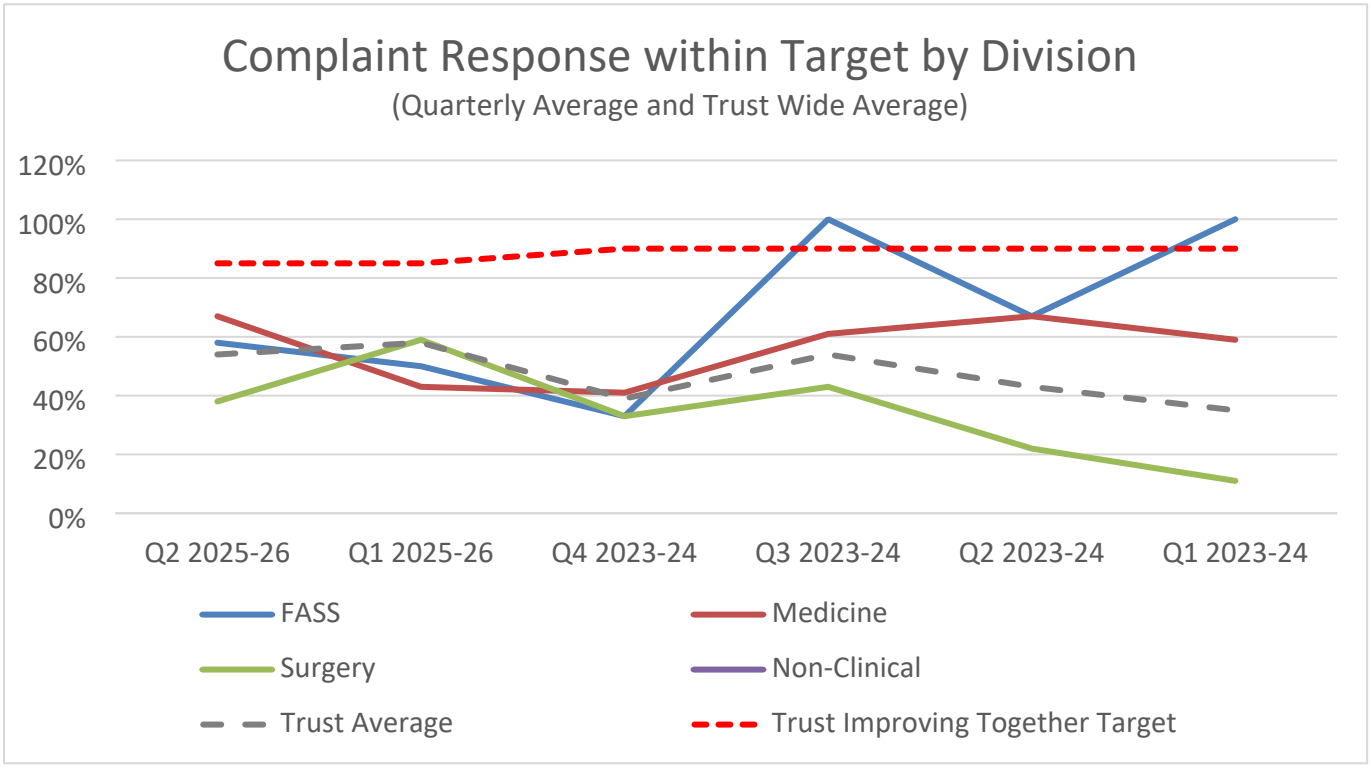
Appointments including delays and cancellations continues to be theme this quarter from Q1. **Appointment date required and appointment system procedures** feature as the highest causes under this category.

Overdue Complaints

The Trust's Improving Together Target for response to complaints within their agreed timescale for 2025/26 remains at 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.

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 **52%** closure on target rate for complaints and concerns in Q2 compared to 40% in Q1, which is an improvement.

Reopened Complaints

Figure 1.4 – Number of re-opened complaints or concerns

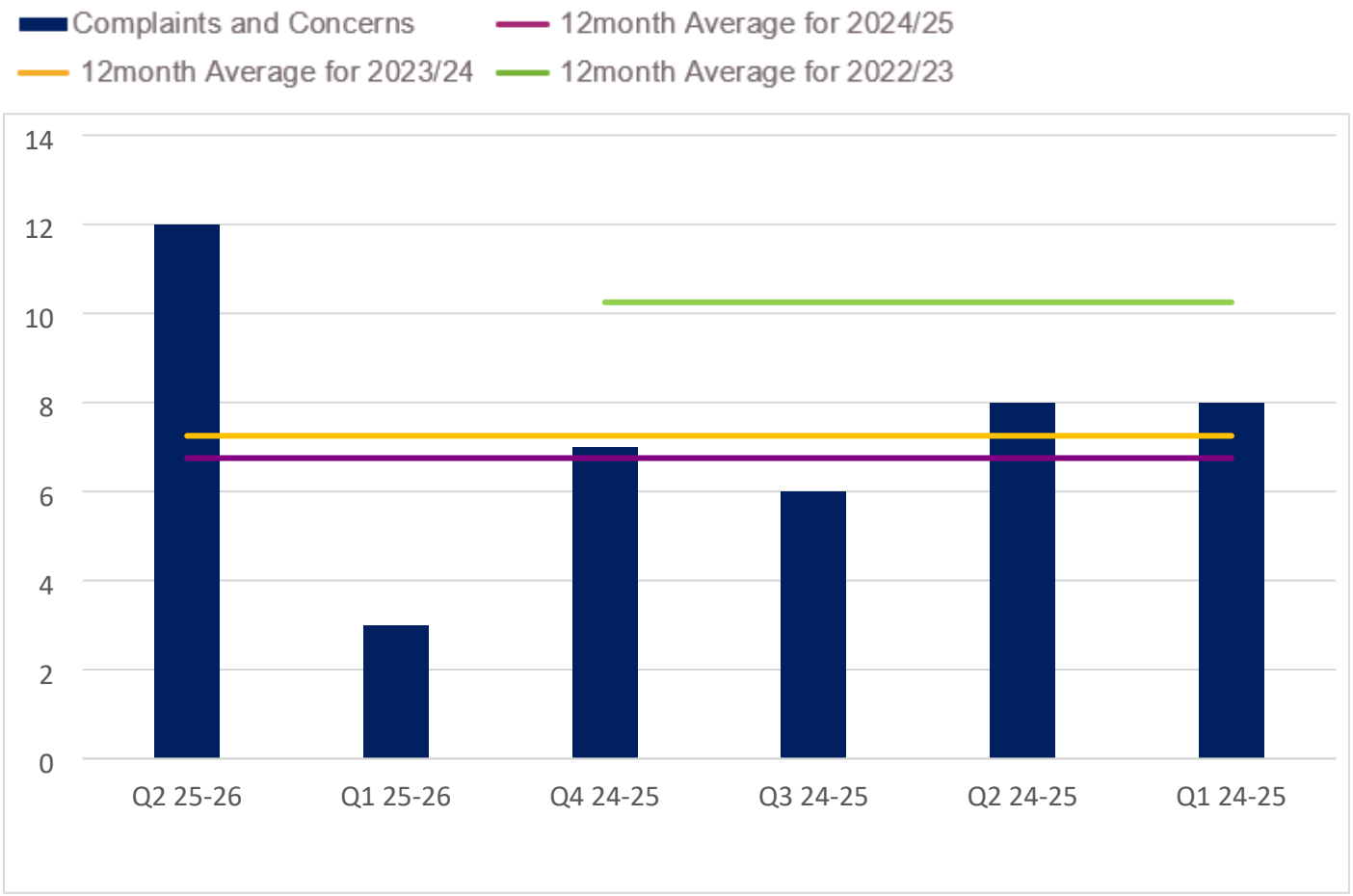


Figure 1.4 shows the number of reopened complaints and concerns (in total), compared with previous quarters. There is a significant increase noted in Q2.

The lines indicate the average number of reopened complaints for that year. This demonstrates a year-on-year reduction to the number of reopened complaints. This is indicative of an increasing success rate of first-time resolution.

2. Learning from Patient Experience

Patient Stories

July PESG: Patient Story – Chrissie's story

Chrissie attended ED with severe abdominal pain. She was diagnosed with an ectopic pregnancy. She was observed overnight but knew something was wrong. The ectopic pregnancy had ruptured badly but this was not immediately identified. She was not scanned or diagnosed until late the next morning when she then went into emergency surgery.

August PESG and subsequent Trust Board - Patient Story – Poppy's story

Poppy, a young adult had transitioned from paediatrics to adult care and the difference in how she was treated with her complex medical problems and communication issues between the different specialties was vast. She became ill with bladder problems which then escalated to no feeling in her lower body. This affected her ability to walk. Care while under paediatrics until she was 18 was very good. She then transferred to adult care and going onto an adult ward was very hard. The ward was cramped and with patients who were a lot more elderly, some with dementia. Poppy heard a patient being given a diagnosis of cancer which she found very distressing and concerning regarding lack of confidentiality. Staff assumed things about Poppy, were not interested in her and seemed too busy to care. There was no comprehensive plan of care produced. The individual care from doctors was good. Poppy was under 8 different specialties at one point but she still felt that staff were not sympathetic. They insinuated it was in her head. A lack of compassion was noticeable even from senior members of staff. There has been a lack of effective communication between departments.

September PESG: Patient story – Dave's story

Following a diagnosis of bowel cancer Dave commenced chemotherapy following an op. Unfortunately, due to side effects the chemotherapy had to stop after 4 months. A subsequent PET scan showed prostate cancer as well as a non-cancerous tumour on his bladder. Dave was invited to join the Wellbeing group run in the Trust, following his treatment for the prostate cancer and it has helped his recovery pathway enormously. The Cancer Wellbeing group has been running for nearly 10 years now. A group of 10-15 patients will be invited to attend a 6 week course covering exercise, anxiety, tiredness and sleep amongst other things. After the 6 weeks, patients are invited to carry on their wellbeing journey by attending further classes, protected swimming time and free leisure centre passes.

Patient Experience Division Presentations

The development of the Patient Experience Steering Group agenda ensures that there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q2, complaints and FFT data from Q1 were 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 were 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.

Table 2.1 – Q1 Patient Experience data presented to Divisions during Q2:

Division	Data presented to Division	Division update to PESG
Surgery	16th July 2025	29th Oct 2025 (deferred from Sept)
Medicine	8th July 2025	27th August 2025
Family and Support Services	30th June 2025	24th September 2025
Facilities (Food & Nutrition /PLACE)	3rd July 2025	27th August 2025

Table 2.2 – Q2 Patient focus groups that have taken place

Focus group	Date met	Recurring/one off
Stoma patient panel	03/07/25	Recurring 3 monthly
Spinal inpatient engagement part 1	21/07/25	One off
Learning disabilities and autism focus group	23/07/25	Recurring 6 weekly
Cancer patient panel	29/07/25	Recurring 6 weekly
Spinal inpatient engagement part 2	31/07/25	One off
Gynaecology patient panel	07/08/25	One off
Cancer patient panel	09/09/25	Recurring 6 weekly
Learning disabilities and autism focus group	17/09/25	Recurring 6 weekly
Discharge focus group	17/09/25	One off
Spinal injury research patient advisory group	25/09/25	Recurring

Table 2.3 – Q2 Patient information leaflets reviewed by our patient readership panel

Patient information leaflets reviewed	Reviewed by panel
Plasma Metanephrine Test	03/07/2025
Short Synacthen Test for CAH	03/07/2025
SST patient information leaflet	03/07/2025
Water Deprivation test	03/07/2025
Free Car Parking	11/07/2025
Early Supported Discharge Service Leaflet	18/07/2025

Novasure PIL Updated	25/07/2025
Lap BSO Patient leaflet	11/08/2025
Draf PAL Medical Cannabis	02/09/2024
Breamore ward information	12/09/2025
Self-administration of medicines in hospital	19/09/2025
Orthoptics Website link	26/09/2025
Safe Swallowing' document review.	26/09/2025
First contact with lung CNS	26/09/2025

Facilities Update to PESG (27th August 2025):

Summary of the following:

- 5 SOX received for the last 12 months
- 3 complaints received in the last 12 months
- Artcare have launched programme of events for staff.
- We have negotiated a free day for bus travel for staff.
- Catering barbecues in the summer for all customers.
- We provided free servicing for bikes; this service is available 4 times a year.
- Facilities had 32 nominations for staff awards. There are 9 finalists.
- Car park updates – we want to make parking on site for patients and visitors as easy as possible. New barriers have been fitted to prevent staff access to patient/visitor car parks.
- 13 additional blue badge parking spaces have been made available. Increasing these around the Green. Also, executive parking spaces are going to be changed to disabled bays.
- Green plan – The Trust has just published our new plan; it is now available on the intranet and Trust website. It explains how we have reduced our carbon footprint.
- Catering – all Trusts need to have digital menu. We are a bit behind and will complete the roll out by early November.
- A Theatre show has been taken around the country. This was developed in Salisbury under Artcare and has been launched nationally.
- Sustainability team – Gemma Heath picked up award.

3. Training & Development for Staff

The PALS Lead continues to work with Division leads and individual staffing groups to ensure staff understand the complaints process and the role of PALS within this.

The following training packages were delivered this quarter:

- Band 6 training – 9th July 2025
- Spinal Staff Induction – 16th September 2025

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 complainant's case details.

Table 4.1 Concerns received via the Care Quality Commission (CQC) – quarterly comparison

	Q3 24-25	Q2 24-25	Q1 25-26	Q2 25-26
Across all Directorates	▼2	▲6	0	0

Parliamentary Health Service Ombudsman (PHSO)

The Ombudsman investigates 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 Q2 the Trust received 0 requests for further information from the PHSO.

Table 4.2a Concerns received via the Ombudsman (PHSO) – quarterly comparison

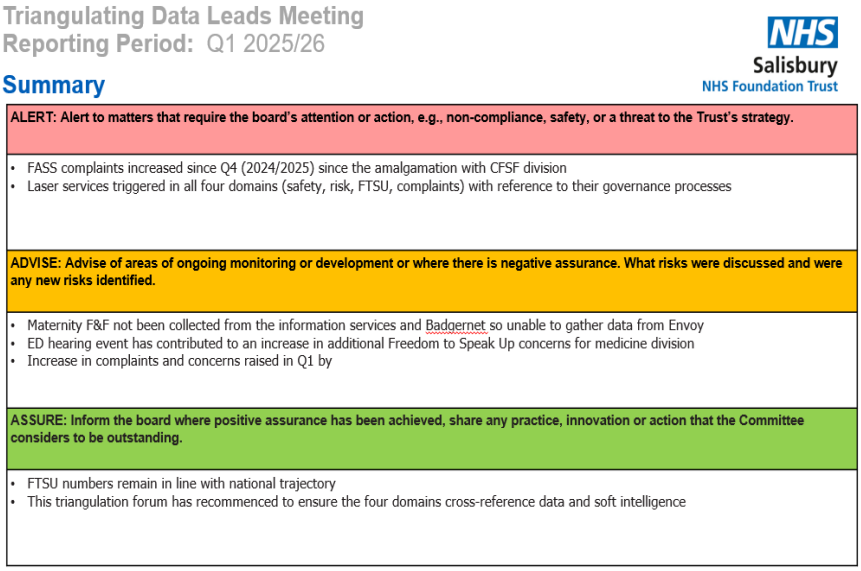
	Q3 24-25	Q2 24-25	Q1 25-26	Q2 25-26
Across all Directorates	▲2	0	2	0

5. Triangulation of data (Risk, Safety, Experience, Freedom to Speak Up)

This quarter leads from Risk, Patient Safety, Experience and Freedom to Speak Up met. This meeting reviewed data from Q1 and Table 5.1 below is a summary of the key conclusions from these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q1 25/26

This is scheduled to be presented to the Clinical Management Board in November 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: Q1 2025/26

Summary

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.
• FASS complaints increased since Q4 (2024/2025) since the amalgamation with CFSF division • Laser services triggered in all four domains (safety, risk, FTSU, complaints) with reference to their governance processes
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.
• Maternity F&F not been collected from the information services and Badgernet so unable to gather data from Envoy • ED hearing event has contributed to an increase in additional Freedom to Speak Up concerns for medicine division • Increase in complaints and concerns raised in Q1 by
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• FTSU numbers remain in line with national trajectory • This triangulation forum has recommenced to ensure the four domains cross-reference data and soft intelligence

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 was agreed and trialled with Q3 data. This demonstrates 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 6.1 Trust KPIs 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 6.2a KPI complaint response target table (Q2)

	Salisbury Hospital	Great Western Hospital	RUH
Target	85%	80%	90% (for within 35 w/days)
Performance	52%	70%	76.8%

Table 6.2b Total contacts via PALS (per 1,000 patient activity) – Q2

	Salisbury Hospital	Great Western Hospital	Royal United Hospital
Total patient Activity	124,473	176,495	196,086
Number of complaints and concerns (per 1,000 patient activity)	1.27%	8.56%	3.81%
Number of total PALS contacts (per 1,000 patient activity)	4.09%	9.0%	4.41%

Themes for complaints are largely similar, with communication and patient care being the top themes across all three Trusts.

Table 6.3 FFT performance comparisons – Q2

	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
Q2 2025-26	16.03%	93.63%	32.13%	90.2%	24.34%	93.4%
Q1 2025-26	17.00%	93.76%	37.61%	90.64%	25.22%	94%
Q4 2024-25	16.96%	93.74%	33.39%	90.27%	24.90%	94.50%
Q3 2024-25	16.13%	93.82%	28.25%	89.28%	21.50%	94.00%

Positive themes for FFT are similar with staff attitude being top. It is also the top negative theme. Amongst the top negative themes, waiting times are common across all three Trusts.

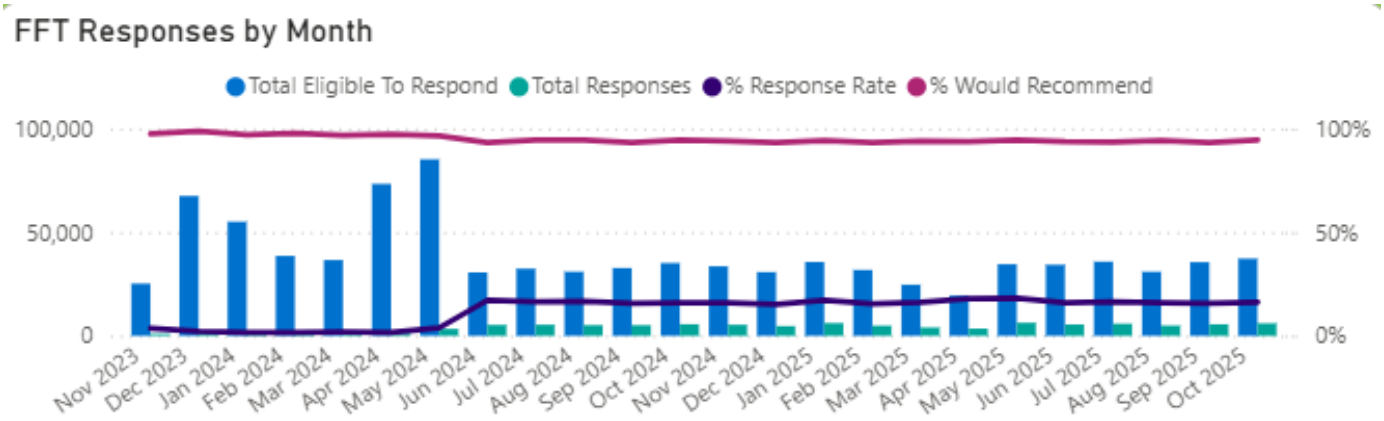
7. Process reviews, audits and policies

Nil to update this quarter.

8. Friends and Family (FFT)

Response Rates

Fig 8.1 Number of FFT responses, broken down by quarter with Trust response rate target.



A total of **16811** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q1. This is **324 less** than the previous quarter.

The future of our online system and gathering of feedback via SMS is currently being reviewed as we consider moving to a group wide process.

The overall target response rate for the quarter was not achieved now the Trust target has increased to 18%. In addition, 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 Q2 2025-26)

16%* Response rate (*of eligible population and averaged for Q2 2025-26)

Of the 16,811 comments received during this period the following positive/negative themes (and their proportion of these comments) are demonstrated below:

Positive

- 65% Staff attitude
- 33% Implementation of care
- 24% Environment

Negative

- 4% Staff attitude
- 3% Environment
- 2.5% Waiting time

Most of these themes are consistent with the last quarter although waiting times are one of the top negatives over communication last quarter.

Tables 8.1a and 8.1b 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 due to the significant increase in sampling.

Table 8.1a Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q2 25-26	Q1 25-26	Q4 24-25	Q3 24-25	Q2 24-25
Across all Directorates	▼ 135.07 (124,463)	▲ 138.2 (123, 910)	▼ 124.25 (121, 251)	▼ 126.86 (123, 125)	▲ 132.31 (121, 862)

Table 8.1b Satisfaction rate across the (averaged from responses received)

	Q2 25-26	Q1 25-26	Q4 24-25	Q3 24-25	Q2 24-25
Across all Directorates	94% (124,463)	94% (123, 910)	94% (15, 964)	94% (16, 039)	▼ 94% (16, 123)

Progress to update all FFT boards in the Inpatient areas is still ongoing and the phase 2 rollout of the Outpatient boards has also been logged with Estates – this is on hold due to capacity issues therefore this work has not been carried out yet.

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 Q2 a total of 100 surveys were completed – achieving an average satisfaction rating of 84.48%. This quarter has seen slightly less surveys completed to that in Q1 (n~108), and the overall satisfaction score has remained pretty much the same. See Table 10.1 for in month breakdown.

RTF is a standing agenda item presented to the Patient Experience Steering Group.

Table 9.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
July	34	11	Durrington, Imber, Laverstock, Longford, Postnatal, Odstock, Pembroke, Pitton, Redlynch, Spire, Tisbury	81.43%
Aug	34	12	AMU, Breamore, Britford, Chilmark, Downton, Durrington, Imber, Longford, Maternity, Pembroke, Whiteparish,	85.73%
Sept	32	11	Farley, Imber, Laverstock, Longford, Maternity, Odstock, Pembroke, Pitton, Redlynch, Spire, Tisbury	86.40%
Total	**100**	**34**	84.48%	

Table 9.1a Average ratings breakdown by ward (April 2025):

Area	Number of inspections	Average score
Durrington	1	78.62%
Imber	2	62.75%
Laverstock	3	96.28%
Longford Ward	3	66.03%
Maternity	4	91.55%
Odstock	3	91.51%
Pembroke	1	100%
Pitton	9	76.91%
Redlynch	3	74.83%
Spire	2	90.38%
Tisbury	3	79.78%

Table 9.1b Average ratings breakdown by ward (May 2025):

Area	Number of inspections	Average score
Amesbury	5	86.18%
AMU	2	86.23%
Breamore	2	85.03%
Britford	3	85.82%
Chilmark	3	82.22%
Downton	2	78.52%
Durrington	2	89.22%
Imber	7	86.61%

Longford Ward	1	63.81%
Maternity	3	91.02%
Pembroke	1	100%
Whiteparish	3	86.26%

Table 9.1c Average ratings breakdown by ward (June 2025):

Area	Number of inspections	Average score
Farley	2	68.32%
Imber	2	77.20%
Laverstock	3	78.24%
Longford Ward	3	81.14%
Maternity	3	86.33%
Odstock	4	87.79%
Pembroke	2	90%
Pitton	5	90.53%
Redlynch	2	92.73%
Spire	3	92.84%
Tisbury	3	96.30%

Tables 9.2 and 9.3 shows the breakdown of average response to specific questions (highest and lowest).

Table 9.2 highest scoring questions:

Question Text	Answer score (% good)	Responded Answers
How would you rate the cleanliness of the ward you are in?	95%	100
How would you describe the trust and confidence you have in those involved in your care?	94%	98
How would you rate the cleanliness of the toilets and wash facilities	88%	92
How would you rate the level of privacy when being examined or treated?	87%	97
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	82%	61

Table 9.3 lowest scoring questions:

Question Text	Answer score (% poor)	Responded Answers
How well have the medical staff explained things to you?	52%	21
How well did the staff explain how you might feel following your operation or procedure? (for example any scans or bloods being taken)	25%	8
How would you describe your understanding or involvement with your discharge plan?	14%	83
How would you describe the quality and selection of dietary options available to you?	5%	99

Again, there are notable consistencies with last quarter in relation to negative themes around involvement with discharge plans and staff explaining things in a way that can be understood. A patient focus group around discharge has taken place to address areas for further improvement and we hope to have an update on this for the next quarter.

Your Views Matter (YVM) Bereavement survey – Q2

The Your Views Matter (YVM) Bereavement survey was established in 2020 and was relaunched in April 2025 after being replaced by a National NACEL Quality Bereavement Survey from 2024-2025 to allow for national benchmarking. The YVM survey was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

The surveys are sent out by the Bereavement suite via an email link alongside the release form (the day after the pts death). There are 3 survey links which include ED, Hospice and the acute trust. The ED and Hospice are new areas for SFT to receive feedback from.

Currently, due to staffing pressures within the bereavement team, if there is no email address or the patient has been referred to the coroner then a survey is not sent (this only occurs in a small percentage of families).

The end-of-life lead nurse is looking to improve the process by enabling families/loved ones to receive a bereavement survey and by providing support in completing and returning them to increase response rates.

During Q2 there was 158 deaths in the Acute Trust and 43 in the Hospice. **143** surveys have been sent via email from the bereavement team to families/loved ones. 13 surveys have been returned, 10 from the Acute trust, 3 from the Hospice and none from ED. (9% of the total sent returned).

Key themes identified:

Communication good or very good – 10/13 (77%)

Compassion good or very good – 11/13 (85%)

Privacy and dignity good or very good – 12/13 (92%)

Timely access to pain relief good or very good – 9/13 (69%)

Overall, how would you rate the care and support provided for your loved one good or very good 11/13 (85%)

Other Improvements:

There was some feedback from a family regarding sympathy cards not being completed and then given to relatives blank.

- An audit was completed on the nursing record of death (NRD) documentation, and it identified that all wards were working differently regarding phoning GPs and sending copies of the NRD to bereavement
- From this we sent out our quarterly newsletter with updates on new processes and ensuring staff are aware to complete the sympathy cards.
- We EOL time continue to adapt their education and training study days to reflect concerns/complaints that have come through PALS.

EOL Care – Correlation with Complaints

There was a total of 159 complaints/concerns logged during this period, of which 0 were related to end-of-life care.

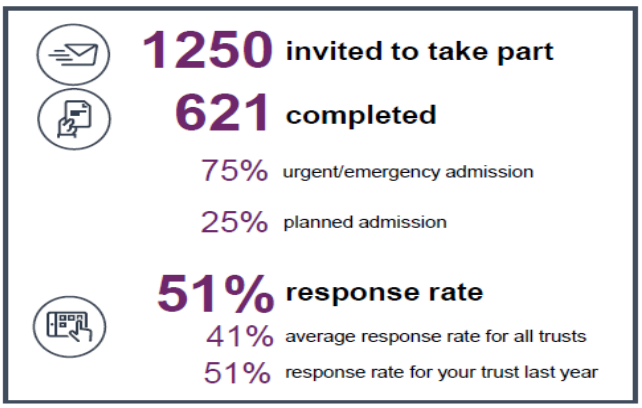
10. Patient and Public Feedback – National Surveys

Adult Inpatient Survey 2024

We have now received and reviewed the 2024 survey

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51.49%.

Matrons are focused on the main areas of concern and action plans are in place.



Positive themes

- Care and general treatment
- Staff
- Hospital/ ward stay

Where patient experience is best

- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ✓ **Leaving hospital:** Staff telling patients who to contact if worried about condition/treatment after leaving hospital
- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival

Negative themes include:

- Communication / information giving by staff
- Insufficient staff
- Discharge process/information
- Noise and disruption

Where patient experience could improve

- **Information while on virtual wards:** Patients feeling they were given enough information about care and treatment on virtual ward
- **Waiting list:** Length of time on waiting list before hospital admission
- **Information while on waiting list:** Quality of information given while on waiting list
- **Drink:** Patients getting enough to drink
- **Help when needing attention:** Patients being able to get help from staff when they need attention

These themes were noted to have some correlations with the Trust's Real-Time Feedback themes captured over the past year. Particularly in relation to noise at night, discharge process and communication.

The Trust scored worse than expected for 3 questions compared with all other Trusts:

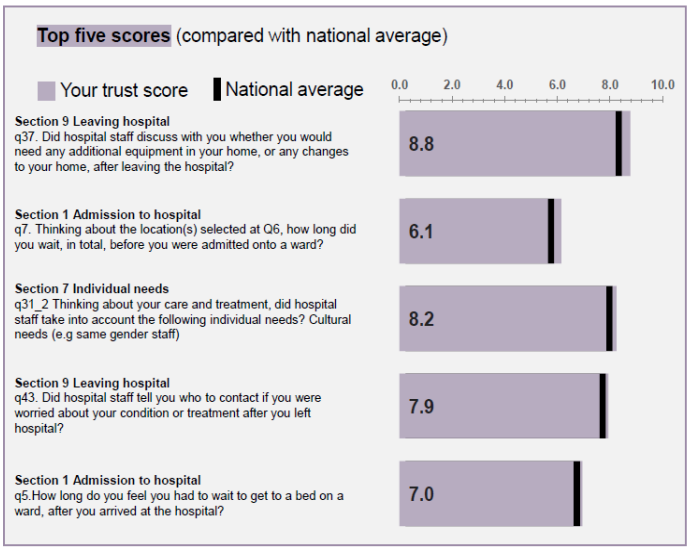
- During your time in hospital, did you get enough to drink?
- When you asked nurses questions, did you get answers you could understand?
- Were you able to get a member of staff to help you when you needed attention?

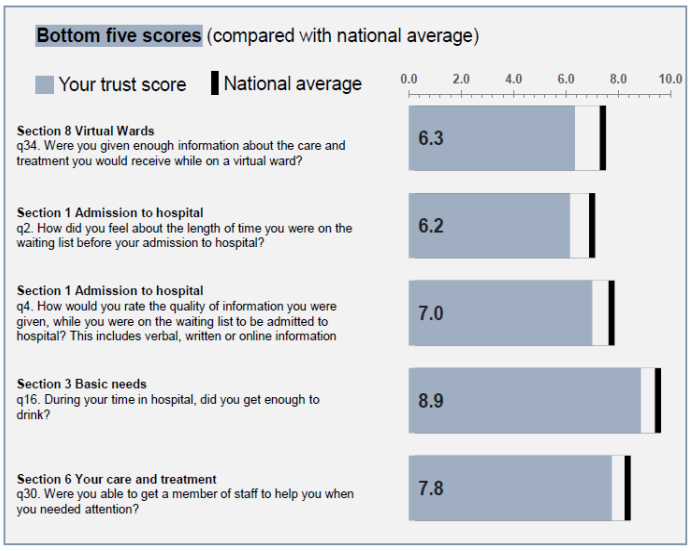
All other 43 questions were scored comparatively the same with all other Trusts.

Our results this year were significantly worse than our 2023 survey results, for 5 questions:

- Getting enough to drink
- Able to get the answers you could understand, from nurses
- Ability to get medical staff to help when attention was needed
- Overall feeling of being treated with kindness and compassion

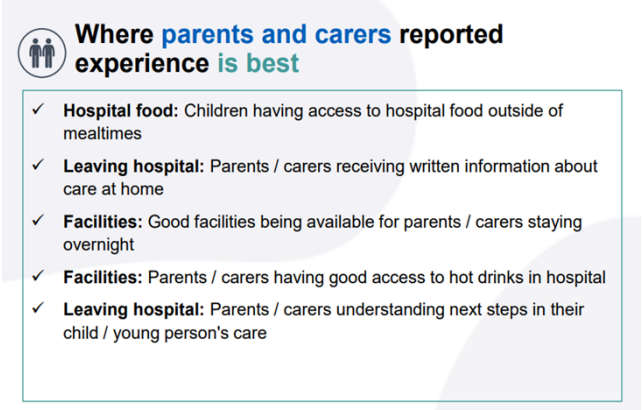
- Overall experience whilst in hospital

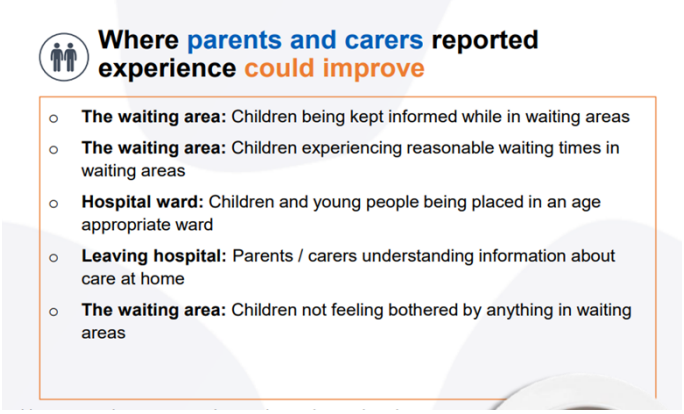




National Children and Young People's Survey 2024

Children and Young People's Survey 2024 reported that SFT are scoring as the highest Trust in our region for overall experience.

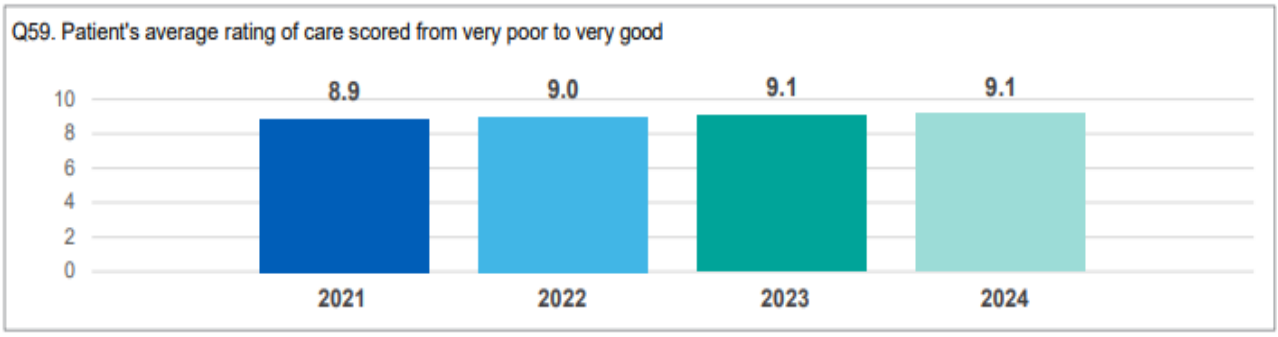




National Cancer Patient Experience Survey 2025

- The report scores 61 questions at Trust level, which are compared to the national average, expected lower and upper ranges.
- 41 questions were within the expected range.
- 20 questions were positive outliers compared to 23 in 2023 and 8 in 2022
- 0 questions were negative outliers compared to 0 in 2023 and 0 in 2022.

Patients are asked to rate their care from very poor (0) to very good (10). The Trust score was **9.1** compared to a national average of **8.9**, consistent with 2023.



Report to:	Trust Board (Public)	Agenda item:	4.3
Date of meeting:	8 January 2026		

Report Title	Learning From Deaths Report Q2		Approval Process	Clinical Governance Committee 25 November 2025
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Mr Charles Ronaboldo, Trust Mortality Lead/ Dr Ben Browne, Associate Medical Director			
Executive Presenting:	Duncan Murray, Chief Medical Officer			
Appendices (if necessary)	Embedded – Appendices A-C			

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.

- Nil

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

- There has been an increase in observed cases of death in patients with serious mental illness by the medical examiners – actions being taken as outlined in report (page 8)
- The Trust has formally withdrawn from their contract with Tesltra Health U.K – mitigated by improvements in internal reporting

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

- At the time of publication, the latest Summary Hospital-level Mortality Indicator (SHMI) figure for the Trust is 0.9267 (12-month period ending in May 2025). This continues to be the lowest figure that the Trust has observed in recent times and remains statistically within the expected range.
- Using statistical modelling from NHS England, during this 12-month period there were 1,015 observed deaths reported in the Trust against an expected figure of 1,095.
- The mortality SHMI figures will now be published monthly in a new 'group' integrated performance reported (IPR), which will help to ensure improved oversight of the data, actions, and shared learning across each of the three acute hospitals that we are grouped with. This includes Royal United Hospital (RUH) Bath and Great Western Hospital (GWH) Swindon. In addition to local processes, the three hospitals continue to convene monthly at a BSW (Bath, Swindon, Wiltshire) systems mortality meeting, where data is reviewed, and learning is shared and discussed.
- A new alert tab has been developed within the Trust's Bi mortality dashboard to provide early warning for statistical outliers (both positively and negatively alerting using SPC methodology). This can be used to track variations in diagnosis group, ward, and clinical specialty. The new dashboard will be presented at the MSG meeting in November for feedback.
- Across the trust during this period there were a total of 159 complaints/concerns logged, of which none were related to end-of-life care.

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

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):	

LEARNING FROM DEATHS REPORT

Quarter 2: 2025-2026

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.

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.

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.

SPC
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

Learning from Deaths 2025-26
Quarter 2 Report

Purpose

1.1 This is a summary document outlining learning from deaths at Salisbury NHS Foundation Trust during the second financial quarter of 2025/26. 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 a reflective and inquisitive clinician culture, driving learning and to improve how Trusts support and engage bereaved families and carers of those who die in our care.

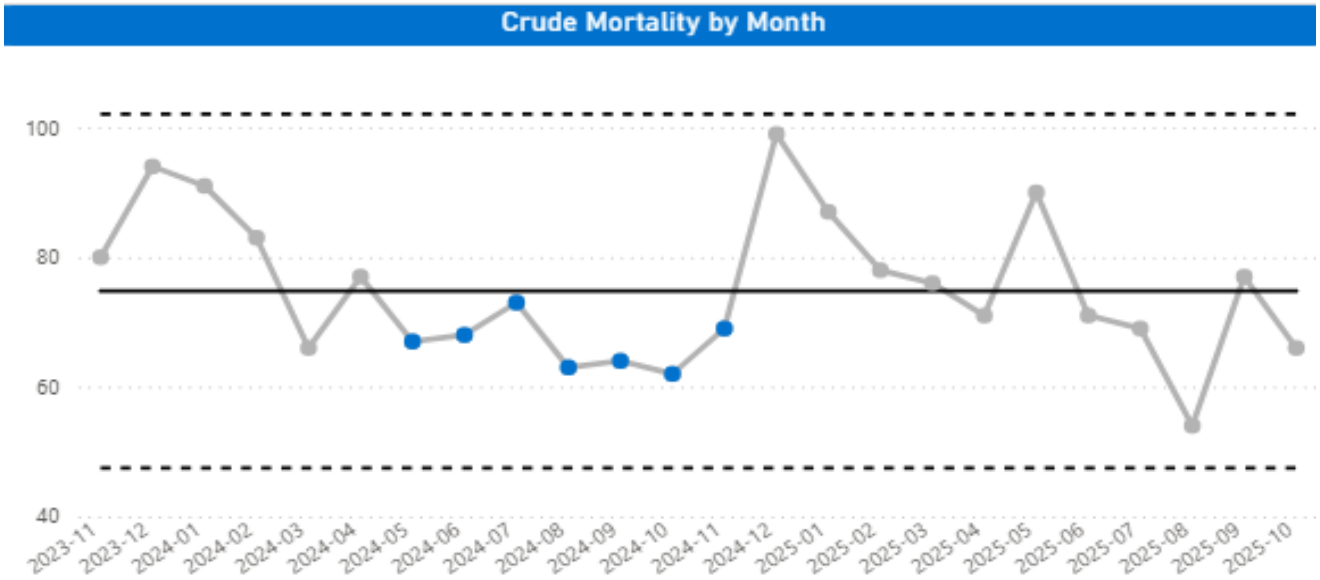
Executive Summary

- At the time of publication, the latest Summary Hospital-level Mortality Indicator (SHMI) figure for the Trust is 0.9267 (12-month period ending in May 2025). This continues to be the lowest figure that the Trust has observed in recent times and remains statistically within the expected range.
- Using statistical modelling from NHS England, during this 12-month period there were 1,015 observed deaths reported in the Trust against an expected figure of 1,095.
- The mortality SHMI figures will now be published monthly in a new 'group' integrated performance reported (IPR), which will help to ensure improved oversight of the data, actions, and shared learning across each of the three acute hospitals that we are grouped with. This includes Royal United Hospital (RUH) Bath and Great Western Hospital (GWH) Swindon. In addition to local processes, the three hospitals continue to convene monthly at a BSW (Bath, Swindon, Wiltshire) systems mortality meeting, where data is reviewed, and learning is shared and discussed.
- All three acute Trusts have now formally ended their contracts with Telstra Health UK (formerly Dr Foster), as of 30.09.2025, and have been meeting to improve share practice and deliver 'real time' reporting of mortality through improvements in internal Power Bi reporting.
- A new alert tab has been developed within the Trust's Bi mortality dashboard to provide early warning for statistical outliers (both positively and negatively alerting using SPC methodology). This can be used to track variations in diagnosis group, ward, and clinical specialty. The new dashboard will be presented at the MSG meeting in November for feedback.
- There has been a recent increase in observed cases of death in patients with serious mental illness by the medical examiners – actions being taken as outlined in report (page 8).
- Across the trust during this period there were a total of 159 complaints/concerns logged, of which none were related to end-of-life care.

2 Learning highlights from Quarter 2

2.1 The hospital mortality group (MSG) met on September 9th during Q2, 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.

2.2 Local Data – Crude Mortality



The above graph has been obtained from the Trust's Power-Bi dashboard and shows the crude mortality figures by month. There has been a general downward trend in the figures from Jan 2025. During quarter 2 (Q2), the crude mortality figure was lower than the mean average during the months of July and August and was closer to the mean average in September 2025.

2.3 Local Data – Breakdown including Medical Examiner Information

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
2025-09	78	78	8	5	19	0	1	0	0	1	0	0	1	2
2025-08	55	55	3	5	12	0	1	0	1	0	0	0	0	2
2025-07	68	68	2	2	12	0	0	0	0	0	0	0	0	2
2025-06	72	71	5	6	11	0	0	0	0	0	0	0	1	4
2025-05	91	91	2	5	16	0	1	0	0	1	0	0	0	0
2025-04	71	71	2	1	11	0	2	0	1	1	0	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

All inpatient deaths were reviewed by the medical examiners during Q2. This represents a total of 201 deaths and was achieved despite the ME service being under significant staffing pressure.

Thirteen additional reviews (primary reviews or SJRs) were requested by the medical examiners during Q2 which were linked to the following categories [**note**: cases can be classified under multiple categories]:

- *Serious mental illness* (SMI) [6]
- *Learning disability and autism* [1]*
- *Bereaved or staff raised concern about care* [5]
- *Will inform quality improvement work* [3]

In addition, there were no maternal deaths, and two stillbirths reported during Q2

For the patients who were considered to have a serious mental illness, upon initial examination from the ME there were no specific themes associated with these cases. There is a regular operational mental health group and quarterly combined mental health governance meeting (including representatives from adult and CYP teams and external partners in particular AWP and Oxford Health), chaired by one of the Trust's Deputy CMO's, where mortality and incidents involving patient with SMI are discussed. These deaths are flagged to the chair to ensure that a review is undertaken, and the cases are subsequently presented to the governance meeting for discussion. As there has been an increase in the number of cases raised during Q2, these cases will also be discussed at the upcoming Trust mortality meeting in November to determine whether any further actions are required.

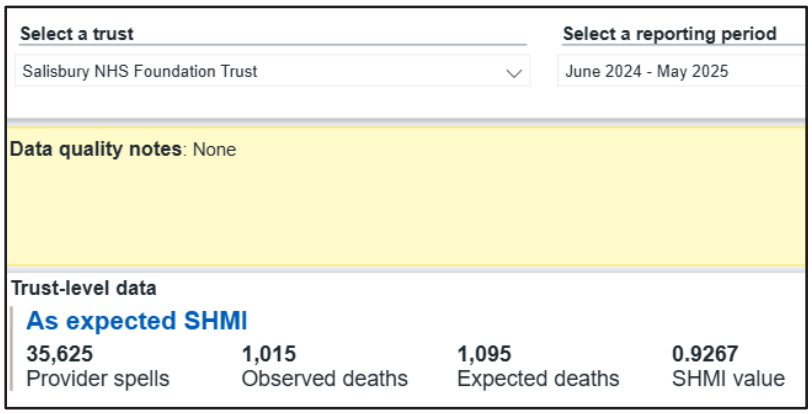
** As per standard practice these patients would be subjected to a mortality review (using the validated SJR method) and a review by our learning disability/autism nurse for a specialist input of potential learning. The specialist nurse is also invited to attend the MSG at least annually to share learning from these cases and to present the findings of any local/national reports related to deaths in patients with learning disability/autism.*

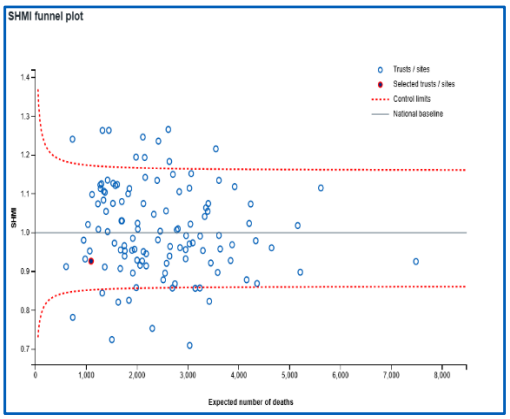
2.4 National Benchmarking

The SHMI methodology determines an 'expected' deaths number by comparison with an equivalent group of patients from a national pool of data from patient who have similar characteristics (including age, sex and comorbidities). It is the ratio between the actual number of patients who die following hospitalisation at the Trust and 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 stillbirths. 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. The data in this section of the report is therefore taken from those published by NHS Digital on their website.

Data as published by NHS England at digital.nhs.uk

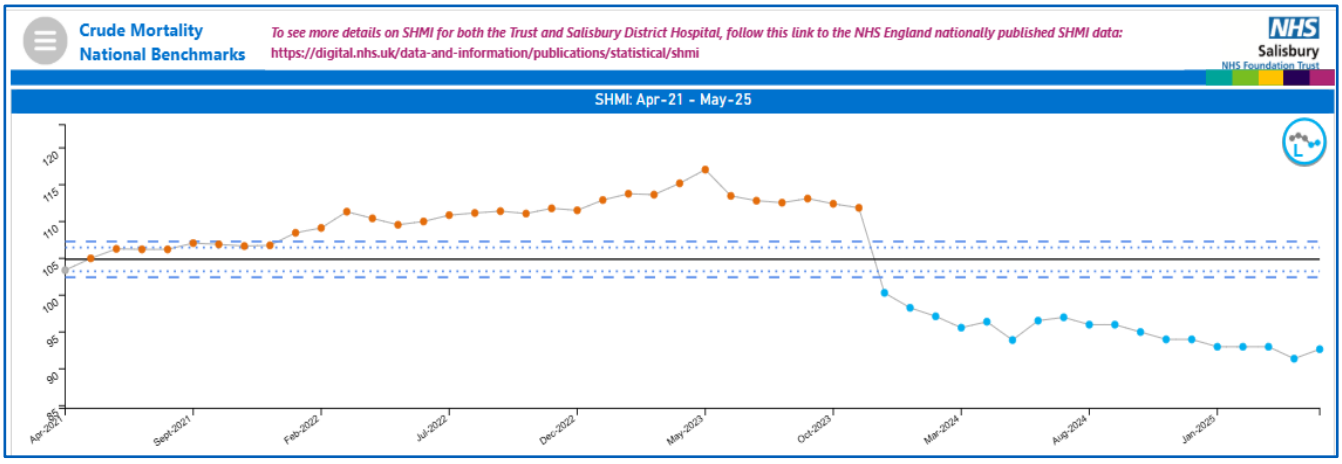




2.5 The SHMI for Salisbury NHS Foundation Trust for the latest reported date range (June 2024 to May 2025) is 0.9267 and represents 1,015 observed deaths verses 1,095 expected deaths.

2.6 The Trust currently lies below national baseline (represented by the red dot on the funnel chart above).

2.7 The graph below highlights the Trust's SHMI position as reported using the SPC methodology. The Trust's SHMI is statistically 'as expected,' and there has been a downward improved trajectory overall.



2.8 Summary of Learning Highlights

Processes	Outcomes
Updates to the Trust's Power BI mortality dashboard now allow individuals specialties to look at their own trends and any early warning patterns Configuration of these dashboards are being shared between the 3 Acute Trusts in BSW to optimise care across the system Improvements to the MaMR online mortality review platform now allow analysis by admission diagnosis and of cases where death occurred shortly after discharge from hospital The BSW System Mortality group continues to meet and enable shared learning and approaches to alerts arising from SHMI data Attendance at the Salisbury Patient Safety Summit by members of the Mortality team has been established, giving a further opportunity to share learning and to ensure that Datix alerts and any PSIIs are fed back and recorded in MaMR	An alert relating to cases with a diagnosis of *Pneumonia*** triggered by the September 2025 Telstra Health UK (THUK) report has led to a review of a cohort of cases which has concluded that the overall quality of care has been to a good standard The latest SHMI figure for Pneumonia is 0.94, now statistically within the expected range A separate review** of surgical mortality cases has confirmed good or excellent care in 92% of cases, and adequate in the remaining 8% The proper use of the *learning point* and *actions* section of the online proforma has been highlighted by this surgical review and there is an opportunity for further improvement and sharing here In both reviews, numerous specific learnings were recorded, and these are shared within the specialties as well as being escalated to the Trust's Mortality Surveillance Group for further dissemination via divisional leads as appropriate *Septicaemia (non-labour), shock* where there has been a previous alert now has a SHMI of 0.78 which is statistically lower than expected Improvements are being made regarding overall access to mortality metrics within the Trust and to learnings for individual teams so that they can respond to real time data and continue to work to enhance patient safety and quality of care

***Further information and learning related to the reviews mentioned above can be found in the appendices section of this report (section 5)*

3 End of Life (EOL) Care

3.1 The Your Views Matter (YVM) Bereavement survey was established in 2020 and was relaunched in April 2025 after being replaced by a National NACEL Quality Bereavement Survey from 2024-2025 to allow for national benchmarking. The YVM survey was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

The surveys are sent out by the Bereavement suite via an email link alongside the release form (the day after the patient's death). There are 3 survey links which include the emergency department (ED), hospice and the acute Trust. The ED and **h**ospice are new areas for SFT to receive feedback from.

3.2 During Q2 there were 158 deaths in the acute Trust and 43 in the hospice. 143 surveys were sent via email from the bereavement team to families/loved ones. 13 surveys have been returned, 10 from the Acute trust, 3 from the Hospice and none from ED. (9% of the total sent returned).

Key themes identified:

- Communication good or very good – 10/13 (77%)
- Compassion good or very good – 11/13 (85%)
- Privacy and dignity good or very good – 12/13 (92%)
- Timely access to pain relief good or very good – 9/13 (69%)
- Overall, how would you rate the care and support provided for your loved one good or very good 11/13 (85%)

If could be implied from the low rate of response that there is a low rate of dissatisfaction with the care delivered

Currently, due to staffing pressures within the bereavement team, if there is no email address or the patient has been referred to the coroner then a survey is not sent (this only occurs in a small percentage of families).

The end-of-life lead nurse is looking to improve the process by enabling families/loved ones to receive a bereavement survey and by providing support in completing and returning them to increase response rates.

OTHER IMPROVEMENTS
There was some feedback from a family regarding sympathy cards not being completed and then given to relatives blank. • An audit was completed on the nursing record of death (NRD) documentation, and it identified that all wards were working differently regarding phoning GPs and sending copies of the NRD to bereavement • From this we sent out our quarterly newsletter with updates on new processes and ensuring staff are aware to complete the sympathy cards. • The end-of-life team continue to adapt their education and training study days to reflect concerns/complaints that have come through PALS.

3.3 **EOL Care – Correlation with Complaints**

There was a total of 159 complaints/concerns logged during this period, of which 0 were related to end-of-life care.

3.4 **Education and Training**

The End-of-Life team currently run a robust education programme including a staff nurse SD, chronic conditions course and a communication course which runs 10 times a year and covers all aspects of communication and over 139 staff attended training for this course alone in 2024-25. New HCAs attend an EOL session within their induction program and a new online training package has been developed to support staff who care for EOL patients and their families. There are strong links between the PALS and end-of-life team to support with any complaints which come in so wards/staff can be supported with any further training/education that is required.

3.5 **The National Audit of Care at the End of Life (NACEL)**

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.

The results of NACEL 2024-25 notes audit have now been published – see key findings in appendix B. The action plan related to this is aligned to staff results and was shared in the previous Q1 report.

4 Litigation

4.1 New Enquiries from the Coroner in Q2

During this reporting period, there were five new enquiries from the coroner concerning the deaths of patients known to SFT. Statements have been requested in all five of those cases. Of the five cases 2 are subject to internal review.

4.2 Inquests concluded in Q2 from previous reporting periods

Two inquests were concluded in this quarter. Statements were provided by SFT in both cases. SFT was an interested party in both cases. In one case the patient was considered to have died because of a combination of the injuries sustained in a road traffic collision and a recognised complication of an elective surgical procedure. In another case the patient was considered to have died because of the injury sustained and complications arising from a fall which occurred in 2024.

4.3 There were no jury cases and no Prevention of Future Deaths reports.

[Authors (multiple)
***Primary Contributors**: Members of the SFT Mortality Team*
November 2025]

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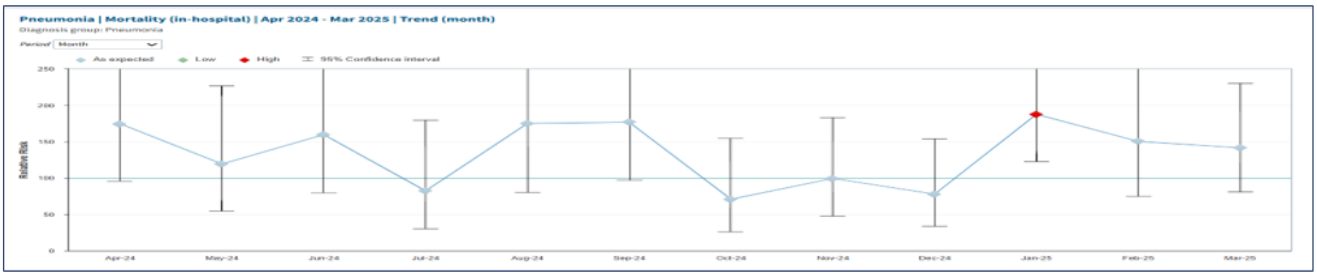
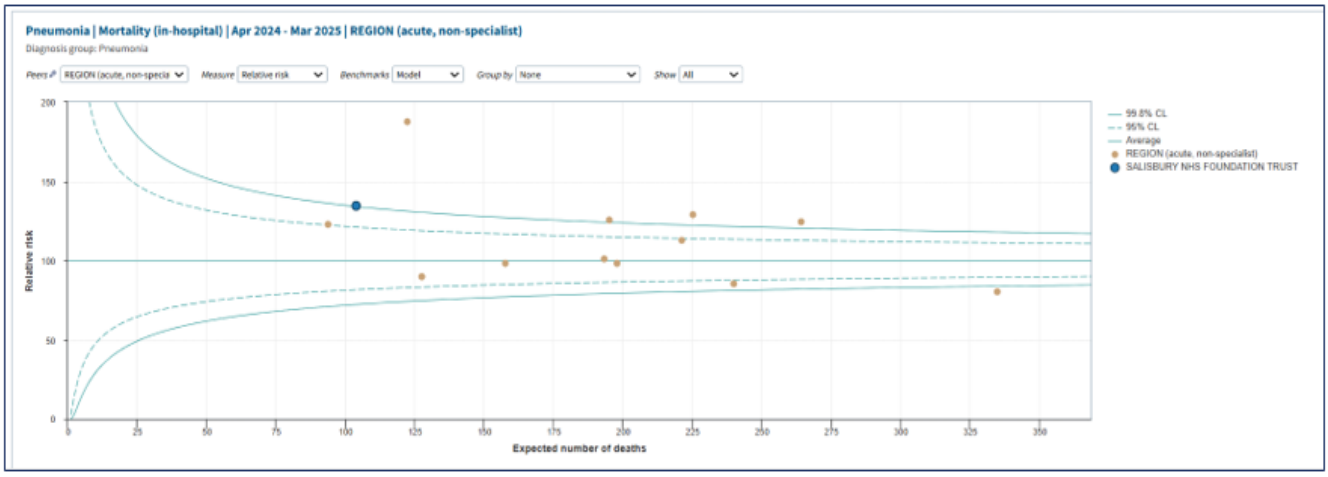
5 Appendices

5.1 Appendix A – *Pneumonia* Alert

In August 2025, a mortality alert was reported by Telstra Health UK (previously mortality insight provider) for patients with an admission diagnosis of pneumonia. This was triggered particularly by a statistically higher than expected number of deaths in January 2025, but the period April 2024 to March 2025 showed that the Trust was just lying outside the 99.8% confidence limits meaning that it was highly unlikely that the results had occurred by chance.





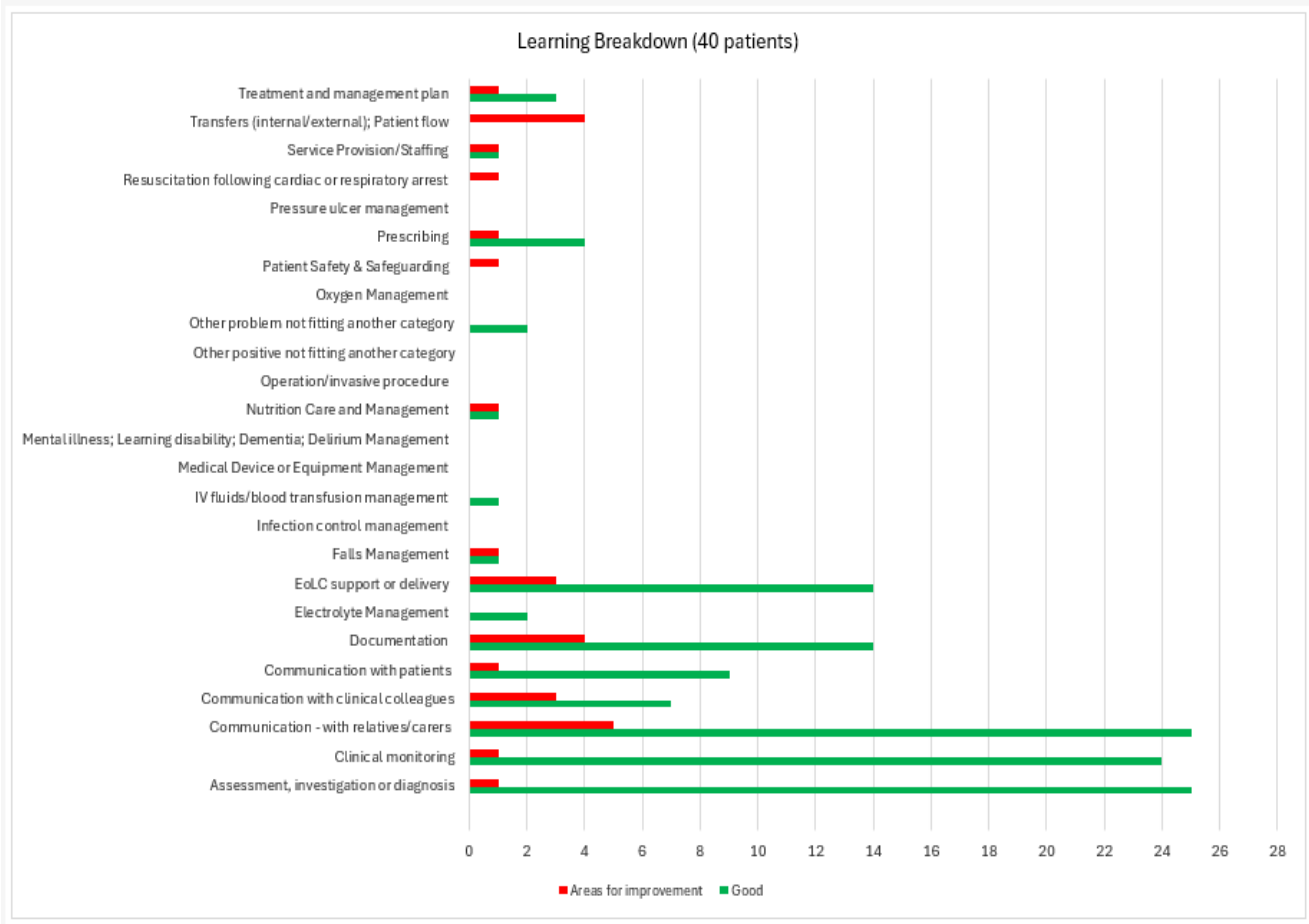
A previous alert for this diagnosis group in 2022 was addressed by a detailed case note review of 45 cases based on the paper records and a paper mortality review proforma following the Royal College of Physicians Structured Judgement Review format. This was a cumbersome process but confirmed that although there was some evidence of poor documentation and falls prevention, overall quality of care had been good and that there were no specific areas of concern where practice needed to be changed.

This new alert was dealt with using the mortality reviews already included in the Trust's online platform (the AMaT MaMR module). There was a total of 138 deaths in the cohort considered to have led to the alert, of which 93 had already received a detailed review. This large (67% of the total number of cases) sample was used in the main overview analysis.

The average age was 83 years (range 56 - 102), with a male: female ratio of 77: 61. The average length of stay was 11 days (range 0 - 76). The comorbidity score which is an indication of how fragile this group was ranged from 0 - 64 with an average of 27.

Reviews of a representative sample of 16 cases were studied in more detail looking at the incidence of sepsis, the quality of end-of-life care (EoLC) delivered, and also the overall quality of care (OAoC) scores. The average age of this subgroup was 89, with sepsis being present in 10/16, of which it was considered to have contributed to death in 8 cases. Three EoLC parameters were analysed: regular consultant review, ReSPECT form completed and PCP (Personalised Care Plan) in place. Every patient had both been regularly reviewed by their consultants and had a ReSPECT form completed. Twelve had a PCP completed, in three the person completing the review was unable to tell if a PCP had been completed, and in only one case had it been omitted. 19/45 cases had had a PCP completed in the review of the 2022 alert so this has improved from 42% to 75% in 2024/2025. Overall completion of these 3 key EoLC parameters was 92%. The Overall Assessment of Care (OAoC) scores averaged 4.25 (range 3 - 5): with a score of 5 being "Excellent", 4 "Good" and 3 "Adequate".

There were 40 learning points documented in the main sample of 138 reviews. The majority were positive, shown in green in the following chart. Communication with relatives and carers was particularly good, also clinical monitoring and assessment, investigation and diagnosis, all of which are cornerstones of good medical and nursing practice. EoLC support and delivery also scored highly, confirmed by the more detailed analysis reported above in the smaller sample, although there were some areas for improvement identified and documented. Transfers and patient flow issues were picked up as noted in previous alert responses and some areas where documentation could be improved.



Specific examples of learnings include good documentation and monitoring of deteriorating patient and good communication with patient. Also, clear concise and timely case note entries. Areas for improvement included documentation issues such as a ReSPECT form not signed by consultant and inappropriate transfers; these are discussed at the relevant clinical governance or MDT sessions which also included specific feedback to a doctor regarding some medication dosing. Further analysis of any specific actions arising from these learnings is in motion. Another consideration is whether there are errors in coding which may have contributed to the initial alert being triggers, as a similar trend has been observed across other BSW Trusts.

5.2 Appendix B – Surgery Mortality Review

A review of all surgical mortality cases was carried out up to the end of Q2 (30 September) for the calendar year 2025.

This included mortality across all surgical specialties. The focus was on what learning had been collected, and key metrics related to quality of care including the incidence of Sepsis, Acute Kidney Injury (AKI), Pressure ulcer and Falls. The Overall Assessment of Care (OAoC) scores were also analysed.

Between 1 January and 30 September there were 50 cases added to the MaMR online review platform with a M: F ratio of 16: 34. One death occurred in the Hospice, the others on the main wards.

Sepsis was reported as having occurred in 18 cases, and in all but one of these was considered to have contributed to the death. It was recorded as not having occurred in 17 cases, was allocated to "unable to tell" in two, and "not stated" in 13. AKI occurred in 13 cases and was considered to have contributed to death in 4 of these. Pressure ulcer was reported in 3 cases, in none of which was it thought to have contributed to death. Finally, Falls occurred in 3 cases and, as with Pressure ulcer, was not thought to have been contributory.

The subsection "Signs of deterioration not acted upon" was recorded as "no" in 35 cases, left blank in 13 and recorded as a "yes" in one, but in that case the failure to act was not considered to have contributed to the death. The latter case had an OAoC score of 5 ("excellent") attributed to it with a learning point and action associated in the narrative. It was considered that symptom control at the very end of life might not have been adequate (which is not exactly what that subsection was intended to identify) and the action resulting was to formally debrief with palliative care and establish further palliative care teaching to nursing staff and clinicians.

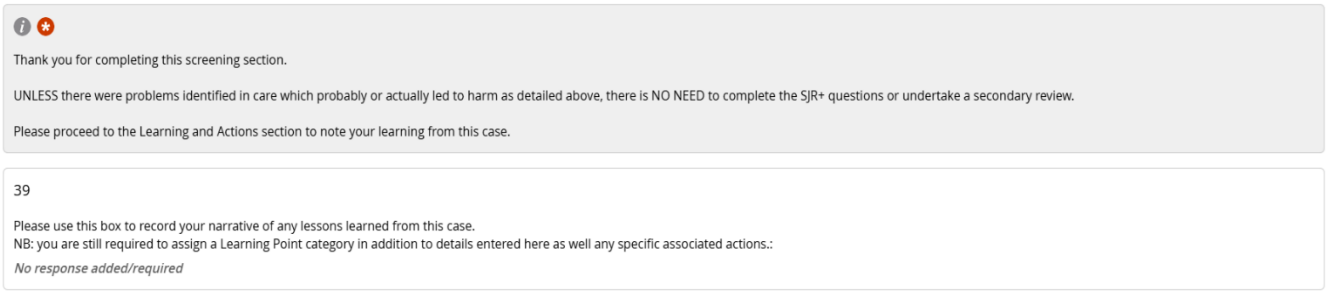
A further 17 cases had comments relating to learning included in their reviews. In five of these the comment was that no specific learning had been identified during case discussions, leaving an overall total of 12 with specific learning comments, which represents 12/50 = 24% of reviews.

Positive comments recorded related to timely progression to PCP completion, good communication and MDT discussions between ITU and the ward team, as well as family involvement.

Areas for improvement included delays to scans in two cases, also delay to dietician involvement on return from ITU, perhaps because the patient was taking oral nutrition at the time. There was a further case where there had been a delay in actioning an intervention but had not impacted significantly, and the OAoC was 4 ("good" care).

Actions related to specific issues to do with communication, for example, improving the pathway with University Hospital Southampton (UHS) for follow up and sharing reports of scans between the two Trusts. M&M discussion of one case shared the need to check past medical history carefully in the context of a patient who had received thromboembolism chemoprophylaxis when in ED, but who had already been taking an oral anticoagulant; this was the only prescription-related learning recorded.

A further generic action for the surgical teams relates to the extensive and exclusive use by them of the narrative box #39 in the proforma whereby no learning point category has been allocated (see below).



Thank you for completing this screening section.

UNLESS there were problems identified in care which probably or actually led to harm as detailed above, there is NO NEED to complete the SJR+ questions or undertake a secondary review.

Please proceed to the Learning and Actions section to note your learning from this case.

39

Please use this box to record your narrative of any lessons learned from this case.
NB: you are still required to assign a Learning Point category in addition to details entered here as well any specific associated actions.:

No response added/required

The instructions do ask for the user to proceed to assign a learning point category (as well as any associated actions) but that was not done in this cohort of 50 cases. This meant that although 24% had learnings recorded, these could not readily be analysed by type (positive or negative) nor by category.

OAoC scores were recorded in 37 cases with an average of 4.4 (range 3 - 5); a score of 5 is "excellent", 4 is "good" and 3 is "adequate". There were three cases scored as a 3, fifteen cases as a 4, and nineteen scored as a 5. In other words, in this large sample of mortality reviews, 51% scored as having received "excellent" overall care.

In conclusion, this analysis of 50 surgical mortality cases confirmed good or excellent practice overall but with many learning points and some specific actions arising from those in addition to the team discussions.

5.3 Appendix C - The National Audit of Care at the End of Life (NACEL)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.4
Date of Meeting:	8 January 2026		

Report Title:	Director of Infection Prevention & Control (DIPC) 6 monthly report April - September 2025			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy Lead Nurse, Prevention and Control Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing and DIPC			
Appendices (list if applicable):				

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

Executive Summary:

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made against the annual plan and 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' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

This report takes the opportunity to celebrate the successes and highlights the challenges of managing infection risk in an acute Hospital trust .

During quarters 1 and 2 of 2025/26, 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)
- *Clostridioides difficile (C.difficile)*
- *Candidozyma auris*
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- *Bordetella pertussis* (Whooping cough)
- Human Metapneumovirus (HMPV)
- Respiratory Syncytial Virus (RSV)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB)

Achievements for quarters 1 and 2 of 2025/26

- Annual PPMs have been completed in Main Theatres, Spinal Unit and Cardiac Catheter Laboratories.
- Further testing and remedial works have been completed on fire dampers and there are still units that require replacement and/or further remedials works. *(Of note: these works are funded via the Trust capital programme which is currently on hold).*
- Faulty pressure stabilisers that had been identified during annual system verifications have been replaced in the Day Surgery Unit (DSU).
- Ventilation duct cleaning has been completed on the supply and extract systems serving the Main Theatres Department.
- Two members of the Estates Team have been trained and appointed as competent persons (CPs) in line with HTM 03-01 in order for them to work on the Trust critical ventilations systems.
- Reviewed the laboratory ventilation systems to determine the laboratories that require works to improve the current air change rate due to the work/chemical(s) that are used on a day to day basis.
- Work completed on the control of ‘core’ area ventilations system in Main Theatres, the time schedules have been adjusted to reduce the total hours run. This will save energy and wear on these ventilation systems.
- Duct cleaning completed in the main kitchens; some sections of the duct have had new access panels fitted to allow access to areas not cleaning on previous visits.

On going challenges

- It remains challenging to increase the Hand hygiene training levels.
- C Difficile cases are increasing in and outside of the acute hospital setting.
- Review of instrument decontamination processes by Sterile Services limited after cases of wet sets and dirty defects, no patient harm has occurred as the issues were recognised prior to any surgical activity however this has caused delay to theatre activity.
- Outbreaks of Candida Auris at UHS has led to increase testing and isolation demand for any admissions from this trust

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 Monthly Update Report

April 2025 – September 2025

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

October/November 2025 (Draft v.1)

CONTENTS

APPENDICES

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 six monthly 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 2025/26 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 six months for infection prevention and control, which has involved:

- Three COVID-19 outbreaks in medicine
- One *Clostridioides difficile (C.difficile)* period of increased incidence (PII) in medicine
- 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 2025/26 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 1.89 whole time equivalent (w.t.e) ICNs and secretary (0.8 w.t.e). In addition, there are 3 Microbiologists, one of whom is the Deputy ICD and one of whom is the Trust Antimicrobial Stewardship Lead. *(Of note: there has been a Band 6 nursing position (1.0 w.t.e) vacancy since beginning of June, and no progress with recruitment plans. Additional hours have been covered by the team secretary to provide extra administration support).*

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 quarters 1 and 2 of 2025/26, 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)
- *Clostridioides difficile (C.difficile)*
- *Candidozyma auris*
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- *Bordetella pertussis* (Whooping cough)
- Human Metapneumovirus (HMPV)
- 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 quarter 1 and 2 of 2025/26, the Trust continued to experience COVID-19 activity, and the ICNs worked closely with the divisions and Clinical Site Team around COVID-19 management. When the Virtual Board Round (VBR) meetings were disbanded in mid-August 2024, 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.

During quarter 1, there were two unrelated outbreaks of COVID-19 declared at different times for the Trust for the medical division (Pitton Ward and Breamore Ward – details below in Table 1). Outbreak Management Review meetings were held and attended by the required staff with additional measures implemented, following established processes and the Trust Outbreak Management policy. The positive patients were isolated, with monitoring of the identified contact patients. Measures instigated during both outbreak periods included increased monitoring and practice checks to provide assurance with IPC practices. This was in relation to compliance with hand hygiene practices, the wearing of personal protective equipment (PPE), patient care equipment cleanliness, and IPC Tendable inspections, with oversight required by the division.

For Breamore Ward with the continued bay closure, the wearing of face masks (FRSM – Level 1 masks) by staff was advised (including requesting for any visitors), with essential visiting for the closed bay in place. For the duration of each outbreak, daily enhanced cleaning by Housekeeping was instigated across the ward templates.

From the PIR documents completed, the division identified learning related to hand hygiene practices, correct use of PPE and patient care equipment cleaning after each use. In addition, there were delays identified in the movement of positive patients into sideroom facilities for isolation nursing as per Trust policy.

Date outbreak declared	Area	Details	Outcome
11.04.25 (ward open)	Pitton Ward	From 30.03.25 to 11.04.25 – 11 patients tested COVID-19 positive, linked to Bays 3 and 4. Bay 3 (6 beds) had closed on 04.04.25 as a C.difficile contact and diarrhoea bay and reopened on 08.04.25 (Bay 4 was not required to close). There were 2 staff members with related symptoms.	16.04.25 – outbreak stepped down internally 14.05.25 – outbreak closed
11.05.25 (ward open)	Breamore Ward	From 04.06.25 to 10.06.25 – 7 patients tested COVID-19 positive, linked to Bay B (included 1 patient discharged from the bay and readmitted 3 days later when tested positive). Bay B (12 beds) remained closed from 06.06.25 to 10.06.25 when the remaining contact patients moved to the smaller Bay A on the ward for continued monitoring and isolation. Bay A (6 beds) reopened on 15.06.25. There were 2 staff members with related symptoms.	17.06.25 – outbreak stepped down internally 08.07.25 – outbreak closed

(Table 1)

There were lower numbers of respiratory illnesses notified to the ICNs at the start of quarter 2, with cases of COVID-19 increasing significantly during September 2025. There was one outbreak of COVID-19 declared for the Trust for the medical division in September 2025 (Breamore Ward – details below in Table 2). Outbreak

Management Review meetings were held and attended by the required staff with additional measures implemented, following established processes and the Trust Outbreak Management policy. The positive patients were isolated, with monitoring of the identified contact patients. Measures instigated included increased monitoring and practice checks to provide assurance with IPC practices. This was in relation to compliance with hand hygiene practices, the wearing of personal protective equipment (PPE), patient care equipment cleanliness, and IPC Tendable inspections, with oversight required by the division. Essential visiting was instigated for the closed bay with the wearing of face masks (FRSM – Level 1 masks) also requested for any visitors to the bay.

From the PIR document completed, the division identified ongoing actions with the monitoring of hand hygiene practices and completion of IPC Tendable inspections, correct use of PPE and patient care equipment cleaning after each use. For the duration of the outbreak, daily enhanced cleaning by Housekeeping was instigated across the ward template.

Date outbreak declared	Area	Details	Outcome
09.09.25 (ward open)	Breamore Ward	From 05.09.25 to 14.09.25 – 6 patients tested COVID-19 positive, 4 linked to A Bay (annexe), and 2 linked to B Bay (larger bay). A Bay (6 beds) remained closed from 07.09.25 to 11.09.25, with positive patients and contact patients nursed under isolation precautions. The B bay (larger bay, 12 beds) remained open, with the positive patients isolated and the contact patients monitored. There were 4 staff members reporting related symptoms, all having worked on the ward template.	18.09.25 – outbreak stepped down internally, with the agreed monitoring remaining in place for an extended period *Post IPCC meeting note: outbreak formally closed on 14.10.25*

(Table 2)

Also during September, increased COVID-19 activity was also experienced initially on Pitton Ward, and then on Redlynch Ward, with both areas included within the discussions at the Outbreak Management Review meetings for Breamore Ward. Similar additional measures were implemented across both Pitton and Redlynch Wards with oversight by the division (not declared as outbreaks).

Following the Respiratory Illness Guide medical escalation plan for respiratory illnesses, and not related to the outbreak, a COVID-19 positive cohort bay was created on Spire Ward from 24th to 29th September.

5.1.2 Influenza and Respiratory Syncytial Virus (RSV)

During quarters 1 and 2 of 2025/26, 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.

5.1.3 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 quarters 1 and 2 of 2025/26, 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). These 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 quarters 1 and 2 of 2025/26.

During quarter 1, following information notified to a Consultant Microbiologist, the Trust instigated additional CPE screening of identified patient transfers to SFT from Royal United Hospitals Bath NHS Foundation Trust. The ICD reviewed the implications for SFT, with the resulting screening requirements and detailed management advice for relevant patients communicated to key staff groups and operational teams. This instruction remains ongoing.

5.3 *Clostridioides difficile (C.difficile)* periods of increased incidence (PII)
During quarter 1 of 2025/26, one PII of *C.difficile* was declared for the Trust for the medical division *(see section 6.4.1 for details).*

No new PIIs of *C.difficile* were declared for the Trust during quarter 2. The previously declared PIIs of *C.difficile* for Redlynch Ward; Durrington Acute Frailty Unit (AFU) and Imber Ward (in 2024/25); were closed by the IPCWG during quarter 2, following feedback by the medical division around PIR completion and continued monitoring of practices (ribotyping outcomes previously provided to the IPCC). *Of note, there has been existing investigations and follow up work that has been coordinated by the ICNs regarding additional ribotyping of positive sporadic samples for identified inpatients. Outcomes are fedback via the IPCWG.*

5.4 Norovirus (viral gastroenteritis)
During quarters 1 and 2 of 2025/26, the Trust has experienced a continued level of activity associated with patients experiencing diarrhoea and/or vomiting. This has 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. There have been no outbreaks of Norovirus declared by the Trust within this reported period.

5.5 Additional patient screening requirements – *Candidozyma auris (C.auris)*
During quarter 2 of 2024/25, following information notified to the Consultant Microbiologists, the Trust instigated additional screening for identified patients:

- Screening for *Candidozyma 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. This instruction remains ongoing. Following the publication of national guidance, the ICD developed a new *Candidozyma auris* policy for the Trust during quarter 1 of 2025/26.

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).*

Of note: with effect from June 2025 release, an update to the MRSA and MSSA bacteraemias infection count methodology has been introduced. MRSA and MSSA bacteraemias were previously reported using just hospital onset healthcare associated (HOHA) cases. It now also includes community onset healthcare associated (COHA).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias
During quarters 1 and 2 of 2025/26, there have been no MRSA bacteraemia cases reported from inpatient blood culture samples by the Trust. The Trust's MRSA hospital onset case target for 2025/26 is zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias
During quarters 1 and 2 of 2025/26, there have been 16 unrelated healthcare associated MSSA bacteraemia cases, of which 3 cases were hospital onset and 13 cases were community onset. For these hospital onset cases, the sources of infection were identified as:

- Peripheral vascular cannula (PVC) associated (2 cases)
- Skin/soft tissue infection (1 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).*

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 by the microbiologists and data entry onto the UKHSA DCS website 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 quarters 1 and 2 of 2025/26, there have been 25 unrelated healthcare associated *E.coli* bacteraemia cases, of which 12 cases were community onset, and 13 cases were hospital onset. Of the 13 hospital onset cases identified, an unknown or no underlying focus of infection was identified for four cases, and the remaining 9 cases had a source of infection identified. Of these unrelated 9 cases, the sources of infection were:

- Lower urinary tract (4 cases)
- Gastrointestinal or intraabdominal collection (1 case)
- Upper urinary tract (1 case)
- Genital system (1 case)
- Bone and joint (1 case)
- Hepatobiliary (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.

The Trust's *E.coli* case threshold for 2025/26 is no more than 29 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2025/26: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 3) updated April 2025).*
NHS England » Minimising Clostridioides difficile and Gram-negative Bloodstream Infections

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*
During quarters 1 and 2 of 2025/26, there have been 9 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 4 cases were community onset and 5 cases were hospital onset. There have been 11 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which 4 cases were community onset and 7 cases were hospital onset. To note, the Trust has exceeded the threshold for *Pseudomonas aeruginosa* bacteraemia cases. The IPCWG continue to focus on measures related to gram negative bacterium.

The Trust's *Klebsiella spp.* case threshold for 2025/26 was no more than 9 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 7 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2025/26: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 3) updated April 2025).*
NHS England » 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)

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 2025/26, the *C.difficile* case threshold objective set for the Trust by NHSE is no more than 21 healthcare associated reportable cases. Guidance for testing and reporting *C.difficile* cases has remained unchanged, and the safety and care of patients remains our concern and priority.

There have been 21 healthcare associated *C.difficile* cases reported during quarters 1 and 2 of 2025/26, 9 cases were community onset, and 12 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; and antimicrobial pharmacist. 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.

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 quarters 1 and 2 of 2025/26, there has been one PII of *C.difficile* declared for the Trust for the medical division (detailed in Table 3 below).

Date PII declared	Area *(number of positive cases in brackets)*	Ribotyping results	Final outcome
15.04.25	Spire Ward (3 cases)	1 case = 005 1 case = 020 1 case = sample not available in Microbiology Laboratory to be sent to the Reference Laboratory*	Remained a PII

(Table 3)

**Delay identified retrospectively by the Infection Control Doctor (ICD) that the Laboratory had not sent the samples to the External Reference Laboratory when originally instructed. It was also clarified that 1 sample had not been retained in accordance with the existing Laboratory protocol and was therefore not available to be sent for ribotyping. This incident is under investigation by the Microbiology Laboratory Manager (DATIX completed), and the medical division and Deputy DIPC have been fully informed.*

In response to this declaration, 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 the PII to ensure escalation to the Patient Safety Summit Group (PSSG). The PII of *C.difficile* was monitored by the IPCWG, with the division required to feedback and provide updates to this group.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for quarters 1 and 2 of 2025/26 for further detail of HCAI data.

6.5 UKHSA Audit of HCAI DCS entries completed by the Trust update

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 was completed during quarter 1 of 2025/26, and an update provided to the IPCWG.

6.6 BSW Collaboratives

During quarters 1 and 2 of 2025/26, representatives from the Trust attended the 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.

There has been IPC team representation from the Trust at other regional IPC meetings for Winter Planning. In addition, the ICNs and ICD have continued to ensure engagement with the various BSW Electronic Patient Record (EPR) workstreams.

6.7 NHS Standard Contract 2025/26

Table 4 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 2025/26 (*as detailed in the Official NHS Standard Contract 2025/26 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 3) updated April 2025).*

Organisation code	Name	Case thresholds for 2025/26			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	→ 21	29 ↓	7 ↓	→ 9

(Table 4)

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 quarters 1 and 2 of 2025/26.

- Final data collection for quarter 4 of 2024/25 was reconciled within the required timeframe. A total of 65 cases were entered onto the national database, with two deep incisional infection identified. *(To note: a surveillance patient from quarter 4 of 2024/25 was readmitted during quarter 1 of 2025/26 and identified to have a deep incisional wound infection. Following discussion with UKHSA, this SSI would be allocated to quarter 4 of 2024/25, and Trust records updated accordingly. Therefore, the final SSI data for quarter 4 of 2024/25 was confirmed as two deep incisional infections).*
- Final data collection for quarter 1 of 2025/26 was reconciled within the required timeframe. A total of 64 cases were entered onto the national database, with no infections identified.
- Data collection has continued in quarter 2 of 2025/26, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 3 of 2025/26 (31st December 2025).

Throughout quarters 1 and 2 of 2025/26, 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. *(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).*

Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

6.9 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 quarters 1 and 2 of 2025/26, the Trust compliance rates for MRSA emergency screening ranged

from 89.14% - 92.28%. For MRSA elective screening, the Trust compliance rates ranged from 81.25% - 87.72%.

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.

6.10 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. *(Of note: during quarters 1 and 2 of 2025/26, data submission from the NNU has not happened consistently and following the appointment of a new NNU Matron, appropriate training will be undertaken to ensure this process is completed moving forward).*

6.11 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 quarters 1 and 2 of 2025/26.

7. HAND HYGIENE
Wards and departments across the three 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' Please see Appendices D, E and F.

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. 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..

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.

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.

8. ANTIBIOTIC STEWARDSHIP

8.1 Purpose

To advise of work being undertaken by the Antibiotic Reference Group (ARG) and to provide a summary of key successes of quarters 1 and 2 of 2025/26, progress of action plan and key challenges.

8.2 Key successes

Antimicrobial stewardship (AMS) ward rounds

Antimicrobial stewardship (AMS) rounds with a Microbiologist and Antimicrobial Pharmacist/Pharmacy Technician takes place twice a week. Around 35 to 60 patients are reviewed each week on the round. It is an ideal opportunity for doctors to ask for advice about their patients, the regularity and frequency of the visits has created its own demand. Many independent prescribers, Biomedical Scientists and Pharmacy staff have also attended the round, to glean experience, add to their portfolios and broaden their knowledge around antibiotics and the related conditions.

8.3 Guidance Development

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 Patient Medication Administration (EPMA) system in 2026. During quarters 1 and 2 of 2025/26, the following guidelines have been reviewed by the ARG:

- Encephalitis and Meningitis guidelines
- Skin decolonisation policy for preoperative assessment
- COVID-19 therapies for adult inpatients
- Neutropenic sepsis guidelines
- Community acquired pneumonia (CAP) guidelines
- New guidance on the sourcing of Disease Specific Immunoglobulin.

8.4 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.

8.5 Antibiotic Reference Group (ARG) Action plan for 2025/26

The action plan agreed the April ARG meeting includes:

- Aligning our antimicrobial policies with BSW partners
- Focus attention on a general reduction of consumption of daily defined dosages (DDDs) of antibiotics, with particular focus on “AWARE” category of antibiotics (as per the national action plan).

8.6 Challenges

8.6.1 Risk reduction relating to antibiotic use is an ongoing challenge

For the 6 months period of 1st April 2025 to 30th September 2025, there have been 76 DATIX reports relating to the use of antibiotics. Of these 76 reports, only 3 were recorded as causing any (minor) harm. The remaining reports were categorised as no harm. There is an ongoing theme with errors with Gentamicin dosing, which has been highlighted in a recent Trust Medicines Safety Bulletin. Another ongoing theme is a duplication of doses of antibiotics being given as a result of antibiotics being administered against a paper prescription in the Emergency Department (ED) and the dose then being repeated on EPMA. The risk of this will be removed once Cerner EPMA is introduced into ED.

8.6.2 Stock shortages of antibiotics used for the treatment of Tuberculosis (TB)

This stock shortage has been subject to a National Patient Safety Alert (NPSA). The stock shortage has been managed by the Pharmacy Antimicrobial Team and Pharmacy Medicines Safety Officer (PMSO). The shortages are likely to continue into 2026 and the Pharmacy Antimicrobial Team have been working with Respiratory Medicine, Microbiology and Rowlands Outpatient Pharmacy to ensure that patients are provided with ongoing supplies.

8.7 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 and reduced staffing levels 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. Of note, the ICNs have met with the Tendable team and reviewed the IPC inspection questions. Please see Appendices C, D, E and F 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 quarters 1 and 2 of 2025/26 were 67.8% for staff completion of hand hygiene assessments and 87.1% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 01.10.25).*

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 addressed back 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. Some 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 quarters 1 and 2 of 2025/26. 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. Discussions are planned via the Mandatory Learning Oversight Group (MLOG).

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 2025/26

Two flexible endoscope storage cabinets have been commissioned and brought into use in Urology and Gynaecology Outpatient areas. These replace the previous arrangements of vac-packed storage, enabling secure, validated storage of flexible scopes whilst reducing packaging waste.

We have received charitable funding to introduce a disposable gastroscope system into the organisation. This will be based in the Endoscopy Unit and primarily used for patients identified at increased risk of Creutzfeldt-Jakob Disease (CJD). Historically, late disclosure by patients on the day of attendance, or high risk patients requiring biopsies caused delays to the procedure whilst equipment challenges were resolved, leading to frustration and poor experience. Having a disposable scope will remove the equipment risks relating to transmission of infection so the procedure can progress without delay. An additional benefit is that the equipment design makes it more mobile and easier to scope inpatients in other locations, minimising the need for patients with known infections to be transferred unnecessarily around site. This also avoids the post procedure requirements for environmental decontamination within endoscopy and minimises disruption to lists.

11.2 Progress on key actions during quarters 1 and 2 of 2025/26

There have been quality issues reported following instrument reprocessing in Sterile Services Limited (SSL), with two key themes of wet sets and dirty defects. Whilst there are no individual patient safety concerns, the issues have caused disruption to Theatre lists and some patients have required rescheduling when equipment is not able to be used. One incident was the subject of a Patient Safety Review (PSR). SSL has processes and procedures in place which should identify dirty defects prior to leaving their department and there are action plans in place to identify gaps. SSLs engineering team are supporting the wet set investigations by assessing autoclave functions and steam supply. The trends are being monitored closely.

Work to develop a more robust auditing method has made some progress. A way to capture data from existing Tendable audit questions has been agreed, avoiding the need for clinical teams to undertake additional work. This should ‘go live’ in quarter 3 and will enable trends associated with gaps in knowledge or practice to be identified and also evidence areas of good practice. The best platform to capture specialist audits undertaken by the Decontamination Lead is still being explored.

11.3 Key challenges for quarters 3 and 4 of 2025/26

Following a Patient Safety Investigation, learning was identified linked to the use of bespoke equipment where correct decontamination steps had not been undertaken. Work is required to identify any clinical teams who may be using bespoke devices, or devices ‘off-licence’, in order to meet specific clinical needs. Once identified, checks to ensure decontamination arrangements are robust will be required and a process put in place to ensure this is captured as part of future service developments within clinical teams.

Unfortunately, there has been no progress on the action to improve accessibility of information by introducing a new section within Eolas Medical. This will house quick reference guides, posters for display and any generic SOPs alongside the main policy. Progress is anticipated during quarters 3 and 4 of 2025/26.

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 PLACE audits which commenced in February 2025. A total of 38 have been completed so far and 28 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 is due to be undertaken on the 16th October 2025.

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in April 2025 and already is a couple of weeks ahead of schedule.

12.4 Improvement Work Over the past 6 months

Three new hydrogen peroxide vapour (HPV) decontamination machines were purchased in April 2025 and training was rolled out to all key staff. The older machines are still working which is enabling us to carry out more HPV processes. So far a total of 150 more HPV processes have been completed compared with the same period last year.

12.5 Challenges for the coming 6 months

The new National Cleaning Standards project has been paused due to the Trust's financial position and funding withdrawn for this year. Functional risk 1 (FR1) and FR2 categories will continue to receive the new standards, however the increased cleaning that was going into Outpatient areas has had to be stopped. There are also challenges around the freeze in recruitment which may also have an impact going forward.

12.6 Post infection cleans

Post infection cleans undertaken remains high (above pre-COVID levels). Please refer to Table 5 below:

2025/26 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTION CLEANS	1038	958	1040	1064	921	1051							
ENHANCED CLEANS HOURS	75	69.5	92.75	95.5	86.5	94.25							
DOUBLE CLEANS HOURS	56.25	74.75	30.5	42.25	51	39.25							
BIOQUELL (HPV)	39	26	33	44	20	23							
INIVOS (HPV)	26	38	19	49	25	36							

(Table 5)

12.7 Successes from the past 6 months

Reaching 99% or above each month for our KPIs linked to the operational response times in starting a clean within 3 hours and purchasing three new HPV decontamination units.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2025/26. 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 designated RP (dRP) for water safety) from ETS and FES Ltd (PFI maintenance contractor) are held monthly, to review progress with PPMs and actions in respect of water safety. 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 Table 6 below – Legionella, listing counts reported >1000 cfu/l) have taken place in the Trust as a result of the sample results. 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.

13.1 Legionella

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 01/09/2025	
					Pre	Post
1	Chilmark Ward	PFI	4.10.107	2nd clear sample, 3rd clear sample required	ND	ND
2	Amesbury Suite	PFI	4.10.245	2nd clear sample, 3rd clear sample required	ND	ND
3	Farley Ward	PFI	2.10.11	2nd clear sample, 3rd clear sample required	ND	ND
4	Ear. Nose & Throat OPD	416102	3.04.24	Point of use (POU) filter fitted, investigate temperature/ circulation issues	4200	
5	Sarum Ward	416064	4.05.17	Clean, disinfect outlet and resample	380	

(Table 6)

13.2 Pseudomonas

Six monthly sampling has been completed, with some live counts identified. Remedial works and re-sampling are being completed. The next round of sampling is due to commence in January 2026.

Pseudomonas						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 01/09/2025	
1	Sarum Ward	L4/S6/17	Sideroom 8	POU filter fitted, clean and disinfect and re-sample	>100	
2	Sarum Ward	L4/S6/59	Bathroom	Clean/disinfect and re-sample	11	
3	Sarum Ward	L4/S6/23	Bay B	POU filter fitted, clean and disinfect and re-sample	>100	
4	Neonatal Unit (NNU)	02/77/22	77.14	POU filter fitted, clean and disinfect and re-sample	>100	
5	Pembroke Ward	L3/S4/61	3.04.56	POU filter fitted, clean and disinfect and re-sample	>100	
6	Pembroke Ward	L3/S4/11	3.04.4a	POU filter fitted, clean and disinfect and re-sample	>100	

(Table 7)

13.3 Pool Water Quality

There have been no failures of pool water quality in this reporting period.

13.4 Achievements for quarters 1 and 2 of 2025/26

- Pseudomonas risk assessments (RA) have been completed, reviewed by the WSG and circulated with actions plans and deadlines to the NNU, Sarum Ward, Radnor Ward, Odstock Ward and Pembroke Wards.
- The Estates Team have recruited a new member of the team to fill the previously vacant post for Lead Technician for water safety. This relatively new role within the team, however it is key to the delivery of PPMs and action plans associated with water safety.
- Improvements in the completion of TMV maintenance, which is a KPI reported to the WSG and has increased from 40% to 72% as reported at the September WSG meeting.
- Six monthly Pseudomonas testing has been completed.
- Maintaining good levels of flushing compliance, at 93% for July and August.
- We have reinstated an Operational Water Safety Group; the group will meet monthly as a minimum and focus the key tasks and actions plans related to water safety.

13.5 Key Focus for quarters 3 and 4 of 2025/26

- Further works on the sites main water risk assessment, currently at 72 % of completion, most of the outstanding actions. The focus of the actions will be around engineering issues that have been identified such as dead legs/blind ends, where possible these will be removed or a mitigation will be put in place to reduce the risk.
- 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.
- 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 actions from the annual water safety audit, to include completion of a Scalding risk assessments, review of the Trust Water Safety Plan, review of the current flushing strategy (linked to previous item listed above), and the formal appointment of a water Authorised Engineer (AE).

14. SPECIALIST VENTILATION SYSTEMS MANAGEMENT

This section summarises the actions/precautions that the Trust has taken over quarters 1 and 2 of 2025/26 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 the Labs) of the system prior to its isolation.

14.1 Achievements for quarters 1 and 2 of 2025/26

- Annual PPMs have been completed in Main Theatres, Spinal Unit and Cardiac Catheter Laboratories.
- Further testing and remedial works have been completed on fire dampers and there are still units that require replacement and/or further remedials works. *(Of note: these works are funded via the Trust capital programme which is currently on hold).*
- Faulty pressure stabilisers that had been identified during annual system verifications have been replaced in the Day Surgery Unit (DSU).
- Ventilation duct cleaning has been completed on the supply and extract systems serving the Main Theatres Department.
- Two members of the Estates Team have been trained and appointed as competent persons (CPs) in line with HTM 03-01 in order for them to work on the Trust critical ventilations systems.
- Reviewed the laboratory ventilation systems to determine the laboratories that require works to improve the current air change rate due to the work/chemical(s) that are used on a day to day basis.
- Work completed on the control of ‘core’ area ventilations system in Main Theatres, the time schedules have been adjusted to reduce the total hours run. This will save energy and wear on these ventilation systems.

- Duct cleaning completed in the main kitchens; some sections of the duct have had new access panels fitted to allow access to areas not cleaning on previous visits.

14.2 Key focus for quarters 3 and 4 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 remedials and fire damper testing (when funding is available).
- Explore options for building management systems (BMS) to improve resilience for critical ventilations systems such as Main Theatres, Catheter Laboratories and the Aseptic Suite in Pharmacy.
- Work with SSL/Steris to resolve issues with the control and alarm status of the ventilations systems that serve SSL department. These are currently not visible on the Trust BMS.
- Form an Operational Ventilation Safety Group (to meet quarterly) that will focus on the key challenges of the Authorised Person (AP) and CPs in the delivery of key PPMs for the Trusts ventilations systems.
- Work with the Estates Project Team to deliver the improvements to rooms within the main laboratories that have been indemnified as having little or no ventilation.

15. CONCLUSION

This six monthly 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 2025/26 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.

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- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Amanda Urch, General Manager Facilities (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2025/26

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	Group CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	Group CEO	In place
Lead infection prevention & control in the Trust and provide a six-monthly public report to the Trust Board	DIPC	
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	In place 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.	Deputy 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)	Group CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of root cause analysis 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 UKHSA for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous
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

Domain and Key Actions	Who By	Status
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
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 (incorporated within the NIPCM)	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

Domain and Key Actions	Who By	Status
Glycopeptide Resistant Enterococcus (GRE)	ICD	In place
Acinetobacter species	ICD	Included in Isolation
Viral Haemorrhagic fever (VHF) (incorporated into Trust HCID Plan (EPRR team))	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Candidozyma auris screening and management policy *(New policy from April 2025)*	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 precautions	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
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 LEARN	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

APPENDIX B - *Dashboard Quarters 1 and 2 of 2025/26*

Salisbury NHS Foundation Trust

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
				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	
Family and Specialist Services	Labour Ward										1	1								
	Longford Ward									1			2							
	Neonatal Unit																			
	Post-natal Ward																			
	Sarum Ward (inc. Children DAU)	1	3																	
	FASS Totals:	**1**	**3**							**1**	**1**	**1**	**2**							
Medicine	AMU (inc. SDEC)	1	1 + 1						2		3	1					1	1		
	Breamore Ward	1																	Q1 & Q2 COVID-19	
	Durrington AFU	1																		
	ED (inc. SSEU)		2 + 3						11		8	37		4	2		3	7		
	Farley Ward	3								2						1				
	Hospice	1																		
	Imber Ward	2					1													
	Laverstock Ward	2											1							
	Pembroke Ward	1								2						1				
	Pembroke Suite																			
(endocrinology from 10.07.25)	Pitton Ward	1					1			1									Q1 COVID-19	
	Redlynch Ward	1														1				
	Spire Ward	1 + 5								3										Q1 C.difficile
(closed 17.07.25 - refurbishment)	Tisbury CCU						1													

(cardiology from 17.07.25)	Whiteparish Ward	1 + 1											1							
	Nunton Unit																			
	Medicine Totals:	**9 + 13**	**3 + 4**				**3**		**13**	**8**	**11**	**38**	**2**	**4**	**2**	**3**	**4**	**8**		
Surgery	Amesbury Suite	2 + 1								1										
	Britford Ward (inc. SAU)									1		1								
	Chilmark Suite																			
	Day Surgery Unit																			
	Downton Ward									1		1	1					1		
	Odstock Ward		1							1						1				
	Radnor Ward												2			1				
	Surgery Totals:	**2 + 1**	**1**							**4**		**2**	**3**			**2**		**1**		
Additional info: Other *C.difficile* samples, e.g. GP, other Emergency Assessment, OPD, Mortuary, Private or Community Hospitals			**2 + 3**																	

***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**

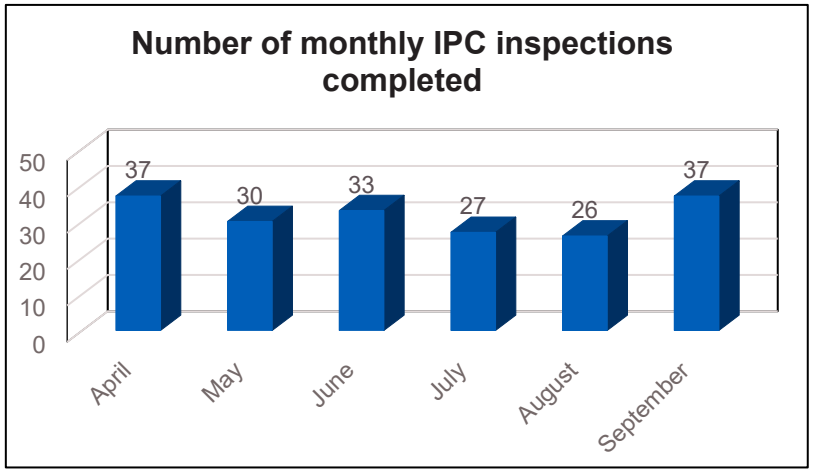
Bacteraemia classification codes:

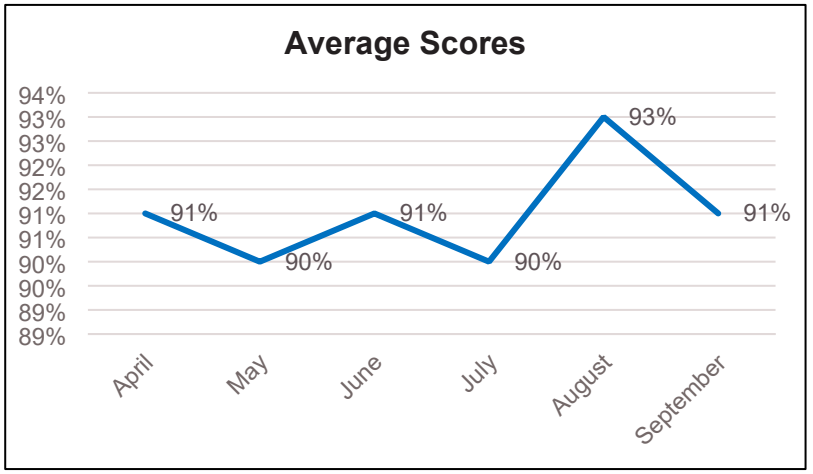
- Hospital onset healthcare associated, is shown as Hospital onset HA
- Community onset healthcare associated, is shown as Community onset HA
- Community onset community associated, is shown as Community onset CA

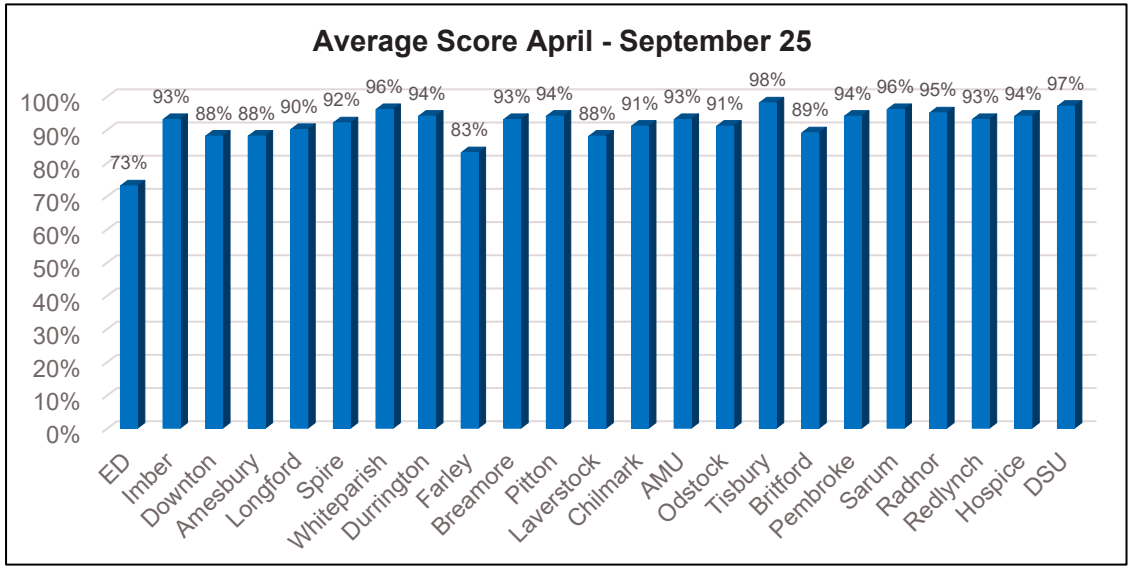
Salisbury NHS Foundation Trust

APPENDIX C

Tendable Infection Prevention & Control (IPC) Audit Inspection Summary for Quarters 1 and 2 of 2025/26







(Information provided by Tendable Review Team at SFT)

APPENDIX D

Medicine Tendable Dashboard

	DOCUMENTATION						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	85%	98%	83%	79%	45%	94%	75%
Breamore	93%	100%	93%	91%	100%	82%	84%
Durrington	80%	90%	83%	89%	85%	94%	87%
ED	100%	40%	67%	44%	25%	23%	48%
Farley	84%	68%	87%	83%	94%	86%	80%
Hospice	100%	100%	82%	98%	100%	97%	98%
Imber	92%	77%	73%	90%	90%	88%	79%
Laverstock	89%	86%	83%	56%	83%	89%	75%
Pembroke	85%	87%	99%	65%	89%	97%	87%
Pitton	93%	91%	85%	N/a	N/a	N/a	N/a
Redlynch	89%	92%	93%	98%	94%	89%	90%
Spire	80%	92%	84%	84%	82%	74%	64%
Tisbury	94%	91%	92%	98%	99%	96%	92%
Whiteparish	98%	100%	98%	97%	94%	87%	86%

	PATIENT						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	96%	96%	100%	100%	97%	82%	92%
Breamore	96%	88%	86%	90%	94%	96%	88%
Durrington	96%	96%	100%	99%	91%	91%	92%
ED	77%	79%	None	94%	88%	None	98%
Farley	82%	89%	86%	81%	94%	81%	99%
Hospice	100%	100%	100%	100%	98%	98%	92%
Imber	99%	100%	94%	90%	97%	None	99%
Laverstock	96%	96%	87%	96%	91%	90%	94%
Pembroke	100%	97%	94%	96%	86%	None	100%
Pitton	87%	96%	92%	100%	N/a	N/a	N/a
Redlynch	95%	96%	96%	88%	95%	96%	96%
Spire	97%	86%	76%	74%	90%	75%	76%
Tisbury	94%	97%	97%	97%	96%	97%	100%
Whiteparish	97%	97%	81%	99%	91%	99%	99%

	IPC						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	92%	92%	90%	94%	97%	94%	94%
Breamore	84%	97%	95%	94%	94%	97%	97%
Durrington	92%	94%	89%	90%	100%	100%	92%
ED	69%	65%	None	64%	84%	84%	69%
Farley	83%	83%	84%	78%	None	89%	86%
Hospice	100%	89%	92%	97%	94%	97%	94%
Imber	84%	100%	84%	95%	90%	95%	95%
Laverstock	95%	84%	95%	82%	89%	83%	81%
Pembroke	97%	92%	94%	95%	94%	92%	92%
Pitton	95%	95%	100%	N/a	N/a	N/a	N/a
Redlynch	92%	92%	86%	92%	100%	97%	89%
Spire	97%	97%	100%	84%	84%	89%	89%
Tisbury	97%	100%	89%	100%	100%	100%	95%
Whiteparish	97%	100%	92%	95%	97%	95%	89%

None = No inspection completed

	WARD STANDARDS						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	82%	89%	87%	85%	91%	78%	91%
Breamore	82%	96%	90%	96%	96%	89%	98%
Durrington	89%	91%	None	82%	91%	92%	90%
ED	82%	87%	86%	94%	None	79%	73%
Farley	76%	84%	94%	92%	89%	None	92%
Hospice	100%	100%	98%	98%	97%	97%	95%
Imber	96%	90%	86%	90%	99%	95%	94%
Laverstock	94%	84%	93%	79%	89%	84%	88%
Pembroke	None	91%	97%	89%	100%	93%	90%
Pitton	96%	91%	94%	N/a	N/a	N/a	N/a
Redlynch	95%	91%	98%	98%	None	94%	96%
Spire	79%	87%	83%	87%	79%	86%	92%
Tisbury	93%	95%	96%	98%	96%	95%	95%
Whiteparish	98%	98%	96%	95%	100%	96%	98%

	HAND HYGIENE						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	90%	85%	70%	95%	100%	95%	100%
Breamore	85%	95%	90%	90%	85%	90%	85%
Durrington	80%	75%	75%	90%	100%	100%	80%
ED	90%	70%	80%	85%	None	95%	60%
Farley	None	80%	60%	90%	None	80%	90%
Hospice	100%	100%	90%	100%	100%	100%	100%
Imber	80%	100%	95%	80%	100%	95%	100%
Laverstock	75%	80%	80%	85%	55%	80%	70%
Pembroke	100%	100%	95%	100%	100%	100%	100%
Pitton	85%	95%	90%	N/a	N/a	N/a	N/a
Redlynch	85%	80%	85%	90%	85%	80%	90%
Spire	60%	100%	85%	50%	100%	75%	90%
Tisbury	95%	80%	90%	95%	90%	90%	100%
Whiteparish	90%	85%	95%	95%	95%	90%	95%

	MATRON EXPERT REVIEWS WARD STANDARDS						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	0	0	0	0	86%	0	0
Breamore	0	0	0	91%	0	92%	90%
Durrington	0	0	0	0	89%	0	0
ED	0	87%	0	0	88%	89%	0
Farley	0	0	0	0	0	81%	0
Hospice	0	95%	0	97%	0	0	0
Imber	0	88%	0	0	0	89%	0
Laverstock	0	0	0	0	73%	0	0
Pembroke	90%	0	89%	0	95%	0	95%
Pitton	81%	0	0	0	0	0	0
Redlynch	0	84%	0	0	93%	0	91%
Spire	0	89%	0	0	0	82%	0
Tisbury	0	0	0	0	90%	0	0
Whiteparish	0	0	0	0	77%	0	0

	MATRON EXPERT REVIEWS ALL INSPECTIONS (including Ward Standards)						
	Apr	May	Jun	Jul	Aug	Sep	Oct
AMU	0	0	0	0	2	0	0
Breamore	0	0	0	1	1	2	1
Durrington	0	0	0	0	2	0	0
ED	1	1	0	0	1	1	0
Farley	0	0	0	0	1	1	0
Hospice	0	1	0	1	0	0	0
Imber	0	1	0	0	0	1	0
Laverstock	0	0	0	0	2	0	1
Pembroke	1	0	1	0	2	1	1
Pitton	3	0	0	0	0	0	0
Redlynch	0	1	0	0	2	1	1
Spire	0	1	0	0	1	1	0
Tisbury	0	0	0	0	2	0	0
Whiteparish	0	0	0	0	2	0	1

Action performance for 2025	COMPLETED	IN PROGRESS	UNWRITTEN
AMU	25	1	7
Breamore	10	6	0
Durrington	5	8	11
ED	3	0	21
Farley	1	3	17
Imber	12	4	4
Hospice	10	0	2

Action performance for 2025	COMPLETED	IN PROGRESS	UNWRITTEN
Laverstock	7	0	28
Pembroke	18	0	0
Pitton	18	10	0
Redlynch	8	7	1
Spire	16	2	4
Tisbury	37	0	0
Whiteparish	0	4	15

The two tables above show the level of Matron Expert reviews completed.

Table one shows the score where a Matron has completed an Expert inspection on the Ward Standards inspection.

The second table shows the number of Matron Expert inspections completed on each ward that month (this includes the Ward Standards).

APPENDIX E

Surgery Tendable Dashboard

	DOCUMENTATION						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	89%	84%	84%	92%	85%	82%	85%
Britford	86%	86%	88%	87%	89%	85%	87%
Chilmark	84%	79%	86%	84%	83%	86%	73%
DSU	85%	90%	92%	89%	100%	93%	67%
DSU Escalation	-	-	-	85%	88%	75%	87%
Downton	71%	75%	87%	85%	79%	77%	62%
Odstock	80%	90%	83%	96%	70%	71%	98%
Radnor	84%	89%	87%	99%	89%	92%	94%

	PATIENT						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	89%	93%	96%	96%	93%	91%	93%
Britford	97%	99%	97%	90%	96%	84%	100%
Chilmark	97%	100%	79%	97%	100%	100%	98%
DSU	100%	100%	85%	100%	98%	100%	100%
DSU Escalation	-	-	-	-	94%	96%	97%
Downton	94%	96%	89%	79%	91%	99%	93%
Odstock	96%	97%	100%	87%	99%	95%	90%
Radnor	81%	100%	94%	92%	91%	89%	None

	IPC						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	84%	89%	91%	90%	95%	97%	88%
Britford	92%	84%	89%	97%	90%	83%	87%
Chilmark	97%	78%	95%	97%	88%	92%	82%
DSU	97%	100%	94%	97%	97%	100%	97%
DSU Escalation	-	-	-	84%	84%	89%	81%
Downton	81%	84%	100%	89%	97%	78%	87%
Odstock	94%	87%	97%	94%	95%	82%	94%
Radnor	97%	87%	94%	97%	97%	100%	94%

None = No inspection completed

	WARD STANDARDS						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	92%	93%	95%	98%	86%	96%	87%
Britford	83%	82%	86%	88%	88%	92%	95%
Chilmark	92%	91%	100%	84%	None	90%	92%
DSU	98%	96%	98%	94%	88%	99%	98%
DSU Escalation	-	-	-	84%	83%	91%	86%
Downton	91%	88%	89%	89%	92%	94%	91%
Odstock	97%	91%	93%	97%	93%	94%	93%
Radnor	95%	92%	88%	94%	87%	91%	91%

	HAND HYGIENE						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	90%	85%	85%	100%	55%	95%	75%
Britford	85%	100%	85%	55%	90%	100%	95%
Chilmark	90%	95%	85%	95%	100%	80%	95%
DSU	85%	85%	95%	90%	75%	80%	95%
DSU Escalation	-	-	-	75%	65%	35%	70%
Downton	75%	55%	65%	70%	75%	80%	65%
Odstock	95%	100%	100%	100%	85%	75%	90%
Radnor	100%	100%	100%	95%	100%	75%	100%

None = No inspection completed

Action performance for 2025	COMPLETED	IN PROGRESS	UNWRITTEN
Amesbury	30	6	3
Britford	3	5	8
Chilmark	3	2	24
DSU	0	0	1
DSU Escalation	0	0	11
Downton	24	5	33
Odstock	12	6	5
Radnor	10	0	8

MATRON EXPERT REVIEWS WARD STANDARDS							
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	0	0	0	0	0	86%	94%
Britford	0	0	0	0	0	0	0
Chilmark	0	0	0	0	0	0	0
DSU	0	95%	96%	0	93%	92%	0
DSU Escalation	0	0	0	0	0	0	0
Downton	0	0	0	0	0	0	0
Odstock	0	0	0	0	0	0	97%
Radnor	0	0	0	0	0	0	0

MATRON EXPERT REVIEWS ALL INSPECTIONS (including Ward Standards)							
	Apr	May	Jun	Jul	Aug	Sep	Oct
Amesbury	1	0	1	0	0	2	1
Britford	0	0	1	1	0	0	0
Chilmark	0	0	0	0	0	0	0
DSU	0	3	3	0	4	4	0
DSU Escalation	-	-	-	0	0	0	0
Downton	0	0	1	1	0	0	0
Odstock	0	0	1	0	0	0	1
Radnor	0	0	0	0	0	0	0

The two tables above show the level of Matron Expert reviews completed.

Table one shows the score where a Matron has completed an Expert inspection on the Ward Standards inspection.

The second table shows the number of Matron Expert inspections completed on each ward that month (this includes the Ward Standards).

APPENDIX F

FASS Tendable Dashboard

	DOCUMENTATION						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	92%	82%	83%	97%	83%	89%	67%
Sarum	100%	94%	86%	100%	96%	92%	100%

	PATIENT						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	99%	99%	93%	None	87%	91%	86%
Sarum	100%	100%	94%	97%	97%	98%	100%

	IPC						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	100%	94%	95%	86%	97%	92%	76%
Sarum	97%	97%	94%	97%	97%	None	100%

None = No inspection completed

	WARD STANDARDS						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	97%	79%	90%	81%	84%	94%	88%
Sarum	95%	97%	91%	97%	96%	99%	96%

	HAND HYGIENE						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	100%	50%	80%	95%	90%	100%	65%
Sarum	100%	95%	100%	100%	95%	100%	100%

None = No inspection completed

	MATRON EXPERT REVIEWS WARD STANDARDS						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	0	0	0	78%	0	71%	0
Sarum	0	88%	0	0	0	0	0

Action performance for 2025	COMPLETE	IN PROGRE	UNWRITTEN
Longford	30	2	44
Sarum	1	0	5

	MATRON EXPERT REVIEWS ALL INSPECTIONS (including Ward Standards)						
	Apr	May	Jun	Jul	Aug	Sep	Oct
Longford	0	0	2	1	0	2	1
Sarum	0	1	0	1	0	1	0

The two tables above show the level of Matron Expert reviews completed.

Table one shows the score where a Matron has completed an Expert inspection on the Ward Standards inspection.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.6
Date of meeting:	8th January 2026		

Report tile:	Maternity & Neonatal Quality and Safety Report for Quarter 2 2025/26.			
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Approval Process: (where has this paper been reviewed and approved):	DMT approval – 13.11.25 Maternity and Neonatal Assurance Committee – 20.11.25 Clinical Governance Committee - 25th November 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 Q2 2025/26, 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.

Executive Summary:

The Maternity and Neonatal Quality and Safety Report for Q2 demonstrates current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Clinical Governance Committee 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 2 25/26** with detail highlighted below:

- Midwifery and Neonatal staffing-
  - Midwifery staffing budget reflects Birthrate plus establishment levels for Salisbury, and escalation plan in place for any times where staffing does not meet acuity to maintain safe staffing levels.
  - Non-complaint for BAPM (British Association for Perinatal Medicine) for Neonatal Nurses.
  - Non-Compliant for BAPM for Medical cover– action plan in progress.

- 2 Stillbirths (Excluding Medical Termination of Pregnancy)
  - Overall stillbirth rate for last 12 months for SFT is 4.08 per 1000 births. (National rate 3.2/1000 National ambition 2.5 per 1000).
  - Reviewed via PMRT with non-executive safety champion and external reviewer as part of panel.

- 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.

- 5 reportable cases referred to Maternity and Newborn Safety Investigations **(**MNSI) in Q2.
  - Thematic review undertaken with external reviewers from GWH and RUH to capture any immediate learning.
  - DoM and Deputy CMO meeting with MNSI monthly to capture themes and learning swiftly.
  - Weekly meeting with MNSi and Q and S matron and Obstetric risk lead to action any requests, receive feedback as appropriate.
  - Awaiting x5 full reports with action plans to embed learning

- 0 new Maternity PSII commissioned in Q2.

- 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, and steady progress being made.

- Progress with three-year delivery plan continues – as of end of Q2 compliant with 25/44 actions. All other actions in progress.

- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q2.

- Feedback received via safety champions, FFT, MNVP. Complaints and concerns actioned and fed back to staff and service users. Well attended safety champions meetings – continued actions around 'you said-we did,' including escalations around administration resource.

- 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. SFT rolling 12-month average of 4.8% against national ambition of 6% and local ODN target of 5%.

- Triangulation meetings continue with focus on considering complaints, incidents, feedback and litigation in collaboration to ensure focussed and collective improvements.

- Continued focus on inequalities and outcomes – in particular, within incident reviews to ensure further support and options available to families accessing maternity care.

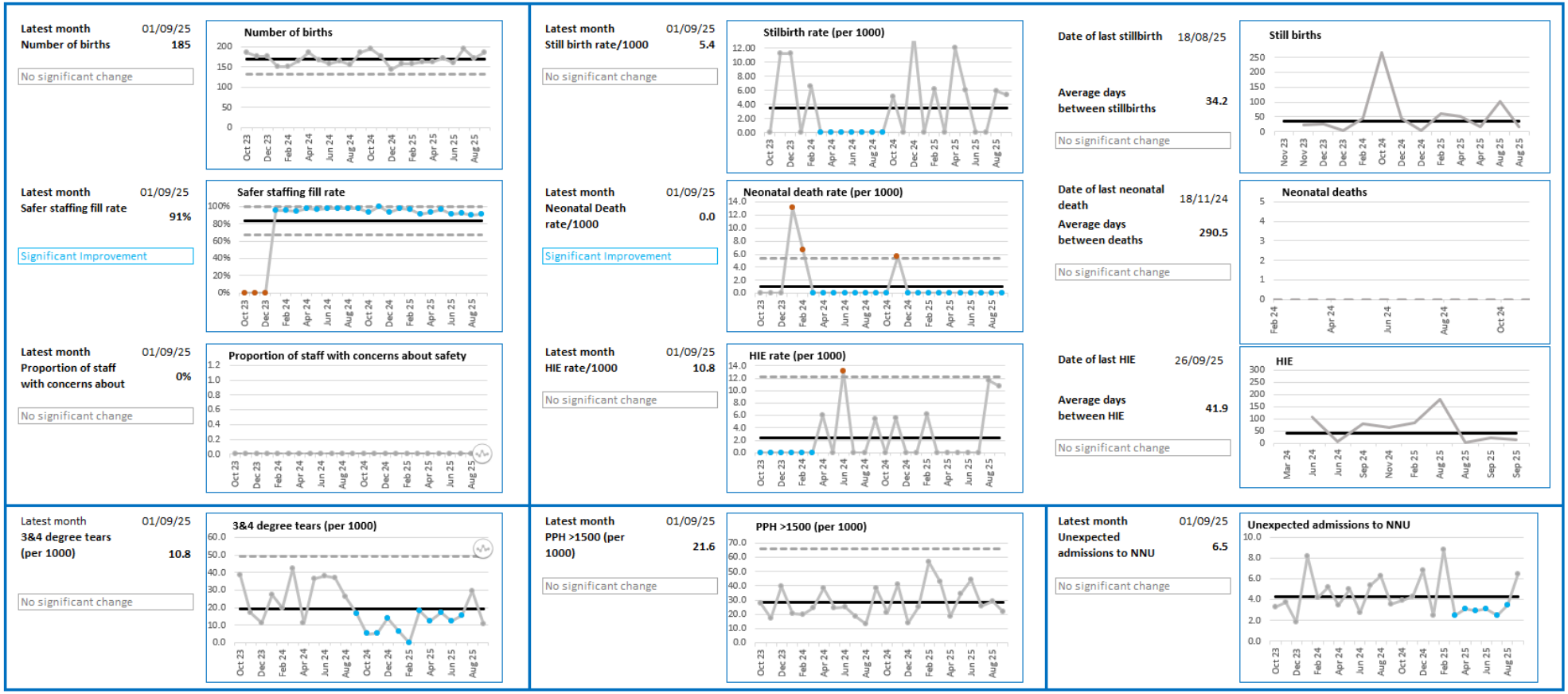
- Litigation scorecard also demonstrates use and interrogation of claims against historic and current incidents to support learning and improved processes, systems and outcomes. This enables greater triangulation and focus on improvements to support better outcomes for women, babies and families.

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 Q2 2025/26

MATERNITY DATA MEASURES: PERINATAL QUALITY SURVEILLANCE TOOL

Maternity overview | Salisbury Foundation Trust



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 Yr 6 targets (inc. CCF)	Compliant with MIS Yr 6 targets (inc. CCF)	Compliant with MIS Yr 6 targets (inc. CCF)	Working towards MIS Yr7 (inc. CCF)	Working towards MIS Yr7 (inc. CCF)	Working towards MIS Yr7 (inc. CCF)	Working towards MIS Yr7 (inc. CCF)	Working towards MIS Yr7 (inc. CCF)	Working towards MIS Yr7 (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	n/a	n/a	n/a	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

Contents

1. Report Overview

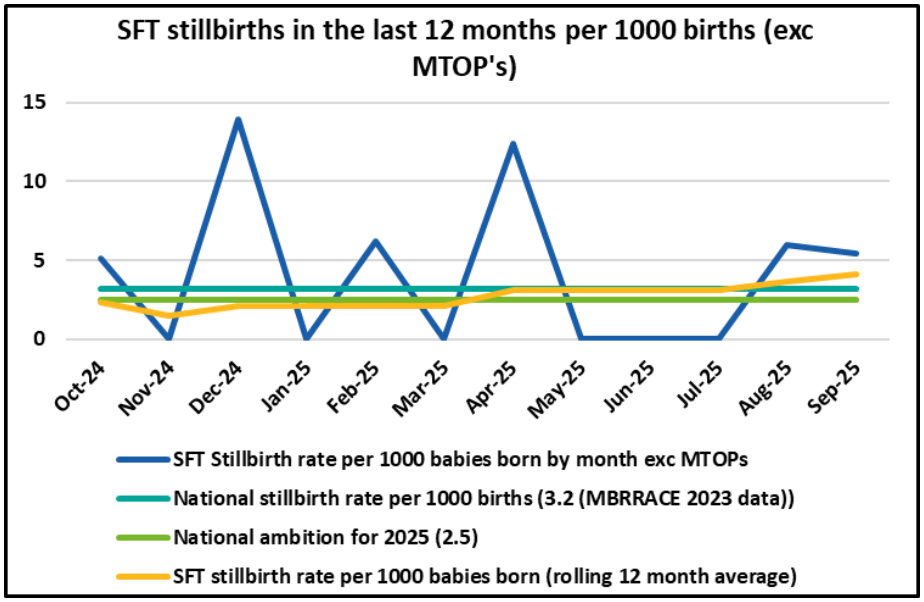
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Trust Board and LMNS Board of present or 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.

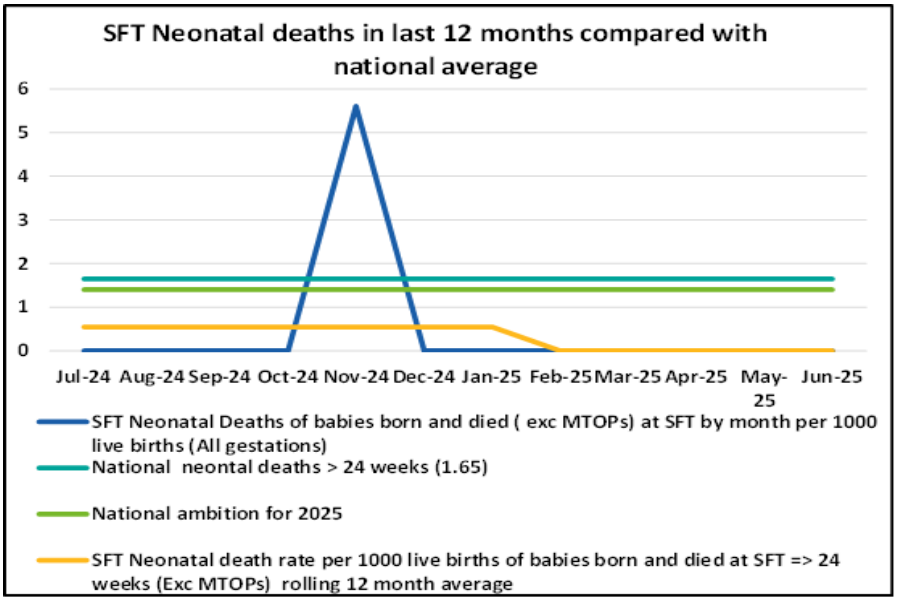
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

Figure 1. Monthly Stillbirth rate (per 1000 births excluding MTOP's) for SFT over the last 12 months, compared with national rate and ambition. Please note since MBRRACE 2023 data became available in October 2025 the national stillbirth rate has changed.



In the last completed quarter (Q2), SFT had 2 stillbirths (Excluding MTOP's). This is a total of 8 in the last 12 months, which equates to 4.08 per 1000 births in the last 12 months and is now above national stillbirth rate, which is 3.2 per 1000 births and the 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. Please note since MBRRACE 2023 data has become available in October 2025 the national neonatal death rate has changed.



In the last quarter (Q2), 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 (Q2 July– Sept 2025)

Figure 3. Perinatal Mortality summary

PMRT ID	Cause of Death	Issues/ Actions / learning
97465 *Case from Q3 24/25*	Gestational Choriocarcinoma	Issue: This mother had a haematological disorder and anaemia, this was not managed within guidance. Action: Work force reminder and audit regarding timing of 28 weeks bloods and follow up of results process. Issue: Kleihauer was indicated but not taken Action: Work force reminder and audit regarding Kleihauer test and follow up of results process.
98122 *Case from Q1 25/26*	Fetal vascular malperfusion	Issue: There was a delay in transfer of the baby to GOSH for post-mortem. Action: To agree timescales for transfer to GOSH in line with GOSH SLA.

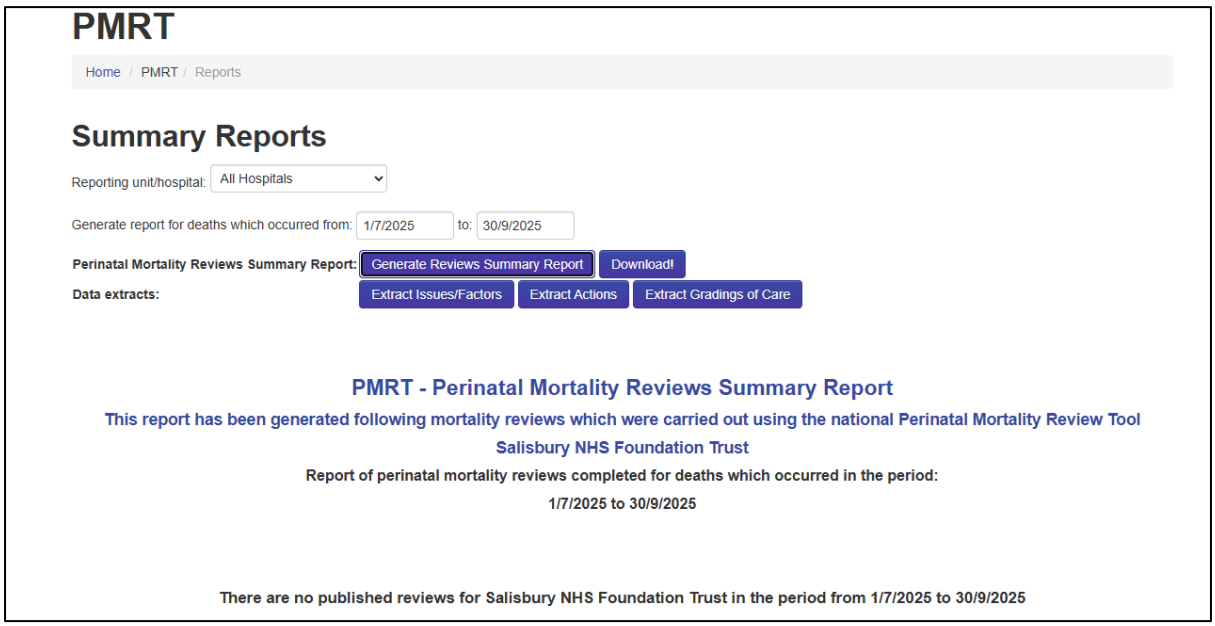
2.2 PMRT real time data monitoring tool

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.

Reports generated from the PMRT tool show 2 cases from Q3 24/25 and Q1 25/26 reviewed in Q2 25/26.

PMRT_BoardReport_Salisbury NHS Four

PMRT_BoardReport_Salisbury NHS Four



The snapshot shows in Q2 where no cases that occurred in 25/26 have been reviewed.

2.3 Learning from PMRT reviews

There were 2 cases reviewed under PMRT in Q2 25/26. Learning and progress against previous actions are detailed in the full report in the appendices.

3. Maternal death

In maternity during 24/25, there have been no direct, or indirect, maternal deaths within the trust. We are aware of one maternal death during the period of 24/25 where the mother received maternity care at SFT and subsequently died in the community 304 days after birth.

The death was of a mother aged 31, this mother died of suicide. The death did not occur in the trust, the trust was made aware of this death in Q2 25/26 and reported the maternal death to MBRRACE. Internal maternity and hospital reviews are in progress and will be shared when completed.

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

4.1 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.

4.2 CNST Maternity Incentive Scheme (MIS) year 7 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). This process is outlined in SFT's Maternity Governance Framework available on EOLAS.

For qualifying cases the Trust Board must be assured that:

- Information is provided to families in a format that is accessible to them NHS England » Accessible information standard (about MNSI and ENS) and,
- Compliance where required is maintained with respect to Duty of Candour (as per regulation 20 of the Health and Social Care Act 2008).

Maternity services are required to report this quarterly to Trust Board for oversight of evidence for Safety Action 10.

During Q2, five cases were referred to MNSI.

Figure 4. Summary of MNSI and ENS cases for safety action 10 compliance in Q2

Cases referred to MNSI (MNSI number)	**Case accepted as eligible for investigation by MNSI**	**Families have received DOC 2 letter** containing information explaining the role of MNSI and ENS in an accessible format*	**Duty of Candour (DoC) compliance**	**Case referred to NHSR ENS*** (if eligible)	**Claims reporting wizard completed** (families informed of NHSR ENS involvement)
MI-045459	Yes	Yes	Complete	To be actioned	N/A
MI-045462	Yes	Yes	Complete	To be actioned	N/A
MI-046313	Yes	Yes Translated to Nepalese	Complete	To be actioned	N/A
MI-046724	Yes	Yes Translated to Vietnamese	Complete	To be actioned	N/A
MI-047134	Yes	Yes	Complete	To be actioned	N/A

**from 6th October 2025 all eligible MBRRACE, PMRT, MNSI and ENS cases are notifiable through the 'Submit a Perinatal Event' (SPEN) portal.*

BadgerNet patient records are reviewed to identify any accessibility needs so that the Q&S team can arrange for information about MNSI and ENS to be provided in an accessible format (New requirement for MIS year 7)

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 7 (safety action 10).

4.3 Investigation progress update (MNSI and PSII cases) for the last quarter (Q2)

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**	**06.02.24**		**Awaiting final report.**

4.4 Coroner Reg 28 made directly to Trust

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

4.5 Maternity Patient Safety Incident Investigation (PSII) during Q2

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 in Q2.**	

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.

5. 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.

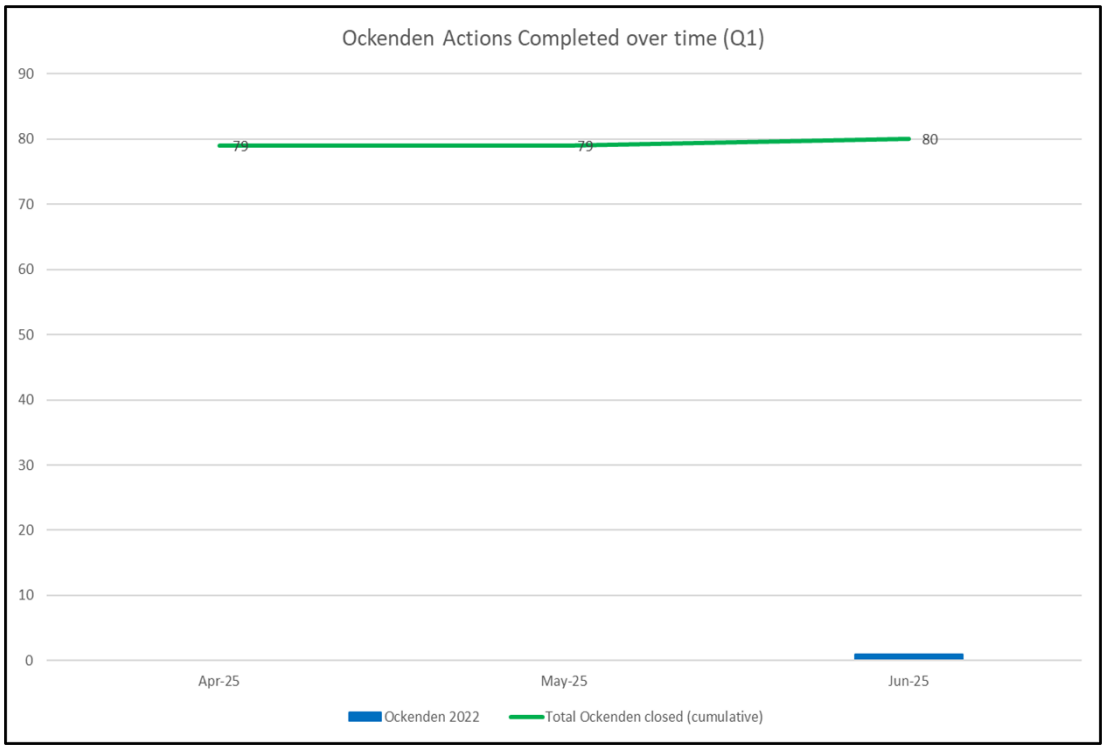
At Salisbury NHS Foundation Trust, there are no midwifery continuity of carer teams presently. Due to historic midwifery vacancies and having a less experienced workforce, plans to implement this model are paused as per recommendation from NHSE and as advised, following the publication of the Ockenden 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.

6. Ockenden updates

For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 sub-actions. The multi-disciplinary Ockenden Working Group has been disbanded, and progress on this workstream is being driven through the Maternity Improvement Group who meet

monthly. Current progress on immediate and essential actions is detailed in the table below.

Figure 7. Numbers of actions closed per month in Q1 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:** 3 actions remaining open, which are monitored through the monthly Maternity Improvement Group meetings.
- **Next steps for progression:** Ongoing work continues around a succession planning gap analysis and leadership development training, centralised CTG monitoring and working towards Neonatal staffing models becoming BAPM compliant.

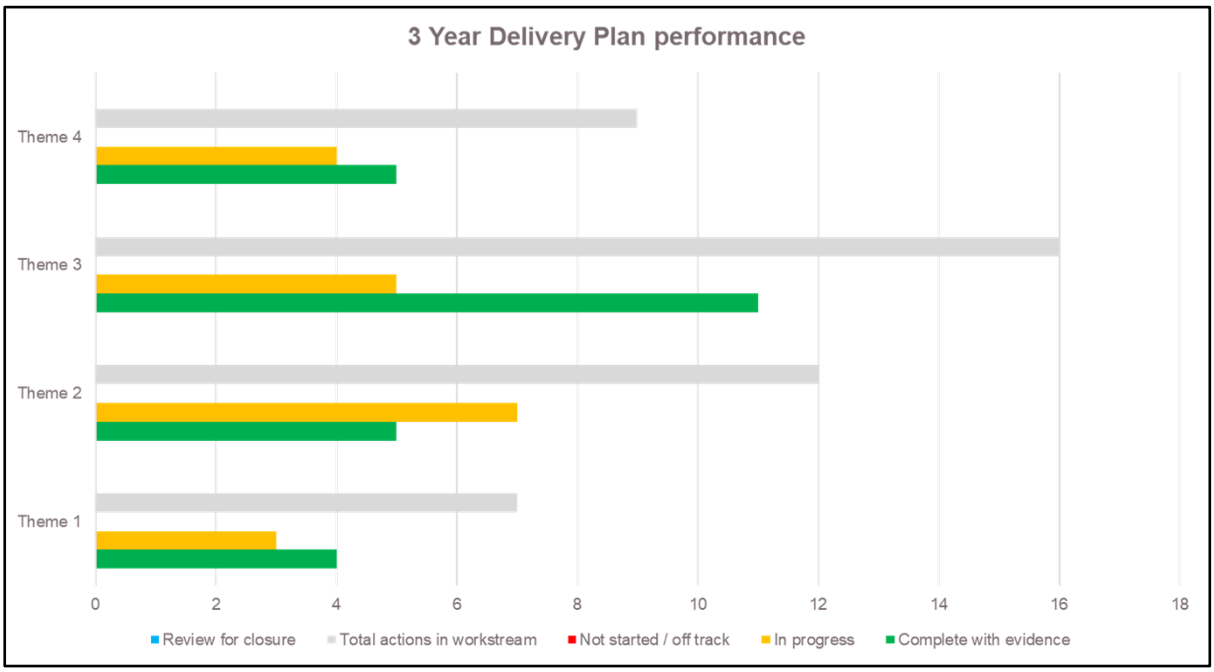
7. Three Year Delivery Plan

Ongoing work continues around the three-year delivery plan.

All actions are now either in progress or complete with evidence collated to demonstrate this, with 25 of the 44 actions now complete, which is demonstrated in the chart below.

All actions continue to be monitored via the monthly maternity improvement group meetings, with a plan to have a more targeted approach in Q3 & Q4 with a separate working group to continue improvement during the final stages of the three-year period. There will also be hospital group level working with Bath and Swindon, to look at best practice and alignment when signing off actions to ensure consistency across the system where necessary.

Figure 8. Three Year Delivery Plan overall performance by theme



8. 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 current 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 which is then reviewed annually. 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 7 requirement is for 90% attendance for each relevant staff group at fetal monitoring training, multi-professional maternity emergencies training and neonatal life support by 30th November 2025. The other core modules were not measured within the MIS requirements.

During Q2, training compliance has not met the ≥90% target for any staff groups. No training

sessions took place in August due to high annual leave rates, and there were multiple changes to the workforce. Anaesthetic and obstetric compliance has been compounded by workforce pressures and sickness. The MSW compliance has also been compounded by recruitment of a number of new staff and all requiring training during Q1 and Q2. 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.

Figure 9. PROMPT Training Day Compliance

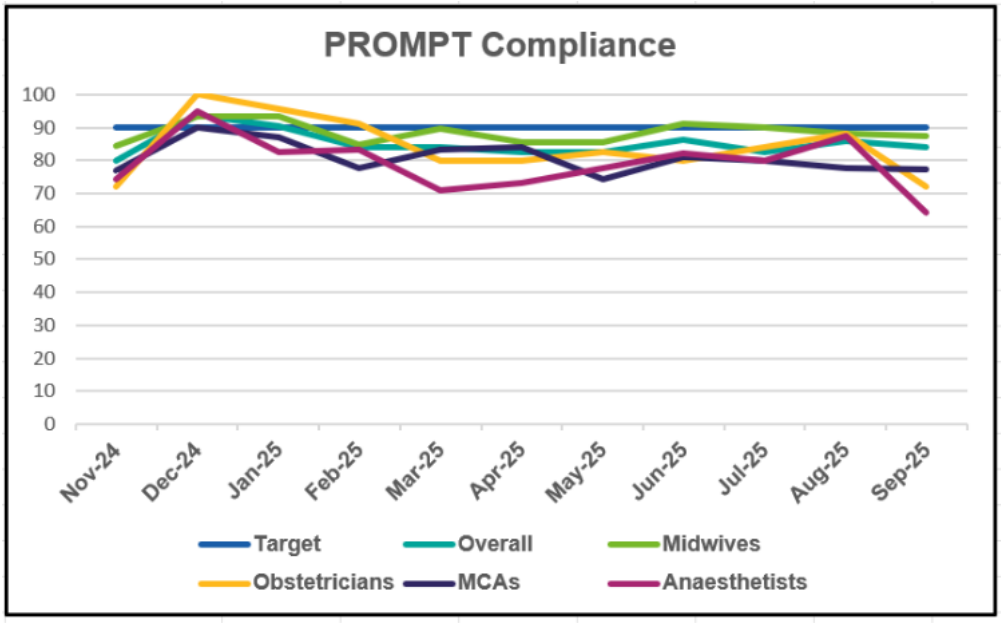


Figure 10. Fetal Monitoring Training Compliance

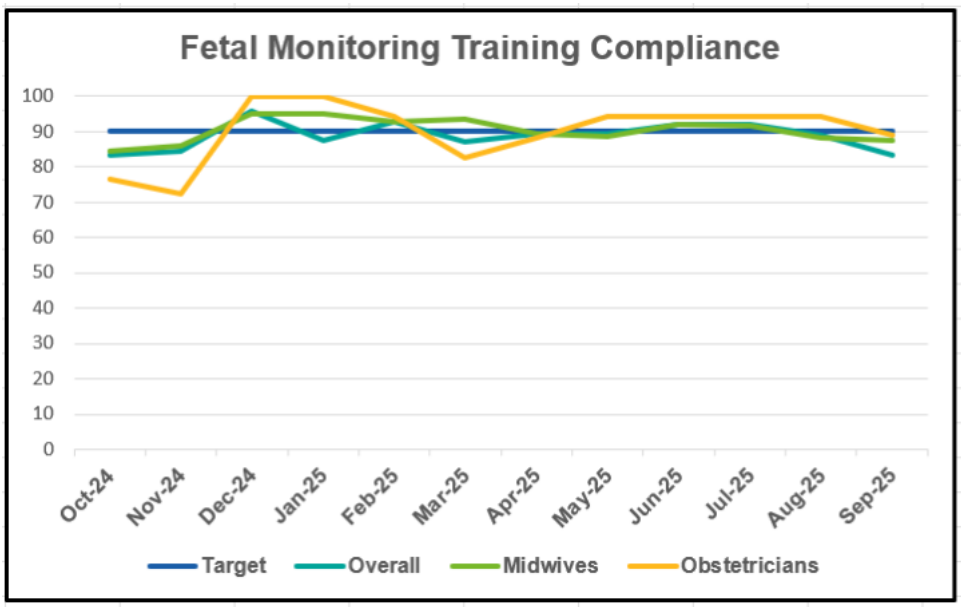
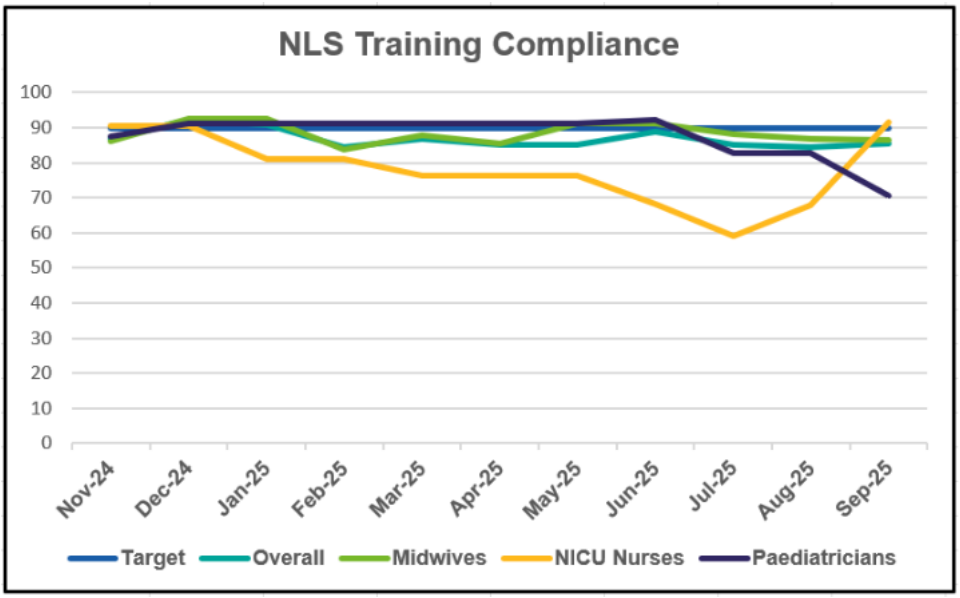


Figure 11. NLS Compliance Training



9. 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 the Terms of Reference which is available on EOLAS for further details of the meeting requirements: Eolas Medical

9.1 Maternity and Neonatal Safety Champions meeting attendance by role for Q2

Figure 12. Maternity and Neonatal Safety Champions attendance by role in Q2

Staff groups	July	August	September
Trust Executives	Non-Executive Director	Chief Nursing Officer	Chief Nursing Officer
Obstetric		Consultant Obstetrician	
Midwifery	Director of Midwifery Quality & Safety Matron OP Matron	Director of Midwifery Quality & Safety Midwives Bereavement Lead Midwife Inpatient Matron	Quality & Safety Matron Family Experience & Inclusion Midwife Community Lead Midwife
MSW			
Neonatal	Neonatal Clinical Lead		NICU Interim Co-lead Neonatal Clinical Lead

MNVP	MNVP Representative	MNVP Representative	MNVP Representative
Secretarial support	Maternity & Neonatal Admin Manager	Maternity & Neonatal Admin Manager	Maternity & Neonatal Admin Manager
Quad support	Operational Manager Neonatal Clinical Lead	Operational Manager Obstetric Clinical Lead	Operational Manager Head of Midwifery & Neonatal services Neonatal Clinical Lead

9.2 Positive points recognised in Q2

The following positive points were highlighted:

- MNVP representative was nominated and won award for “outstanding partnership” at the Staff Awards
- New Matron for Neonatal team started in September, improved stability in the leadership team
- PocketTalk device and implementation approved at CMB to be rolled out to clinical areas in Q3
- Chief Nursing Officer- completed a safety walkaround of the Neonatal unit and the feedback was exciting and positive towards patient care- “The best experience of all four births” was a comment from a patient staying in Kangaroo care, who felt the opportunity for the room was overwhelming and a great asset.

9.3 Concerns raised in Q2

Figure 13. Concerns raised in Maternity and Neonatal Safety Champions meetings*

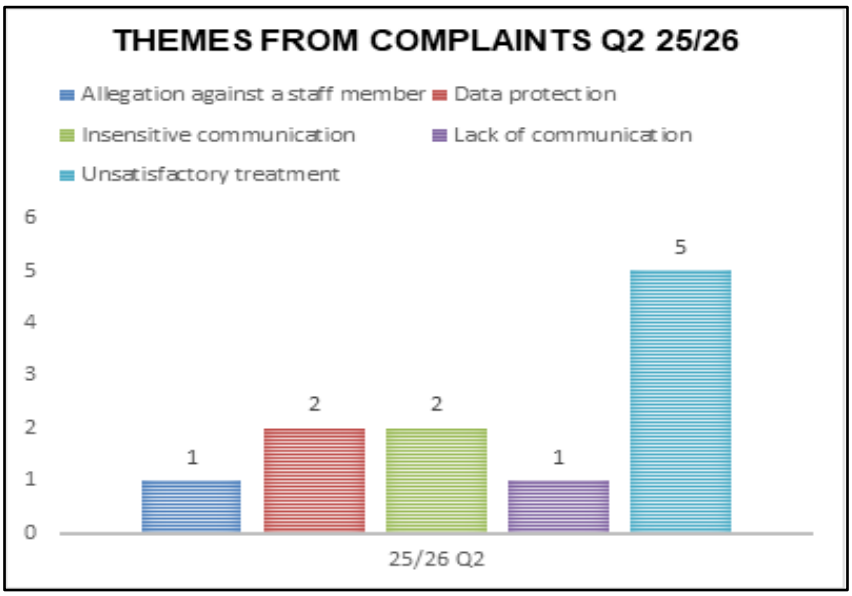
Concerns raised	Action and Progress
Paediatricians shared they do not feel confident with inputting resuscitations into BadgerNet due to lack of training.	The digital midwife arranged to attend the Paediatric Consultant meeting for face-to-face training of the Maternity module.
Concerns with admin support in Antenatal clinic reception environment due to recruitment restrictions within the Trust.	Approval for the role to be recruited into to support two members of the team in the unit again.
Perceived increase in BBA’s.	Review of all cases to ensure appropriate triage and advice given.
Persistent IT issues in community.	Focus on identifying the cause and exec safety champion to continue to support with senior IT team.

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

9.4 Concerns raised by service users

There have been 11 formal complaints logged in Q2 25/26. There has been an increase in formal complaints in Q2, with ‘unsatisfactory treatment’ being the top theme.

Figure 14. Summary of complaints in Q2



In Q2, there were 9 complaints closed, 6 was closed within target time, offering a 60% compliance rate- a 6% decrease in compliance from the previous quarter.
For those outside of the target date for closure there was close liaison maintained with complainants regarding any delay this was often due to aligning diary capacity of both parties.

For learning and action points taken from closed complaints in Q2 please see appendix 3.

9.5 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 15. Walk around findings

Area/date visited	Discussion points	Concerns raised	Actions
Executive Safety Champion visit 01/08/2025: Beatrice Maternity Ward, Labour Ward, Day Assessment Unit and Neonatal Unit.	Good feedback from NICU. Very busy across Maternity areas.	Staffing issues raised during busy period.	Address vacancy concerns.
Non-executive Safety Champion visit 07/08/2025 with Chief Digital Transformation Officer: Maternity and Neonatal areas.	Discussed digital and IM&T challenges for Maternity.	No immediate safety issues raised.	Chief Digital Transformation officer to support with IT issues particularly within the community setting.

Executive Safety Champion visit 03/09/2025: Beatrice Maternity Ward, Labour Ward, Day Assessment Unit and Neonatal Unit.	Undertook a "go and see" walkabout as heard staffing was tricky and activity really high. Excellent feedback from parents in NICU.	Staff being pulled from Beatrice Maternity Ward when it was full. WCP process was slowing down recruitment and making staff uneasy.	

9.6 Culture/SCORE Survey findings

A second staff event was held in Q2 with a focus on "Celebrating our successes" which had good feedback. The perinatal quad continues to use the action plan produced following the SCORE survey and subsequent staff questionnaires to prioritise their workstreams, using feedback from the staff events held in Q1 and Q2 to ensure current suggestions and views of staff a represented.
The perinatal quad will be getting support from the Wessex Health Innovation Network team to help align cultural work with clinical escalation which has been a recent theme identified both locally and nationally which feeds into the wider cultural and leadership workstream. There has been an overlap of themes from the initial SCORE survey and more recent staff events, and this will be captured in the quad action plan for progression.

10. Saving Babies Lives V3

Saving Babies Lives Care Bundle (SBLCB) version 3 was originally published on 31st May 2023. This has recently been updated with version 3.2 being published on 24th April 2025.

The SBLCB represents Safety Action 6 of the Maternity Incentive Scheme for Trusts.

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

10.1 Update

The current Saving Babies Lives Care Bundle (v3.2) contained new requirements and has been fully implemented in the most recent submission (August 2025). The NHS England national SBLCB implementation tool is used by maternity services to use to track and evidence improvement and compliance with the requirements. The changes have swiftly been identified and reviewed with leads and the LMNS.

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 in October 2023 was validated at 7%, followed by submissions of 37%, 40%, 51%, 66%, 73%, 87% and then more recently in August 2025 (updated version 3.2) currently 86%. SFT self-assessments are largely in-line with LMNS validated assessments. SMART action plans are being developed for all non-compliant requirements to support increased compliance.

11. NHS Resolution Maternity Incentive Scheme

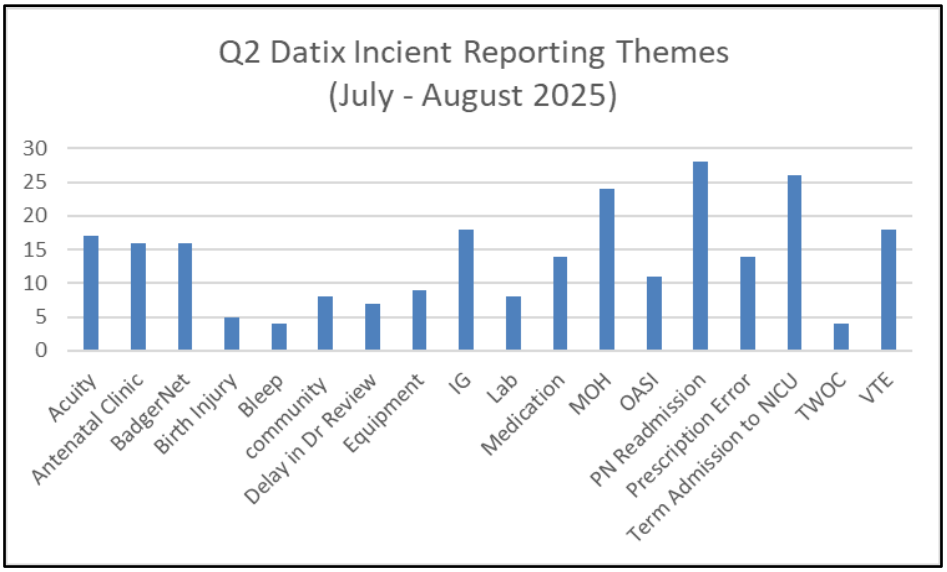
MIS Year 7 requirements were published on 2nd April 2025 and SFT is required to be compliant by 30th November 2025.

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. The evidence for year 7 requirements is beginning to be collated in anticipation for presentation at the end of the reporting period.

12. The number of incidents in Q2 and actions being taken

A summary of incidents themes reported in Q2 are provided below.

Figure 16. Datix incident report themes during Q2

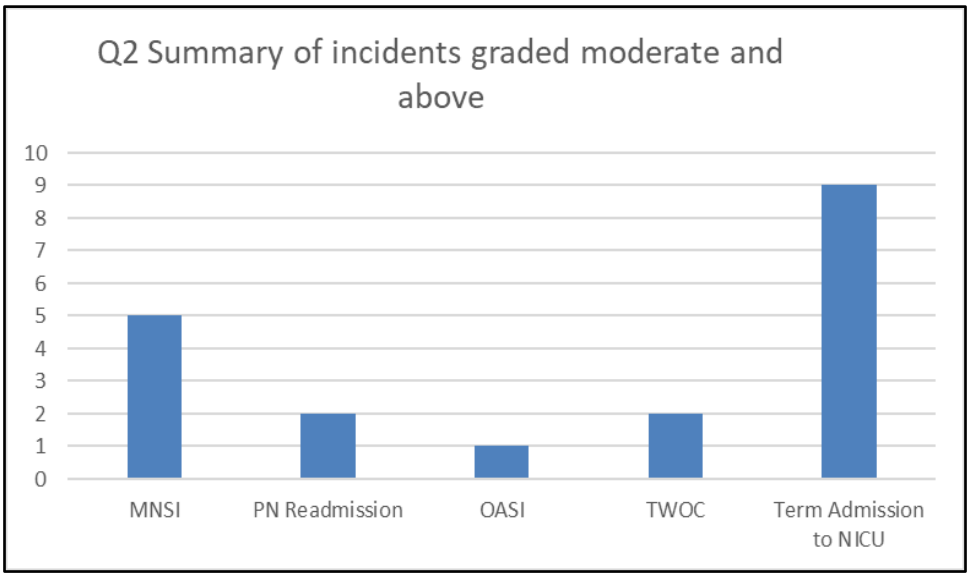


Throughout Q2 there has been an increase in acuity related delays and staff unable to facilitate breaks. Some of the acuity related delays involve delaying induction of labour and postponing elective caesarean sections to the following day. These decisions have been made within the multidisciplinary team and women have received appropriate safety netting clinical advice.

The incidents graded moderate or above at the end of Q2 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: 01/07/2025:30/09/2025
- Severity: Moderate and above
- Directorate: Women and Newborn Division

Figure 17. Summary of incidents graded Moderate or above incidents at the end of Q2



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.

13. 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 Maternity and Neonatal Assurance committee 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.

13.1 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 18. Percentage shift fill rates for the inpatient areas by month in Q2

Month	Day qualified %	Night qualified %
July 2025	92.2	98.2
August 2025	90.6	93.8
September 2025	91	91.9

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.

13.2 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.

In Quarter 2 (1st July 2025 – 30th September 2025), there were 9 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard and is detailed in the table below.

Figure 19. Cases meeting the above criteria

Date	Clinical Situation(s)	Comments
11/07/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present. Nb; Cons phoned several times, no answer. Different Cons phoned, caused delay of Cons attendance by 30 mins
15/07/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present.

13/08/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present. Nb; 2222 done & Cons was not called. Mat staff phoned directly and got hold of them but there was a delay with attendance. Datixed.
16/08/25	Caesarean birth for women with a BMI > 50	Consultant present.
04/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
10/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
16/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
17/09/25	Unexpected Intrapartum stillbirth	Consultant present for diagnosis and delivery the next day
30/09/2025	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present.

13.3 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 July 2025 – 30th September 2025. The audit demonstrated that during this period, 24 (short term) middle grade locum shifts were required. 6 Doctors completed these shifts, all of these Doctors were employed by Salisbury NHS Foundation Trust, therefore the trust is 100% compliant with the criteria described above.

13.4 Long term locum usage

During the time period 1st July 2025 – 30th September 2025, the trust has not utilised any long term middle grade locum doctors, the 1 long term middle grade locum doctor who was in use prior to this quarter has now become a substantive member of staff. Feedback was provided in a reference format as part of their recruitment checks.

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

Figure 20. Long-term locum compliance with standards

Standard	Compliance % for Locum 1 (in post prior to Q1)
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 – doctor became member of substantive staff

13.5 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 21. Anaesthetic staffing compliance

Month	July 2025	August 2025	September 2025
% compliance	100	100	100

13.6 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 been reviewed by the divisional DMT and a full paediatric workforce review has been requested to support the business case progressing to the next stage. In addition to this 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 September 2025 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for QIS registered nurses but under-funded for non-registered nurses. The requirement would be an additional 1.69wte 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 and a revised business case to increase nursing staffing in line with BAPM is being written. 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.

We have successfully recruited a Band 5 neonatal nurse and the vacancy to 2.24WTE with ongoing recruitment for Q3.

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

- Friends and Family feedback (FFT) text messaging service will be reinstated in December 2025. To mitigate the gaps in patient feedback, Maternity Services has been added to the Trust's Real Time Feedback (RTF) schedule.
- 11 complaints and 3 concerns were received in this quarter. The top theme remains ‘unsatisfactory treatment’, which is consistent with the previous quarter. There has been a significant increase in complaints logged this quarter (6), and a raise in concerns (3).
- Families of babies admitted to SFT neonatal unit will soon be asked to take part in NHS England’s National Neonatal Care Experience Survey. The survey helps monitor what is working well and how neonatal care services could be improved, both locally and nationally.
- 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. This is scheduled to commence in Q3, November 2025.
- The Birth Reflection Service is now accepting self-referrals, via the Maternity Website.
- It is anticipated that the translation tool bar will be implemented next quarter.
- A patient story was kindly provided, with the focus on recognising a deteriorating patient and the escalation process. The intention is to share this story at the Perinatal meeting and in local mandatory training.

- The Maternity Service received the headline report for the National Maternity Patient Survey 2025.
- Maternity Services are due to launch the Pocketalk translation device next quarter. The implementation and evaluation will be supported by Health Innovation Wessex's Insights team.

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

- To undertake listening events with hard-to-reach groups with the poorer maternity outcomes.
- Clients of the 'Baby Steps' programme will be asked if they wish to provide feedback on maternity services.
- To support the implementation and evaluation of the 'Pocketalk' translation device.
- Continue to drive the development of a local Health Inequalities dashboard.
- Continued monitoring of the 2025 National Patient Experience Maternity Survey action plan and support the introduction of the National Neonatal Care Experience Survey.
- Progress the actions detailed in the Three-Year Delivery Plan.
- Respond and designate action holders following the results of the '15 Step' assessment.
- Continue the quarterly Triangulation meetings to coordinate service users feedback to identify service improvement opportunities.
- Support the reintroduction of SMS text messages for the Friends and Family Test.
- To support the update of the Maternity Website.

15. 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:

- Exit interviews
- Working group to increase Flexible working patterns
- Fluid balance compliance.
- Re-launch of the local escalation toolkit (based on RCOG Escalation toolkit)
- Compliance to NICE Category 1 & 2 caesarean section delivery timings

Projects planned in the next quarter (Q3):

- Sickness absence management
- Increasing the use of Beatrice Birth Centre
- Review of BSOTS antenatal triage compliance

16. Implementation of the A EQUIP model

The Professional Midwifery Advocate (PMA) Team is 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.

16.1 PMA Update

- Restorative Clinical Supervision (RCS): It is aimed 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 and the PMA team are looking at solutions. There was a total of 1 RCS in Q2.
- 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 2024 and a further 2 in November 2024. 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 are each offered quarterly 1:1 restorative supervision from a PMA. There were no group RCS sessions with the Preceptee Midwives in Q2 due to lack of PMA availability however there is a session planned in Q3 for the new cohort of Preceptee Midwives (starting Oct 2025). 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 planned to be shared with Director of Midwifery for awareness and via appropriate channels to support action and improvement.

16.2 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 7 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 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. Arrangements are back in place to meet monthly with Director of Midwifery and Neonatal Services and Head of Midwifery and Neonatal Services to feedback any themes and concerns.

17. Avoidable Admission into the Neonatal Unit (ATAIN)

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

17.1 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.

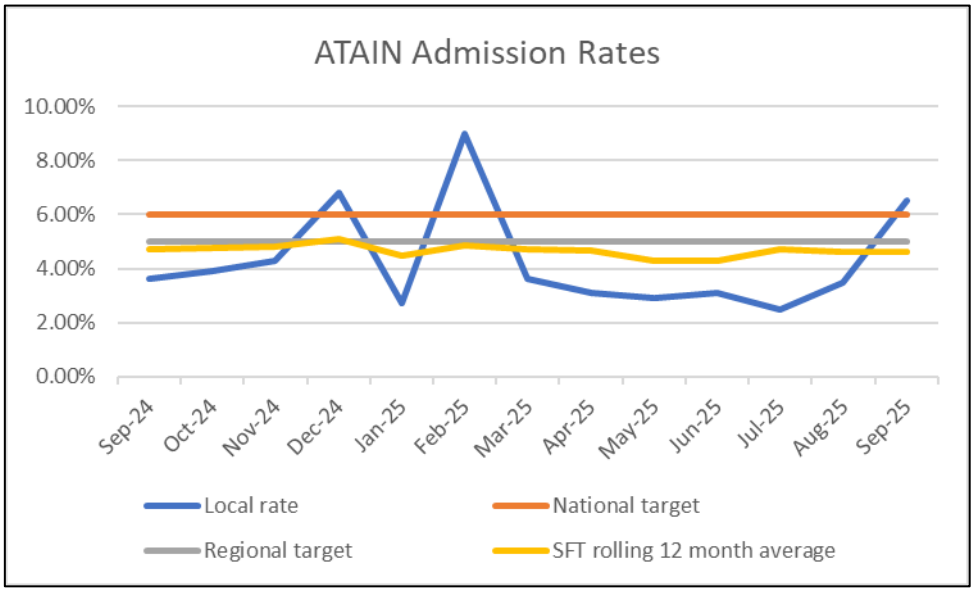
This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme with a key focus on:

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

17.2 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 22. Monthly ATAIN rates 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 23. ATAIN reviews during Q1 (babies equal or >37 weeks' gestation)

	July 2025	August 2025	September 2025
Total number of admissions in month	**5**	**6**	**11**
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU	**0**	**0**	**0**

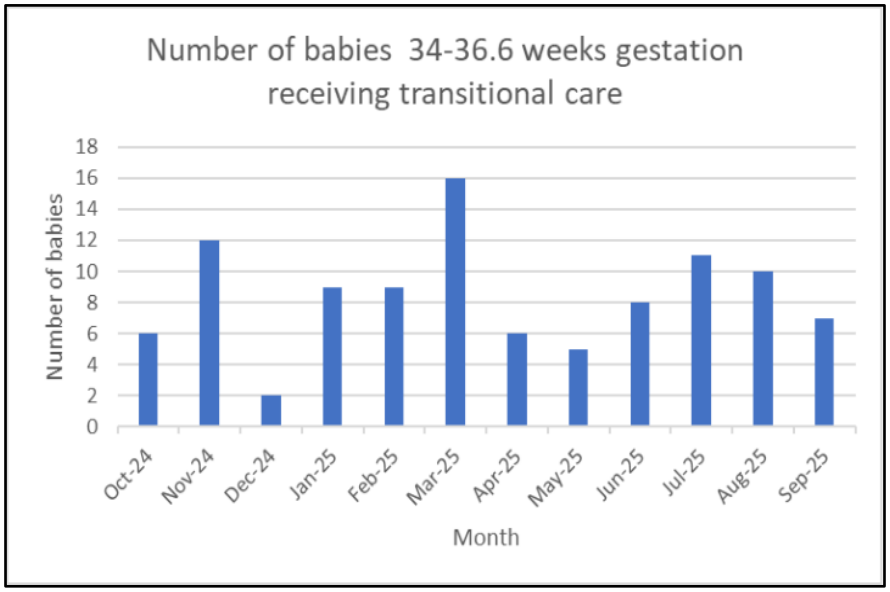
due to capacity or staffing issues.			
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	**0**	**0**	**0**
Total number of case reviews undertaken in month	**0**	**8**	**0**
Total number of case reviews with both maternity and neonatal staff present	Due to unavailability of specialist staff	**8**	Due to unavailability of specialist staff

17.3 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. Further detail is contained within the appendices.

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.

Figure 24. Total number of 34-36+6 babies born each month in receiving Transitional care



18. Staff Survey

Flexible working groups were held in Quarter 2 in response to the staff survey whose divisional actions were based around “we work flexibly” and “we are always learning”. The communication to staff and actions arising from these groups were created in conjunction with the divisional OD & P business partner and plan to be rolled out in quarter 3.

There was also review of the current appraisal process across Maternity & Neonatal to ensure all staff have the same opportunity for development and growth, this work will be conducted alongside the succession planning work being undertaken by the OD&L team within the trust.

19. Maternity and Neonatal Safety Improvement Plan

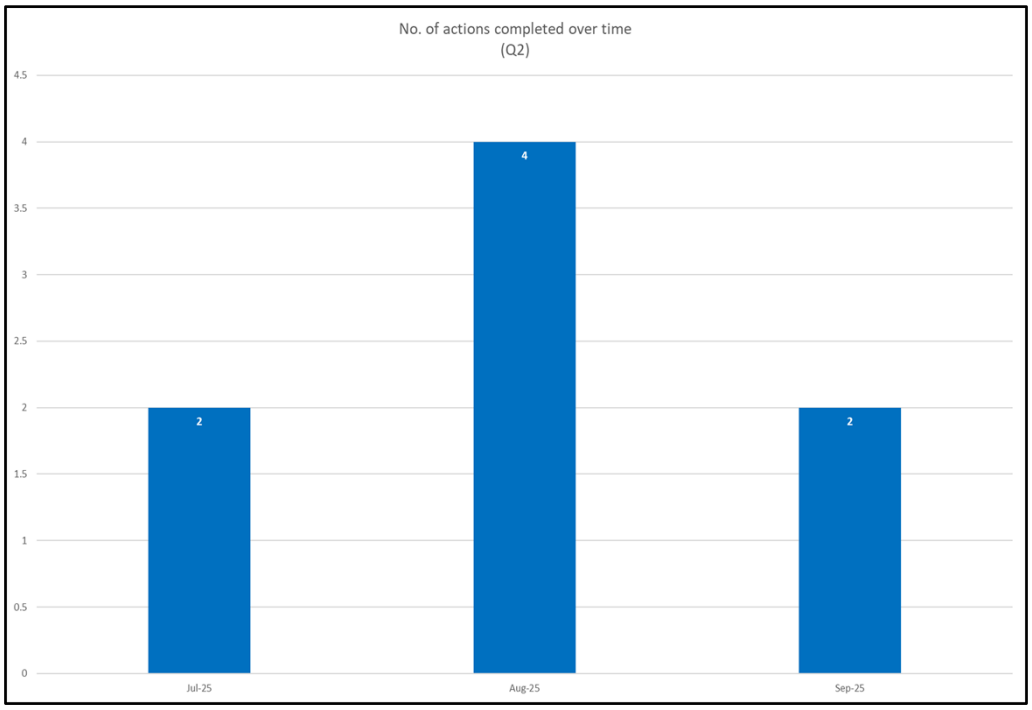
Every Trust is required to develop a bespoke Maternity & Neonatal Safety Improvement Plan, which brings together existing and new plans to progress these projects into one place. Salisbury NHS Foundation Trust exited the NHSE Maternity Safety Support programme in November 2024 but continue to focus on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

19.1 Progress made over the last quarter

In Q2, 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.
The final two actions relating to the screening workstream were closed within Q2 meaning all 44 actions that were originally identified during the assessment of the service have now been implemented – a testament to the hard work and dedication of the team.

There will be a focus on the remaining four open workstreams (Governance, Digital, Ockenden 2022 and Three-Year Delivery plan) over the next quarter.

Figure 25. Progress with Maternity Improvement Plan actions Q2


No. of actions completed over time
(Q2)
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2
4
2
Jul-25
Aug-25
Sep-25

20. Risk Register highlights

The Maternity and Neonatal Departmental Risk Register is reviewed bi-monthly with leads being encouraged to review and update any risks ahead of this. The current open risks on the risk register are noted below.

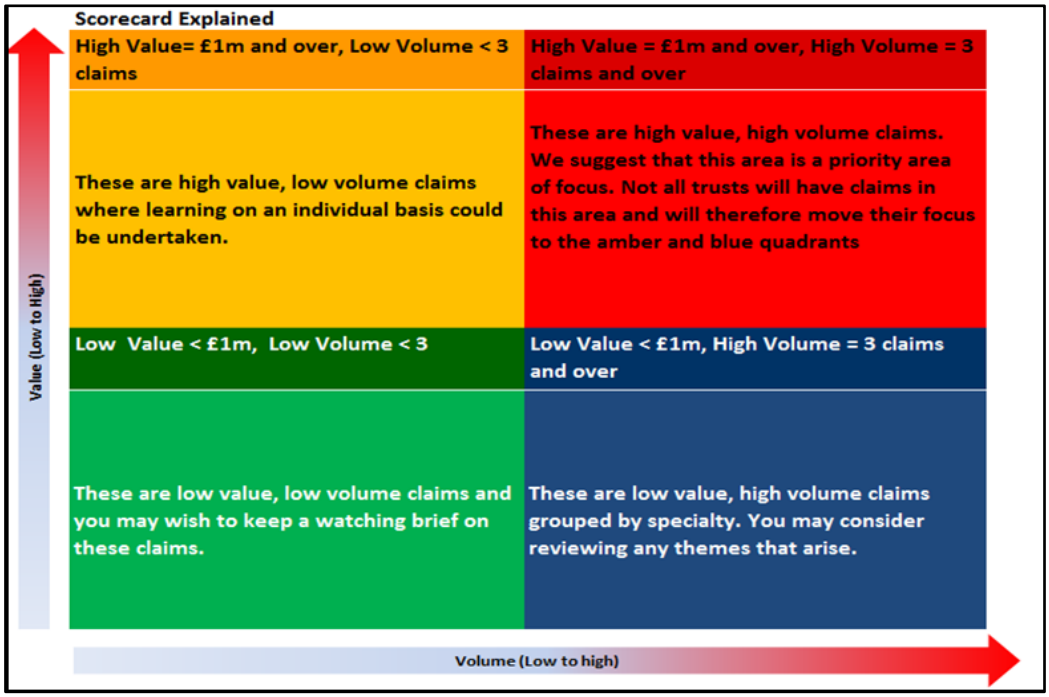
Figure 26. Current Open Risk Register items for Maternity and Neonatal services

MatNeo Risk Register as of 9/10/2025		
ID	Title	Rating (current)
8508	Inadequate Antenatal clinic reception cover	12
	Security issue due to door access to maternity and Neonatal Services being availabl	
8494	via salto to high numbers of staff who shoul	12
8491	Clinical dashboard unavailable for maternity and Neonatal Services	12
8448	Non-compliance with BAPM for nursing levels on NNU	12
8325	New Maternity Information System Rollout - BadgerNet	12
8310	AUDIT NON-COMPLIANT re timing of delivery for Intrahepatic Choleostasis (IPC)	12
8259	Floor lifting on labour Ward	12
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	12
8399	Access to translation service in Maternity services	10
8387	Saving babies lives Version 3 - Element 4. Fetal monitoring, non compliance	10
8386	Saving babies lives Version 3 - Element 2. Fetal growth, non compliance	10
8382	SBL v3 - Element 1 (Smoking) - non-compliance of staff training for VBA and Co monitoring	10
8413	Lack of leadership in Neonatal Unit due to absence	9
8451	Not running peripheral Tidworth ANC due to lack of IT	8
8388	Saving babies lives Version 3 - Element 5. Pre term birth, non compliance	8
8333	AUDIT NON-COMPLIANT re BSOTS triage and review	8
8309	AUDIT NON-COMPLIANT re Documentation of BP, Urine, CO testing, FM's, FH and risk assessment in ANC	8
8465	Poor compliance Perinatal mental Health Audit (data 2025/26) criteria 4.5	6
8447	No specialist epilepsy nurse or midwife in the Trust or in BSW to support pregnant women with Epilepsy	6
8411	Non compliance audit with moderate risk to patient safety re suturing swab counts in maternity	6
8389	BabyPac ventilator on the shuttle unsupported with service	6
8385	No Dietician service availble to maternity patients	6
7923	Neonatal unit heating	5
7623	Neonatal ROP	5
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over re	5

21. 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 7 Maternity Incentive Scheme. The scorecard can be understood within the following table.

Figure 27. NHSR litigation scorecard explained in terms of value and volume of claims

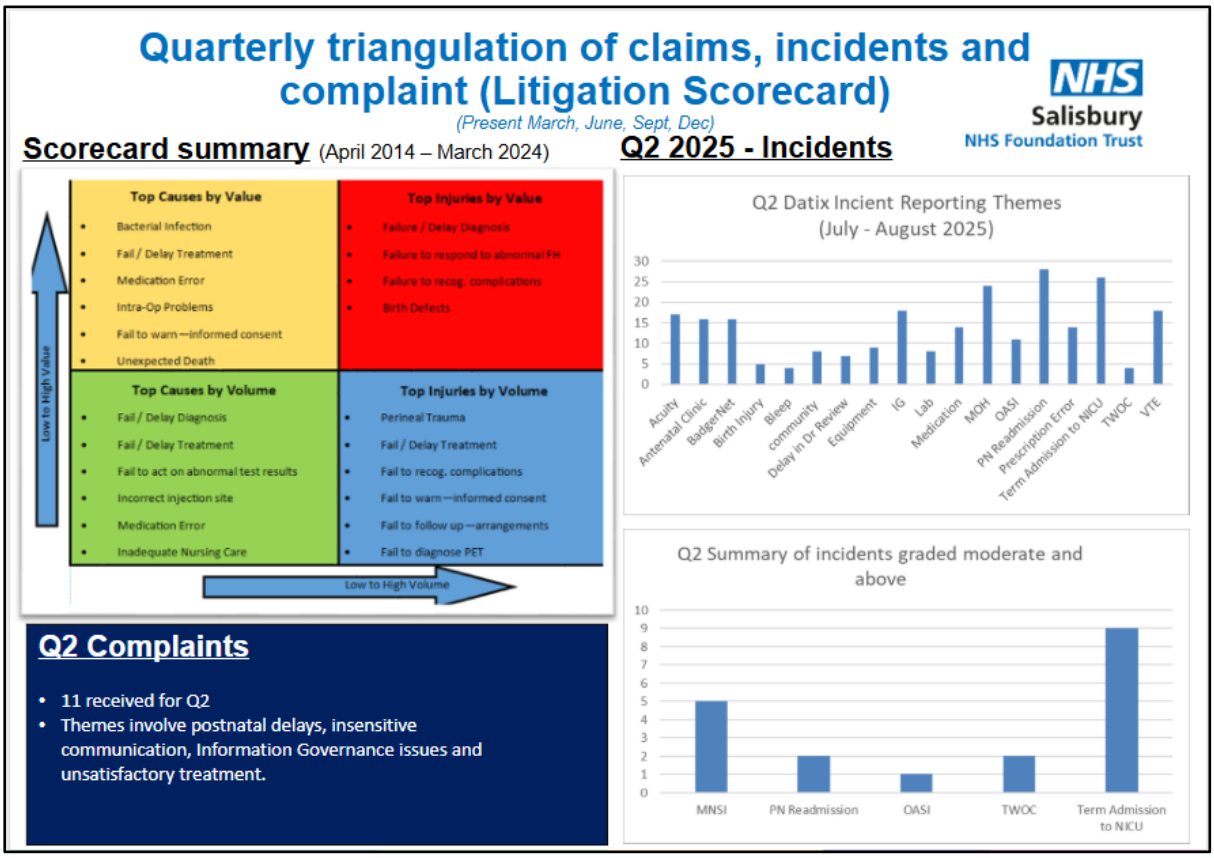


Themes from incidents, claims and complaints are reviewed at the quarterly triangulation meeting and Maternity Governance meeting.

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

- Legal claims over the last 10 years - 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 include care pathway issues, post-partum haemhorrage (PPH), postnatal re-admissions and term admissions to NICU. Term admissions and PPH are listed on the trigger list and all receive a robust review using the 'Datix Incident Review Proforma' and are included in a continuous rolling audit. This is in line with the Trust PSIRF plan and SFT are not outliers for either of these against national targets.
- Themes from complaints include 'Postnatal delays', 'Insensitive communication' and 'Unsatisfactory treatment'. 11 complaints raised in Q2

Figure 28. Litigation scorecard - triangulation of complaints, incidents and legal claims in Maternity and Neonatal services



During Q2 5 eligible cases were referred to MNSI. This is a significant increase in referrals, and all cases have been accepted for investigation by MNSI. An MDT rapid review is taking place involving RUH and GWH to identify any immediate learning and themes.

The themes from 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), inform and drive the priorities of service development and quality improvement. These are presented and discussed at the Triangulation meetings.

22. Recommendation

The 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 2 2025-26)

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 7 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 deaths notified to MBRRACE from 20 weeks gestation, PMRT from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 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.

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%**

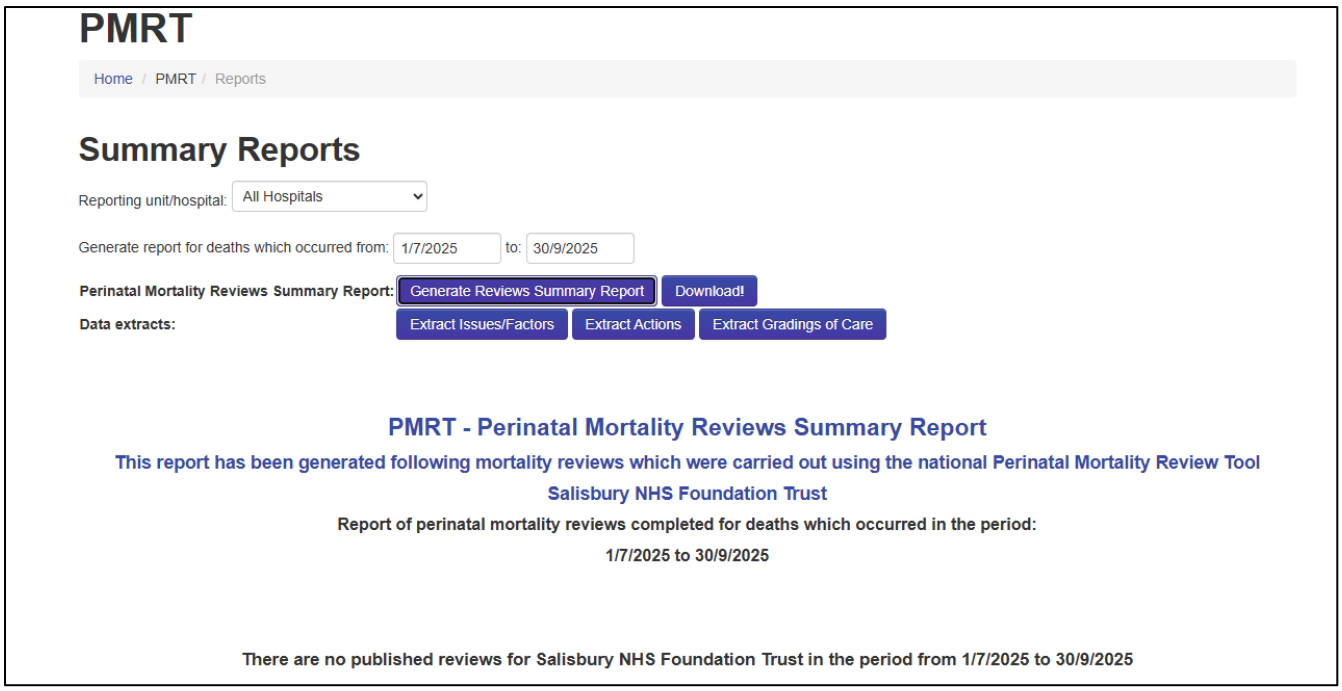
PMRT Report

There were 3 cases that met PMRT review criteria in Q2 25/26. 2 of these cases are scheduled to be reviewed in Q3 25/26, the other case has been referred to the Maternity and Newborn Safety Investigations programme (MNSI) as this case meets MNSI criteria. Once MNSI have published the final report this case will be reviewed under PMRT with MNSI as external reviewers. There was 1 case from Q4 24/25 reviewed under PMRT in Q2 25/26, this was an outstanding case that had been referred to MNSI, with the final MNSI report published. MNSI were external reviewers for this PMRT review, there was also 1 case from Q1 25/26 that was reviewed under PMRT in Q2 25/26.

The PMRT board reports embedded below show the 2 cases reviewed in Q2 25/26. The PMRT board snapshot embedded below shows that the cases that have occurred in Q2 have not been reviewed yet.

PMRT_BoardReport_Salisbury NHS Four

PMRT_BoardReport_Salisbury NHS Four



3. Recommendations

3.1 Eligible Incidents in Q2 25/26 (appendix A)

There has been a total of 3 incidents reported to MBRRACE-UK in Quarter 2 25/26.

The antenatal stillbirth of one twin at 35 weeks. This was notified to MBRRACE, surveillance was completed and PMRT is due for completion in Q3 25/26. This was not eligible for MNSI referral in view (antenatal still birth)

One late fetal loss at 22 weeks and 2 days. This was notified to MBRRACE, surveillance was completed and PMRT review due for completion in Q3 25/26.

One intrapartum stillbirth at 40 weeks and 1 day. This was notified to MBRRACE, surveillance was completed. This case was referred to MNSI and accepted. PMRT review will take place following MNSI final report
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 2 25/26 (appendix B)

There were 2 incidents closed in Q2 25/26.

During Q3 24/25 there was 1 PMRT case that met the threshold for referral to the MNSI programme. This review was completed and closed.

During Q1 25/26 there was one case that was reviewed under PMRT, completed and closed.

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:

- 1 cases had no issues with care identified for the mother following confirmation of the death of her baby.
- 1 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 7 Standards (appendix C)

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 7.

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 were 2 stillbirths (excluding MTOP's) in Q2 25/26. This makes a total of 8 stillbirths in the last 12 months, which equates to 4.08 per 1000 births in the last 12 months. The national rate per 1000 births is 3.2 per 1000 with a national ambition to reduce to 2.5 per 1000 births.

There were 0 neonatal deaths > 24 weeks in Q1 25/26. 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 1.63 per 1000 live births.

Appendix A - Summary of all **eligible incidents reported** in Q2 2025/26

	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
Q2	**99676**	Stillbirth	35	03/08/25	01/08/25	1910g	SFT	SFT	SFT	N/A	N/A	Yes	Yes	Yes	Yes	Yes
Q2	**99965**	Late fetal loss	22+2	22/08/2	22/08/25	450g	SFT	SFT	SFT	N/A	N/A	Yes	Yes	Yes	Yes	Yes
Q2	**100392**	Stillbirth	40+1	18/08/25	17/09/25	3538g	SFT	SFT	SFT	Yes	N/A	Yes	MNSI	To do	Once MNSI report published	Yes

Appendix B - Summary of **all incidents closed** in Q2 2025/26

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/ Date	Update
96580	Gestational Choriocarcinoma *(death occurred in Q3 24/25)*	B, B	This mother had a haematological disorder and anaemia, this was not managed within guidance. Kleihauer was indicated but not taken.	Work force reminder and audit regarding timing of 28 weeks bloods and follow up of results process. Work force reminder and audit regarding Kleihauer test and follow up of results process.	S. Tribb S. Thom	
98343	Fetal vascular malperfusion	A, A	There was a delay in transfer of the baby to GOSH for post-mortem.	To agree timescales for transfer to GOSH in line with GOSH SLA.	Mortuary and Pathology Managers and Funeral Directors	

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

*New MIS criteria for year 7

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% Target	From 1 Dec 24 Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100	2	1	3 (1MTOP)	3	9
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%	100%	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	1 eligible (1 MNSI not eligible)	1	2	2 eligible (1 MNSI case not eligible)	6
		100%	100%	100%	100%	100%
A PMRT review must be commenced within four months following the death of a baby. (Cases that are outstanding and still within timescales are not included in these numbers)	95	1	1	1	0	3
		100%	100%	100%	3 outstanding cases within timescales	100%
*Minimum of 75% of multi-disciplinary reviews should be completed and published within six months. (Cases that are outstanding and still within timescales are not included in these numbers)	75	1 eligible (1 MNSI not eligible)	1	1	0	3
		100%	100%	100%	3 outstanding	100%

					cases within timescales	
***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.** **(Cases that are outstanding and still within timescales are not included in these numbers)**	**50**	**1**	**1**	**1**	**0**	**3**
		100%	**100%**	**100%**	**3** outstanding cases within timescales	**100%**
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an ongoing basis for all deaths from 1 December 2024. **(Includes notifications and stages of review for eligible cases)**	**100**	**2**	**1**	**3**	**3**	**6**
		100%	**100%**	**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 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. Awaiting-PN referral being put into BadgerNet. 15/10/25- referral on badger completed-training in progress then the referral can be used.
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. 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.	ET - ANC S TR - CMW EJ - Trust New date due to new action holder in post 12/24.	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. 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. 15/10/25- PDG has been approved PDG training being rolled out to all CMW.

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.
PMRT ID 96580	This mother had a haematological disorder and anaemia, this was not managed within guidance. Kleihauer was indicated but not taken.	Work force reminder and audit regarding timing of 28 weeks bloods and follow up of results process. Work force reminder and audit regarding Kleihauer test and follow up of results process.	S. Tribb 31/01/2026 ST 31/01/2026	
97465	There is no DNA policy for patients planned to attend DAU. There was a delay in transfer of the patient from the home setting to the maternity unit. There was a delay in processing initial blood results. Processes and equipment used to support the use of blood products in a major haemorrhage in maternity	To 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. Continue to support SWAST in their case review. To share case learning with LMNS once SWAST case review complete for exploration with LMNS re. centralised triage. Safety notice has been circulated for staff to call the lab when sending bloods through the 'whooshy' or taking bloods to the lab by hand when urgent results are needed. Transfusion services have recently undertaken a workforce review. This case has been shared for consideration to support onwards review and escalation to	NH/LK SWAST Completed. DF/LP	In progress Debrief with SWAST staff undertaken. Awaiting further outcomes of SWAST external review. In discussions.

	and the wider trust are limited by: Staffing: Only one staff member in transfusion overnight.	ensure staffing template matches national requirement and contingency plans for emergency situations are adequate.		
	There is only one Blood product defroster which can defrost 2 units of blood products at the same time.	This is to be escalated to the Hospital Transfusion Team (HTT) to discuss considerations in purchasing another defroster to allow for multiple emergencies and a contingency if one defroster becomes out of action.	Completed	Contingency defroster is present in case of failure but less efficient than usual product. Use of fibrinogen concentrate may reduce need for frozen product use in future.
	Fridges: There are no satellite blood fridges for quick access to blood products stored in preparation for high-risk patients or to keep blood from emergency shock packs in maternity or main theatres until used or returned.	This has been discussed with the transfusion team and is not a viable option therefore mitigations are in place at SFT- Mitigation processes are to be re-shared with relevant teams to update.	JB/DF/FM	Discussed at CG June 25.
	Fibrinogen concentrate- could this be held on labour ward?	SFT are currently part of the Obs UK trial. SFT to explore the possibility of sourcing fibrinogen concentrate to be held on labour ward. If this is feasible to then start a business case to fund this. None - Discussed parent's questions at the Consultant debrief appointment.	IJ/JB	Approved by HTC, to take request to DTC.

Appendix E - Perinatal mortality rate

Stillbirths

The graphs below show the monthly and annual stillbirth rates (per 1000 births) at Salisbury. Please note that the national stillbirth rate has been changed to reflect the MBRRACE 2023 stillbirth rate published in October 2025.

Figure 1. Monthly stillbirth rate per 1000 births for SFT over the last 12 months set against national rate and ambition

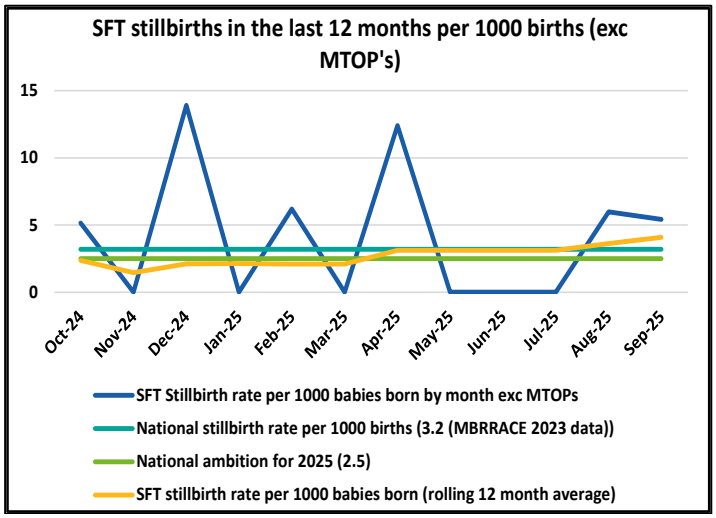
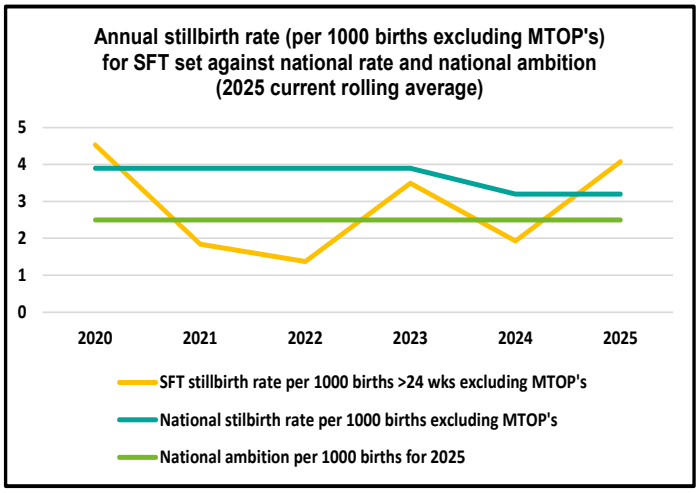


Figure 2. Annual stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2025 current rolling average)



Neonatal Deaths

The graphs below show the monthly and annual neonatal death rates (per 1000 live births) at Salisbury. Please note the national neonatal death rate has been change to reflect the MBRRACE 2023 data.

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

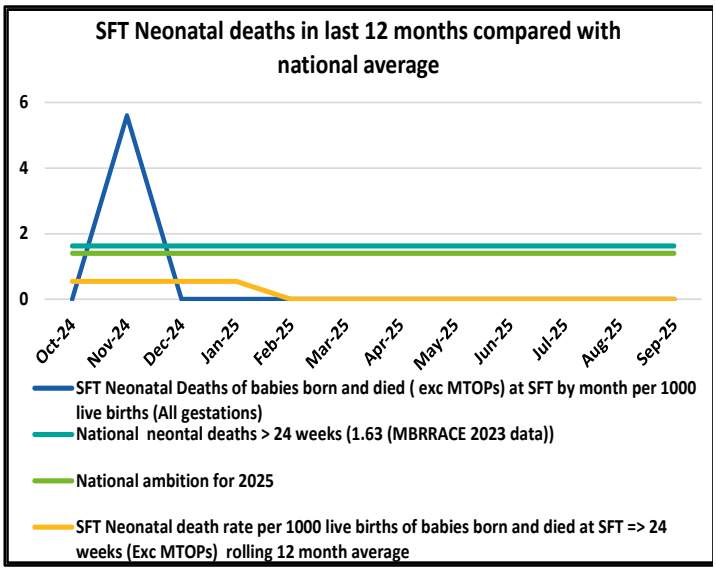
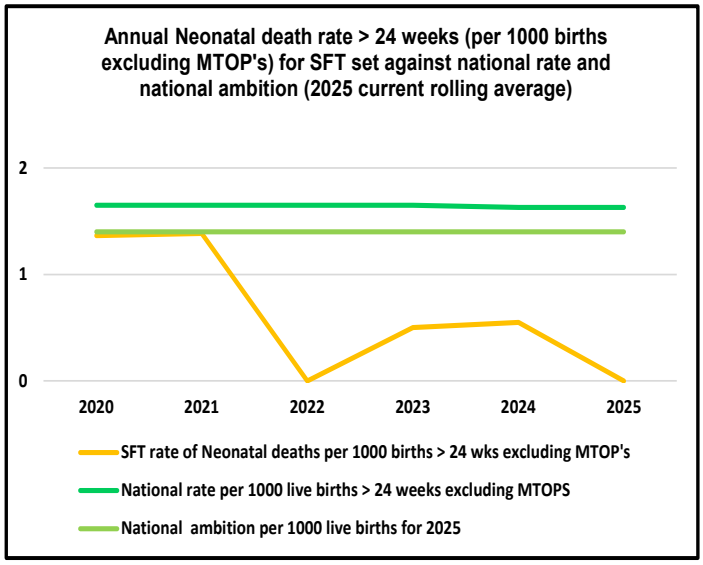


Figure 4. Annual neonatal death rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2025 current rolling average)



Maternity and Neonatal Training Report
Maternity and Neonatal Services
(Quarter 2 2025-26)

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 originally noted and agreed by the LMNS on 17/09/2024. The TNA has since been updated by SFT and then noted by the LMNS on 16/09/25. This covers January 2025 – December 2027, as per the CCFv2 and is reviewed annually within the three-year cycle. 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 originally reviewed November 2024, in line with the CCFv2, to start a new 3-year programme for all maternity-specific training commencing January 2025 with any updates being presented to the Maternity risk and Governance meeting (08/08/2025).

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

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.

Saving Babies Lives Care Bundle (SBLCB) version 3.2 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. Compliance and actions continue to be monitored and escalated through governance mechanisms.

During Q2, compliance has not been met for PROMPT, fetal monitoring nor NLS. Compliance has not been met for the SBL CB elements. For most of these training sessions and staff groups, compliance is >85% and expected to reach 90% by Q3, with a robust plan in place to ensure staff can attend the remaining training sessions for 2025.

The data in this report has been taken from the Local Maternity Dashboard held within the Maternity Education Team. The Trust's eLearning platform, LEARN, is currently unreliable in pulling the correct staff details and compliance. This has been escalated to the Trust Education Team and discussions are ongoing.

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 (now version 3.2 published April 2025). 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. This is attended by midwives only. Compliance is held once attendance has been confirmed. There are 10 SBL study days running across 2025 and therefore it is not expected that midwifery compliance will be met until November 2025 when all midwives have attended.

Obstetricians and MSWs are expected to complete this training via the National Saving Babies' Lives eLearning package on eLearning for Health (eLfH). Compliance with eLearning was recognised as poor and has since been incorporated into rotating doctors' inductions for the remainder of 2025.

MSWs are being provided with rostered time to complete training. Multiple changes to the MSW workforce has led to challenges in rostering this training time, however recruitment is now complete and training completion is being followed up by the MSW Lead for Education. A face-to-face session for Element 1 training now takes place at the end of each PROMPT study day, while midwives are doing their NLS training. This is expected to improve compliance over the next year.

Figure 1. Compliance progress with SBL Element 1 eLearning in Quarter 2

	July 2025	August 2025	September 2025
Midwives	88.3%	88.3%	85.7%
Obstetricians	52.0%	60.0%	76.0%
MSWs	56.1%	62.2%	61.4%

1.2 Fetal Growth Restriction (FGR) (SBL Element 2)

Minimum standard:

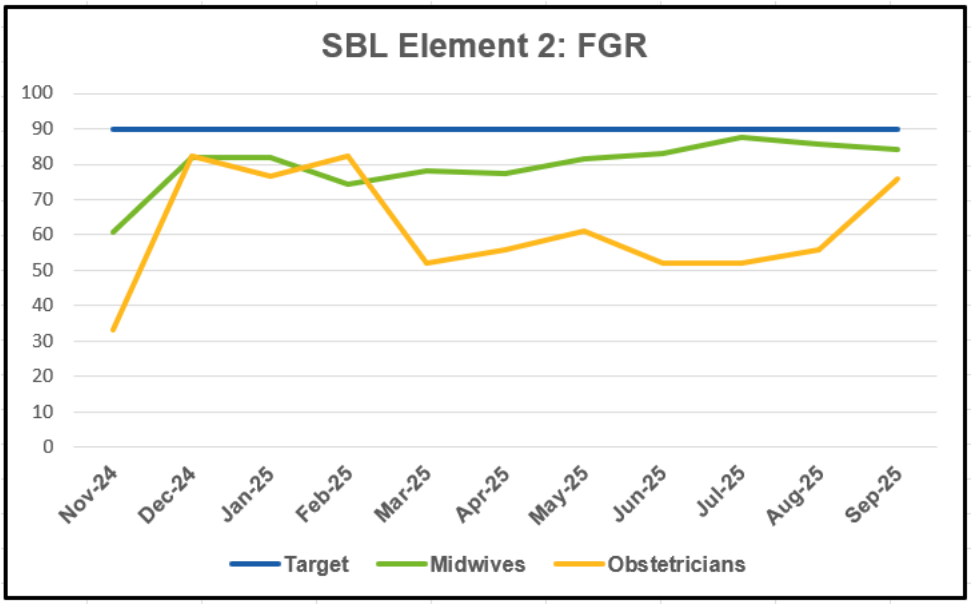
- Local referral pathways, identification of risk factors and actions to be taken.
- Evidence of learning from local Trust detection rates and actions implemented.
- Symphysis fundal height measuring, plotting, and interpreting results practical training and assessment, and case reviews from examples of missed cases locally.

FGR detection and surveillance is now required to be completed by midwives and obstetricians only, as per the CCF and SBL Care Bundle. Midwives are now taught face to face on the SBL study day. 90% was not achieved during Q2. There are 10 SBL study days running across 2025 and therefore it is not expected that midwifery compliance will be met until November 2025 when all midwives have attended.

Obstetric compliance remains challenging due to the rotations of trainee resident doctors and poor compliance with eLearning. As per element 1, face to face training for rotating resident doctors' has been incorporated into their local induction timetables. For consultant obstetricians, a face-to-face training session for element 2 has also been provided as there has been a lack of engagement with completing eLearning.

The following chart demonstrates overall compliance for the last quarter.

Figure 2. FGR compliance (Q2 July - September)



1.3 Reduced Fetal Movements (SBL Element 3)

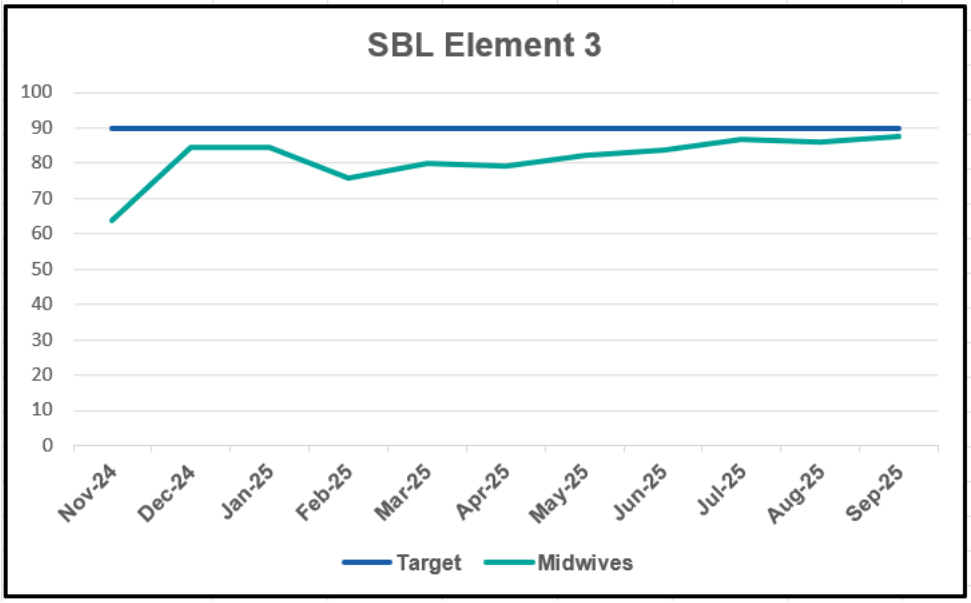
Minimum standard:

- 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. Though there has been a steady increase in compliance over the past 12 months, 90% has not been achieved in Q2. There are 10 SBL

study days running across 2025 and therefore it is not expected that compliance will be met until November 2025 when all midwives have attended.

Figure 3. SBL training compliance (Q2 July – September)



1.4 Fetal Monitoring (SBL Element 4)

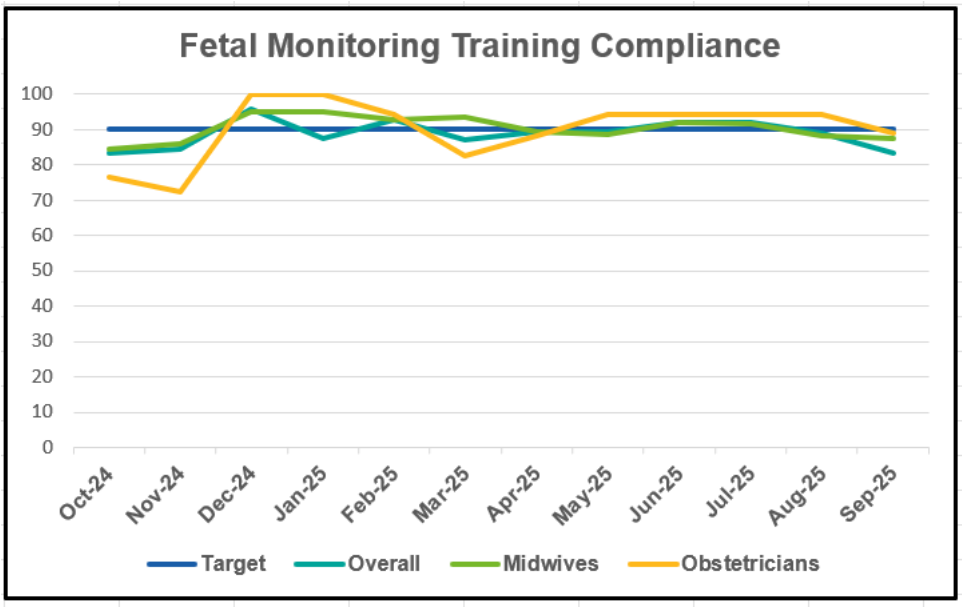
Minimum standard:

- 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 and 7, 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 (as per MIS technical guidance).

The following graph demonstrates compliance for midwives' and obstetricians' fetal monitoring over the past 12 month. Compliance has fallen slightly below the 90% target during Q2 due to staff changes and no training session taking place in August because of annual leave.

Figure 4. Fetal Monitoring training compliance (Q2 July - September)



The below data is specific to attendance on the fetal monitoring study day.

Figure 5. Fetal Monitoring Training compliance

Attendance & overall compliance	Midwives	Obstetricians
1st July attendance	9	2
July % compliance	91.7% ↓	94.1% ↔
1st August attendance	14	1
August % compliance	88.3% ↓	94.1% ↔
1st September attendance	0 (no August dates)	0 (no August dates)
September % compliance	87.4% ↓	84.2% ↓

1.5 Preterm birth (SBL Element 5)

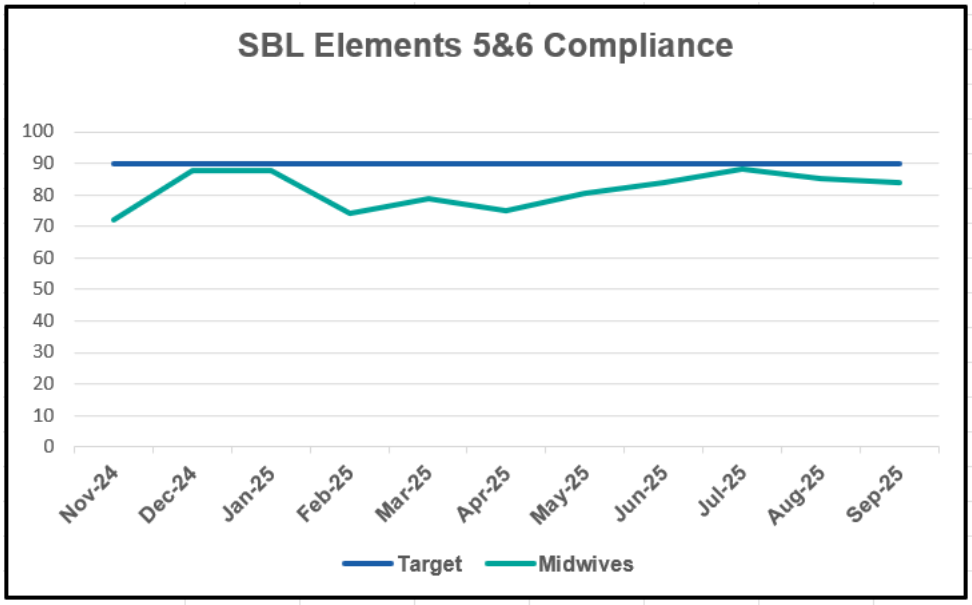
Minimum standard:

- 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 fallen slightly during Q2 due to staff changes and no training session taking place in August because of annual leave. There are 10 SBL study days running across 2025 and therefore it is not expected that compliance will be met until November 2025 when all midwives have attended.

Figure 6. SBL Elements 5&6 compliance (Q2 July - September)



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.

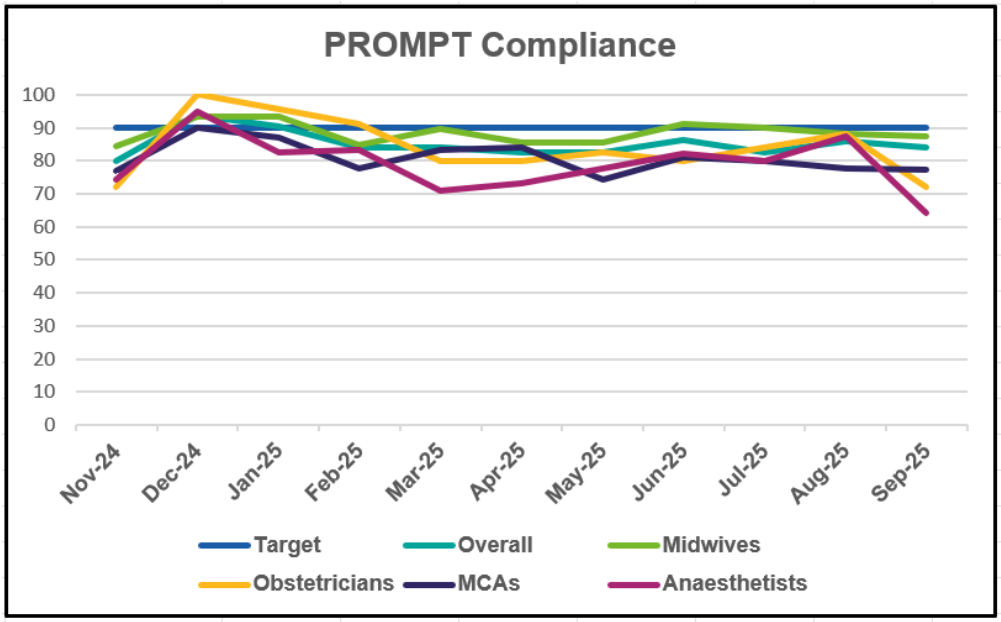
2. Maternity Emergencies and Multi-Professional Training Day (PROMPT)

CNST MIS year 7 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 (Q2 July - September)



PROMPT attendance has been affected by junior doctor industrial action, sickness and a conflict in workload for anaesthetists. There were no training days in August due to annual leave.

PROMPT has 10 planned study days throughout 2025 to enable opportunities for attendance, with an extra date being added in October 2025 in anticipation for junior doctor rotations, newly qualified midwives being recruited and to overcome challenges of meeting

compliance requirements. Current trajectories show that >90% compliance for all staff will be met by 30 November 2025 (subject to sickness absence and clinical workforce pressures). The Education Team is working closely with anaesthetic and obstetric workforce leads for assurance of training attendance and adequate clinical cover for the remaining 2025 dates.

Multiple changes to the MSW workforce has meant compliance has been challenging to improve however recruitment has now been completed and a plan has been made to achieve compliance by November 2025.

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
July attendance	9	3	3	5
1st July % compliance	90.0 ↓	84.0% ↑	80.1% ↓	80.1% ↓
August attendance	11	5	3	4
1st August % compliance	88.3% ↓	88.0% ↑	87.5% ↑	77.8% ↓
September attendance	0 No	0 Training	0 in	0 August
1st September % compliance	87.4% ↓	72.0% ↓	64.4% ↓	77.3% ↓

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 7 RC-trained instructors, with a further 3 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.

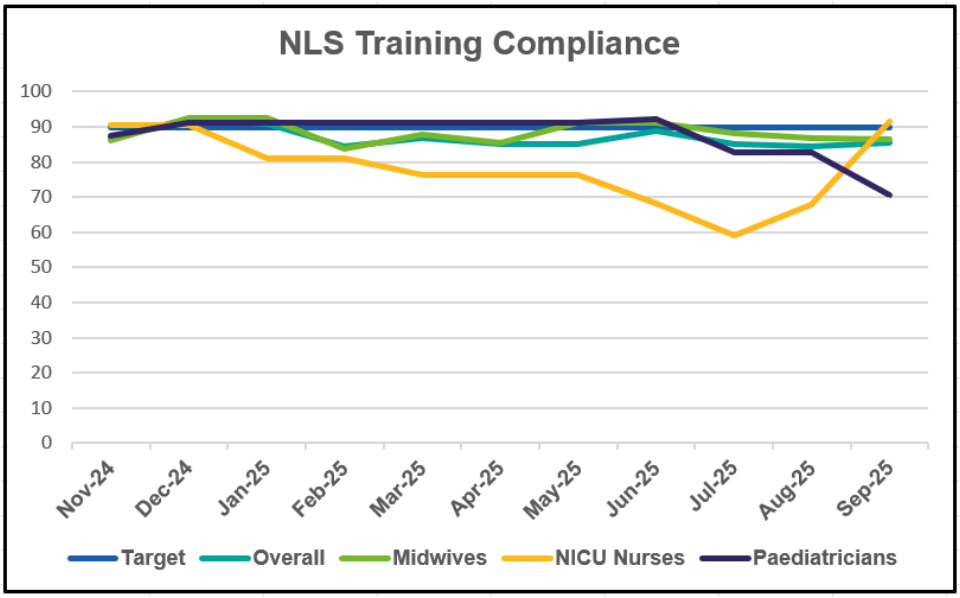
All midwives are trained as part of PROMPT and compliance was not met in Q2 due to staff changes and no training sessions running in August because of annual leave.

Paediatrician compliance has been sustained throughout much of 2025 however many staff need to attend training before 30 November 2025. This has been escalated to the Neonatal Matron, the Neonatal Education Team and the Lead Paediatrician.

NICU nurse compliance has been met.

The following graph demonstrates compliance for the specific staff groups in the past 12 months.

Figure 9. NLS training compliance (Q2 July - September)



**NB: This data includes staff that have completed a Resus Council NLS course.*

4. Maternity Update Day

The maternity update day is an annual day for midwives 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.

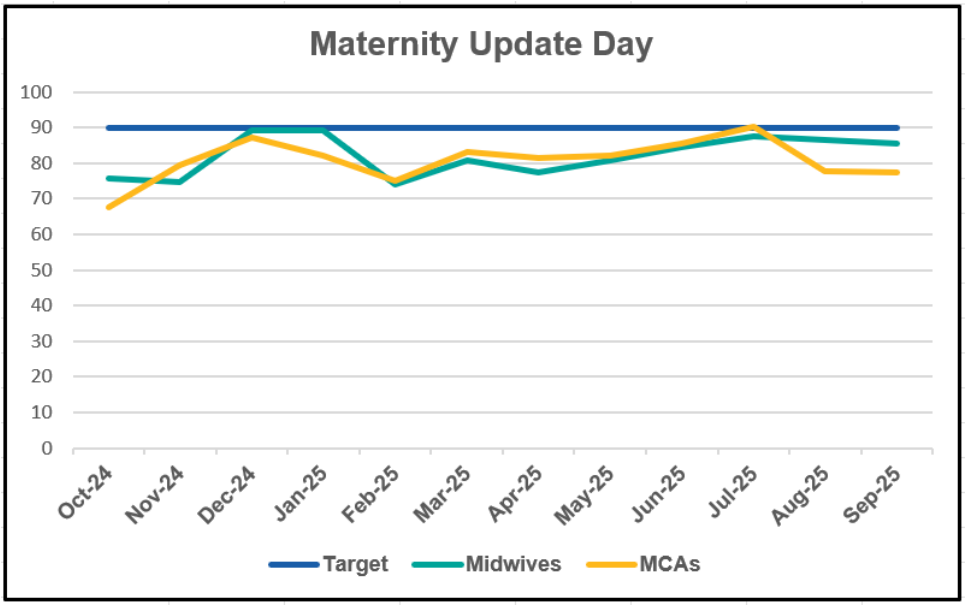
Minimum standard:

- 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 October 2024.

Figure 10. Maternity Update Day attendance (Q2 July - September)



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.

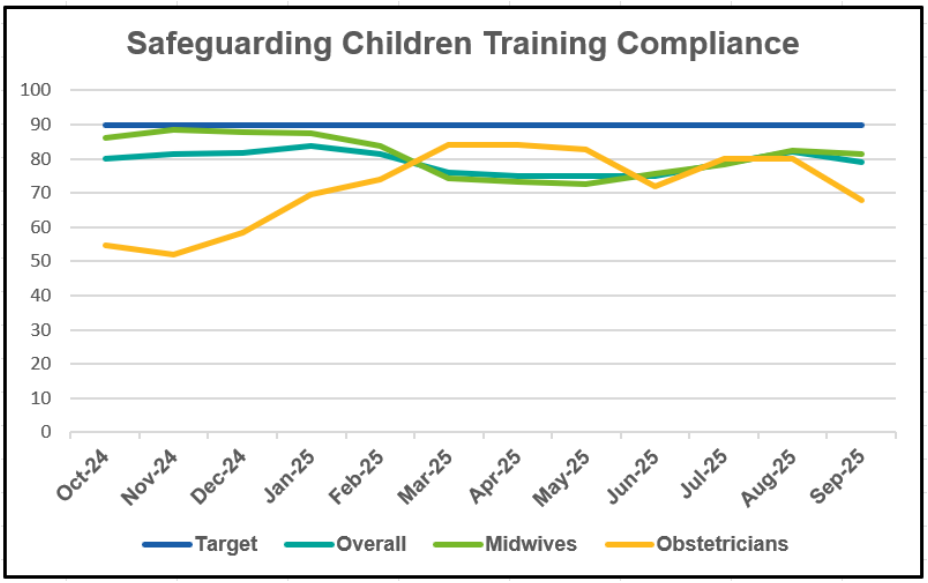
Initial training: Professionals will complete the equivalent of a minimum of 8 hours education, training and learning related to safeguarding/child protection. Those requiring role specific additional knowledge, skill and competencies should complete a minimum of 16 hours.

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. Recently eLfh online training has been introduced for obstetric SHO level and experienced maternity staff who are non-compliant, due to the reduced compliance levels within maternity. The overall vision is for all staff to receive this training face to face.

During Q1 and Q2 the Lead Safeguarding Midwife has facilitated some additional training days that meet the level 3 standards of knowledge, skills and competencies and chased all staff to book on, with the aim of achieving compliance by November 2025.

Figure 11. Safeguarding children training compliance (Q2 July – September)



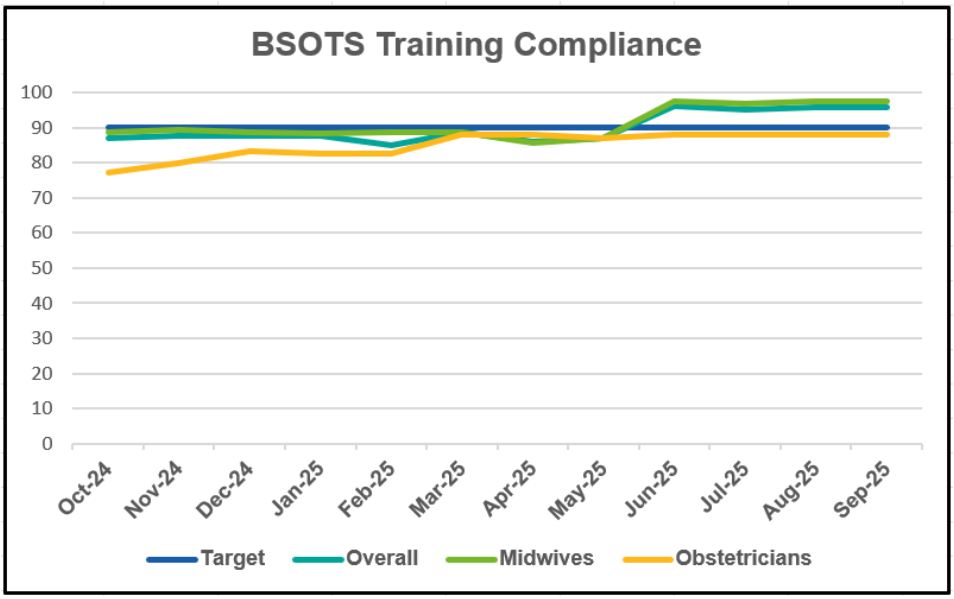
6. BSOTs Training

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 2025.

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 (Q2 July - September)



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 49 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 95.9%, with 2 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. SFT have 6 Midwives currently undergoing NIPE course training.

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.

The resuscitation department are responsible for updating training compliance records on LEARN. Within Maternity, it has been a challenge to collect reliable departmental data on BLS compliance for staff groups from LEARN (Trust eLearning platform) as it has been identified that organisational staffing lists held in Maternity and Neonatal Services differ from what is reported via LEARN (LEARN system not identifying all staff members/holding correct

list of current employees). This has been escalated to the Trust Education Team for resolution and support. Meetings are ongoing.

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.

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 according to the data that has been obtained. There are known inaccuracies.

Figure 13. Adult Basic Life Support training compliance (data collected from LEARN 15/10/2025)

Obstetricians	Midwives	Maternity Nurses	MCAs & MAs
81.8%	75.2%	N/A	74%

All staff out of date for Adult BLS have been contacted and advised to book via the Trust's LEARN platform.

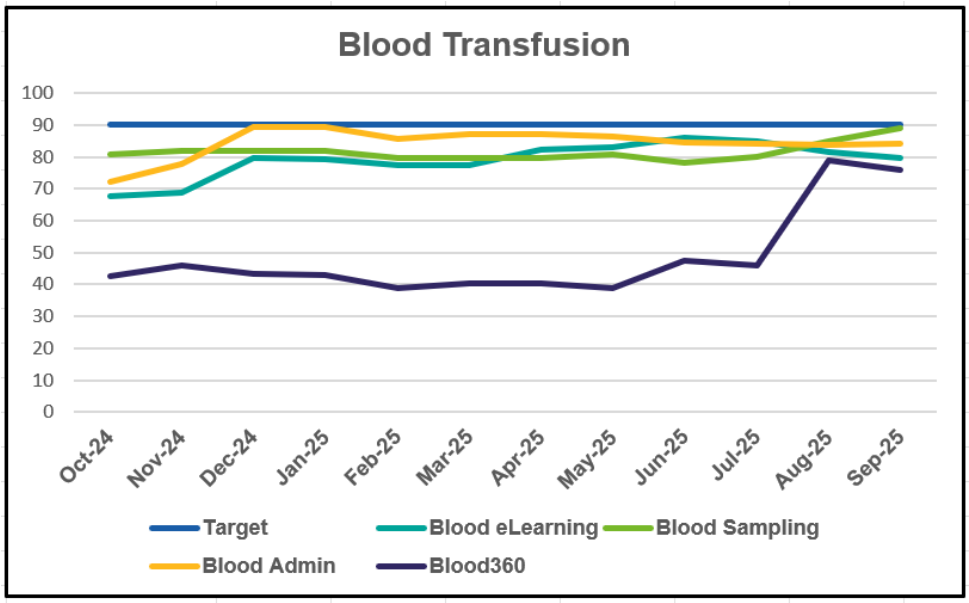
9. Blood Transfusion Training

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 this included time to complete the eLearning. This has shown an improvement in training compliance which has continued into 2025. In 2025, the Maternity Education Team have continued working with the blood transfusion link nurses to improve training compliance and this has been effective.

The midwives to be included in the Blood360 training compliance has been updated so that non-clinical midwives and community midwives are exempt due to being extremely unlikely to be collecting blood.

Figure 14. Blood transfusion training compliance (Q2 July - September)



10. Simulation Training

During Q2, the Maternity Education Team supported regular simulation training in PROMPT including pool evacuation, maternal sepsis, and newborn life support. Additional support to facilitate ad-hoc SIMS has been sought from obstetric colleagues and an adhoc SIM occurred in August 2025.

The plan is to provide 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 Q1

	Scenario details	Attendance	Findings	Actions Taken
July	Nil sessions			
August	1	8 - MDT	Successful. Impacted Fetal Head algorithm to be available in theatre	Training implemented to September 2025 PROMPT programme.
September	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.This has since been reviewed and updated with it being noted by the LMNS on 15/09/25.

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:

- Implement new PROMPT training programme from September 2025.
- Plan content for 2026 SBL Study day & Maternity Update day in line with the TNA and ensure all midwives, maternity support workers, obstetricians and anaesthetists are booked onto the relevant training sessions for the remainder of 2025.
- Liaise with anaesthetic and obstetric rota co-ordinators frequently to ensure all remaining staff and new rotational staff are rostered to attend maternity-specific training by 30 November 2005, alongside adequate clinical cover to ensure attendance at training days.
- Escalate concerns regarding training compliance, sickness and reasons for non-attendance to Staff group leads and Risk and Governance meetings.
- Continue to chase all outstanding eLearning and escalate this to relevant line managers.
- Further discussions with the Trust Education Team to improve the availability and accuracy of reports pulled from the LEARN platform.

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 existing and rotational obstetricians are booked to attend all required study days before MIS deadline in December.	Helen Showan Helen O'Shea Yazmin Faiza	November 2025	Complete however to monitor for changes due to clinical workload and staff sickness	Helen O'Shea mapped all consultants and registrars for remainder of 2025.
Arrange group NLS update for all paediatricians	Sam Heaton Tamsyn Crane	October 2025	Relevant staff aware to include in next consultant meeting	In Progress
Improve Level 3 Safeguarding Compliance.	Laura Ware	September 2025	All out-of-date staff contacted to book onto available sessions. Laura contacted in September to chase those who are not yet booked. Obstetricians are all booked to attend over the next 6 months.	To obtain update on whether the out-of-date midwives are now booked on.
Plan content for 2026 SBL Study Day and Maternity Study Day	Helen Showan	December 2025	TNA completed	Some subject leads contacted regarding teaching sessions. Training dates shared.
Actions from simulation training				

Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Arrange more Ad Hoc Sims for in-situ learning	Helen Showan Elinor Carlisle SFT Simulation Team	March 2026	Education team to diarise some potential times to run SIMS and meet to plan SIM.	Not yet actioned due to workload
Further Actions				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Create new PROMPT programme to run Sept 2025-Sept 2026	Helen Showan Elinor Carlisle Q&S Midwife Julia Bowditch/ Juliet Barker	September 2025	Programme planned and finalised.	Ready to implement 12/9/25.
Improve accuracy of reports from LEARN platform	MLE Team Helen Showan Cris Mulshaw	January 2026	MLE helpdesk & Head of Education emailed	Further follow up required to open communication with the right person.

Patient and Staff Experience Report
Maternity and Neonatal Services
(Quarter 2 2025-26)

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**
	• Friends and Family feedback (FFT) text messaging service will be reinstated in December 2025. To mitigate the gaps in patient feedback, Maternity Services has been added to the Trust's Real Time Feedback (RTF) schedule. • 11 complaints and 3 concerns were received in this quarter. The top theme remains 'unsatisfactory treatment', which is consistent with the previous quarter. There has been a significant increase in complaints logged this quarter (6), and a raise in concerns (3). • Families of babies admitted to SFT neonatal unit will soon be asked to take part in NHS England's National Neonatal Care Experience Survey. The survey helps monitor what is working well and how neonatal care services could be improved, both locally and nationally. • 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. This is scheduled to commence in Q3, November 2025. • The Birth Reflection Service is now accepting self-referrals, via the Maternity Website. • It is anticipated that the translation tool bar will be implemented next quarter. • A patient story was kindly provided, with the focus on recognising a deteriorating patient and the escalation process. The intention is to share this story at the Perinatal meeting and in local mandatory training. • The Maternity Service received the headline report for the National Maternity Patient Survey 2025.

	• Maternity Services are due to launch the Pocketalk translation device next quarter. The implementation and evaluation will be supported by Health Innovation Wessex's Insights team. **Key priorities for patient experience and inclusion, next quarter includes:** • To undertake listening events with hard-to-reach groups with the poorer maternity outcomes. • Clients of the 'Baby Steps' programme will be asked if they wish to provide feedback on maternity services. • To support the implementation and evaluation of the 'Pocketalk' translation device. • Continue to drive the development of a local Health Inequalities dashboard. • Continued monitoring of the 2025 National Patient Experience Maternity Survey action plan and support the introduction of the National Neonatal Care Experience Survey. • Progress the actions detailed in the Three-Year Delivery Plan. • Respond and designate action holders following the results of the '15 Step' assessment. • Continue the quarterly Triangulation meetings to coordinate service users feedback to identify service improvement opportunities. • Support the reintroduction of SMS text messages for the Friends and Family Test. • To support the update of the Maternity Website.
3.	**Patient Story**
	A patient story was provided this Quarter, with the theme of escalation and lack of recognition of a deteriorating patient. The patient story is due to be discussed at the next Perinatal Meeting.
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. This is an annual survey. Women receiving maternity services in January and February 2025 were selected for the survey. The team are working in collaboration with the Maternity and Neonatal Voices Partnership (MNVP) on a robust action plan. The full report will be available to share end January 2026.
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 discussed:

- Lack of postnatal obstetric follow up following discharge, for those women with a complex birth outcome.
- Delayed recruitment in administration staff leading to prolonged waiting times in ANC, delays in incorrect appointment being sent.

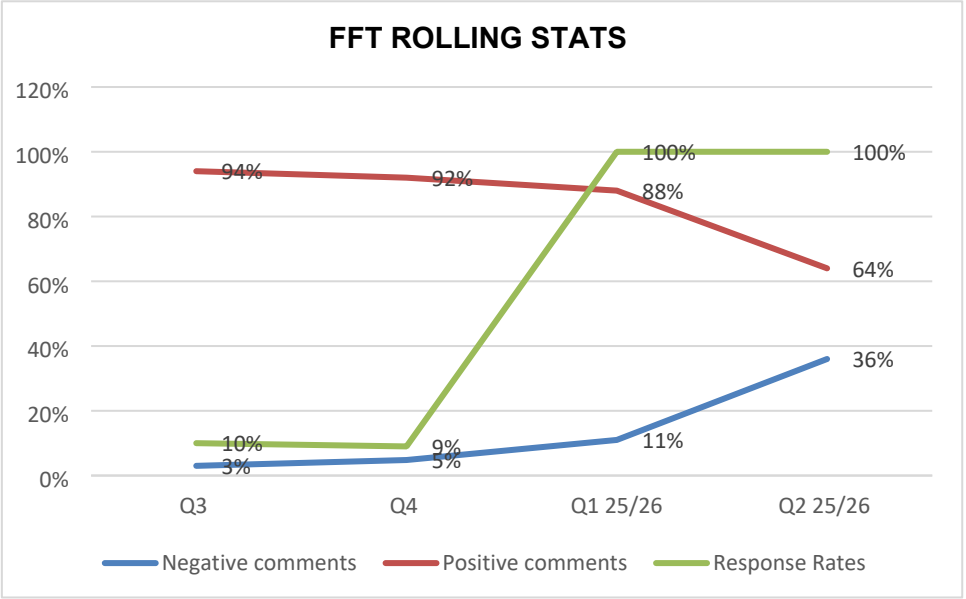
Update on actions:

- A criterion for obstetric postnatal follow up has been agreed. A referral pathway will be added to the BadgerNet. It is anticipated that the referral will be made by obstetrician directly following the birth.
- The PIL relating to issues associate with consent, has been devised and is waiting comment from the MNVP.

Figure 1. Update provided from the MNVP regarding planned and completed engagement events (from September's Maternity Risk and Governance meeting)

	The Maternity and Neonatal Voices Partnership (MNVP) undertook an initial survey surrounding service users' feedback on accessing the Maternity Department following safety prompts from recent MNSI cases. A robust review of the signage is planned for October 2025. The findings from both reviews will be reported in Q3.
6.	**Friends and Family Test (FFT)**
	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 Q2 2025/26 Data:** Due to the continued work ongoing on the data warehouse, SMS text messages are unable to be sent to service users requesting their feedback. To mitigate this, QR codes have been made available in all clinical areas. The paper FFT cards have been reinstated. In this quarter, only 11 FFT responses have been received, therefore whilst the feedback is valued, the figurative results cannot be reliably used to provide a comparison with Q3 and Q4 24/25.

Figure 2. Positive and negative responses in number and percentage



Full analysis of FFT can be viewed via the embedded document:

Friends and Family Test 2025.docx

In the absence of FFT Feeback, work has been undertaken with the PALS department in collaboration with the MNVP to amend the Real Time Feedback (RTF) standard questions, to ensure relevance to maternity patients. The maternity department has been added to the Trust's RTF schedule. The survey was undertaken in July 25. The overall rating for the service was 92.6%. Feedback will be monitored through the Triangulation and Safety Champions meetings.

FFT Priorities for the next quarter (Q3 25/26):

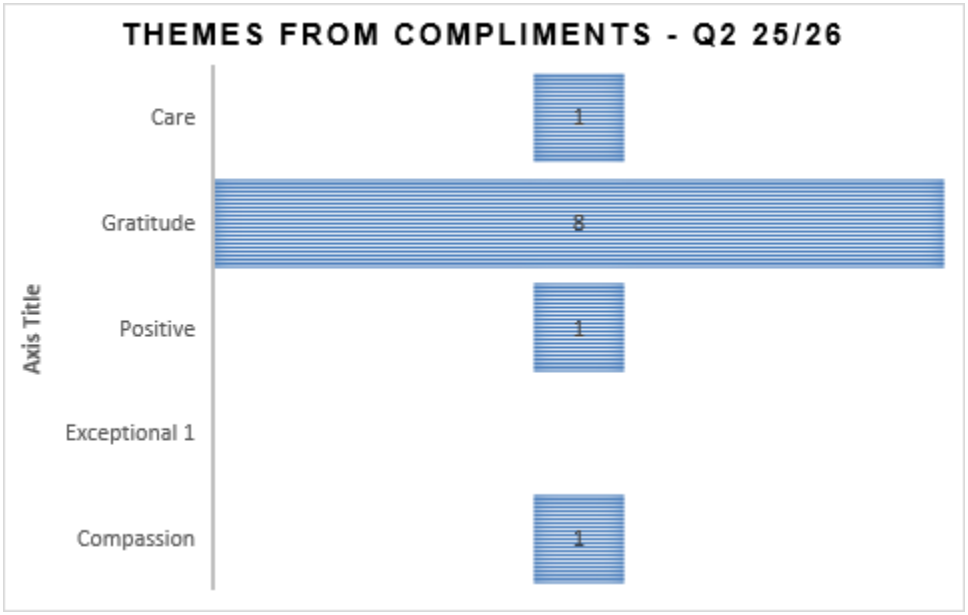
- The FFT data will be presented at the next Triangulation/ Antenatal Quality meeting and used to inform any learning opportunities or service improvements.

	• Continue to support the work to reinstate SMS text messaging, with the anticipation of commencing text messaging in December 2025 • 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 **National NNU Patient Experience Survey 2025** Families of babies admitted to SFT neonatal unit may soon be asked to take part in NHS England's National Neonatal Care Experience Survey. The survey helps monitor what is working well and how neonatal care services could be improved, both locally and nationally. All eligible parents or guardians of babies who were discharged from neonatal care in June, July or August 2025 will be contacted by Picker during Q3 to take part in the survey. Results of this survey will be monitored through Neonatal Governance, and any themes will be presented at the Triangulation meeting. **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 Q2.
8.	**Feedback from Black, Asian and Minority Ethnic Backgrounds and Families Living in Areas with High Levels of Deprivation**

	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. **Continued priorities for Q2:** • 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. It is anticipated that the tool bar will go live in the next month. • In June 25, Maternity and Neonatal Services have purchased 10 new at the point of contact translation devices; Pocketalk. These are awaiting implementation and evaluation. In collaboration with Health Innovation Wessex, and the Pocketalk working group, discussions are being had with the provider to map out the implementation and evaluation of the device in practice. The provision Launch date is 20th October 2025. • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with poorer maternity outcomes. The next listening event with Baby Steps is scheduled for September 2025 has been postponed until October 2025. • Development of a Health Inequalities dashboard. • The Family Experience and Inclusion Midwife to attend the Trust Health inequalities committee/ working group to network and influence this area of practice. • Undertake audit of access to translation services. • Explore ways to provide a bespoke parent education classes for women whose first language is not English.
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 Q2 2025/26, Maternity and Neonatal Services received 12 compliments. The top theme reported in this quarter was 'gratitude'.

"Thank you so much for everything, you have been such an amazing midwife, not just through this pregnancy. We appreciate all you have done!"

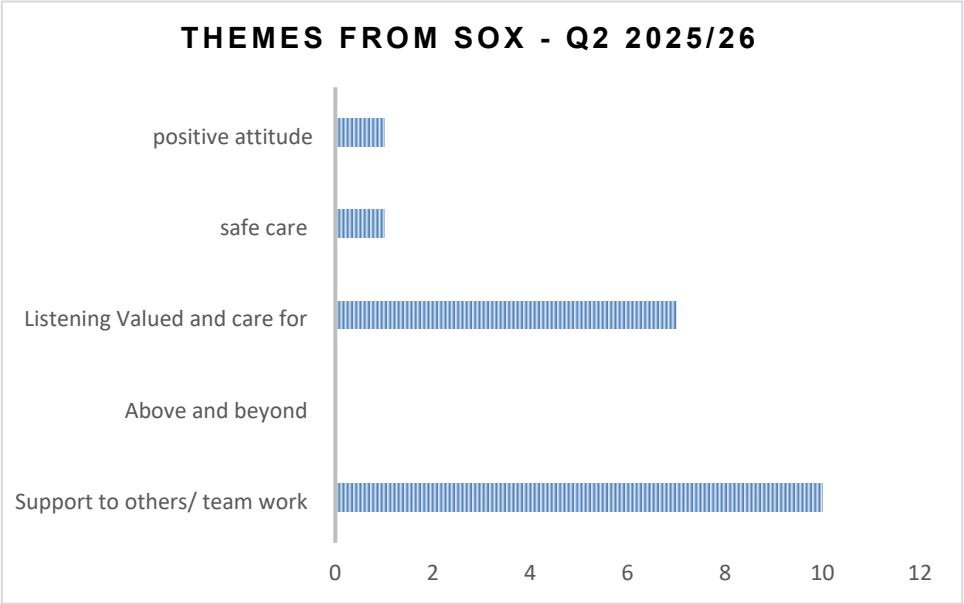
Figure 3. Themes from compliments



In Q2 maternity and neonatal service received 19 SOX nomination. The top theme being Support to others and teamwork.

"They worked together as a team to provide urgent care to a very sick neonate whilst ensuring that the other babies in their care were safe. They supported the parents and maintained a calm working environment, overcame some environmental challenges with teamwork and role modelled civility under pressure."

Figure 4. Themes from SOX in Q2



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

Maternity and Neonatal complaints and concerns data

11 complaints and 3 concerns were received in this quarter. The top theme remains ‘unsatisfactory treatment’, which is consistent with the previous quarters. There has been a significant increase in complaints logged this quarter (6), and a raise in concerns (3). Figure 5 shows the trends over the last 5 quarters.

Figure 5. Number of complaints received over the past 4 quarters

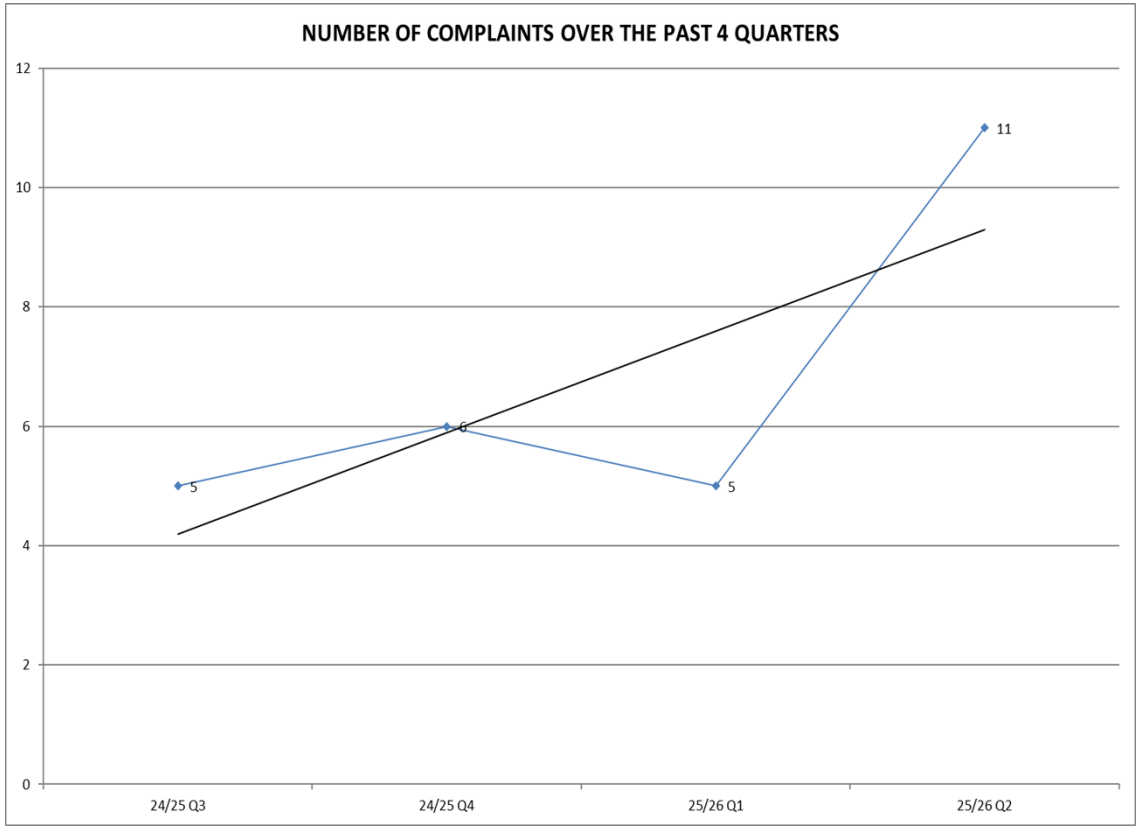


Figure 6. Themes from complaints

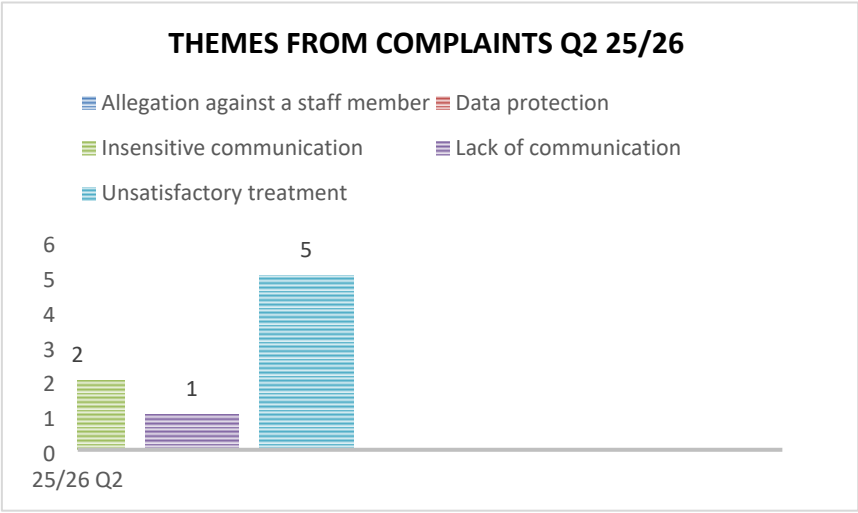
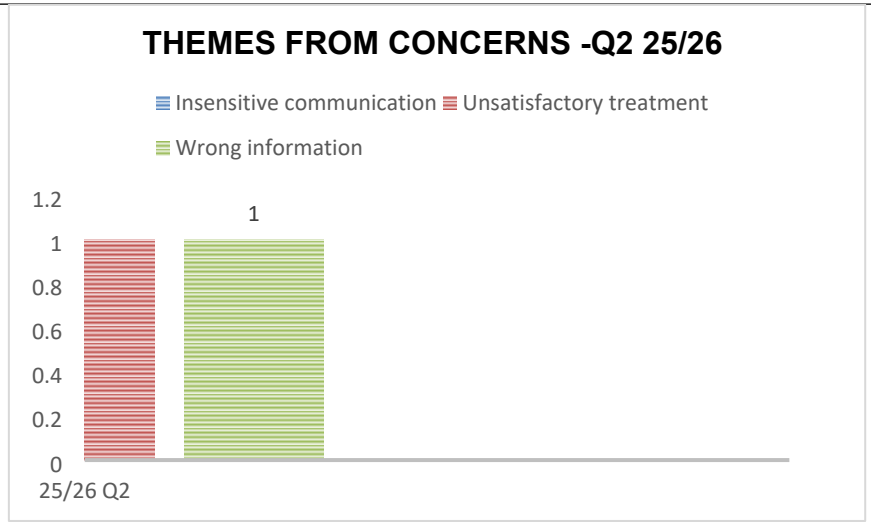
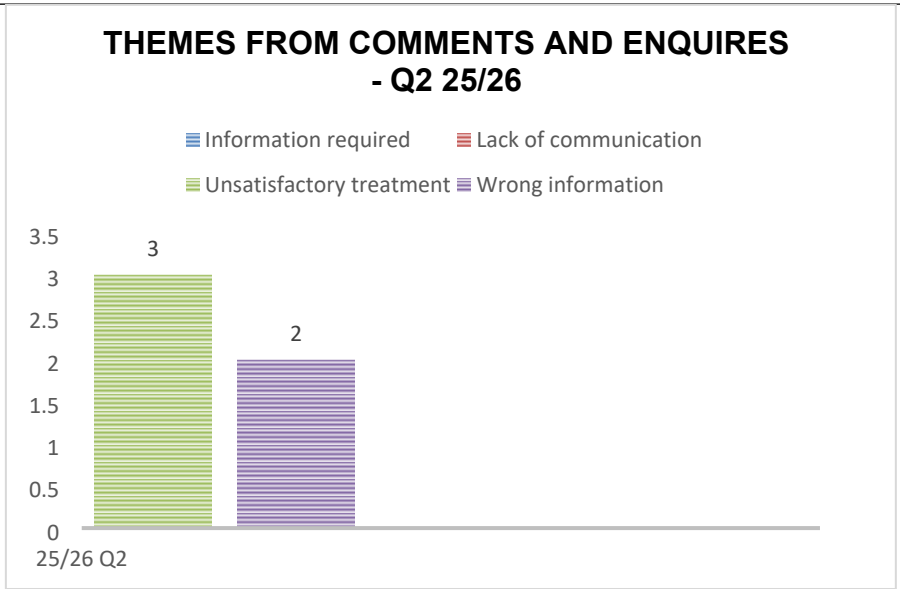


Figure 7. Themes from concerns



The overall theme from complaints and concerns remain 'unsatisfactory treatment'.

Figure 8. Themes of comments and enquiries



10 comments and enquiries were logged with the PALS Department. Top 2 themes were surrounding the provision of information and Unsatisfactory treatment.

Learning and action points taken from closed complaints in Q2

In Q2, there were 9 complaints closed, 6 was closed within target time, offering a 60% compliance rate- a 46% increase in compliance from the previous quarter.

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 long-term priority was to continue the work to enable women to self-refer to the service via the maternity website. This action has been concluded. All themes from intelligence gained during these appointments are shared with the relevant ward leads, clinical Matrons and discussed at the quarterly Triangulation meetings.
11.	**Matron/ Ward Manager Audits**
	The department is keen to reestablish face to face parent education, within the community Hubs, or community spaces. A pilot was undertaken in June, where an in-person parent education sessions was undertaken. Service users were asked to comment on the session. The feedback was extremely positive and highlighted the value of this much needed service. Work is ongoing to support these in person sessions and develop a sustainable programme of parent education within the community.
12.	**Internal/ External Visits (relating to patient or staff experience)**
	In June 2025, the MNVP conducted a 15 steps assessment. Results were published in Q2. Work is ongoing to establish a robust action plan to address the suggested service improvements.
13.	**Staff Survey Results**
	Flexible working groups were held in Quarter 2 in response to the staff survey whose divisional actions were based around “we work flexibly” and “we are always learning”. The communication to staff and actions arising from these groups were created in conjunction with the divisional OD & P business partner and plan to be rolled out in quarter 3. There was also review of the current appraisal process across Maternity & Neonatal to ensure all staff have the same opportunity for development and growth, this work will be conducted alongside the succession planning work being undertaken by the OD&L team within the trust.
14.	**Staff Experience/ Wellbeing**
	Restorative Clinical Supervision (RCS): During Q1, a total of 1 RCS sessions were carried out (incorporating wellbeing and Career conversations). This is a decrease on the 14 sessions held in Q4.

	RCS support: the PMA team aim for all NQMW continue to receive RCS as part of a retention initiative. The current cohort consists of 12 preceptees. 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 continues to undertake sessions on health inequalities and cultural competence during the annual maternity study days. • The ask has been from women to reinstate the face-to-face parent education sessions. A pilot session was run in June 25. The feedback obtained following this session was largely positive and would support the reintroduction of face-to-face local parent education sessions, within the Community Hubs. • Work commences to update the Maternity Website. • 'Flexible working' groups held for staff to discuss flexible working needs and preferences. • Ongoing work to improve staff rest areas. • Maternity and Neonatal celebration event hosted by the Perinatal quad where staff had the opportunity to come with lunch and refreshments provided.
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 Any staff named in service users feedback are shared with the staff member.

17.	**Update on Actions Outlined in the Previous Report**
	The 5 main priorities were previously identified in the last Quality and Safety report: **1. Introduction of Pocketalk translation device:** Update: It is anticipated that Pocketalk will be launched on 20th October 2025. The maternity department was successful in their application to the Real-World Evaluation Competition. The Health Innovation Wessex's Insights team will be supporting the implementation and evaluation of the device. **2. Review themes from the feedback obtained via FFT.** Update: Due to the challenges with SMS Text messaging of FFT, it is anticipated that this service will resume in December 2025. Maternity Services has been added the Trust's RTF schedule to mitigate the gaps in feedback during this time. **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. It is hoped that work on the Health Inequalities Dashboard will commence later this year. **4. Self-referral to the Birth Reflections Service** Update: Service users can self-refer to the Birth Reflection service via the Maternity Website. **5. Continue to listen to the voices from service users from hard-to-reach groups.** Update: Baby Steps listening event was scheduled in Q1 25/26 has been deferred to October 2025.
18.	**Next Steps/ Looking Forward**
	Key priorities for patient experience and inclusion, next quarter includes: • To undertake listening events with hard-to-reach groups with the poorer maternity outcomes. • Clients of the 'Baby Steps' programme will be asked if they wish to provide feedback on maternity services. • To support the implementation and evaluation of the 'Pocketalk' translation device. • Continue to drive the development of a local Health Inequalities dashboard. • Continued monitoring of the 2025 National Patient Experience Maternity Survey action plan and support the introduction of the National Neonatal Care Experience Survey. • Progress the actions detailed in the Three-Year Delivery Plan.

	• Respond and designate action holders following the results of the '15 Step' assessment. • Continue the quarterly Triangulation meetings to coordinate service users feedback to identify service improvement opportunities. • Support the reintroduction of SMS text messages for the Friends and Family Test. • To support the update of the Maternity Website.

Saving Babies Lives Quarterly Report
Maternity and Neonatal Services
(Quarter 2 2025-26)

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 the Saving Babies Lives Care Bundle.

The current SBLCB technical guidance and implementation tool (version 3.2) were published in April 2025. In line with the current NHSR Maternity Incentive Scheme (MIS), SBLCB maintains an approach of continuous improvement and comprehensive evaluation of organisational processes and pathways. This is part of developing an understanding of where improvements can be made.

The national implementation tool helps maternity services to track and evidence improvement and, compliance. It has been continued for use with MIS Year 7 requirements. The 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 7 requirements and with the ICB. Evidence is submitted quarterly, and feedback meetings are arranged with the LMNS. These meetings form the basis of the quarterly improvement conversations with the LMNS.

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. 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 1-4 2024/25 and qurter 1 25/26 have been completed to provide assurance to the Trust and LMNS that all six elements of SBLCB are implemented and quality improvement progress monitored.

Due to the process of submission to LMNS and dates associated with this, **Q2 July-Sept 2025/26 data** (SBLCB v3.2) is currently being collected for submission to the LMNS on 7th November (Q3). This **will be reported in the next Quarterly Quality and Safety Report (Q3 Oct-Dec 2025/26).**

Each organisation is expected to look at their performance against the outcome measures for each element using the national implementation tool, with a view to understand where improvement may be required. The previous MIS Year 6 and current MIS Year 7 requirements mandate that providers should fully implement Saving Babies Lives 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

Q1 2025/26 data (SBLv3.2) was submitted to the LMNS for Assessment 7 in Q2. This has been validated by the LMNS that 86% of interventions are fully implemented at SFT (see figure 1 for progress and current compliance).

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	Assessment 6	Assessment 7
Review Quarter	Initial							
Assurance Review Date	25.10.2023	23.12.2023	24.06.2024	13.09.2024	02.12.2024	04.03.2025	29.05.2025	04.09.2025
Element 1	10%	29%	20%	40%	60%	80%	80%	60%
Element 2	5%	50%	50%	70%	70%	80%	90%	95%
Element 3	0%	100%	50%	50%	100%	100%	100%	50%
Element 4	0%	0%	20%	40%	60%	40%	40%	100%
Element 5	11%	37%	48%	52%	63%	78%	100%	92%
Element 6	7%	33%	17%	17%	67%	33%	67%	67%
TOTAL	7%	37%	40%	51%	66%	73%	87%	86%

4. Implementation Progress

SFT has made steady progress and has several actions in place to move towards full implementation. The LMNS validated implementation progress demonstrated that overall, there has been an *increase in the % of interventions fully implemented* (see above and below). Progress has been hampered by audit and data challenges since the transitions from paper patient records to Badgernet electronic records. Action plans are in place for all outstanding actions.

Figure 2. Implementation progress for Q1 2025-2026 with self-assessment of 86% and LMNS validated of 86%.

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)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	95%
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	92%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	86%	Partially implemented	86%

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 Q1 2025-26

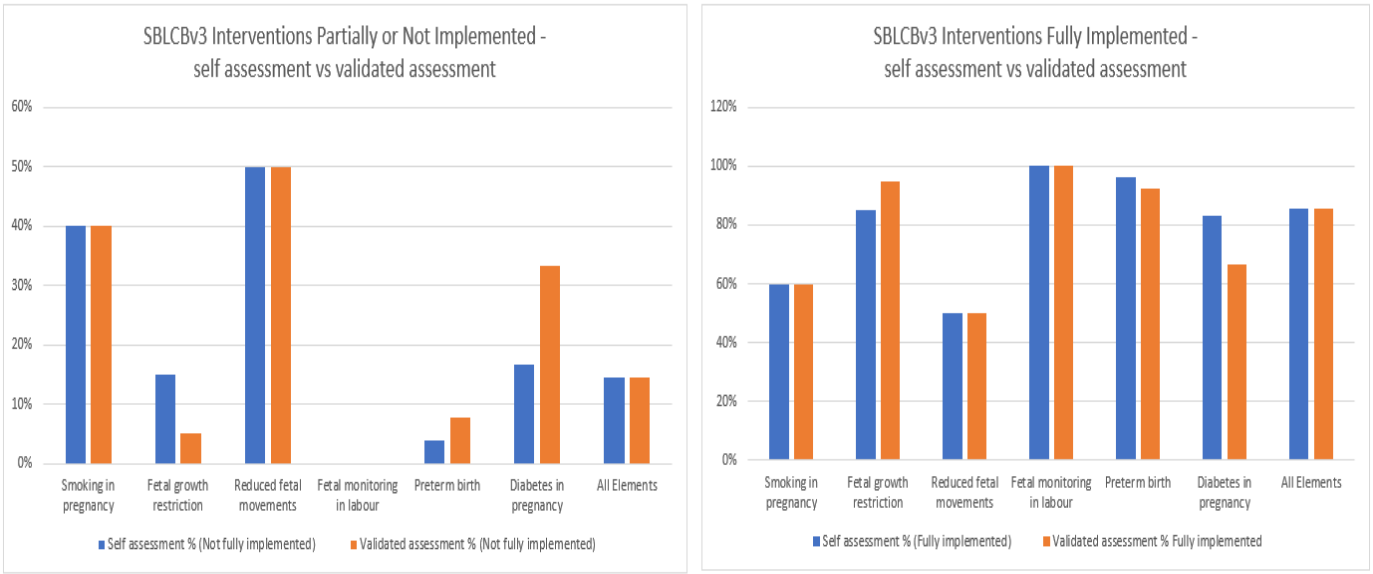
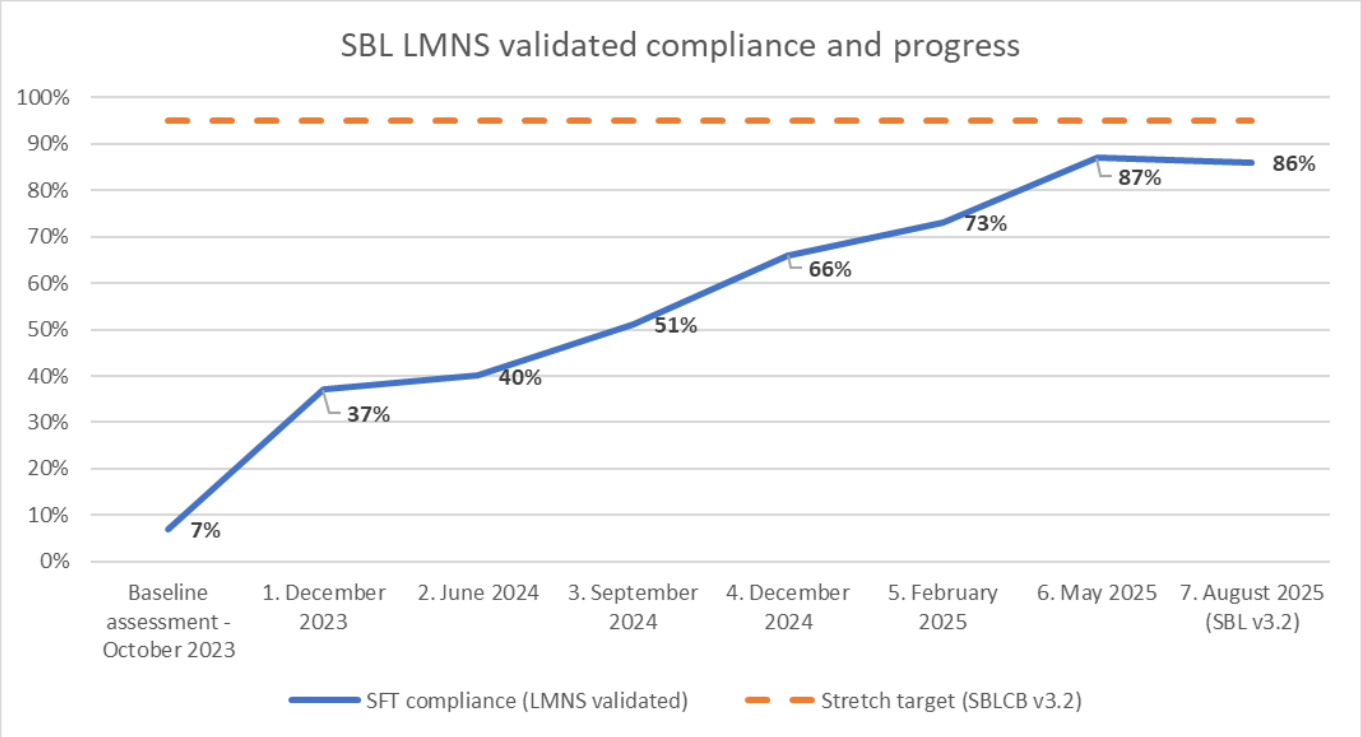


Figure 4. LMNS validated compliance progress against stretch target Oct 23 – August 25



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 identified and progress made during the last quarter
60%	• **CO testing and smoking status** Action: Stop Smoking Strategy (2024) - requires dates, logo and information relating to CO monitoring at other antenatal appointments. **Ongoing.** Update: SMART action plan continues with Mandatory Study Week in effect to ensure training compliance is reached for SBL training requirements. • **Tobacco dependence treatment and support** Action: to review audit data re process indicator re % of smokers who set a quit date and are verified as non-smokers at 4 weeks. **Ongoing.** Update: Audit lead reviewing data and amending for Q2 data collection. • **Staff training** Action: 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: SMART action plans: Mandatory Study Week now in effect to ensure training compliance is reached and in turn to increase compliance for SBL purposes. SMART action plans: All new Starters to Maternity have an induction programme including a session with HIP facilitators where the service is explained, and relevant CO machine training is provided. Mandatory study week is in effect.

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).

Compliance %	Actions identified and progress made during the last quarter
	• **Aspirin and Vitamin D** Action: V3.2 contains a revised requirement whereby all women on a moderate risk pathway require an SFH measurement at 28 weeks. **New.**

95%	Update: Guideline lead and author amending current guidelines to reflect subtle changes to requirement. • **UtAD for high risk women between 18-23+6 weeks** Action: Query over BadgerNet data quality re risk assessment completion for all women who have been express booked that are high risk and where information is reported (BadgerNet or viewpoint). **New.** Update: Audit lead to clarify in the next audit submission. Data quality is likely to improve as all women who have been expressed booked will have had their babies. • **Low risk SFH from 24 weeks** Action: LMNS recommend that a process is established by sonography team for USS discrepancy reviews and whether a mother requiring more than 1 USS due to SFH discrepancies should go onto a serial surveillance pathway. **New.** Update: Audit lead to liaise with sonography team. LMNS recommended changes to growth surveillance pathway would not follow GROP/GAP or NICE guidance. • **Maternal and fetal Risk assessment** Action: PLGF testing not implemented at SFT as recommended by NICE **Ongoing.** Update: Smart action plan in place. LMNS have noted no progress and recommend Obstetric input required to support. • **Staff training for SFH** Action: Staff training for symphysis fundal height (SFH) measurement not compliant. **Ongoing.** Update: Training for SFH is improving monthly as per planned mandatory annual training programme.

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.

Compliance %	Actions identified and progress made during the last quarter
50%	• **RFM advice** Action: Update leaflets and guideline now that SFT have moved to BadgerNet records re how information is shared with parents. **New.** Update: Leads working together to address this.

Element 4: Effective fetal monitoring during labour

Compliance %	Actions identified and progress made during the last quarter
100%	• **Hourly systematic review** Action: LMNS request that in addition to PMRT report, SFT identify if there have been any HIE cases associated with fetal monitoring. **New.** Update: Fetal monitoring leads to include in audit report for next reporting quarter.

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 identified and progress made during the last quarter
92%	• **Use of VTV** Action Draft SOP for the use of VTV ventilators needs to be approved. **Ongoing.** Update: Guideline lead chasing with guideline author for SOP to go through guideline consultation process and ratification.

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 identified and progress made during the last quarter
67%	• **HCL, education and support** Action: Onboarding and staff training described in audit report. LMNS request that this is included in a SOP or appendix to current guideline. **New.** Update: Audit lead and guideline author asked to do. • **HBA1C measurement in 3rd trimester** Action HbA1C should be measured at the start of the 3rd trimester as per SBL (not NICE requirement which is to consider HbA1C): audit not compliant. **Ongoing.** Update: To arrange meeting to discuss with diabetic team and LMNS • **Diabetic Ketoacidosis** Action: DKA SOP requires minor amendments and Trust corporate level ratification. For staff comms when live. **Ongoing.** Update: Chased by Audit and guidelines Midwife.

5. Quarterly improvement discussions with the LMNS*

The MIS requires that Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust.

These discussions should include the following:

- Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
- Progress against locally agreed improvement aims.
- Evidence of sustained improvement where high levels of reliability have already been achieved.
- Regular review of local themes and trends regarding potential harms in each of the six elements.
- Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.

SFT has met quarterly to discuss feedback and improvement activity (as set out above) as follows:

Reporting period	Meeting date*	Attendees	Comments
Q3 24-25	6.3.25	LMNS: SR SFT: FB	Review of National tool, local improvement trajectory and LMNS tracking tool to discuss feedback and improvement activity
Q3 24-25 (as above)	11.3.25	LMNS: SR SFT: FB	Review of National tool, local improvement trajectory and LMNS tracking tool to discuss feedback and improvement activity
Q4 24-25 submitted 13.5.25	29.5.25	LMNS: SR SFT: FB, DF, AK	Review of National tool, local improvement trajectory and LMNS tracking tool to discuss feedback and improvement activity
Q4 24-25 (as above)	17.7.25 (rescheduled from 12.6.25)	LMNS: SR SFT: DF	Review of National tool, local improvement trajectory and LMNS tracking tool to discuss feedback and agreed improvement activity. Changes also discussed re SBLCB v3.2 particularly audit changes, removal of continuity of care requirement and element 6 changes. BadgerNet system continues to embed at SFT.
Q1 25-26 submitted 7.8.25	9.9.25	LMNS: SR SFT: DF	Review of LMNS tracking tool to discuss feedback and improvement activity
Planned quarterly improvement meetings:			
27.10.25 - to discuss progress following final validated assessment received on 6.10.25 from Q1 August submission.			

**Confirmation of dates presented annually to LMNS Programme Board (last presented 28.11.24)*

Midwifery, Maternity and Neonatal Staffing Report
Maternity and Neonatal Services
(Quarter 2 2025-26)

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 %
July 2025	92.2	98.2
August 2025	90.6	93.8
September 2025	91	91.9

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 7.86 WTE on maternity leave. There are also 12.12 vacancies, 9.76WTE of which will be filled by the preceptee Band 5 midwives when they start at the beginning of Q3. Further recruitment is planned for the remaining (Band 6) vacancy. 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	July	August	September
Birth to midwife ratio	1:31	1:30	1:35

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

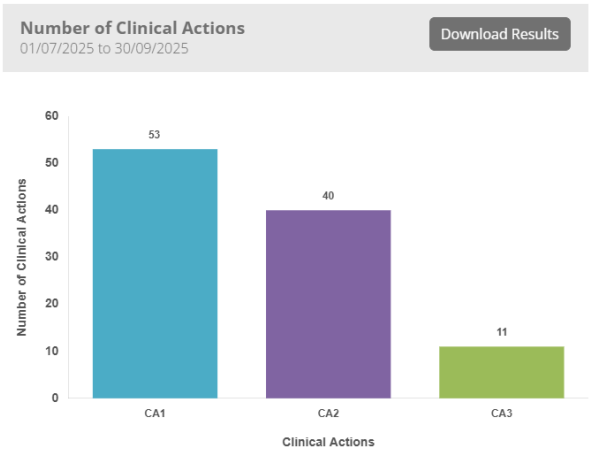
The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas on 1st December 2014 and has since gone live in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during 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.

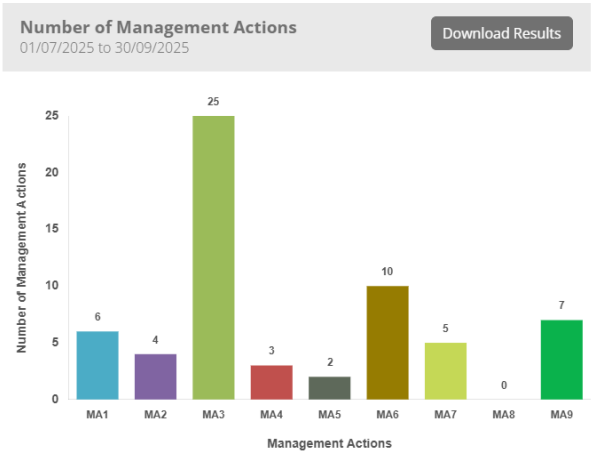
Figure 3. Number and percentage of clinical actions taken



Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay commencing IOL	53	51%
CA2	Delay on-going IOL	40	38%
CA3	Delay/cancel Elective LSCS	11	11%
TOTAL		104	

*The % is rounded to nearest whole number

Figure 4. Number and percentage of management actions taken



Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff from ward	6	10%
MA2	Redeploy staff from community	4	6%
MA3	Staff unable to take breaks	25	40%
MA4	Staff working beyond rostered hours	3	5%
MA5	Staff sourced from Midwifery Bank	2	3%
MA6	Matron/Midwifery Managers working clinically	10	16%
MA7	Specialist Midwives to work clinically	5	8%
MA8	Initiate the escalation policy	0	0%
MA9	Contact on-call duty Manager	7	11%
TOTAL		62	

*The % is rounded to nearest whole number

The data above indicates that there has been a higher incidence of occasions where clinical or management actions have been taken compared to quarter 1. This has been due to high birth numbers in both July and September and the impact of sickness, maternity leave and vacancy. There are mitigations for high acuity and when 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
July	31	62	100%
August	31	62	100%
September	30	60	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

	July	August	September
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 July 2025 to 30th September 2025. There were 7 red flags entered onto the system with the reasons detailed below:

Figure 7. Number of red flags recorded during Q2

Red flags	Breakdown of Red Flags	Times occurred
RF1	Delayed or cancelled time critical activity	0
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	4
RF3	Missed medication during an admission to hospital or midwifery led unit (for example, diabetes medication)	0
RF4	Delay of more than 30 minutes in providing pain relief	2
RF5	Delay of 30 mins or more between presentation and triage	0
RF6	Full clinical examination not carried out when presenting in labour	0
RF7	Delay of 2 hours or more between admission for induction and beginning of process	1
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	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

RF10	Supernumerary status of labour ward co-ordinator not achieved	0
	Total	7

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 Hemorrhage protocol has been instigated.

The audit for Quarter 2 (1st July 2025 – 30th September 2025) there were 9 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard and is detailed in the table below.

Figure 8. Cases meeting the above criteria

Date	Clinical Situation(s)	Comments
11/07/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present. Nb; Cons phoned several times, no answer. Different Cons phoned, caused delay of Cons attendance by 30 mins
15/07/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present.
13/08/25	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated	Consultant present. Nb; 2222 done & Cons was not called. Mat staff phoned directly and got hold of them but there was a delay with attendance. Datixed.
16/08/25	Caesarean birth for women with a BMI > 50	Consultant present.
04/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
10/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
16/09/25	Caesarean birth for women with a BMI > 50	Consultant present.
17/09/25	Unexpected Intrapartum stillbirth	Consultant present for diagnosis and delivery the next day.
30/09/2025	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 July 2025 – 30th September 2025. The audit demonstrated that during this period, 24 (short term) middle grade locum shifts were required. 6 Doctors completed these shifts, all of these Doctors were employed by Salisbury NHS Foundation Trust, therefore the trust is 100% compliant with the criteria described above.

10.3 Long term locum usage

During the time period 1st July 2025 – 30th September 2025 the trust has not utilised any long term middle grade locum doctors, the 1 long term middle grade locum doctor who was in use prior to this quarter has now become a substantive member of staff. Feedback was provided in a reference format as part of their recruitment checks.

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

Figure 9. Long-term locum compliance with standards

Standard	Compliance % for Locum 1 (in post prior to Q2)
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 – doctor became member of substantive staff

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	July 2025	August 2025	September 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
Divisional DMT has reviewed the business case and requested a full paediatric workforce review prior to re-submitting business case	Mary Pedley-Duncalfe	October 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 September 2025 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for QIS registered nurses but under-funded for non-registered nurses. The requirement would be an additional 1.69wte 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 and a revised business case to increase nursing staffing in line with BAPM is being written. 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.

We have successfully recruited a Band 5 neonatal nurse and the vacancy to 2.24WTE with ongoing recruitment for Q3.

Figure 12. Compliance with BAPM standards for Neonatal Nurses with respect to QIS

	Funded June 2025	**In post June 2025**	**BAPM calculated requirement** *(from ODN tool, based on NNU activity)*	**Variance** *(BAPM less funded)*
Total direct care nurses	20.60	20.75	22.29	-1.69
of which QIS	14.7	13.34	13.87	0.83
Total Non-QIS	5.90	6	5.90	0
Total Non-Reg	0	1.41	2.52	-2.52
% Registered Nurses QIS Qualified		69%	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 2 2025-26)

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, 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?

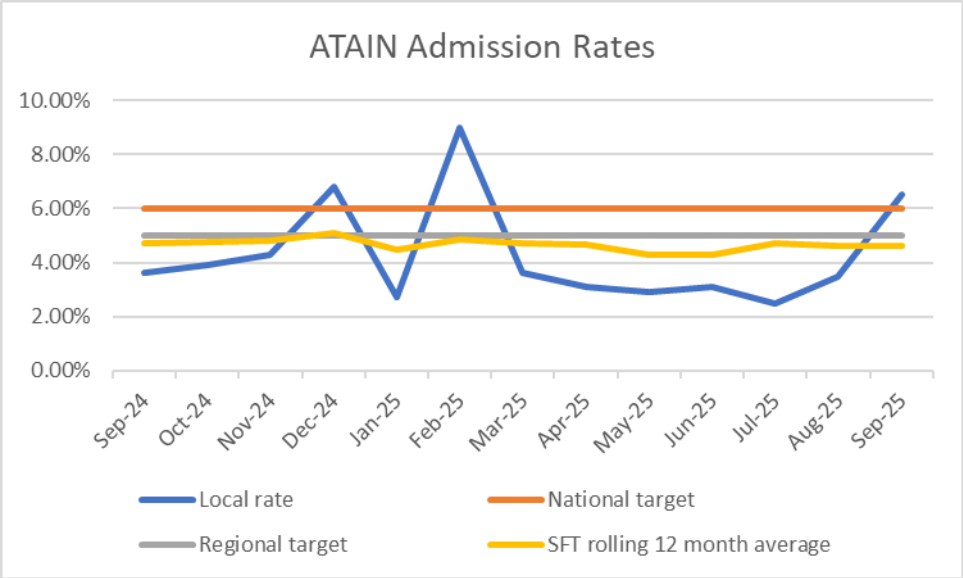
There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling 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.

3. ATAIN rates

Babies that are included in the local ATAIN rates and receive a review of their care are those that are admitted immediately from birth (either birth at SFT or at home) and those that are subsequently admitted from the inpatient maternity wards. Babies excluded include community readmissions and those babies known to have a congenital difference.

The following graph outlines the rolling calendar year ATAIN rates for Salisbury NHSFT Trust.

Figure 1. Monthly ATAIN rates since September 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)

	July 2025	August 2025	September 2025
Total number of admissions in month	**5**	**6**	**11**
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**
	July 2025	**August 2025**	**September 2025**
Total number of case reviews undertaken in month	**0**	**8**	**0**
Total number of case reviews with both maternity and neonatal staff present	Due to unavailability of specialist staff	**8**	Due to unavailability of specialist staff

4. Findings and learning from the ATAIN review meetings

4.1 Maternity

4.2 Review Summary

It has been challenging to identify any overarching themes during Quarter 2. This is primarily due to clinical service pressures, competing responsibilities, and unplanned staff absences whereby two of the three scheduled review meetings were unable to take place. Consequently, opportunities for comprehensive case review and thematic analysis were limited during this reporting period. However, it is worth noting that in line with the Maternity Governance Framework, all babies born at term and requiring admission to the neonatal unit are reviewed by a member of the quality and safety team using the relevant datix incident review proforma. The notes are reviewed and if there are any readily identifiable omissions in care or concerns, this is escalated to a PSR1.

4.3 Learning

The multidisciplinary case review held during Quarter 2 did not identify any avoidable admissions to the neonatal unit. Of the eight cases discussed at the August review meeting, no consistent themes were observed.

One case highlighted the potential impact of remifentanil on neonatal respiratory effort and its similarities to diamorphine. The review panel recommended that this topic be raised as a discussion point and learning opportunity at the next perinatal meeting. Additionally, the maternity education team has agreed to disseminate this learning across relevant staff groups to enhance awareness and clinical understanding.

5. Transitional Care Service (TC)

Please see appendix below regarding local policy:

Salisbury TC policy 1.6 (2023).pdf

6. TC Audit

6.1 How many TC babies did SFT have?

The graphs below demonstrate the numbers of babies born each month that fit within the TC gestational criteria and the length of stay.

Following the 2023 update to SFT's Transitional Care (TC) policy, which introduced a defined staffing model, it has been recognised that SFT's neonatal staffing levels do not consistently meet the standards outlined by the British Association of Perinatal Medicine (BAPM).

In alignment with the Maternity Incentive Scheme's Safety Action 3 and using the Improving Together methodology, a review of 2024 data identified that the number of recorded TC days at SFT was lower than comparable units. This suggests potential underutilisation of Transitional Care, leading to unnecessary separation of mothers and babies.

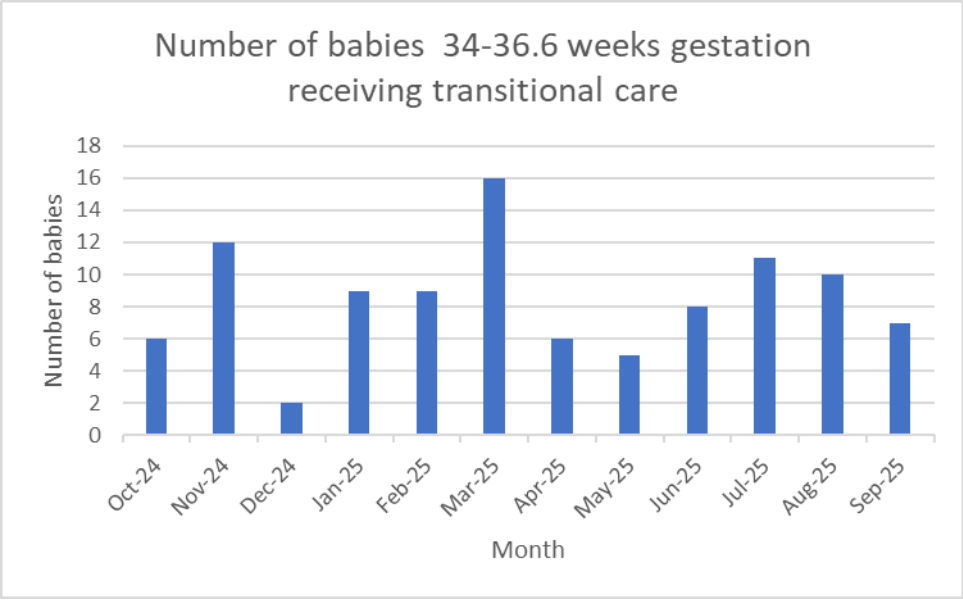
At SFT, TC operates through a virtual model, enabling babies to receive care either on the neonatal unit or the postnatal ward according to clinical need. However, during the scoping phase, variation in the categorisation of TC babies was observed. Some infants remain on the neonatal unit throughout their stay but continue to be recorded as receiving "special care" rather than being reclassified as TC. Similarly, on the postnatal ward, babies meeting TC criteria — such as those receiving intravenous antibiotics — are not always coded appropriately.

While BAPM provides clear criteria for TC, interpretation and implementation differ between Trusts. Recognising this, the TC team has secured project management support to help coordinate and drive improvement efforts.

This project will therefore focus on:

- Reviewing and standardising the Transitional Care guideline.
- Improving accuracy in data recording and collection.
- Ensuring consistent classification of TC babies across all care locations.
- Progressing towards full compliance with BAPM staffing standards.

Figure 3. Total number of 34-36+6 babies born requiring transitional care



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 4. ATAIN and TCU action plan

Actions from TC pathway /policy audits				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Nursing model to be reviewed and business case written to support greater nursing numbers in line with BAPM standards.	MPD	30/11/25		
Transitional care guideline to be reviewed, ensuring clear guidance as to those babies who are categorised as transitional care.	MPD	30/11/25		
In line with new guideline and BAPM guidance ensure that all TC babies are recorded appropriately on data systems	LB/CJ	01/11/25	Exploring ways of using Bager to record TC babies and their location more accurately. Badger training bites to improve accurate inputting of data	
Actions from ATAIN reviews for babies >37 weeks				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Update ATAIN meeting TOR as >3years old.	ATAIN group	August 2025	Terms of reference agreed	

8. 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:	4.7
Date of meeting:	8th January 2026		

Report tile:	Perinatal Quality Surveillance Report - Salisbury NHSFT Maternity & Neonatal services –**November 2025 (October 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	DMT – 13.11.25 Maternity and Neonatal Assurance Committee – 20.11.25 Clinical Governance Committee - 25th November 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. 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 October 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 1:33 (1:29 with bank)– SFT recommended ratio 1:24.
    - Increase in maternity leave rates (7.06 WTE).

  - Band 6 Midwifery vacancies (6.13 WTE).
  - Increased sickness absence rates.
  - 9 WTE B5 Midwives commencing in October (Non-supernumerary in November)
  - Staffing levels maintained by bank usage and use of escalation policy.
- 1:1 care in labour achieved 100% of time.
- Supernumerary status of Labour Ward maintained 100% time.

PMRT:

- 0 stillbirth in October 2025.
- October's stillbirth rate means SFT rate remains just over the National Stillbirth rate at 3.66 SB per 1000 births (national average 3.2 per 1000 births, national ambition 2.5 per 1000 births).
- 0 Neonatal death in October 2025.
- 0 cases for PMRT in October.

Incidents reported as moderate:

- 10 Incidents reported as moderate or above. Immediate review complete.
  - 2 Term admission to Neonatal Unit.
  - 3 x Low apgars.
  - 1 cord gases <7.
  - 1 Postnatal readmission.
  - 1 preterm baby transferred to tertiary unit.
  - 1 Failed TWOC.
  - 1 18/40 Miscarriage and secondary PPH.

Service user and staff feedback:

- Feedback to Executive and Non-Executive Trust Board Safety Champions at Safety Champions meeting re vacancy and sickness levels contributing to staffing challenges.

Training:

- Doctors training levels in safeguarding children reduced due to new trainees staring who are non-complaint. All booked onto future training and trajectory in place.

Compliance to National Standards:

- .Latest Saving babies lives submission (Q2 data) self-assessed as 87% - awaiting LMNS feedback.

Themes:

- Thematic reviews into Massive Obstetric Haemorrhage, OASi, shoulder dystocia and term admission to neonatal unit completed and learning shared.

Perinatal Quality, culture and leadership programme:

- Continuing with cultural work. The quad is working on an action plan related to staff feedback from the event on 19th September. Planning in place for future staff events over 2026.

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

Perinatal Quality Surveillance

November 2025 (October Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role

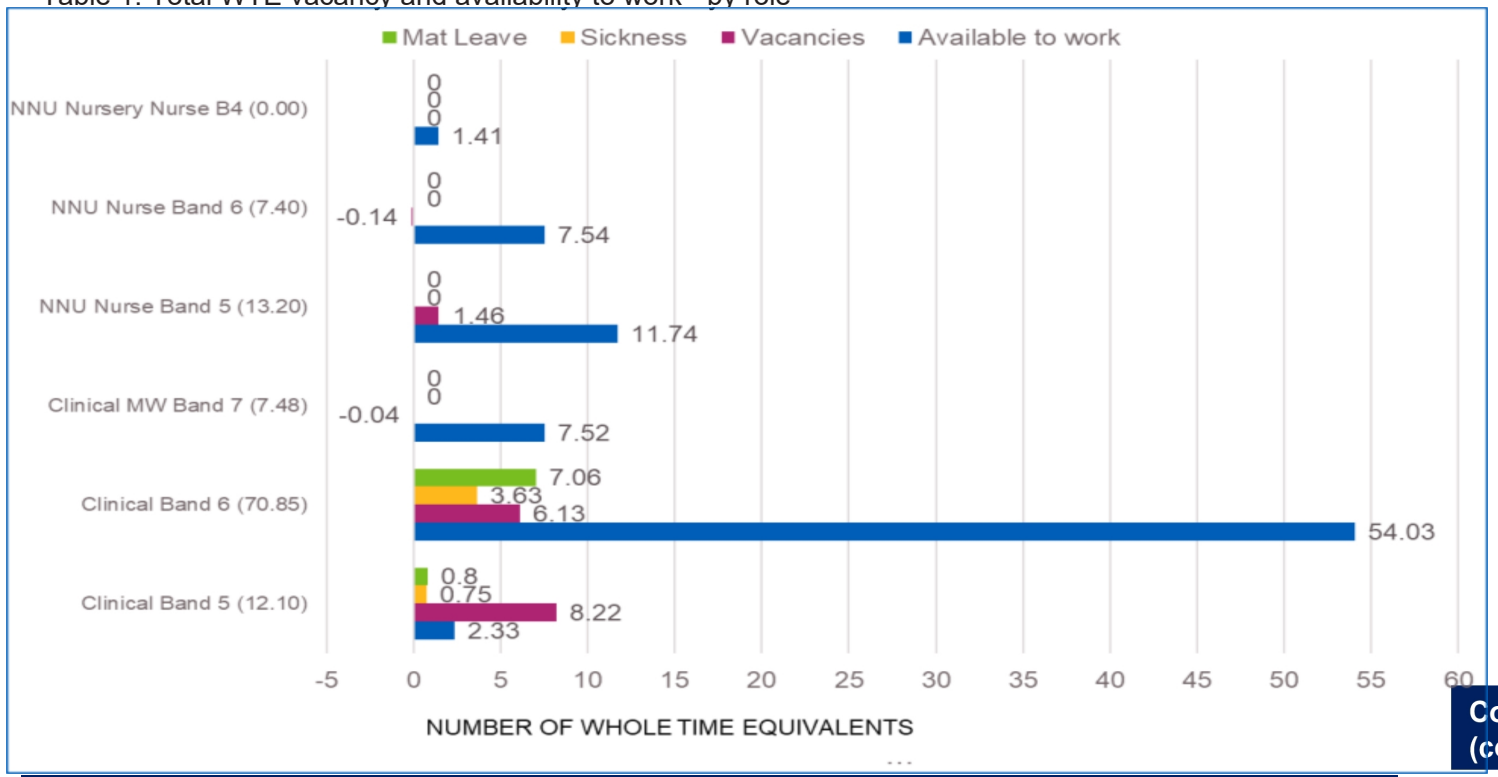


Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Aug'25	Sept'25	Oct'25
Midwives	Day	90.6%	91%	87.9%
	Night	93.8%	91.9%	93.9%
MCA / MSWs	Day	82.5%	78.8%	78.7%
	Night	93.3%	77.5%	84.9%
NNU Nurses	Day	92.8%	96%	98.1%
NNU Nurses	Night	98%	98.6	96.5%

Is the standard of care being delivered?

- Staffing vs acuity ratio was lower this month showing 86% compliance of required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Band 5 midwifery vacancies have increased as some have successfully achieved their Band 6 competencies and reduced the Band 6 vacancy. Some of the newly qualified Band 5 midwives start at beginning of next month (8.75 WTE) with a period of supernumerary, with 2 further WTE to start between now and January. Mitigations are in place with bank cover and robust escalation processes.
- Further Band 6 recruitment in process through WCP – see countermeasures
- MCA fill rates have improved in month due to impact of reduced sickness.

Countermeasures / Action (completed last month)	Owner
• MCA recruitment	MCA Lead

Countermeasures / Action (planned this month)	Owner
• Recruitment of Band 6 midwives (awaiting approval) • Recruitment Community MCA (awaiting approval)	Inpatient Matron Outpatient matron

Safe: Maternity & Neonatal Workforce (cont)

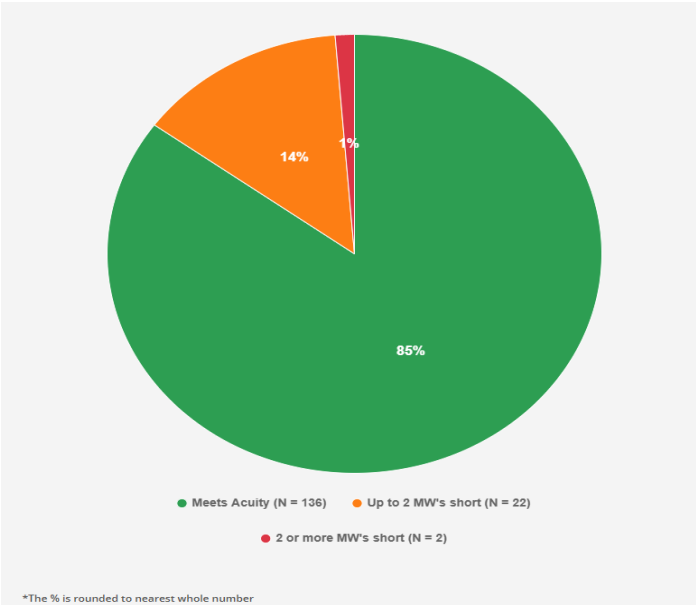
	Target	Threshold		Aug'25	Sep '25	Oct'25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1:30	1:35	1:33/ 1:29 (with bank)	Ratio decreased this month due to an increase in acuity, as well as maternity leave and increased sickness.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	81.7	87.78%	83.87	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	77.4%	71.67%	77.5%	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.
Neonatal Nursing shifts staffed to QIS standards	70%	>70	<70	96.7	88.3%	96.7%	BAPM standards define that 70% of staffing should be QIS trained.
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 maintained >70%. Activity being monitored and support given on a shift-by-shift basis to maintain safe care (evidenced by good adherence to QIS standards percentage).

What are the top contributors for under/over-achievement?
- The Midwife to Birth ratio increased this month due to decrease in acuity and births numbers.
- Acuity vs staffing increased due to decrease in acuity and birth numbers.

NHS Salisbury NHS Foundation Trust

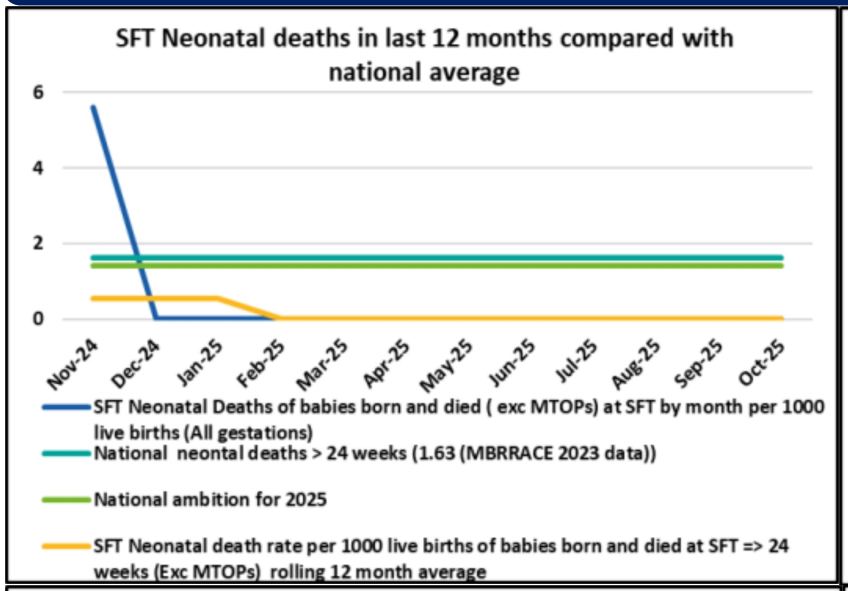
Graph 1. Acuity by RAG vs staffing data:

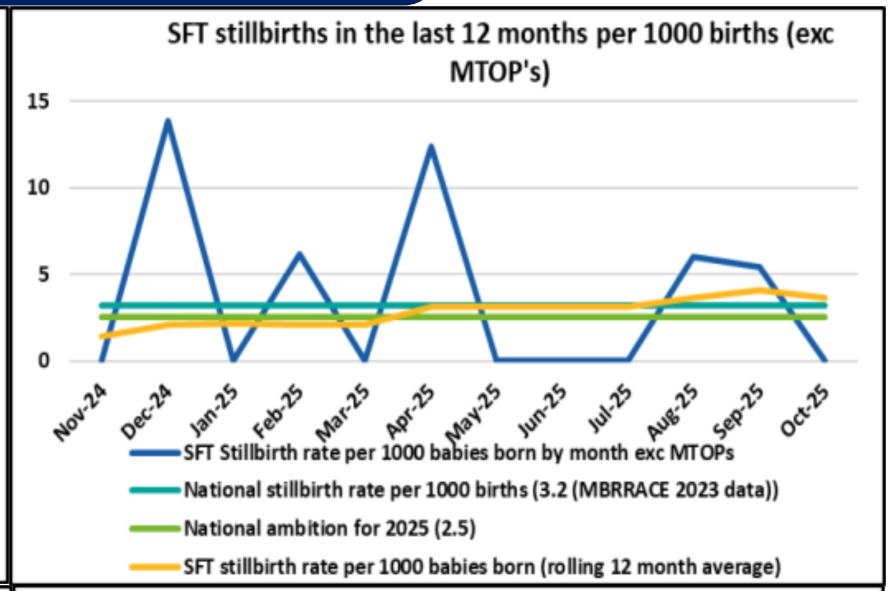


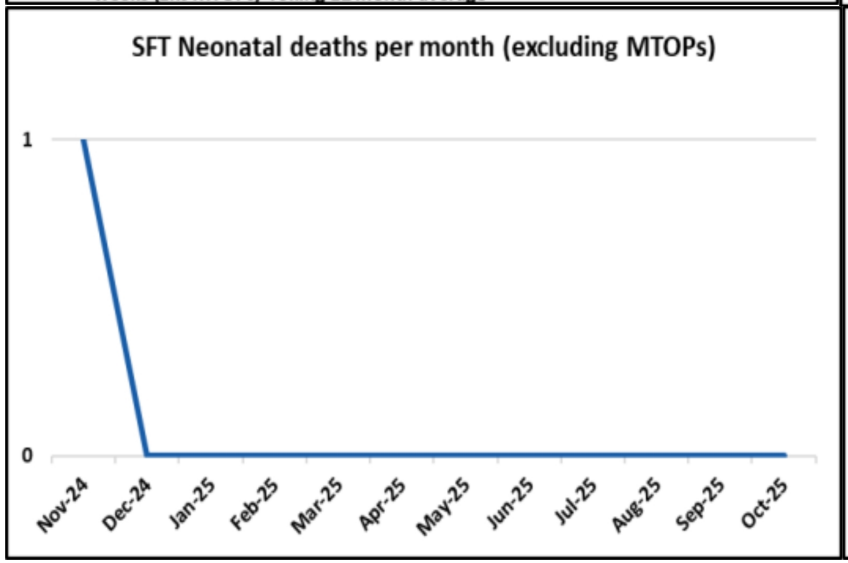
Countermeasures / Action (completed last month)	Owner
- Neonatal workforce review in line with BAPM standards data.	HoM/Neonatal Matron

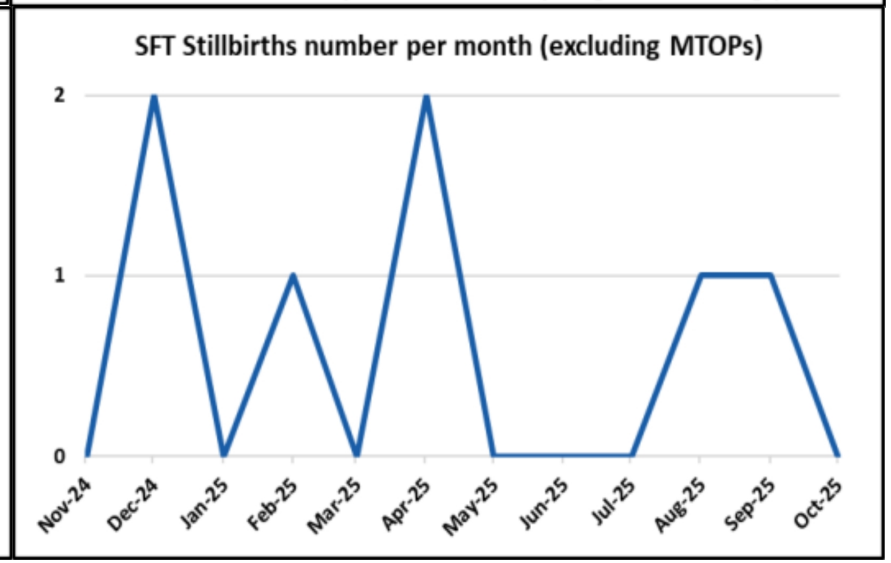
Countermeasures / Action (planned this month)	Owner
- Progression of Neonatal nursing business case	HoM/ MatNeo Operational Manager

Safe: Perinatal Mortality Review Tool (PMRT)









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- 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.
- The stillbirth rate for SFT in October is 3.66/1000 births. This has reduced from Septembers stillbirth rate however remains over the national stillbirth rate of 3.2/1000 births and the national ambition 2025 stillbirth rate of 2.5/1000 births.
- There were 0 perinatal losses in October >12 weeks.

PMRT grading of care – Key

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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
			There were no PMRT reviews in October		

INCIDENTS: Moderate Incidents and PSRs

DATIX Incidents classified as moderate harm and above at month end

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Case Ref (Datix)	Date of Incident	Category	Incident Summary	Comments	PSII Commissioned?	MNSI Referral?
181967	10/10/2025	Moderate	APGAR 5 @ 5 minutes	PSR 1 completed for presentation 04/11/2025	No	N/A
182023	15/10/2025	Moderate	Term admission to NICU	Datix proforma started – awaiting notes (ordered)	No	N/A
171362	20/11/2024	Moderate	Preterm baby transferred to tertiary unit	To discuss in Q&S MDT meeting 05/11	No	N/A
182137	10/09/2025	Moderate	18/40 loss and secondary PPH	To be reviewed by Bereavement midwife	No	N/A
182157	19/10/2025	Moderate	APGAR 5 @ 5 minutes	PSR 1 completed for presentation 04/11/2025	No	N/A
182159	21/10/2025	Moderate	Postnatal readmission ? sepsis	PSR 1 in progress	No	N/A
182385	28/10/2025	Moderate	Failed TWOC	To be reviewed by ward lead	No	N/A
182441	29/10/2025	Moderate	Cord gases < 7	PSR 1 completed for presentation 04/11/2025	No	N/A
182442	29/10/2025	Moderate	APGAR 2 @ 5	PSR 1 in progress	No	N/A
182494	31/10/2025	Moderate	Term admission to NICU	Awaiting review	No	N/A

*19 incidents were reported as ≥ moderate during October. All incidents have been triaged, reviewed and either reclassified as minor or no harm or, listed as above.

INCIDENTS: Investigation update

Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Datix	Date presented	Category	Incident Summary	Outcome / learning / actions
162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Draft Report updated following feedback. Awaiting final report

PSR's Submitted

Datix	Date presented	Category	Incident Summary	Outcome / learning / actions
181375	07/10/2025	Moderate	Emergency caesarean section birth (category 2) Term admission, HIE, transferred out for therapeutic cooling	Referral to MNSI – accepted for investigation. **Rapid MDT thematic review completed** during October with external input from RUH and GWH
108581	07/10/2025	Moderate	Shoulder dystocia and neonatal resuscitation at planned homebirth.	No omissions in care found – closed. Cord gases not taken, feedback provided to the midwives involved including positively for their excellent management of the obstetric emergencies.
179298	14/10/2025	Moderate	Spontaneous vaginal birth. 3a tear sustained – no episcissors available.	To be closed with actions – individual feedback and some actions for discussion with inpatient matron.
179518	14/10/2025	Moderate	Emergency caesarean section birth (category 2). Term admission, transferred out for management of nectrotising enterocolitis and surgery for volvulus.	PSR 2 commissioned. MDT meeting scheduled for 05/11, then for After Action Review.

INCIDENTS: Investigation update - continued

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PSR's Submitted

Datix	Date presented	Category	Incident Summary	Outcome / learning / actions
181787	21/10/2025	Moderate	Emergency caesarean section birth (category 2),	No omissions in care found – closed,
181315	28/10/2025	Moderate	Elective caesarean section birth. APGAR 6 @ 5 minutes, term admission to NICU.	No omissions in care found – closed.
181281	28/10/2025	Moderate	Emergency caesarean section birth (unsuccessful trial of instrumental birth in theatre) APGAR 4 @ 5 minutes, term admission to NICU.	No omissions in care found – closed.
180701	28/10/2025	Moderate	Emergency caesarean section birth (category 2), APGAR 6 @ 5 minutes, term admission to NICU.	Themes of CTG classification, escalation and the identification of infection. Similar themes to MNSI thematic review, no new learning. Closed with actions. Safety notice issued to staff regarding CTG review and documentation. CTG training has already been updated with more emphasis on the identification of infection. Escalation and hyperstimulation to be included in a planned 'Theme of the Week'.
180354	28/10/2025	Moderate	Emergency caesarean section birth (category 3). APGAR 5 @ 5 minutes, term admission to NICU.	Closed with actions. Individual reflective session planned with midwife. NEWTT 2 guidance in process. To consider guidance around trial off PEEP and observations following PEEP,
180147	28/10/2025	Moderate	Postnatal readmission with sepsis on day 3. Unreviewed pyrexia prior to original discharge home.	Closed with actions. Individual reflective session planned with midwife. Safety notice issued to staff regarding the importance of following guidance for actions and escalations post-MEWS observations.
176882	28/10/2025	Moderate	Emergency caesarean section birth (category 1). APGAR 5 @ 5 minutes, term admission to NICU, equipment problems in theatre,	Closed with actions. To discuss need for further oxygen cylinders in maternity. Lack of piped oxygen already on risk register. Safety bulletin issued to staff regarding the importance of documenting medications contemporaneously. Theatre team now aware how to pause 'checking mode'.

Responsive – Patient Experience

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MNVP Service User Feedback

Positive Themes:

- Great care from the Stonehenge team
- Exceptional kindness from Midwives
- Good support from homebirths and Ocean team
- NNU nursing staff described as proactive
- Great feeding support
- Calm and Friendly environment

Areas for improvement:

- Parents feels their concerns are sometimes dismissed
- Parents feel pressured to make decisions about IOL
- Other parents on BMW ward disturbed – snoring partners, loud phones calls
- Slow to respond to call bells
- ANC hard to find due to inadequate signage

Complaints and Concerns

Complaints received	Summary / themes
1	• Bladder care

Concerns received	Summary / themes
0	

Safety Champions

Concerns from staff	Action
• Vacancy and sickness/leave levels alongside high acuity in August and September have been challenging.	• 9 new preceptee midwives joining end of October (with 2 more in January) • Advert out and interviews in place for B6 midwives

Items for escalation...

- Ongoing support required for administration support in antenatal clinic – progressing slowly.

You said, we did...

- Vacancy and sickness/leave levels alongside high acuity in August and September have been challenging.
- 9 new preceptee midwives joining end of October (with 2 more in January)
- Advert out and interviews in place for B6 midwives

Friends and Family Test

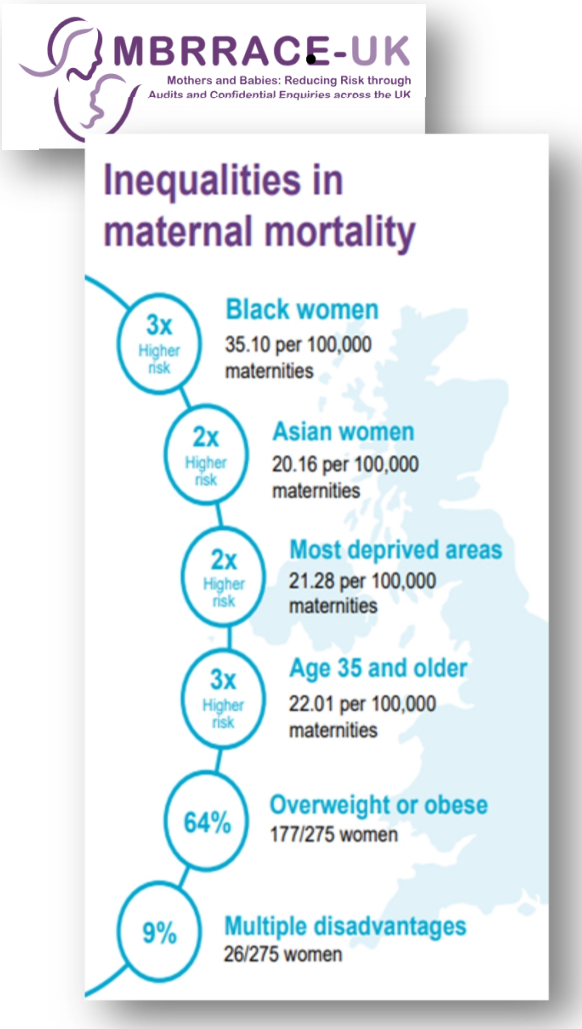
- **As Maternity Services moved to BadgerNet in February, this has had an impact on FFT maternity reporting during March - October 2025.**
- **2 responses in October with 100% positive rating**
- **No RTF undertaken October to report**

Service User Compliments

- **1 compliment reported on Datix in October for NNU and maternity services.**

Compliments - top themes	Numbers received
Gratitude	1

Health Inequalities – Priorities



Listening events: MNVP 15 Steps assessment was undertaken in June 2025 - Work commenced on the action plan.

Baby steps listening event concluded. Work ongoing RE the action plan.

Collaboration with external stakeholders :

- Refugee Resettlement and Migration Service
- MOD General Practitioner, Support Battalion REME- Military working group 2.

Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for the summer 2025, however; this work has been postponed until November 2025 . This will support targeted activities and bench-marking against national MBRRACE data.

Translation service:

- Translation tool bar- The project has been signed off. It is anticipated that the function will be activated in the next month.
- Implementation of Pocketalk: Launched on 27th October. In collaboration with WHI Insights team and Scale Innovation, Maternity and Neonatal service are engaging with the evaluation process.

Well-led: Training

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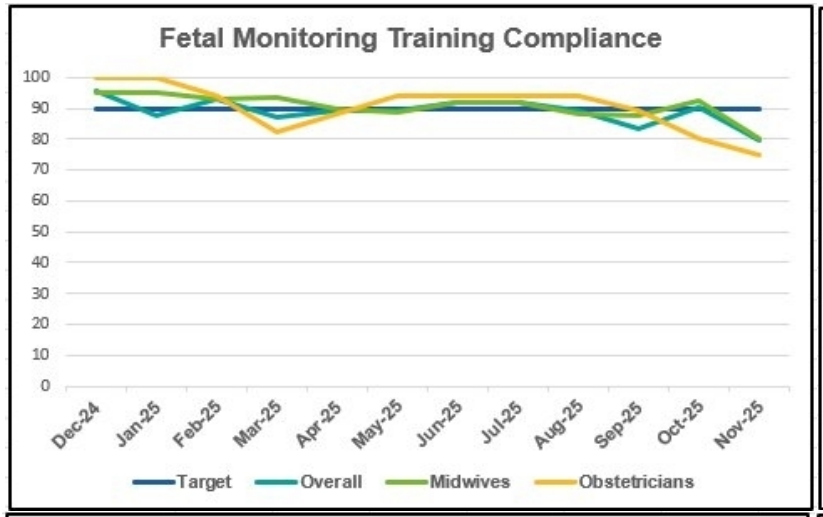
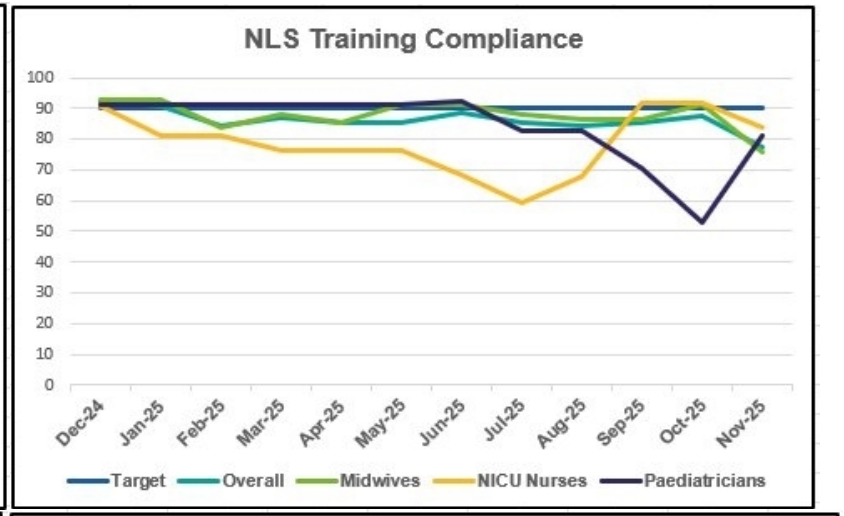
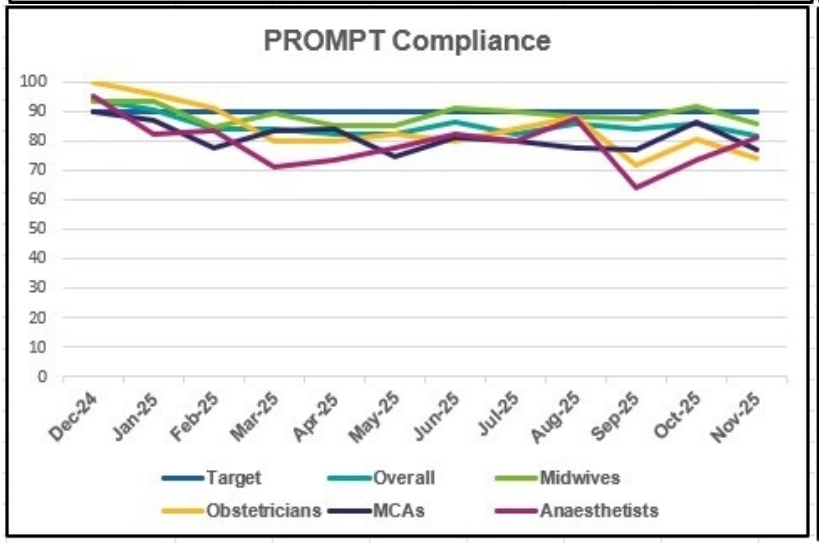
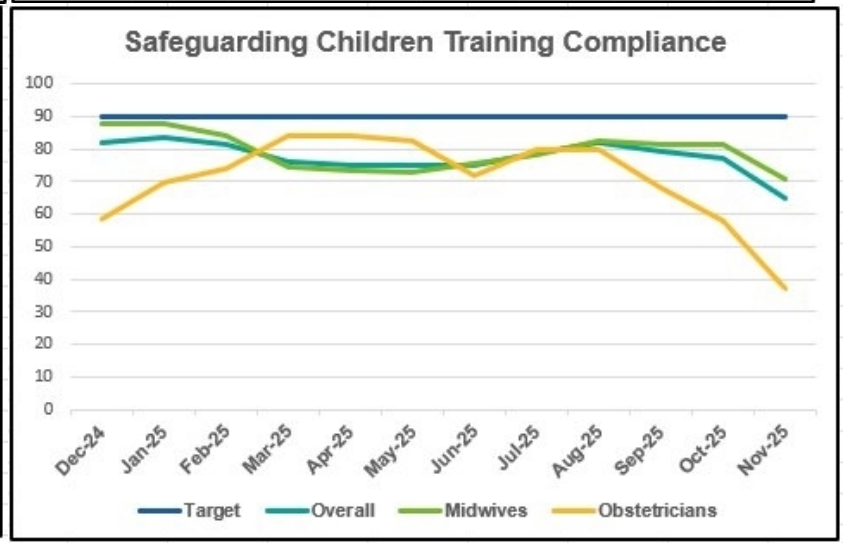








Training

New PROMPT programme was rolled out in September 2025. Content for the Maternity Study Day and Saving Babies' Lives Study day will be renewed in January 2026 in line with CCF V2.

Countermeasures/ action:

- All staff groups have adequate numbers booked onto the remaining PROMPT session on 10 November to meet 90% compliance.
- All outstanding obstetricians booked on to attend L3 Safeguarding sessions over the next 4 months.

Risks:

- No scope for any MSWs to DNA PROMPT – this will result in <90% compliance.
- Obstetric face-to-face SBL Elements training has been incorporated into rotating obstetricians' induction programme. Challenges remain in MSW compliance with SBL eLearning.
- Multiple changes in MSW workforce, plus high sickness levels has meant compliance has been difficult.

Compliance to National Guidance (1)

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.

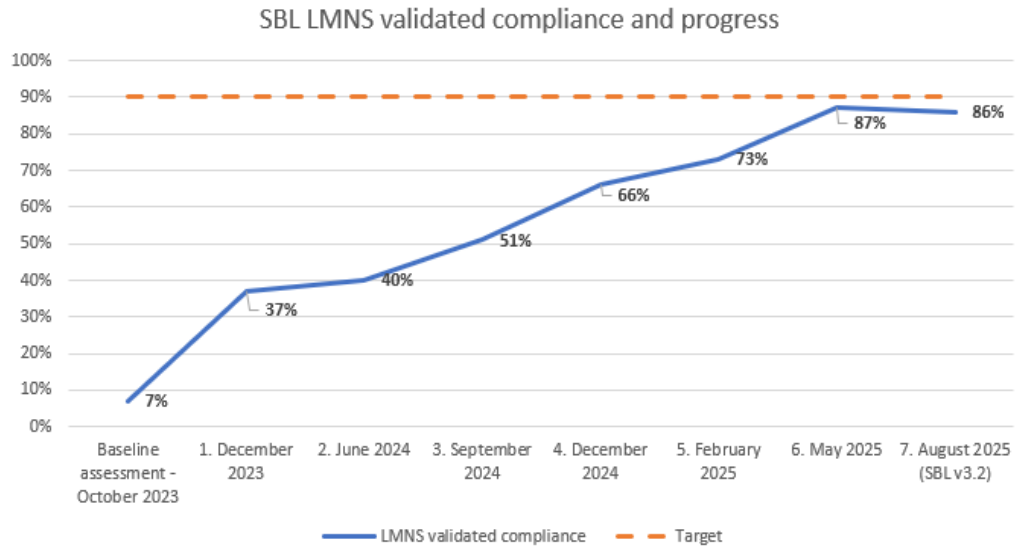
Next steps for progression:

- Continue to collate evidence required for the year 7 reporting period and work with action holders to ensure all reporting and evidence requirements are met. Meeting scheduled with NHS-R to first level verify evidence after reporting period.

Risks:

- Challenge with workforce review, and business case for paediatric medical workforce and timelines for CNST.
- Challenge with ensuring compliance of mandatory training, particularly for smaller staff groups.

Saving Babies Lives v3.2



Saving Babies Lives v3.2

Key Achievements:

- Updated SBL v3.2 implemented for the August evidence submission.
- Last LMNS validated compliance: 86% (August 2025 submission).
- November 2025 submission (Q2 data) self-assessed as 87% - awaiting LMNS feedback

Next steps for progression:

- Audit compliance challenges with BadgerNet: Mandatory fields have now been introduced. Audit leads to monitor compliance.
- SMART action plans in place for all non-compliant aspects SBL v3.2 implementation tool.

Compliance to National Guidance (2)

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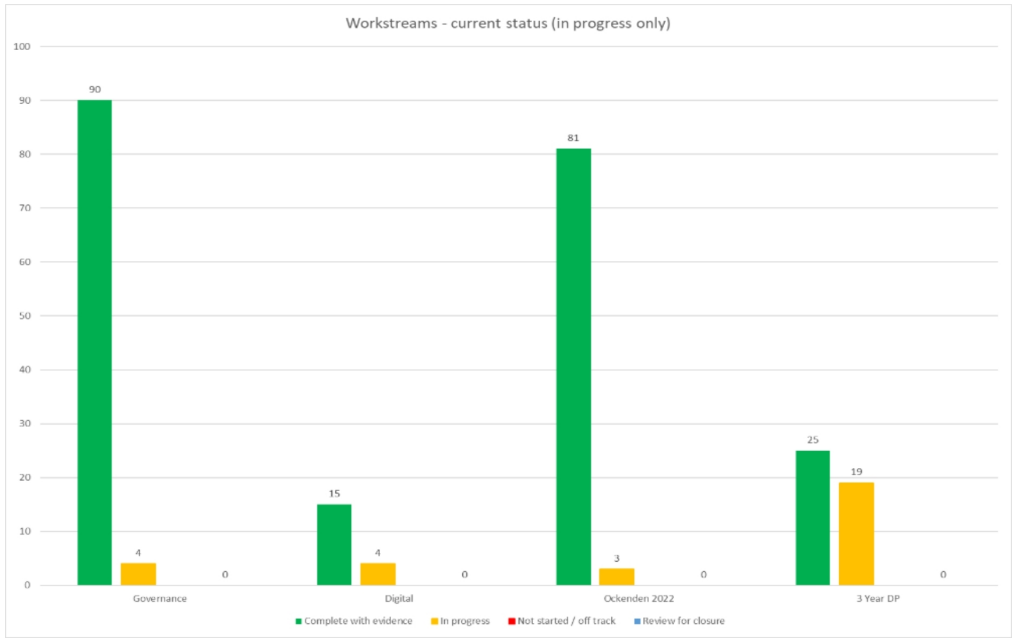
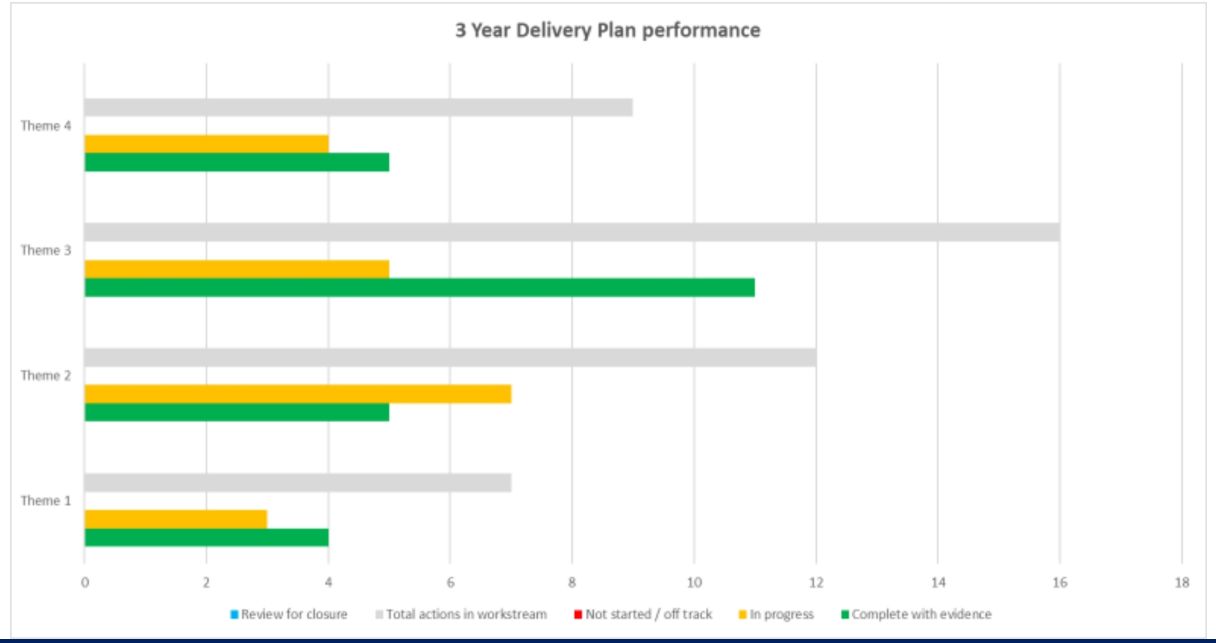
Maternity Improvement Plan



3 Year Delivery Plan



Maternity Improvement Plan

Key Achievements:

- Only 4 workstreams remain open currently.

Next steps for progression:

- Continue to focus on remaining 4 open workstreams; Governance, Digital, Ockenden 2022 & 3 Year Delivery Plan.
- Monthly working groups with a focus on the 3YDP to be established.

3-Year Delivery Plan

Key Achievements:

- Of the 44 actions; 25 have been completed.

Next steps for progression:

- Provide more targeted work on the 3YDP via the working group to increase sign off of actions.
- Work alongside RUH/GWH for shared learning of signing off actions.

Themes
PSIRF ‘continuous audits’ & DATIX

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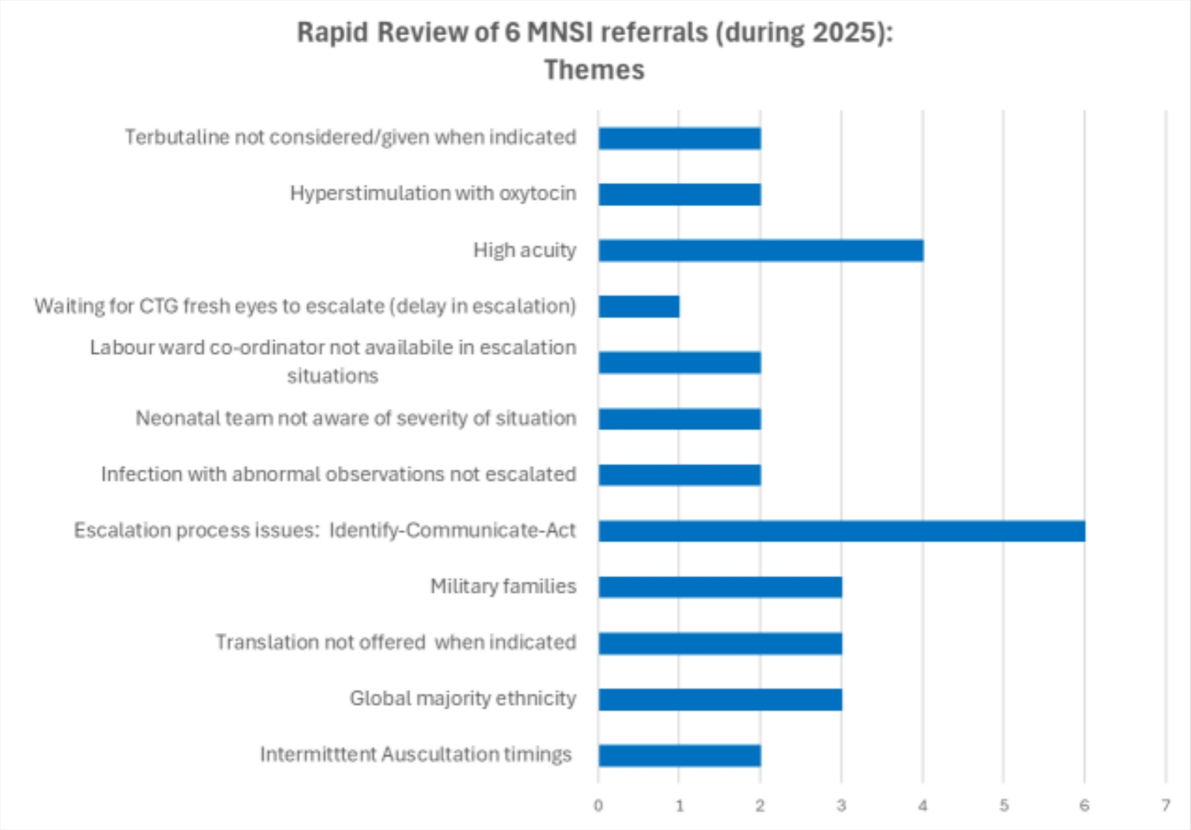
MNSI Maternity & Newborn Safety Investigations



Rapid Review - MNSI referrals

There was a significant increase in MNSI referrals during August and September.

- Two cases referred in August 2025
- Three cases referred in September 2025

A Rapid Thematic Review of all the MNSI referrals in 2025 (6 in total) was undertaken to include all referrals in 2025 in order to identify any themes and learning. The review involved a Multi-Professional Team with input from Senior clinical leads from RUH and GWH.

Interim results:

- Key themes were around health inequalities and translation services, high prevalence of military families, clinical escalation issues and fetal monitoring (see graph)

Proposed Actions:

- A number of actions have been drafted, this report is being circulated to members of the team who were not present at the meeting to review and comment. A final slide will be presented in the next PQS report

Unexpected Neonatal Admissions

Q2 July-September 2025/26

19 unexpected neonatal admissions

NHS Salisbury NHS Foundation Trust

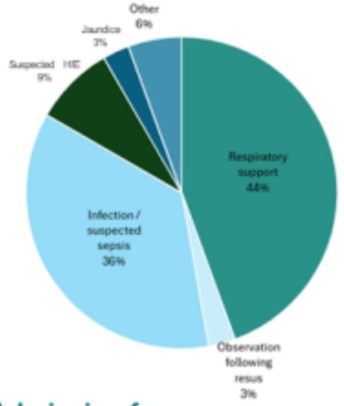
Learning identified: Datix

- 19 reported cases reviewed , 5 cases with identified learning

Themes:

- **Fetal monitoring issues:** CTG interpretation, documentation and escalation
- **Oxytocin and hyperstimulation** not managed correctly
- Students with **inappropriate supervision**
- **Cord bloods not taken** when indicated
- **Delays in care due to high acuity**
- **Documentation and escalation**
- **NEWTT 2 observations not completed** as per guidance

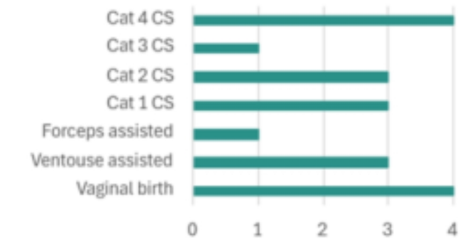
Reason for admission



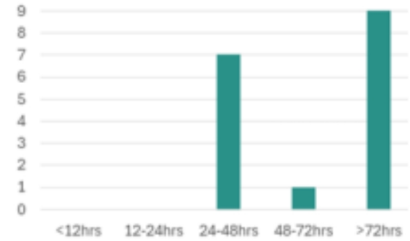
Admission from:

Data coming soon

Mode of birth



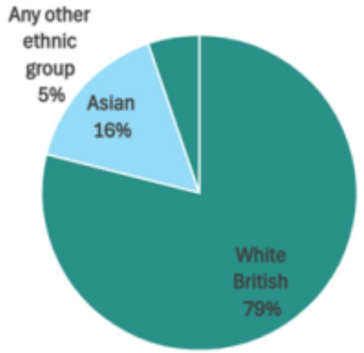
Length of stay



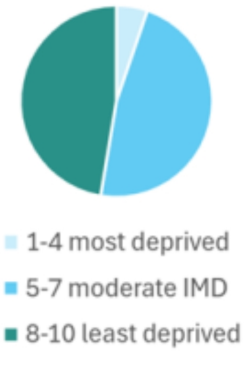
Ethnicity of mothers / birthing people

All term livebirths

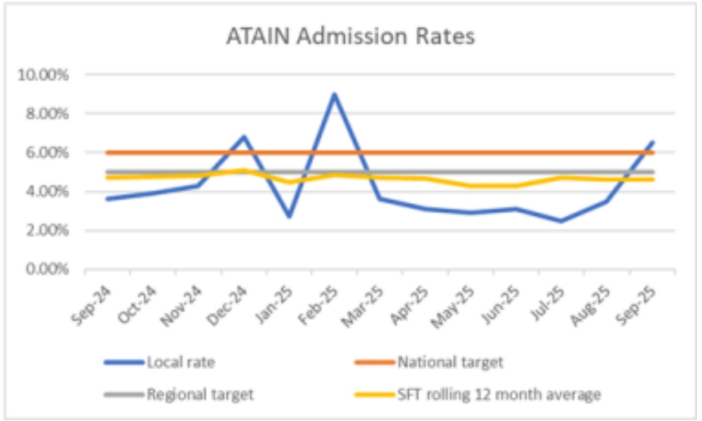
Unexpected LNU admissions



IMD deciles of mothers / birthing people (deprivation) whose baby was admitted to the LNU



Avoidable Term Admission (ATAIN) rate



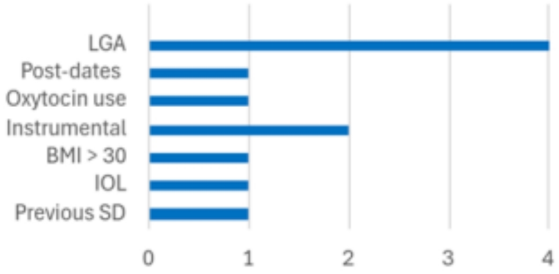
Shoulder Dystocia

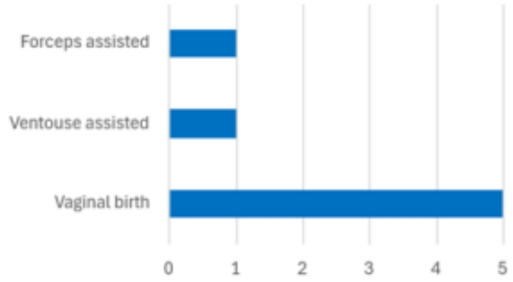
Q2 July-September 2025/26
7 Shoulder Dystocias

NHS Salisbury NHS Foundation Trust

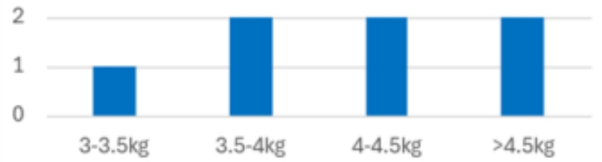
Learning identified
Datix
- 4 cases identified a theme of debriefs not taking place.
- Cord gases not completed in 2 cases.
- Proforma not used in 2 cases.

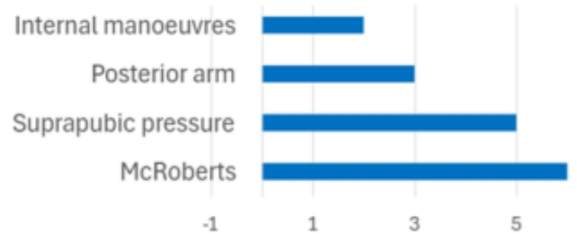
Themes
- **Cord bloods not being taken when indicated**
- **Emergency proforma not used** or scanned
- **Debrief not evidenced or did not take place**
- The average time for head-to-body interval was 2.5 minutes. The longest was 5 minutes.

Risk Factors


Mode of birth - numbers


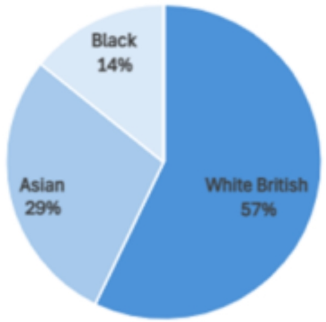
Proforn used


Birthweight


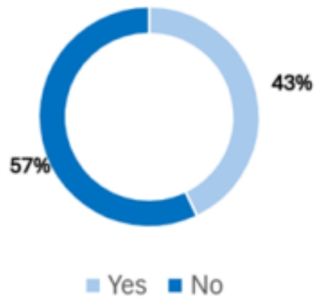
Manoeuvres required


Ethnicity of mothers / birthing people
All term livebirths | Shoulder dystocia

Data coming soon



IMD deciles (deprivation) of mothers / birthing people
whose baby was admitted to the LNU

NLS required


Obstetric Anal Sphincter Injury

OASI CARE BUNDLE

Q2 July-September 2025/26
12 Obstetric Anal Sphincter Injuries (OASI)

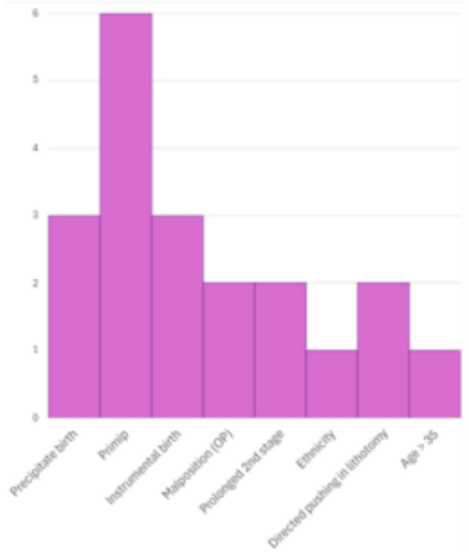
NHS Salisbury NHS Foundation Trust

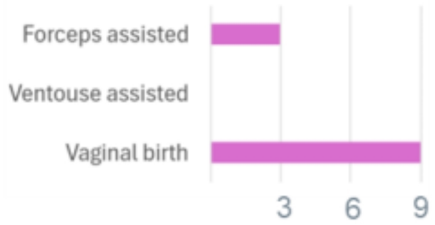
Learning identified
Datix

- 12 reported cases reviewed, 1 case identified learning – well done everyone!

Themes
- Equipment problems - documented that **Episcissors not available.** Please remember that **Mayo scissors can also be used** for an episiotomy if this is required
- Referral for **pelvic health follow-up missed**
- X2 precipitate births, **OASI bundle documented and implemented** in most cases

Risk Factors present in local cases for OASI.
* Be mindful of multiple risk factors and the increased risk these will have



Mode of birth


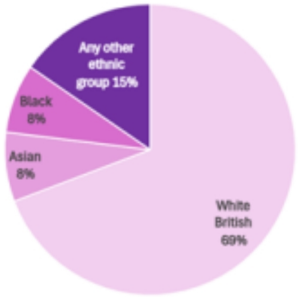
OASI care bundle provided and documented
Patient info, manual perineal protection, 60° episiotomy, perineum & PR examination

Type of OASI

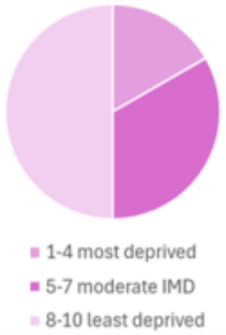

Ethnicity of mothers / birthing people
All term livebirths

OASI

Data coming soon



IMD deciles of mothers / birthing people (deprivation) who experienced an OASI



OASI rate (per 1000 births) – local vs national

Major Obstetric Haemorrhage

Q2 July-September 2025/26
14 Major Obstetric Haemorrhage (MOH) ≥1500mls

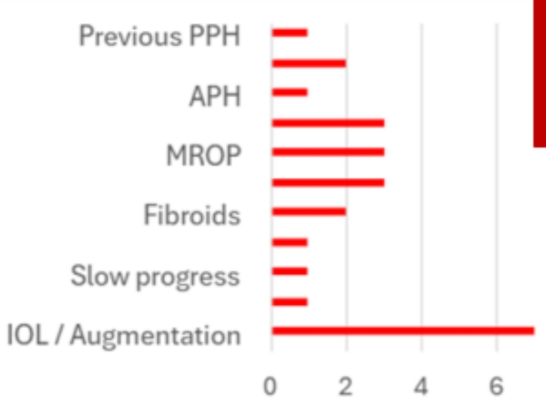
OBS UK Obstetric Bleeding Study UK

NHS Salisbury NHS Foundation Trust

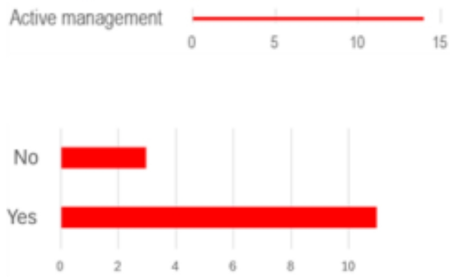
Learning identified
- 14 reported cases reviewed , most cases were well managed

Themes
- Generally **risk assessed correctly**
- Proforma not used consistently : sometimes **missing information, incomplete documentation.** Similar themes noted in Q1
- **Debriefing staff and parents** remains an improvement area from Q1

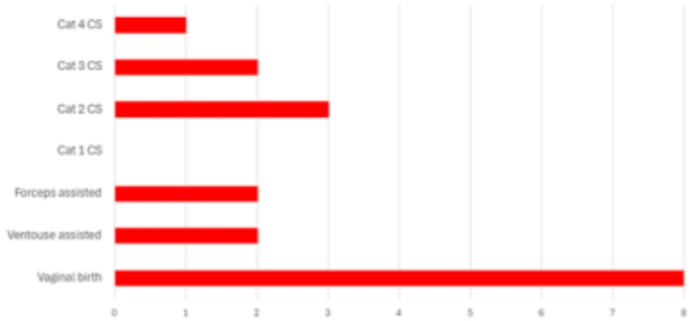
Risk Factors for PPH
Some women have multiple risk factors which increases risk



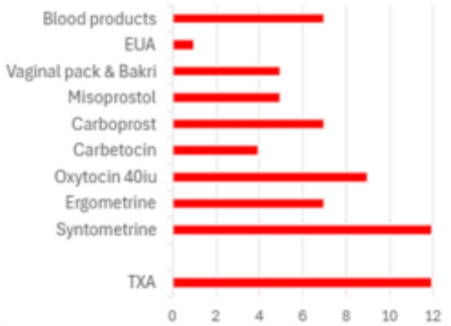
3rd stage management



Mode of birth - numbers



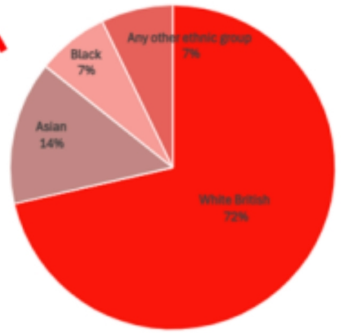
Management of PPH



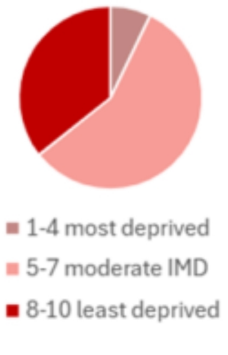
Ethnicity of mothers / birthing people

All term livebirths MOH

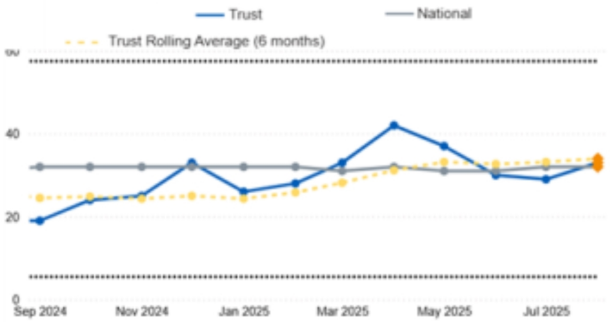
Data coming soon



IMD deciles of mothers / birthing people (deprivation) whose experienced an MOH



PPH rate (per 1000 births) – local vs national



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.
- A second staff event took place on Friday 19th September 2025; this had a focus on "Celebration" where different groups across Maternity and Neonatal services shared their successes over the last year. This was further supported by the MNVP representative who also shared women and service user feedback. All slides and information shared on the day has been cascaded to all staff groups for anybody who was unable to attend on the day.

Actions in progress:

- The Quad have reviewed and are working on an action plan related to staff feedback from the event on 19th September. Planning in place for future staff events over 2026.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.8
Date of meeting:	8th January 2026		

Report title:	Rapid Review of Maternity and Neonatal Safety Investigation (MNSI) cases January - September 2025			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes		Yes
Approval Process: (where has this paper been reviewed and approved):	DMT approval – 13.11.25 Maternity & Neonatal Assurance Committee – 20.11.25 Clinical Governance Committee- 25th November 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 report that has been provided in response to an increase in adverse outcomes for neonates that were eligible for referral to Maternity and Neonatal Safety Investigation (MNSI) between January and September 2025.

Executive Summary:

During August and September 2025 Salisbury NHS Foundation Trust (SFT) experienced an increase in cases of adverse outcomes of babies. These cases were eligible for referral to Maternity and Neonatal Safety Investigation (MNSI) for investigation. There were a total of 5 cases (two in August, three in September) and therefore a 'Rapid Review' of all cases referred to MNSI throughout 2025 was agreed.

This review involved external input from experienced senior clinicians across providers in Bath Swindon and Wiltshire (BSW) system. In total 6 cases have been reviewed; one case was rejected by MNSI and five cases that have been accepted for investigation. This has identified several themes and learning around non-English speaking service users and military families, fetal monitoring and clinical escalation.

Following the review of the six MNSI referred cases (one rejected, five accepted for investigation) several themes have emerged around health inequalities (three of six cases involving women from the global majority), fetal monitoring issues (All 6 cases) and clinical escalation issues (All 6 cases).

Whilst awaiting the conclusion of the MNSI investigation and final reports the team plan to continue to provide pastoral support for the staff involved in these incidents, work with both MNSI and families affected and, to ensure learning and actions are disseminated to the wider workforce.

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

Rapid Review of Maternity and Neonatal Safety Investigation (MNSI) cases January - September 2025

Executive Summary

During August and September 2025 Salisbury NHS Foundation Trust (SFT) experienced an increase in cases of adverse outcomes of babies. These cases were eligible for referral to Maternity and Neonatal Safety Investigation (MNSI) for investigation. There were a total of 5 cases (two in August, three in September) and therefore a 'Rapid Review' of all cases referred to MNSI throughout 2025 was agreed.

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In addition to the Rapid Review the Maternity and Neonatal Quality and Safety Team are meeting weekly with MNSI link for the Trust to support the MNSI investigations to be undertaken in a timely manner and to identify any additional staff support required. Both MNSI and SFT are working together to swiftly identify and share learning ahead of any final reports being published.

Background

In response to an increased number of cases being referred to MNSI a review has been undertaken with the aim of determining any themes and learning.

The review considered six cases and involved a multidisciplinary team involving two external Consultant Obstetricians and two internal Consultant Obstetricians, Internal and External Midwifery and Neonatal Matrons, Fetal Monitoring leads, Quality and Safety Team and Education lead Midwife.

The review took place over two days and utilised PSR reports and clinical records with consideration of the PSIRF 'Contributory Factors Checklist' and the 'DuPont's dozen' for human factors.

Findings

The following cases have been reviewed:

February 2025 (one case)

1. This case involving a baby born at 37+4 weeks by emergency caesarean section during which there was an impacted fetal head.
   This baby was diagnosed with **Hypoxic Ischemic Encephalopathy (HIE) grade 2** following concerns at 24 hours of age**.**
   This case was referred to MNSI but was not accepted by MNSI. A Patient Safety Review (PSR1 & 2) was completed.

August 2025 (two cases)

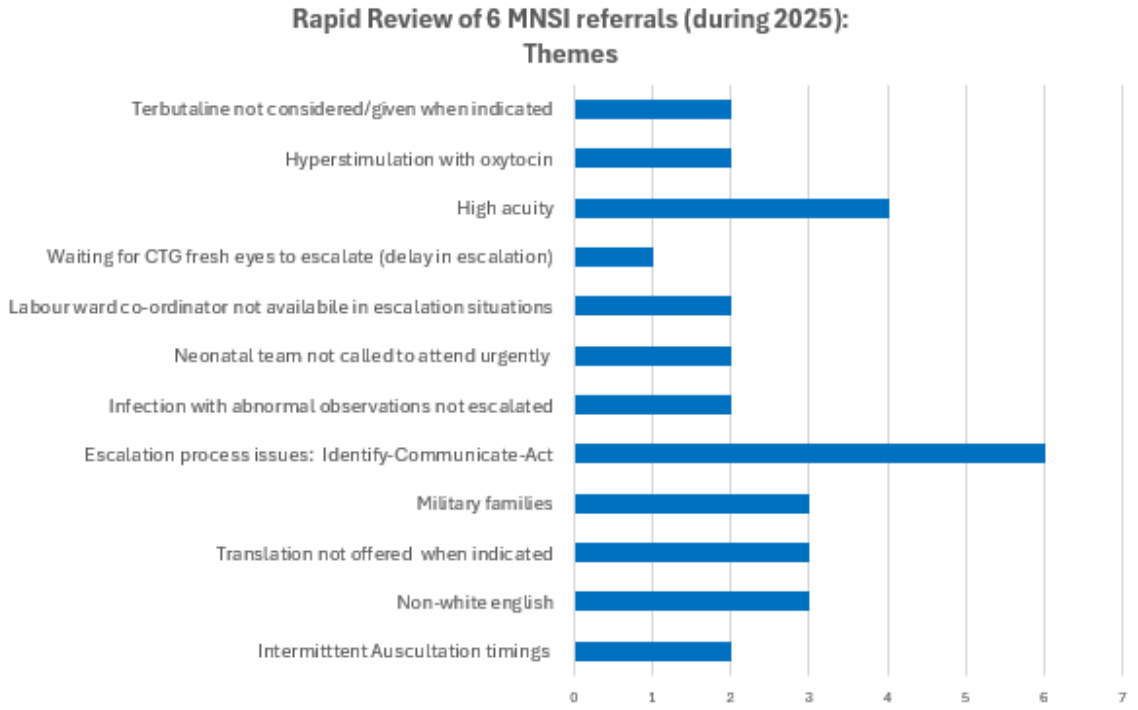
2. One baby was 39+6, born by ventouse delivery. This baby was transferred to the local tertiary centre for therapeutic cooling following resuscitation.
   This baby was referred to MNSI and the referral was accepted.
3. One baby was 37 weeks, born by emergency caesarean section.
   This baby was transferred to the local tertiary centre for therapeutic cooling following resuscitation. Diagnosis **HIE Grade 2 and sepsis.**
   This baby was referred to MNSI and the referral was accepted.

September 2025 (three cases)

4. One baby was 41 weeks and 1 day, born by Nevelle Barnes forceps.
   This baby was transferred to the local tertiary centre for therapeutic cooling following resuscitation.
   This baby was referred to MNSI and the referral was accepted.
5. One baby was stillborn at 40 weeks and 1 day following diagnosis of intrauterine fetal death in early labour.
   This baby was referred to MNSI and the referral was accepted.
   This case is also included in the stillbirth review undertaken by SFT.
6. One baby was 41 weeks and 4 days, born by emergency caesarean section.
   This baby was transferred to the local tertiary centre for therapeutic cooling following resuscitation. **HIE grade 3 is suspected**.
   This baby was referred to MNSI and the referral was accepted.

Thematic Review Findings:

Summary



Non-English speaking service users and military families

- Military families: three of 6 cases were military families
- Ethnicity: three cases of 6 cases involved mothers from the global majority
  Two of the mothers were Asian, one mother was Fijian. The remaining three mothers were white. It was identified that not all mothers were offered translation services (interpreter) when it was indicated and it was not offered consistently at appointments.

As part of this rapid review the MDT sought clarification re current local demographics. The maternity services dataset reports the percentage of mothers who birthed at SFT who have identified as Black or Asian or Mixed ethnicity between Oct 24- July 25 was 12%. 73% were white, 7% not stated/ data missing. There is no data available after July 25.

This data highlights a potential disparity (12% of local population) when compared to the group of mothers from the global majority involved in this cohort reviewed (50%). Albeit the numbers of cases reviewed is small (six cases), this represents a significant disparity and was also recognised in the recent stillbirth thematic review.

Fetal monitoring and clinical escalation.

- Intermittent auscultation: in two cases (33%) frequency of intermittent auscultation in early labour was outside of local and national guidance
- CTG concerns in all cases (100%) regarding various issues including:
  - Not identifying fetal deterioration / interpreting correctly / using the correct tool to interpret

  - Not escalating concerns in a timely manner / waiting for next fresh eyes rather than escalating when indicated
- Escalation concerns in all cases (100%) regarding various issues including:
  - Continuous fetal monitoring (CTG) concerns
  - Observations outside of normal range being normalised and not being escalated when observations deteriorate further/ delivery not expected as plans in place for delivery pre labour.
  - Informing the neonatal team of urgency of situation / CTG concerns
  - Labour Ward Coordinator not being available to escalate to as supporting other staff (two cases) – no bleep or mobile to locate team
  - Not using the emergency buzzer to escalate
- Communication concerns:
  - Closed loop communication not being used
  - Wrong information on 2222 calls

Additional factors:

- High acuity: in four cases (66%) acuity was high on review of the BirthRate Plus tool. In one case acuity was amber and in one case acuity was not recorded. This contributory factor can impact on decision making when it is busy and potentially stressful for individuals and teams.
- Assisted births (incidental finding): two assisted births were undertaken by a resident junior doctor (SHO) - this was thought to be appropriate in one case and not appropriate in the other case due to urgency of situation.
- Documentation (incidental finding): In some cases, there was incomplete/ minimal/ no documentation or no narrative in which made it difficult to understand rationale and decision-making or to understand any barriers / pressures around providing care.

Actions

Maternity and Neonatal Services recommended actions:

- Re-run an adapted Royal College of Obstetricians and Gynaecologists (RCOG) escalation tool kit campaign (Labour Ward Coordinator)
- Initiate a multidisciplinary 'task and finish' group to lead on some of these plans.
- Re-design of labour ward communication boards with emergency contact details / 2222 posters.
- Explore the possibility of the Labour Ward Coordinator holding a bleep to increase accessibility and for maintaining situational awareness.
- Implementation of centralised fetal monitoring (surveillance) – 17.11.25
- To heighten staff awareness re undertaking fetal monitoring risk assessment on Badgernet and, a workforce reminder that Badgernet does not fully align with local and national NICE guidance around certain parameters with CTG categorisation.

- To work with Badgernet digital lead to escalate nationally re correct CTG interpretation tool (aligned to NICE) and, language for Antenatal CTG interpretation
- Training opportunities: To increase CTG training opportunities via masterclasses (TNA funded) - 1 day for MW's, 2 days for LW coordinators and consultants. A training plan will need to be developed and agreed re-funding and release staff for this training.
- To increase understanding of health inequalities locally regarding ethnicity and military families and associated poorer outcomes. This includes understanding barriers to use of interpreter services and accessibility of patient information for users. Set up EDI working group?
- Acuity was a factor in 4 of 6 cases. To develop and agree an action that supports a review of particular acuity issues and any potential learning around this

Review staff support/education and processes:

- Labour Ward Coordinators/ Duty Managers to have training on hot debriefs to support staff and prompt identification of systems learning
- TRIM process to support staff to be reviewed by Professional Midwifery Advocates (PMAs) and Head of Midwifery & Neonatal services (HoM).
- PMA team to arrange and lead on cold-debriefs
- Session for staff to learn about MNSI process and can ask questions, this will be recorded and made available to all staff. (In place)
- Skills workshops running bi-weekly by education team on NLS, cannulation, CTG interpretation, suturing (In place)

Sharing learning

The findings of this review have been shared with the external reviewers involved in this review. This report and its findings will also be shared within the department via Maternity Risk and Governance Group and externally with the LMNS to support wider sharing of learning and provide assurances around the implementation of actions.

Trust wide: To support the maternity and neonatal teams to implement the suggested actions from this review, ensuring timely and robust learning and system changes are imbedded to continuously improve delivery outcomes.

Conclusion

Following the review of the six MNSI referred cases (one rejected, five accepted for investigation) several themes have emerged around health inequalities (three of six cases involving women from the global majority), fetal monitoring issues (All 6 cases) and clinical escalation issues (All 6 cases).

Whilst awaiting the conclusion of the MNSI investigation and final reports the team plan to continue to provide pastoral support for the staff involved in these incidents, work with both MNSI and families affected and, to ensure learning and actions are disseminated to the wider workforce.

To support the implementation and embedding of actions a multidisciplinary working group is to be established to promote engagement and support further actions to be developed and embedded.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	8th January 2026		

Report title:	Digital Plan Annual Update			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Russell King, Head of Digital Business Management Jon Burwell, Chief Information Officer			
Executive Sponsor: (presenting)	Jonathan Hinchliffe, Chief Transformation and Innovation Officer			
Appendices	None			

Recommendation:

Trust Board is asked to note the contents of the report.

Executive Summary:

This report summarises the progress against the Trust's Digital Plan over the last 12 months. The majority of the workstreams expected to commence in 2025/26 are now underway, however the report highlights some workstreams were either due to capacity or a change of strategic direction, have not commenced, paused or stopped. Most of these are due to having a significant dependency with the new EPR programme

The report highlights a range of wider programmes of work that have completed over the last 12 months and the programmes that are currently in progress. Where possible the Trust continues to work with ICS partners to standardise solutions and ways of working, helping build resilience between the digital teams. This has become increasingly important with the formalising of the Hospitals Group and the expected migration to a single digital function across the Group with the initial phases expecting to complete by March 2026. The convergence of digital technology and infrastructure are critical enablers to create a comprehensive single digital function. The majority of wider corporate service also require digital enablers to support realising opportunities at Group level. There continues to be a stronger emphasis on understanding the benefits that technology has enabled and the report covers examples of this.

All programmes have been prioritised through the Corporate Projects Prioritisation Group. Digital Steering Group still oversees the delivery of Digital Programmes and considers how any new requests fits in with the

Digital Plan's priorities and expected outcomes. This is the final year of the Trust's Digital Plan with the current expectation that a single digital strategy will be developed as part of the enabling strategies to deliver the Group strategy. This is expected to be complete around April 2026.

Alongside progressing the implementation of the new EPR programme, the next 12 months will see a focus on finalising plans for improving digital literacy, improving digital inclusion and data alignment across the BSW Hospitals Group.

The main risks to the plan are available funding and the capacity of staff to engage in the digital agenda. Given the dependency of the EPR programme on most digital programmes, any delay or change in scope could have a significant impact on wider delivery and priorities. The EPR programme is currently being reset and then the overall digital roadmap will be updated.

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):	

Digital Plan Update - November 2025

1 Introduction

This report summarises the progress against the Trust's Digital Plan which was signed off in November 2022. The Plan is split into five priorities:

- Our Electronic Patient Record
- Digitally enabled partnership working
- Supporting the people we serve
- Empowering a digital workforce
- Modern and Secure Infrastructure

The delivery of the activities with the Digital Plan is overseen through the Digital Steering Group. Digital Steering Group monitors progress against existing digital programmes alongside approving that new digital programmes align with the Digital Plan. The governance around prioritising transformation resource for programmes of work is managed through the Corporate Projects Prioritisation Group (CPPG).

The primary focus for digitally for the Trust is now the programme to replace Lorenzo Electronic Patient Record (EPR) with a combined single instance EPR across BSW Hospitals Group. This programme commenced in August 2024, with the full business case (FBC) approval nationally in March 2024 (originally planned for late 2023). The programme is in a period of review and reset to ensure it is set up in a manner to successfully deliver and realise the benefits outlined in the FBC.

The national funding available for the EPR Programme included funding for enabling infrastructure, is predominantly upgrading the current wireless network to a modern environment. The Digital Steering Group signed off the networked infrastructure improvement plan in 2024 with phase 1 of this partially being funded through the EPR Programme and phase 2 through the 2025/26 capital plan. The remaining phases of the plan will be completed as capital funding becomes available however the existing wireless network has already been confirmed as EPR ready, the improvements will bring the Trust to industry standard and in line with ICS peers.

To ensure successful EPR delivery, there is an expectation that transformation programmes that are not essential will be paused/stopped unless they are required to deliver breakthrough objectives or key elements of strategic initiatives. Where new initiatives are progressed, there will be careful planning in conjunction with the EPR programme team to ensure they complement one another, there is no risk introduced without approval and there is sufficient capacity to successfully complete the new initiative.

2 Project and Planned Work Progress

The table below outlines the major workstreams within the Digital Plan that were anticipated to be completed in 2025/26, alongside any workstreams that remained in progress at the last annual report in November 2024. Many programmes of work run over multiple years and have a range of activities and milestones within them as can be seen in the overall plan on a page in Appendix 1.

Workstream	Status	Update
Our Electronic Patient Record		
New EPR programme	In Progress	Commencement of the programme in August 2024, with programme now in a period of reset to ensure

		programme delivers successfully. Go Live to be confirmed post review in Q3 2025/26.
Paperlight electronic bookings in Lorenzo	Complete	
Digitally enabled partnership working		
Integrated digital care record (ICR), expansion of shared content	Complete / In Progress	The ICR is now live and embedded across the ICS, holding a range of key information across multiple Health and Care settings. Digital Respect forms went live in the ICR over the last year and HCRG (new community provided are being onboarded.
Cloud Power BI	In Progress	With the delay in moved to a single Business Intelligence function across the three Acute Trusts (proposed in November 2023), this was paused over the last 12 months. The updated convergence proposals will see the Trust converge onto a single Power BI across the Hospitals Group but is subject to approval in line with the Corporate Services Review.
Procurement of archiving solution	In Progress	This has been procured jointly across the Hospitals Group, with go live in tandem with the EPR Programme. The convergence of the existing solution (CITO) into the new archive will commence post EPR go live as a phase 2 programme.
GP order comms replacement	In Progress	This programme was paused for completion post EPR. However given the delay in the programme, a review is underway with the supplier to consider if it can be complete in 2026 calendar year, before the new EPR go live.
Standards based regional image sharing	In Progress	The West of England (WoE) implementation of a regional PACS is underway with go live expected in early 2026/27. The Trust has moved clinical networks given its mature strategic partnership with the SWASH PACS consortium and will work with the WoE network to ensure learning from SWASH can support the WoE go live. Consideration of how best to sharing images across SWASH and WoE in a cost effective manner is being discussed.
Digital Histopathology rollout	In Progress	The programme is commenced in Q2 2025/26 and will be extended to all clinicians across 2026/27 now that the Pathology LIMS has been replaced.
Implementation of a BI Portal	Complete	
Adoption of SNOMED CT via new EPR implementation	Paused	The programme to improve the use of SNOMED CT coding will form part of the post go live EPR transformation once it is clear when go live will be.
Supporting the people we serve		

Maternity and Cancer PHR pilots	Complete	Both Maternity (BadgerNotes) and specific Cancer services have access to a personal held record which are now being embedded in clinical practice.
Virtual appointment rebooking	Paused	This has been paused due to challenges with interoperability with the existing EPR supplier. This will be completed post new EPR go live.
Online resources to support patients and wayfinding	In Progress	A solution for digital signage and digital communications (SnapComms) has now been rolled out. Digital wayfinding will be considered as funding allowed and is subject to prioritisation.
Expansion of Digital Improvement Network to include patients	In Progress	The Digital Improvement Network will continue to be built upon as part of the EPR Programme, with the intent to have patient engagement governance to support hearing the patient voice in the evolution of this programme. The Trust, in conjunction with the ICS, now engages with the council run “Get Connected” groups.
Patient access to digital devices	In Progress	The Trust continues to provide access to devices as requested by wards, alongside supporting patient Wi-Fi availability. The current direction for estate refreshes is to ensure Wi-Fi is industry strength and can support patients bringing their own devices in wherever possible, given this is largely the access needs requested. Some areas are exceptions such as the Spinal Unit.
Expansion of PHR and patient portal linked to the new EPR	Not commenced	Given the delay in the EPR programme, the future plan and design of PHR has been paused until after EPR go live with existing contracts extended.
Empowering a digital workforce		
Digital Maternity – Badgernet EPR	Complete	
Medical eRostering roll out	In Progress	Deployment is underway, having commenced later the planned.
Online corporate filing structure	Paused	Currently this is paused whilst the ICS awaits further guidance from NHS England on the Shared Tenant access controls to provide greater assurance that the proposed approach is viable.
Pathology LIMS	Complete	
Digital literacy support roll out	In Progress	This programme has now been aligned with the new EPR programme, with a proposal on how best to re-baseline staff digital literacy and provide appropriate support being written for Q4 2025/26, led by Chief Nursing Information Officers. The Trust’s digital learning microsite has been expanded to support new technologies. Guidance for the use of AI goes live in Q3 2025/26.
Digital Consenting solution	Not Commenced	This product will be reviewed post EPR Go Live, considering the options of extending out the RUH solution or reviewing the market as one.

Expansion of RFID	Complete	RFID has been expanded in medical devices as appropriate, with alignment of technology being reviewed across the Hospitals Group
Modern and Secure Infrastructure		
Virtual Smartcards/Authentication	In Progress	The new authentication approach being rolled out (CIS2) nationally has commenced with the Trust largely compliant. Future smartcard provision is being closely monitored with technology such as self-service password reset part of this.
Approval of Trust cloud strategy	In Progress	An ICS Cloud Strategy was agreed in 2024 with a "cloud appropriate" approach when developing business cases. Moving to the cloud will be on a case by case basis for applications currently. A cloud landing platform has been launched across the Hospitals Group. The Trust is about to commence an assessment of infrastructure to consider how the Hospitals Group can converge data centres and consider the further use of cloud infrastructure.
Data Warehouse migration complete	In Progress	After significant delay, all reporting is expected to be migrated to the new data warehouse by December 2025. A review of future provision needs as a Hospitals Group is underway to ensure plans align with required outcomes.
Phase 1 network refresh	Complete	Phase 1 of wireless network plan has been completed alongside network refreshes aligned with wider programmes such as Imber and Maternity. The approach to network refreshes allows for a modular refresh approach so that it can be flexed depending on capital provision.
Datacentre Hardware Replacement Project	Complete	
Unsupported Server Programme	In Progress	This is largely expected to complete for the existing unsupported servers in 2025/26 with the next cohort of servers expecting to go end of support in the next 12 months being reviewed to ensure the Trust maintains compliance going forwards.
Phase 2 Wi-Fi improvement	In Progress	This is being completed in 2025/26 with the scope structured to fit within the available financial envelope.

2.4 Other Project and Planned Work Completed

There are a range of wider projects and planned works in progress across the Trust. The following have also been completed during 2024:

Projects and Programmes
Pathology MES roll out of managed equipment
Windows 11 implementation, roll out & upgrade
Lille (Sexual Health) System upgrade
Theatreman to Aqua system upgrade
Wayfinder – NHS App – Phase 2
Optimisation of Clinical Digital Administration Processes (letters)
Auditbase (audiology) System upgrade
AOVPN Roll Out
Extension of the use of the Federated Data Platform
TPP View Upgrade
ODP – Digital Files
Occupational Health IT System replacement

2.5 Projects & Planned Work In Progress

The table below summarises the list of planned key activity items/projects that are either already in progress or due to commence over the next 12 months, recognising the EPR programme should mean that digital transformation significantly reduces.

Projects and Programmes
Pathology LIMS upgrade
GP Order Comms – Replacement
Voice Recognition Software (subject to business case approval)
ECGs storage in PACS (subject to Capital availability)
Continue the extended use of the Federated Data Platform as an incubator
PACS Based reporting
Corporate Services Service Management Tool replacement (currently House on the Hill)
Learning Management System (LMS) replacement (currently MLE)
Bleep replacement (subject to business case approval)
iRefer rollout
Ambient Voice Technology Pilot (further roll out subject to business case)
Group Dashboard Alignment
Theatres Connectivity improvement programme
Outpatient Check In Kiosks
Outpatient Room Booking (FDP)
IBD Patient Initiated Follow Up/PHR (subject to business case approval)
Electronic Dental referrals
NHS APP eRS Dr DR Integration

Spec Ops technology extension
Medilogiks Urology and Respiratory extension (subject to business case approval)
Aria upgrade (subject to funding approval)
Friends and Family solution replacement (subject to funding approval)
CoPilot (shared tenancy) pilot
Pockettalk AI (subject to funding approval)

3 Benefits realisation

Over the last 12 months there has been improvement in monitoring the benefits from transformation enabled by delivery digital programmes. Some examples are as follows:

Programme/Project	Benefits Realisation
Pathology LIMS – replacement of core Pathology Laboratory system	Replacement of Salisbury's aging core pathology system with WinPath enterprise, delivered on a single database network solution, across the Southern Counties Pathology Network. The move to the new system has and will enable: • Enable seamless working across the SCP network, linking all laboratories together seamlessly so that staff at any site can manipulate patient records and results at any other site • Provide a stable and future-proofed platform to build future pathology services on. • Improve clinical quality with better data interpretation, enhanced reporting algorithms and the ability to export data for external reporting such as COSD and SGSS. • Optimise the use of workforce with less manual intervention, more flexible result interpretation pathways and business intelligence tools to assist with reporting and data requirements. Sharing of quality management across the network will improve efficiency. • Overtime there is an expected delivery of operational cost savings utilising evidenced based requesting to inform demand management. Improved use of reflex testing and testing cascades • Optimise the utilisation of technology and infrastructure across the Southern Counties pathology network. The standardisation of test codes, ranges and processes will increase efficiencies, and a single instance of LIMS will allow samples taken anywhere in the network to be run at any site giving patients greater choice and clinicians vastly improved access to results and testing services.
BadgerNet – Maternity Electronic Patient Record	Move from paper based process to a Maternity Electronic Patient Record using BadgerNet system. Multiple benefits associated with move to digital processes include: • Improved clinical safety and continuity of care through the timely and audited sharing of records across teams, divisions, wards, hospitals, Trusts and agencies. Medical history, risk assessments, care plans and safeguarding information are available 24/7 for all authorised personnel to access, with no reliance on service users to remember to carry notes. Even during system

	failures, failover mode will be activated and BadgerNet also allows for working offline. • The provision of end-to-end digital care will reduce paper storage costs and minimise the risk of missing or losing patient information. Ability to better evidence our quality of care and consequently improve Trusts' income generation and reputation through enhanced capability to provide comprehensive and up to date data for national data sets such as CNST. " • Reduced workload and improved responsiveness to national directives. BadgerNet, being the leading national maternity system, is updated bi-monthly to remain in line with or even ahead of national requirements. This includes the digital safety measures required for Saving Babies' Lives Care Bundle v3 and other national data sets. • Reduction in avoidable contact as service users will receive pregnancy information and advice in a more timely and accessible manner through the BadgerNotes app. • Improved service user experience due to greater involvement in the development of their own care plans because of the additional functionality available to them in BadgerNotes. • Efficiency gains from the significant reduction in provision of duplicate information across multiple systems and documents. • Enablement of the opportunity to consider standardisation of practices across the ICS to help improve patients' experience of shared care."
Digitisation of Discharges, Nursing Assessments and Inpatient Booking Processes through current EPR	Digitisation of patient discharges, nursing assessment (bundles) and inpatient booking processes in the current Electronic Patient Record (Lorenzo) • The nursing bundles reduce the number of individual digital forms a nurse has to find / open and complete from 14 forms down to 2 forms. • The new bundles allow the nursing team to flow from one form to the next for completion which is a more efficient way of working and reduces the time spent on completing the information required for each patient. It also allows the nursing team to prioritise the forms for completion and is much easier to keep track of what has been completed for the patient. • In patient bookings - Reduce the risk of potential patient harm due to missed or lost (paper) outpatient appointment bookings: booking requests will be visible to all users in Lorenzo and accessed at any time (single source of truth) • Removal of manual process for managing patients XIP booking requests standardised and auditable data recording for patient which will result in reduction in booking errors due to the misinterpretation of data recorded. • Electronic process flow to the booking teams using our existing SBI platform which is currently used successfully for managing outpatient booking requests. • Discharges - Improved patient safety through improved availability of drug charts and prescription information • Reduced need to access multiple applications where the patients care records would be stored – sole source of the truth • Reduction in Discharge medication errors due to reduced transcription errors on prescriptions - the new discharge summary removes the risk of any

	transcribing errors occurring as it will all recorded within the same system so no more transcribing will need to take place. • Aligns the with the Transfer of Care Standards set out by NHS Digital
Integrated Care Record – Digital RESPECT Forms	Creation and sharing of Digital Respect forms via the Integrated Care Record (BSW wider system with shared access by acute hospitals, GP practices, Mental Health and Community providers) • Following roll out in the spring, over 1600 RESPECT forms have been created and shared digitally via the Integrated Care Record on admission for Salisbury patients • 88.9% of the Digital RESPECT plans are being created by the Trust on admission leading to improved patient experience as it removes the need for multiple difficult conversations across different case provider occurring at a distressing time. • The digital plan is shared across Wiltshire so that GPs, SWASH, community partners as well at RUH and Great Western hospitals can digitally access leading to improved patient care as there is no longer a reliance on paper copies.
RPA	Introduction of 7 robotic automation processes into finance, procurement and tele dermatology administrative processes • Improved the accuracy and timeliness of data processing in finance and procurement • Removed repetitive manual administration tasks, improving efficiency and job satisfaction • Efficiency /time saving equivalent to £90k per annum
NHS APP	Extending use of the NHS App, reducing reliance on in house SMS messaging solutions. • Over the first 3 months of go live a total of 134,250 NHS App notifications, informing patients of changes to their OP appointment information, have been sent. • 104,212 NHS App notifications have been successfully read by patients within the 8-hour fallback window, avoiding full SMS cost from being incurred. • A financial saving of £1.2k in the first three months of implementation • Generally, uptake of the NHS App for Salisbury patients is showing a steady monthly increase. Contributing to national and local digital strategies and improving patient accessibility in their healthcare information.
Server Refresh Programme	Across a three year programme over 500 unsupported servers supporting key digital systems and infrastructure have been upgraded or decommissioned. • Each of the upgrades has increased cyber security and reduced our cyber risk profile. • Operational efficiency has been improved through more stable system /server performance

	• Patient safety has increased through supported versions of systems operating on more modern infrastructure. • The overall cyber risk improvement has enabled successful annual DSPT submission
Digitisation of delivery of Clinical Letters	The transfer of outpatient GP correspondence from traditional paper postal services to digital solutions including email and digital print services. • Reduced operational costs replacing postage with digital delivery – estimated benefits of £7k per month • Improved data security using encrypted NHS systems rather than physical paper • Improved patient care by improved timeliness of letter delivery (same day delivery) and accurate clinical information • Support to wider Net Zero commitments through reduced paper, and postal delivery
Bronchoscopy Medilogik	Digitisation of paper based EBUS reporting. • Improvement in patient safety, patient care and operational efficiency though improved digital data capture, image capture and results analysis • Improved patient reporting • Improved Data capture and audit data (digital) • And MDT information sharing (digital) with Lung Cancer MDT
Key digital operational and clinical system upgrade	Lorenzo (EPR), Auditbase (audiology), Lille (Sexual Health), Theatreman /Aqua (Theatres) system upgrades. There have been a number of significant system upgrades to both operational and clinical systems. Thematic benefits that apply in all circumstances include: • Enhanced cyber security – ensuring we are on support versions of systems, reducing our organisation cyber risk profile • Improved operational efficiency – reduced instances of user issues associated with out of date / unsupported versions of software • Enhanced patient care – exploiting new functionality available in latest versions of software

4 Risks to the Digital Plan

The main risks to the delivery of the Digital Plan remains funding, the availability of resources to support and the overall quantum of change the organisation can sustain.

Nationally, funding available continues to be predominantly capital whereas increasingly the requirement is for recurrent revenue funding as solutions move to cloud hosting and/or different licensing models. Further to this, the national funding for digital is at times unpredictable and allocated to areas not currently a priority for the Trust but aligns to the national priorities. It is proposed that national funding will be provided in broader thematic areas, with regions working with local systems to understand how best to use national funding to deliver the theme, whilst improving local digital maturity in a more coherent manner. The EPR programme will also use most of the available internal capital funding over the next two years. The Trust will continue to prioritise investment in

technology through existing governance arrangements. This may slow the pace of some programmes outlined in the Digital Plan if funding is not available or wider strategic directions are required to change (and thus there is a need to focus funds and capacity to different areas).

Over the coming years the Trust will need to continue to respond proactively to the significant resource need to implement and optimise the new EPR. This will include ensuring the wider impact of releasing staff onto the EPR programme is understood and closely monitored. Over the last 12 months technical roles in areas such as Business Intelligence, Clinical Coding and Infrastructure continue to be stretched, with demand outstripping funded capacity and external third parties used to bridge this gap. As the requirements for different technologies including the increased use of cloud evolves, it will be important to continually review the skills needed within technical teams to provide the expected level support. The Trust has focused on upskilling and retaining staff however there will be a requirement to consider how resilience can be built in conjunction with peer organisations across the as part of the Corporate Services Review. This has already successfully happened across Salisbury and Great Western Hospitals in some areas.

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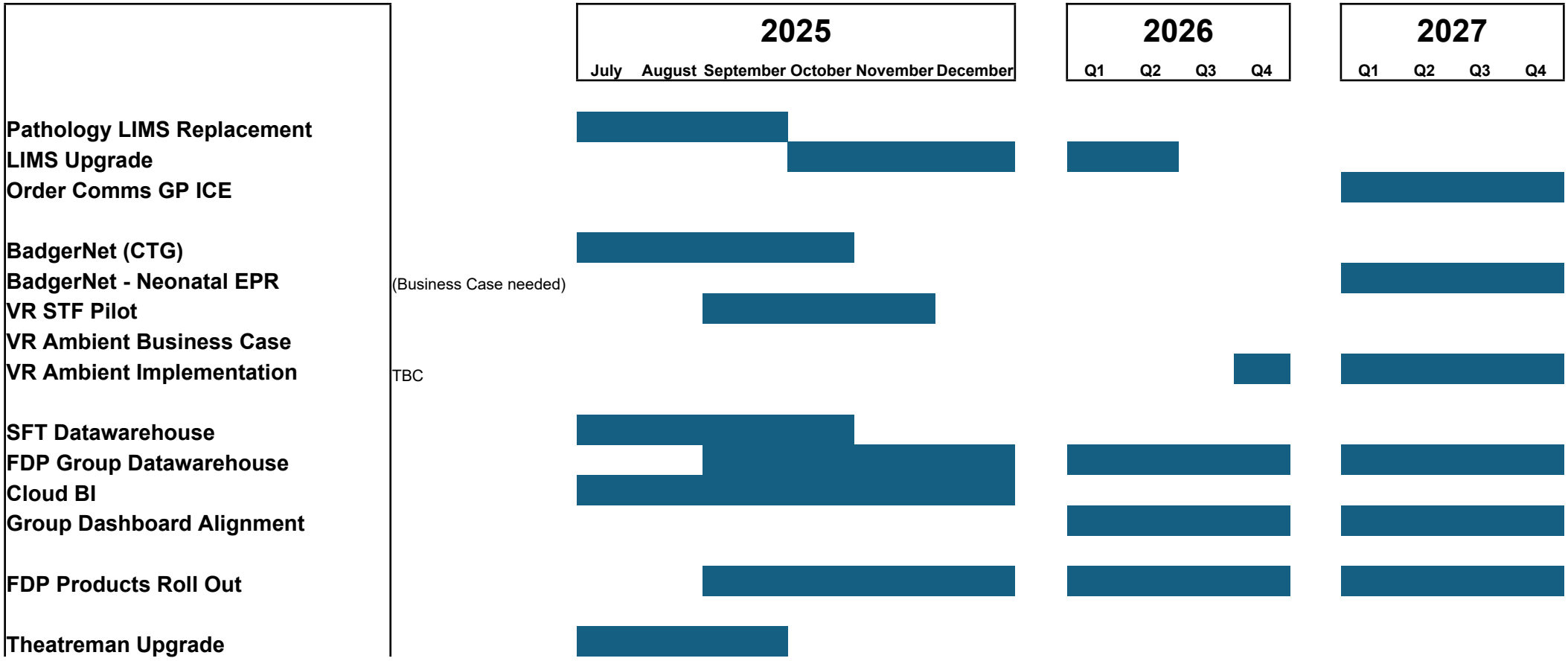
Appendix 1: Digital Plan on a Page




Theatres Connectivity
Network Imp Programme
(EPR Dependency)
Server Refresh - 2003/6/12
Server Refresh - 2016
Network Improvement
WIFI Improvement
Windows 11
Azure Collaboration
VOIP
Environment Refresh
AOVPN
SAN Replacement - Consultancy
ODP - Starter, Movers, Leavers
ODP - Digital Files
ODP - MLE Replacement
ODP - OH Replacement
Digitisation of Clinical Letters
Check in Kiosks
Outpatient Room Booking (FDP)
E Consenting
Local and Group

Patient Held Record - TOM	
Booking Template Review	
Booking Improvements	
Surgery Outpatient Booking AI Pilot	TBC
Respiratory Lung Function Requesting	TBC
UEC- NCTR	TBC
UEC - Flow	TBC
Urgent Treatment Centre	
South Newton	
CDC (current)	
CDC Future	TBC
RPA	
ICR (SHCR)	
Bleep Replacement	Subject to approval/Funding
Endoscopy - Small Bowel Capsule	Subject to approval/Funding
My Medical Record - IBD PIFU	Subject to approval/Funding
Pockettalk AI	Subject to approval/Funding

Aria Upgrade	Subject to approval/Funding
Larkhill MOD Oral Clinics	Subject to approval/Funding
Electronic Dental referrals	Subject to approval/Funding
RADF	Subject to approval/Funding
Friends and Family	Subject to approval/Funding
Medilogiks - Respiratory	
Medilogiks Urology	Subject to approval/Funding
iRefer (PACS)	Subject to approval/Funding
PACs based Reporting	Subject to approval/Funding
NHS APP eRS Dr DR Integration	Subject to approval/Funding
Spec Ops (Tech/Cyber) - ICB	Subject to approval/Funding
New EPR Programme (EPR) - Medical Record Review	
RPA Integration	TBC
System Integration	TBC

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	8 January 2026		

Report title:	Improving Together Triannual Roadmap Progress Report: - January 2026			
Status:	Information	Discussion	Assurance	Approval
	✓		✓	
Prepared by:	Emma Cox, Head of Continuous Improvement and Coach House Alex Talbott, Director of Improvement			
Executive Presenting:	Alex Talbott, Director of Improvement			
Appendices (if necessary)				

Executive Summary:

The embedding of a culture of continuous improvement at SFT continues to progress positively. Coach House time and resource continues to focus on coaching for improvement at the frontline to drive increased sustainability of improvement routines.

The last quarter as seen us continue to rollout performance review meetings across the speciality and team layers in both clinical and non-clinical departments. The effect of this is to introduce the ways of working that reinforce strategic alignment, scientific thinking and data-led analysis that is central to Improving Together becoming the way we work. A3 thinking as our structured way of understanding and solving problems continues to grow, however we should be careful to ensure this acts to reinforce the thinking about and understanding a problem part of the tool and does not become a tickbox exercise.

As we undergo the changes associated with corporate service redesign and development of our BSW Hospitals Group it remains important we maintain these fundamentals at SFT and across the Group to ensure we build on the successes to date of our continuous improvement management system.

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

1. To have defined and agreed an approach to roll out clinical and corporate Performance Review Meetings (PRMs) across the organisation, which can be sustained and embedded across all layers (divisions, specialities and teams). Completed through good collaboration with Divisions and Coach House colleagues. Clear approach now available and which will be aligned to training material moving forward.

2. To have produced and presented an aligned approach to the Improving Together Board on the roll out of benefits realisation at SFT. Commenced using A3 thinking and alignment to existing Trust structures, further focused work required to establish a Trust wide approach.

3. Embed the routine of the maturity assessment process for divisions, speciality and teams resulting in identification and support offered in focus areas that require improvement moving forward. In progress, further discussion relating to measuring maturity and reviewing existing assessment paperwork at SFT continues. Balancing opportunity vs compliance remains an important consideration as this develops.

4. Review the maturity of driver meetings across clinical and non-clinical areas and provide further training and coaching to areas where this is not yet embedded in routine practice/BAU, resulting in a positive improvement and sustained use of this tool. Commenced with further support being deployed to divisions during Q4 to support the strengthening and maturing of the OMS.

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

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

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

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

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

- None escalated from Improving Together Board.

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

- There are 46 active improvement huddles, and whilst there has not been an improvement in this during the last quarter, there is a greater understanding of the reasons for this and a greater number of teams using other improving together methodology to support improvement. The Coach House team has increasing active huddles as one of their improvement drivers. We expect an increase in teams using improvement tools and routines through Q4 as further teams are trained and supported post-training.

- The development of A3's to support two new breakthrough objectives, aligned to the recovery plan, are in progress. The Coach House are supporting their development, including the identification of associated countermeasures and this will remain a focus during Q4.

- Increasing and improving how we routinely include patients, families and carers continues to score low in our NHS Impact self-assessment. Examples of good practise exist at SFT and we will continue to explore, promote and expand these into 26/27.

- A review of Improving Together by KPMG has highlighted areas of continued growth and opportunity. This learning third party insight will help inform and guide the next 18-month roadmap for SFT (April 26 – Oct 27). This roadmap will be drafted throughout Jan/Feb with sign off at the March Improving Together Board meeting.

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

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• The training trajectory is on track to have 100% of teams trained by Q2 of 26/27, 32 teams require a plan to complete their training. • Our leadership behaviours are part of recruitment, appraisals, team development and succession planning. • Appendix 2 continues to show the benefits delivered through our project delivery system, a key component of Improving Together. • The embedding of go and see within the Improving Together Board standard work bi-monthly is providing an opportunity for senior leaders to practice the methodology at the same time as providing the space for teams to celebrate and share their improving together journey with senior colleagues. • Externally SFT continues to host visits (go and sees) from NHS Trusts and is seeking reciprocal visits to continue learn and bring experience from others into SFT.

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):	

Salisbury NHS Foundation Trust

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This progress report provides an update on the outcomes identified as the next steps in September's report to Trust Board. It includes assurance on the rollout of Improving Together and summarises the areas of focus for 25/26 Q4 and 26/27 Q1 to continue to embed a culture of continuous improvement at SFT.

Since September, we have focused support in the following areas, with identified outcomes and benefits noted as a result:

1. **Training and Coaching Support**
   We remain on track to achieve the target of 100% of teams trained to Improver Standard level by Q2 of 26/27. A total of 32 teams remain outstanding between now and then. The Coach House are working with those areas to book in the best dates for their training. The current split of teams awaiting training is one third (10) clinical, two thirds (22) corporate.

   The Coach House continues to provide teams with coaching support after their initial 2-day Improver Standard training. The time used to deliver this has increased in the current quarter to 93 hours per month, up from 73 hours during Q2. This has resulted in improved use of and confidence in our improvement methodology. The focus during Q4 and Q1 will be to maintain this level of support to sustaining the use of the tools and behaviours used to continually improve our services. Coach House staffing will reduce in Q1 as the three rotational 12-month secondments come to an end. Therefore, work is underway to prioritise the team's work on training and delivery of coaching to sustain the use of Improving Together across the hospital.

   The Coach House teams at SFT, RUH and GWH have reviewed training content in three core areas; the 'Why' at Group, Improvement Huddles and Go and See – developing standard slide decks for use across the Group. Further opportunities to work collaboratively and build effective relationships are being supported and by the Heads of the Coach Houses and will continue throughout Q4.

2. **Celebrating our Successes, Maturity and Culture Change**

   In quarter 3, KPMG colleagues provided a review and recommendation report on SFT's maturity in using Improving Together and the Shingo Principles that underpin it. This will now be analysed in Q4 and used to help inform the development of the April 26 to Oct 27 roadmap for SFT. Initial review would indicate that the greatest area of opportunity is linked to how we connect our systems together from team to speciality to division and into the Board. *See image 1 on next page*.

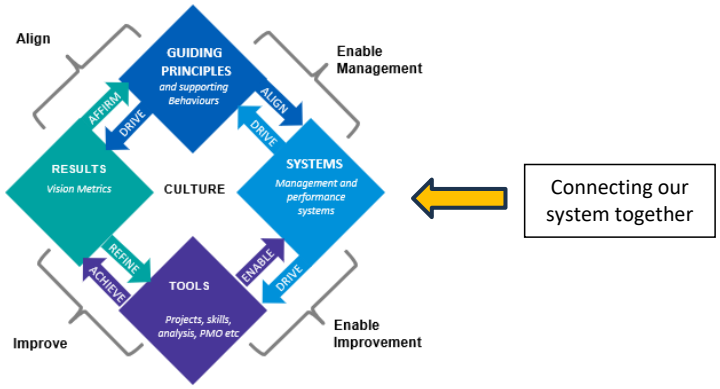

Figure 1: The Align, Enable, Improve cycle that drives ideal and sustainable results from ideal behaviours.

Regular and routine sharing of successes continues across the hospital's corporate communication channels and at teams' huddle boards. A monthly Improving Together slot at the cascade brief has given a voice to staff to share their experiences of using Improving Together to improve their services - with colleagues from pharmacy and the discharge team leading the way. This alongside our regular celebrating it tickets, monthly spotlight and case studies offer insight into improved performance and use of the methodology that can be shared to establish greater impact and sustained improvement. A trust-wide launch of the pink ticket during Q4 is being planned with the impact of this reported at the Improving Together Board.

Our Leadership behaviours continue to develop and grow our workforce whilst shaping the organisational culture. This is important to support the embedding of a culture of continuous improvement. Key areas of focus have included the application of learning post training delivery, incorporation within the appraisal process, developing of a talent and succession planning programme for senior leaders and the launch of the licence to manage programme. As we transition to the new Group structures further developments to maximise value at group will be explored alongside the planned roll out of NHSE's leadership and management capability standards in 2026.

Three internal SFT Improvement Coaches continue to work with five groups of senior leaders (19 people) on the Catalysis Academy programme to develop their competencies in leading and coaching for improvement. The Catalysis Academy is a structured programme which deepens each individuals personal practise of the Shingo principles that underpin the sustainable use of Improving Together (Operational Excellence) in any organisation. The impact of this work to date has been to increase the leader's confidence in and routine use of Improving Together across clinical and corporate divisions. In turn this expands the breadth and depth of Improving Together across SFT. Over the last two years 42 senior leaders have had access to the programme, with 38 remaining in the organisation and 4 having left SFT (two retirements, two promotions). Access to the Catalysis Academy programme is funded by a BSW Hospitals Group approach and work is underway to continue that into 26/27. The current licences expire in April 2026.

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

The mapping of team and specialty level performance review meetings (PRMs) in clinical teams has helped increase alignment and consistency of routine and approach across the organisation. This is a significant milestone for the programme which supports the Coach House's work in engaging speciality leaders from the start of their areas entering training and coaching. Developing the governance and data flows to support the PRMs is in progress, including ensuring alignment with CQC requirements.

As we continue to embed and mature the function of PRM's across the organisation, easy access to data dashboards to support the meeting routines will be critical. However, there remains a persistent issue with manual data reporting in team and speciality PRMs that acts as a brake on the speed at which we are able to rollout the routines and use data-led enquiry at the core of our meetings. This is a key area of debate and focus as new team structures around information services and business intelligence teams are designed.

There has been an increase in the number of team level PRM meetings being established since the September report, there are now 10 areas actively undertaking this routine. Further work to strengthen information flow between divisions, specialities and teams will be a continued focus, with good engagement and support from divisions to secure this way of working during Q4. Increasing support to speciality tri's to mature their drivers has also been identified as a gap in maturity, with coach house support being deployed to that in Q4.

Establishing the corporate PRM roll out continues to build momentum with only two corporate services yet to commence the process, but with plans in place. Initial feedback continues to be positive, with corporate services valuing the time to discuss their drivers, success and challenges in a focused way with Executive colleagues.

Along with the change of breakthrough objectives in year, we continue to support teams to align their drivers with the strategic priorities of the organisation. There are 116 driver metrics in total identified, as shown below:

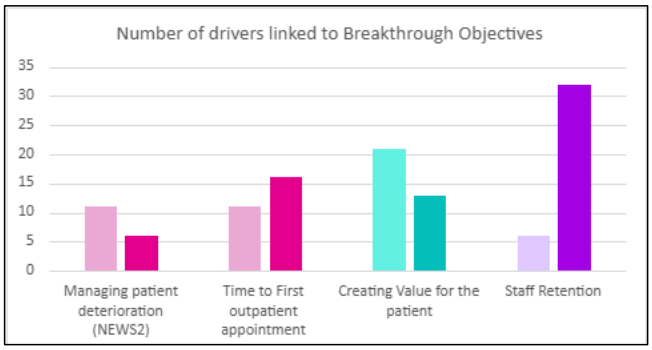

Figure 2:Number of drivers aligned to each breakthrough objective. Coloured by Vision Domain, with lighter columns relating to Team drivers and darker columns Specialty drivers.

A monthly overview is made available at the monthly engine room of the number of driver metrics supporting each Breakthrough Objective.

Alignment of our corporate resources to our strategic priorities continues to be routinely worked on at the Corporate Project Prioritisation Group (CPPG) and during the monthly Executive-led Engine Room. There are currently 18 organisational wide projects which have been prioritised in support of our strategic initiatives, breakthrough objectives (BTO) and mandated time sensitive/patient safety priorities.

As the OMS continues to mature, and in line with the project delivery system methodology, over the next year we are focusing on aligning 70% of corporate projects in support of delivering strategic initiatives (SI), which would reflect the transformation focus we'd want to see underpinning these large scale 3-5 year programmes of change. Since September, there has been a positive shift to supporting strategic initiatives (67% of corporate resource focus), which indicates that more improvement work linked to breakthrough objectives is being operationally led as central corporate resources focus on more of the mission critical large programmes of work.

It is acknowledged that the number of large capital programmes of work are increasing and these are often dependent on external decisions. This has increased the number reporting as off-track. This is a risk and a theme emerging, impacting pace and delivery and timely delivery of benefits. This reflects the wider context of capital programmes in the NHS.

Appendix 2 shows a summary of a number of corporately resourced projects and the benefits being realised from them. This includes the replacement of whole digital systems in areas such as Pathology's Laboratory Information Management System (LIMS), Maternity's electronic patient record (Badgernet) and our theatres software (AQUA). All examples of how transformation, digital, informatics, operational and clinical teams can come together to deliver step changes in our digital platforms while maintaining business as usual and care for our patients and population.

4. Collaborative Working

Collaborative working and the use of Improving Together methodology at Group continues to develop. The corporate services redesign work across the Coach House (Improvement), Transformation, Strategy and Planning functions continues into Q4.

The development and building of routines to support the Group Engine Room, portfolio office and process to agree the scorecards between care organisations and the Group are all helping to ensure Improving Together remains as our core way of working across the BSW Hospitals Group.

Continuing to work in partnership with Chemring Countermeasures following the Catalysis visit of 2024, whereby lean working and approaches is embedded within this industry maintains focused. Professional Coaching conversations to five staff at Chemring Countermeasures from SFT Coaches has commenced with a reciprocal site visit to SFT in Q4 planned and future dates to be scheduled during Q1/2 of 26/27 for a go & see visit to Chemring for SFT identified staff.

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5. Emerging Risks

No new emerging risks have been identified since September and regular review of existing risks is maintained and reported via the Improving Together Board.

BI capacity as reported is consistently shared within improving together board and other meeting forums. This continues to be raised as a risk and discussed at Improving Together Board and in divisional performance reviews. Awareness of and training in the set of dashboards and data we already have available is mitigating the risk, however capacity constraints remain.

Maintaining fidelity to Operational Excellence and the methodology remains challenging whilst balancing delivery of National policy and changes within BSW Governance and Assurance. The Executive and Senior Leadership team continue to advocate this way of working, practise them personally and run the routines that underpin the OMS.

As SFT transitions to the new risk and governance frameworks for BSW Hospitals Group, how we transition the purpose of SFT's Improving Together Board and ensure Improving Together is weaved through the respective agendas is being considered as part of the governance task and finish group. This is chaired by Lisa Thomas, Managing Director at GWH, while Mark Ellis and Alex Talbott attend from SFT.

6. Outstanding items from the previous report:

The following two items have not progressed as far as was anticipated and expected.

However, the next steps and work that has commenced is detailed below. These will roll forward into the next identified steps, with progress updates provided in the next report.

- **Aligned approach of benefits realisation standardisation at SFT** – *the development of an A3 to help drive focus and improvement has been initiated within the Transformation and Coach House teams with countermeasures identified and in progress. Further alignment to existing meeting structures i.e. TIG and TMC are included.*
- **Embed maturity assessment process for divisions, speciality and teams** – *further discussion through the coach house SLT driver on approaches to measure maturity at SFT continues to be prioritised, alongside a review of the existing maturity assessment paperwork. This focus will continue throughout Q4 and Q1. There is a balance to be struck between understanding where our opportunities lie in becoming more mature and turning the maturity assessment into an audit and compliance tool, which wouldn't align as well with a culture of continuous improvement. This balance remains a key consideration as we develop this work.*

7. Identified Next Steps

The following have been identified as key areas of focus between January and March 2026, and have been identified based on balancing our Group's development and the corporate services redesign work alongside work that is currently in progress/due to start.

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1. Design and implement the new governance routes and routines for Improving Together Board and this report in the new governance and risk framework for BSW Hospitals Group

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

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

4. To continue to support clinical and corporate specialities and teams in introducing and undertaking Performance Review Meetings (PRMs) across the organisation, aligning the governance approach to meet CQC requirements. A trajectory aligned to the Coach House driver set in collaboration with specialities and divisions will be produced in Q4.

5. To continue to work in partnership with Chemring Countermeasures, including reciprocal site visits through Q4, reviewing the future partnership working arrangements during Q1.

6. To support rotational role colleagues transition back to their substantive role, whilst seeking opportunities for them to continue to practice and use their skills back within their home divisions.

7. To continue to work collaboratively with RUH, GWH coach house teams, identifying key areas of focus opportunity, linked to training delivery and further maturing working relationships between team members.

8. To continue to embed the corporate PRM function at SFT aligning to new governance arrangements emerging at Group.

9. To continue to celebrate and share successes Trust wide – launching the pink ticket Trust Wide during Q4.

10. To align our annual operational and recovery plans with potential new large scale transformation work – helping to ensure we start Q1 with our corporate resources aligned to our top opportunities in our annual and multi-year plans.

11. Further support the embedding of weekly driver meetings across clinical and non-clinical areas through training and coaching support where this is not yet routine practice/BAU. This aims to help deepen our routine work on the organisation's top priorities.

12. Review NHSE leadership and management capability standards and consider approaches to align our leadership offering with the new national framework (Draft Management & Leadership Framework)

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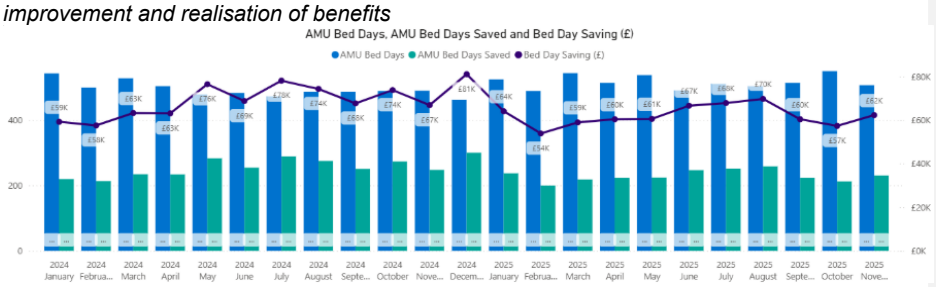
Appendix 2 - Examples of the benefits delivered through the project delivery system, aligned to the SPF - supported by the Trust-wide Transformation Team

Creating value for our patients

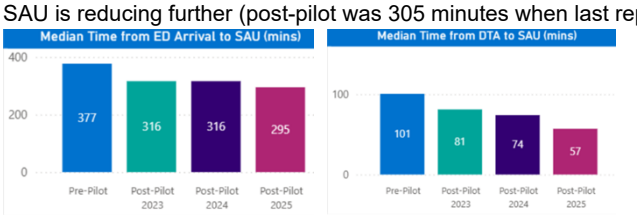
Urgent Emergency Care projects:

Medical SDEC Bed Days saved and bed day saving maintained – *demonstrating sustained improvement and realisation of benefits*



- Improvement in ED 4-hour performance to 68.2%
- Improvement in ambulance average handover to 23 minutes
- While overall demand continues to rise by around 3%
- **SDEC** Continued maintenance of Length of Stay and % 0-day Length of Stay
- **AFU** average Length of Stay further reduced to 2.6 days, from 3 days in July 25.
- **AFU** % 0-day Length of Stay performance saw a reduction in variation and continuing upward trend.

Surgical SDEC average Length of Stay continues to reduce, and time from ED arrival to SAU is reducing further (post-pilot was 305 minutes when last reported, now 295):



These projects closed in Q3 and are now being operationally led through the Operational Management System at a local divisional driver level. This is a positive sign of the developing improvement capacity and capability within our teams.

Total Bed Day Saving since commencement SDEC £1,867,000 AFU £9,668,079

The No Criteria to Reside (NCTR) project moved to BAU and operationally led during Q3 and so the corporate project overseen by UEC moved onto ward processes, the next top contributor to process delays. This is providing capacity and focus on the 'middle' section of our patients' pathway (admission, ward based care, discharge).

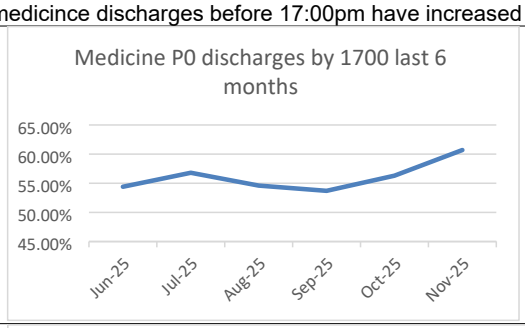
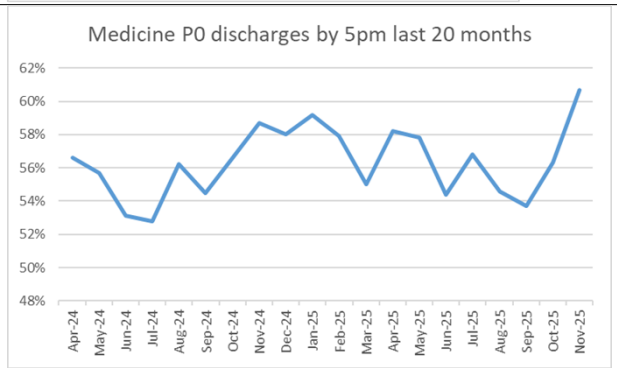
Commented [AT1]: Can we continue reporting this as it is now BAU. Not sure it still stands as a saving from ?March 2024.

Commented [EC2R1]: As they closed in Q3 we shouldn't probably report on them moving forward. As we have noted they closed in q3 safe and ok to put in.

The data driven quantitative benefits as specified within the Urgent and Emergency Care Board (UECB) show a sustained shift to earlier discharge times. There are multiple factors impacting on this both within and outside of the ward processes programme e.g. Early Supported Discharge, however, this is supported by the Bed Occupancy/flow driver countermeasure that helps align ward teams with this work

All programme focus groups (EDS, Bed Occupancy and Steering group) conclude that the biggest impact is a focus on patients being discharged on a P0 pathway (with an Initial focus on Medicine).

In the last six months, P0 medicince discharges before 17:00pm have increased as below

June 2025 54.4% July 2025 56.8% August 2025 54.6% Sept 2025 53.7% October 2025 56.3% November 25 60.7%	
The imapct of the focus on P0 pathways (discharges to a patient's usual resdience without additional care packages/requirements) is shown as we recovered and exceeded historic performance.	

Qualitative:

Though it is not without its challenges, the use of Improving Together methodology and data has undoubtably supported a positive shift in culture, more evidently within Nursing, with ward leads and teams pro-actively engaging in the programme and methodology to understand what their data is telling them and the small steps they can take to support improvements in their work areas and processes.

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Reducing patients' wait time to first

Outpatient Elective Reform

9% improvement in Trust TT1OPA performance between Dec 24 (132 days) – Nov 25 (120 days)

Multidisciplinary Outpatient Operational Group (OOG) has overseen the implementation of the OPERA approach across SFT. Working with three focused specialties over a 3-month period to explore challenges, test improvements, and strengthen outpatient pathways, with the aim to support TT1OPA performance.

- Collaborative working with Coach House to facilitate sessions and help ensure support at both the Team and Specialty level in using Improving Together methodology.
- First 3 specialties (Rheumatology, Respiratory and T&O) engaged through the support process between October – December 2025. Formal feedback sessions scheduled for January to establish benefits delivered. Performance change from week ending 5th October – week ending 21st December.

Rheumatology	183.6 to 149. days
Trauma and Orthopaedics	157.4 to 146.8 days
Respiratory	153.7 to 158.4 days

- Next set of focus specialties (ENT, Cardiology and Gynaecology) begin their 3-month support in January 2026

Central and satellite booking teams supported to use Improving Together methodology, such as A3 thinking, collaboratively identified improvement countermeasures and delivered sustainable change in their working practices. Some of the benefits delivered include:

- **Reduced the time to fill short-notice outpatient appointments by up to 86%,** by using DrDoctor Broadcast Messaging to tell patients about available slots.
- Creation of an Outpatient Booking dashboard increasing visibility of unutilised clinic slots at specialty, consultant and clinic level. Data is used to identify gaps and support prioritisation of booking activity.
- Addressed the communication gap between the point of e-RS referral and appointment confirmation. Patients now receive a letter from SFT as soon as they are added to Lorenzo, confirming the specialty, information about the booking process and next steps.
- The theatre admission letter has been rewritten with patient group input and has **reduced from 8 pages to 2** (1 double sided page) with improved quality and clarity of information for patients.
- Removal of outdated COVID information from all letter templates.

Benefits delivered that only affect central booking team processes:

- **Netcall wrap-up time extended to 90 seconds (50% increase)**, to enable booking tasks to be completed effectively, before taking the next call

- Embedding of monthly RTT focus days in Central Booking, to give specialties an opportunity to address longest waiting patients and catch up on administrative booking tasks. This focus has led to reductions of c. 40% in undated 52 week wait patients across our specialities and is helping us deliver on our 52ww targets for 25/26.
- Redundant partial booking paragraph (endoscopy appointment) has been removed from the letter. **Anticipated impact of a reduction of ~850 calls per month** which **equates to ~41 hours of time** usually spent by bookers on these calls.

Project initiated to deliver a validation solution for outpatient waitlists, using the FDP and DrDoctor platforms. **Expected benefits to the Trust, Patients and outputs captured below:**

- The project objectives will enable the Trust to meet the NHSE standards for validating patients every 3 months. This will benefit the Trust reputation and performance against national standards.
- Streamlined patient-led validation workflows and automated validation action information will reduce the manual administrative burden and result in an increase in validation activity.
- Anticipated to contact ~1000 patients per week – currently only completed ad-hoc with less than 1000 patients contacted over a 6-month period in the last year.
- Increase in the number of RTT clock-stops, and associated income generation, as a result of the increased validation activity. Pilot sites using this functionality have seen 7.5% of patients eligible for discharge, following validation.
- The identification and discharge of patients will ensure patients are being seen in the right place at the right time. Identifying and removing patients who no longer need treatment could therefore result in shorter waiting times for those who still require care.

The launch of an Outpatient Forum to discuss and monitor performance, improve the coordination of approaches across key outpatient improvement areas and promote best practice for service delivery has realised the following benefits:

- **Delivered 8 Outpatient Forums since April 2025**, **covering 10 key topics**, including increasing PIFU utilisation and validation approaches.
- Implemented a **targeted communications strategy** in collaboration with the Communications Team to expand engagement meaning that we **increased monthly Forum invitations from 15 members in April 2025 to 131 members, representing a 589% increase in reach in January 2026.**
- Created a dedicated SALi staff intranet page, providing access to recordings and slide decks so staff can catch up at any time and view the Forum.

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Delivering digital care to improve pathways

Digitally enabled clinical transformation

Badgernet (Maternity EPR)

The following additional benefits are reported from the previous Quarterly Report. This project has now completed and ongoing oversight has moved to operational BAU.

- Enhanced Data Visibility: A dedicated Maternity Power BI Dashboard has been implemented, providing improved oversight of patient data metrics and supporting informed decision making.
- Strengthened Business Continuity: Business Continuity Planning (BCP) has been refreshed and successfully tested to ensure resilience ahead of the Phase 2 rollout of the CTG Central Monitoring System.
- Digital Integration Achieved: Phase 2 of the CTG Central Monitoring System is now live, enabling seamless digital transfer of patient traces to the Badgernet system via Moxa Box technology.

Operational Improvements: Central Monitoring screens have been installed in Maternity handover rooms, enhancing real-time visibility and clinical coordination.

Pathology LIMS (WinPath)

The migration of the Pathology Laboratory Information Management System (LIMS) from the 30-year-old Telepath model to the state of the art WinPath Enterprise on the 15 September 2025, has resulted in the following benefits:

- Vastly improved structure of queries, richness and format of data extracted.
- Ability to schedule, run and distribute extracted data automatically.
- Clinical details are directly available in WinPath (legacy LIMS recorded clinical details in a ‘notepad feature’
- Improved patient safety for shared care patients within the 6 Trust’s in the Pathology Network.
- Decrease in blood product wastage now there is the ability to transfer blood and blood products within the network.
- Interoperability enabler for Digital Histopathology, analysers (some), middleware solutions (some) and in future will enable GP tQuest to be replaced by GP ICE.
- Electronic requests and results for ‘send away / referral tests’ done within the Network.
- Standardisation of reference ranges and clinical comments across the network meaning improved results charting / trending across secondary and primary care.
- Quicker training of staff recruited from within the network (same system now being used in surrounding counties).

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AQUA TheatreMan

Upgrade from our previous TheatreMan system to AQUA on the 19 August 2025, resulted in the following benefits:

Digital Clinical Safety and DTAC Compliance: Trisoft offered the upgrade for free on the basis that it will ensure compliance on DTAC, DCB0129 and DCB0160 standards. New NHSE Digital standards would recommend that the best practice principles of DCB0129 and DCB0160 are put in place for this system and the supplier has provided assurance that if we progressed with the upgrade, no open or transferred risks would be handed over to us.

Resolving HL7 Messaging from Lorenzo: The current HL7 messaging were be reviewed, redeveloped, and tested. This has had positive impacts on patient safety and improved working practices within some operational teams.

Allergies and Alerts: The upgrade enabled any allergies and alerts listed within the patient profile on Lorenzo to pull through to AQUA. Visibility of this data improves patient safety and reduces the need for Theatre staff to access another system for this information.

Procedure Descriptions: As part of the AQUA upgrade the data feed was changed so that procedure descriptions are connected to the Access Plan ID (rather than the Patient ID). This has resolved the issue of procedure descriptions being overridden if operations are split over separate visits and reduce the patient safety risk associated to overridden data.

Multiple Access Plans: Patients on more than one surgical access plan were linked from TheatreMan to CCS based on their Hospital Number, not Access Plan ID. This has been updated so multiple entries per patient are seen by the booking team and pre-op teams where they were previously overridden.

Avoiding Additional Contract Fees: Moving to the upgraded version of TheatreMan saved the Trust around £28k, which would otherwise be incurred if the current software version had been maintained. AQUA offered a 3-year contract option which can be renewed on a **yearly basis.**

System development & configuration: One of the operational benefits of the upgrade is AQUA will now enable users to develop their own forms and reports within the system, without additional costs or resource required from Trisoft (the supplier). This will benefit operational teams if further configuration of the system forms or reports were needed to meet business needs. Compared to the current version of TheatreMan, there will also be shorter turn-around times and greater accessibility in producing reports from the system, which currently need to be requested from Trisoft sometimes at a cost.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	8th January 2026		

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

Recommendation:

1) The Board is asked to **note** the report and progress against our Vision Metrics and Strategic Initiatives.
2) The Board is asked to **note** the ongoing development of a process toward a Group Strategy.
3) The Board is asked to take assurance in the process standard work surrounding our strategy deployment.

Executive Summary:

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

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

People

The Trust continues to make progress against its people-focused metrics. Staff engagement remains at 7.09, continuing to outperform the falling national average, with the Trust now ranked in the top quartile nationally for all People Promise elements and for Morale and Engagement. Data from the 2025 National Staff Survey is expected imminently for internal analysis to direct activity in 2026. Tent Talks have been confirmed for 19-20 May 2026 with the theme 'Leading through complexity'.

Staff retention has significantly improved with the Breakthrough Objective for Additional Clinical Services staff turnover successfully achieved, reducing from 21% to 15%. The associated Breakthrough Objective has now evolved to focus on Staff Availability, addressing both retention and absence. Care certificate compliance amongst HCAs has reached 100%, and HCA Preceptorship has been fully implemented. The number of outlier engagement scoring departments has been reduced by 50% from the 2024 figure.

The EDI Steering Group, established in September 2025, is now operational with broad stakeholder membership. The Licence to Manage programme has been initiated to equip managers with essential people management skills, including Health Passports and reasonable adjustments. The Strategic Initiative to embed a continuous

improvement culture has shown strong results, with quarterly Senior Leadership Team PRMs now established alongside monthly Driver Lane Meetings.

Population

The Trust is actively tackling wait times through UEC and Planned Care Board actions. SDEC has expanded to 7-day service with specialty expansions including Surgery and Frailty SDEC now established. An outpatient operational group has been established to oversee all aspects of OPD, and a new perioperative journey group has been created linking pre-op, central booking and theatres to improve utilisation and reduce elective waits.

Patient harm reduction is being addressed through a refreshed approach focusing on Safety-II principles, examining the gap between 'work as imagined' and 'work as done'. Thematic analysis is underway for the three most frequently reported incidents: falls, pressure ulcers, and medication errors. The Pressure Damage Breakthrough Objective is on track and more information is available in the IPR.

Patient engagement continues to improve with FFT response rates consistently above 17% target and 95% rating good or very good. Digital care transformation is progressing well with EPR implementation scheduled for October 2026. Complementary systems including BadgerNet Neonates and GP ICE Order Communications are being implemented.

Partnerships

The partnerships pillar demonstrates continued progress in reducing health inequalities. Previous improvement sprints have delivered measurable impact, including the 30% reduction in time LDAN patients wait for care. Our metric is now aligned to the Group IPR and tracks any difference in waits for access to our care (RTT) between the most and least socio-economically deprived neighbourhoods (CORE20).

Length of stay reductions continue through multiple interventions. The Acute Frailty Unit has maintained its dramatic improvement, sustaining stays under 5 days compared to the previous 17 days. SDEC expansion will further reduce 1+ day LoS spells, and work with HCRG as they take on the community services contract targets reducing LoS through flow-out improvements.

Organisational sustainability is being addressed through the 'Creating Value for our Patients' Breakthrough Objective targeting 10% improvement in productivity. Backlog maintenance programmes continue with DSU, Spinal and Maternity improvements aligned to the 10-year campus masterplan. The new Strategic Initiative on 'Designing services to meet population needs' has completed system workshops to define the problem statement, addressing Wiltshire's nationally significant ageing population and demographic shifts.

Group Strategy + Interim Statement

In recent months work began on a Group strategy due for publication in Spring 2026. However, due to a desire for broader and deeper consultation this work has been postponed (although colleagues in strategy teams across the Group continue to plan engagement regarding its development). RUH and GWH have existing strategies with a 2028 time horizon. SFT's strategy concludes this year.

Board have previously approved the compilation (with publication in mind) of a 2026-2028 'interim strategy statement', rolling forward our commitments set out in the strategic planning framework. This will come for ratification at March 2026 Board given the pause to Group strategy development.

Governance and Oversight

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

Significance for Board

This update is important for the Board for several reasons:

- It demonstrates how all levels of the organisation are **aligned** to deliver the Trust's vision of providing an outstanding experience for patients, families, and staff.

- The clear **ownership structure** with executive sponsors, responsible leads, and contributing forums ensures proper oversight of strategy implementation.
- Metrics show tangible **improvements across multiple domains**, from staff engagement outperforming national trends to measurable patient outcome improvements.
- The **timeframes** provide clear expectations of when benefits will be realised, helping the Board understand the maturity and trajectory of different initiatives.

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

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Triannual Strategy Deployment Update

The organisation's strategy is overseen through the Strategic Planning Framework (SPF). It has three areas of focus - People, Population and Partnerships - all with assigned **Vision Metrics** which allow the organisation to track progress over a 7-10 year timeframe. Flowing from these are our:

Strategic Initiatives, which are programmes of work we consider 'must do, can't fail' for our vision to be achieved; these deliver over a 3 –5 year timeframe and flow from multiple Vision Metrics.

Breakthrough Objectives, which are programmes of work taking place over 18-24 months driving at key areas of improvement. Each Breakthrough Objective is the top (trust wide) contributor to a Vision Metric. I.e., the most significant (current) cause of moderate or high harm is inadequately managing patient deterioration. Progress against these is covered in the IPR.

This paper is an outline of progress against our **Vision Metrics** and **Strategic Initiatives** as the principal means by which we track the delivery of our vision over the medium and long-term.

These are each 'sponsored' by an executive, and executive scrutiny takes place monthly in the Engine Room, chaired by the Managing Director and with each executive, the associate director of strategy, and the heads of transformation and coach house present.

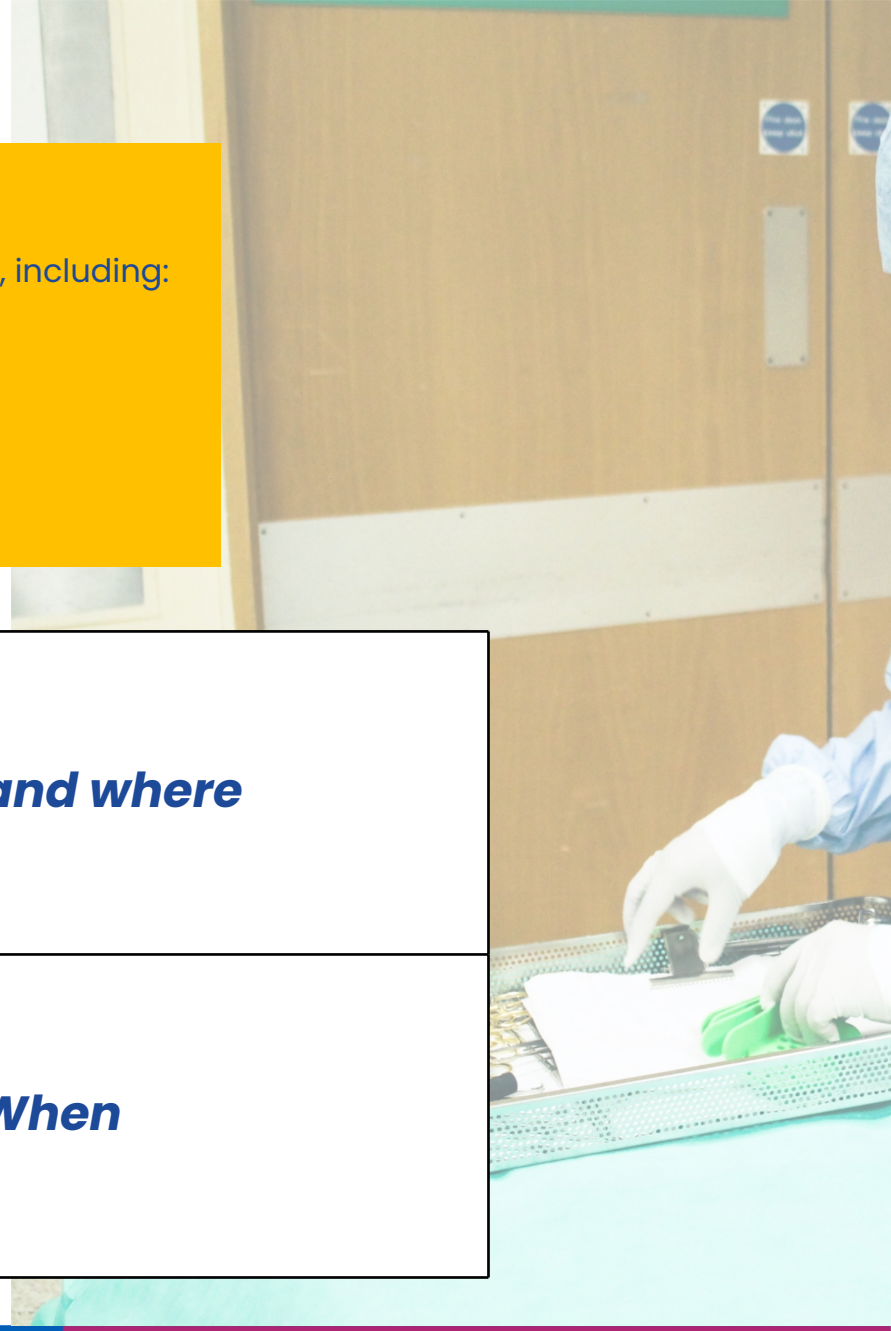
To lead the work each vision metric and strategic initiative has a responsible lead and a forum providing support to iterate the A3. These leads and forums are supported through 'clinics', led by the associate director of strategy and the head of coach house, which help with A3 iteration, strategic alignment, and provide a peer support network.

The content within the following slides is not exhaustive, but demonstrates the progress against each aspect of our strategy at the Trust-wide level.

Purpose

This paper aims to provide assurance to board that we are making progress against our strategy, including:

- How we're **measuring** our progress
- **What** we're doing to deliver progress
- **Who** is doing it and **where** that work takes place
- **When** we will expect to see benefit



Report format

Metric	***Who and where***
What	***When***

TITLE

Strategic Planning Framework 2025-26

Vision

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

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing Health Inequalities
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Reducing pressure injuries
- Reducing patients' wait time to first outpatient appointment
- Reducing staff unavailability
- Creating value for our patients

Strategic Planning Framework Ownership

		Executive Sponsor	Responsible Lead(S)	Contributing Forum(s)
Vision Metrics	Increasing staff engagement	Chief People Officer	Associate Director, Communications	Engagement Working Group & OD&P Management Board
	Increasing staff retention	Chief People Officer	Associate Director, Operational HR	Retention Steering Group
	Staff are treated equitably	Chief People Officer	Associate Director, Culture, OD & Learning	Dedicated working group
	Reducing wait times	Chief Operating Officer	Deputy Chief Medical Officer	Captured in Planned Care Board and UEC Board.
	Reducing patient harm	Chief Nursing Officer	Head, Risk Management	Dedicated working group
	Our population help improve our services	Chief Nursing Officer	Head, Patient Experience Deputy Chief Nursing Officer	Patient Experience Steering Group
	Reducing Health Inequalities	Chief Medical Officer	Associate Medical Director, Health Inequalities	Health Inequalities Operations Group Wiltshire Health Inequalities Group Dedicated working group
	Reducing overall length of stay	Chief Operating Officer	Deputy Chief Medical Officer	Captured in Planned Care Board and UEC Board.
	Organisational Sustainability	Chief Finance Officer	Associate Director, Finance & Deputy Director, Strategy & Operational Planning	Dedicated working group
Strategic Initiatives	Embedding our culture of continuous improvement	Director of Improvement	Head of Coach House	Dedicated working group
	Developing a sustainable workforce	Chief People Officer	Deputy Chief People Officer	Dedicated working group
	Delivering digital care to improve pathways	Chief Information Officer	Chief Information Officer	Digital Steering Group
	Designing services to meet population needs	Chief Operating Officer	Deputy Director, Strategy & Operational Planning	Dedicated working group

People

working for us

Vision

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

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

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- Organisational Sustainability

Strategic initiatives 3-5 years

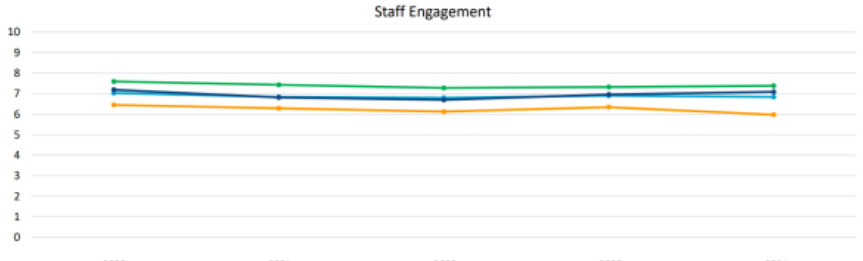
- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

Last report to board



	2020	2021	2022	2023	2024
Your org	7.19	6.82	6.70	6.96	7.09
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	2041	1858	1859	2254	2640

2024 increase to 7.09
Above a falling national average

Who & Where

The engagement vision metric is overseen by the Associate Director Communications, Engagement & Community Relations.

The AD CECR Chairs the Engagement Working Group.

The working group reports to the OD&P Management Board.

Increasing staff engagement

What

The engagement score is made up of questions that assess staff advocacy, involvement and motivation.
A core measure within these questions is staff likelihood to recommend SFT as a place to work and for treatment.
Due to positive progress over the past 2 years the goal is moving towards being the numerical scores being top quartile not just the national ranking.
We have focussed work on delivering the 7 elements of the People Promise – with a focus on listening to the workforce, rewarding and recognising staff, delivering improved wellbeing, developing line management skills and creating an inclusive, equitable and compassionate workplace.
It has been agreed that in 2026 *Tent Talks* will be held (19&20 May) – the theme will be "Leading through complexity" – along with leadership, team building and wellbeing sessions and some evening fun.
Data from the 2025 NSS is expected to be available very soon for internal analysis and will help direct activity in 2026.

When

2025/26

Building momentum behind recent results to generate further engagement.

2026/27

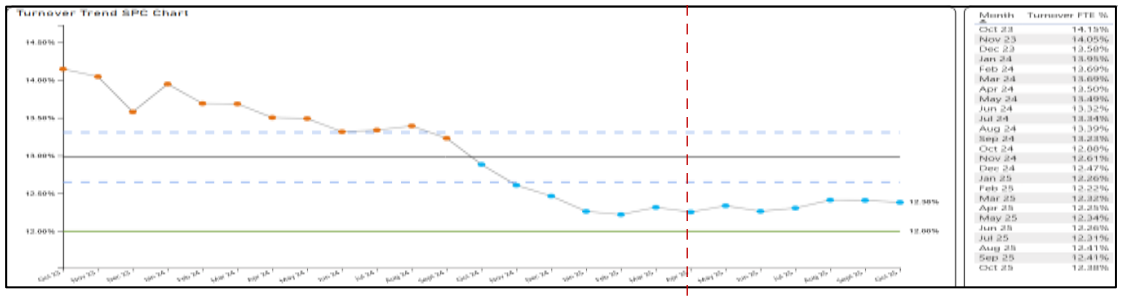
SFT scoring in the top quartile nationally.

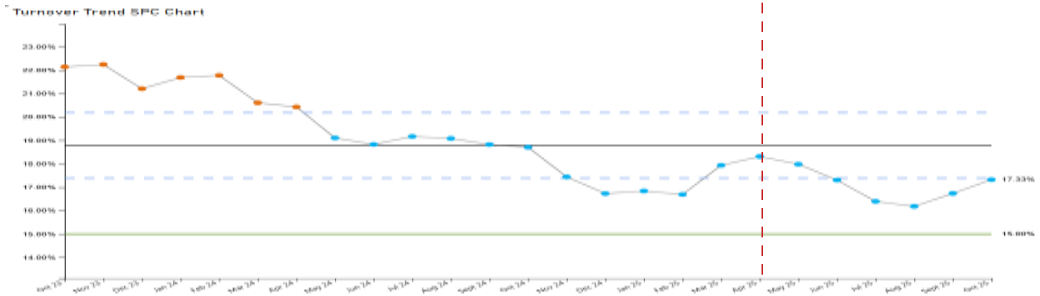
2027/28

Ranked top quartile for all People Promise elements and Morale and Engagement.

Reduced number of outlier engagement scoring depts. by 50% from 2024 figure.

Last report to board





Who & Where

The Retention Steering group meets monthly to review current workforce availability context (focussing on turnover, sickness absence and vacancy data). This also reviews progress against the current three focussed workstreams:

- Breakthrough Objective – Additional Clinical Services staff turnover has changed to Staff Availability
- 'We work Flexibly' People promise focus – Flexible working group
- Overhauling recruitment project – currently phase two of project focussing on improving ED&I elements of recruitment practice.
- Additional focus on absence management (short term sickness)

Retention Steering group (chaired by AD for HR Ops)
Flexi working group (chaired by HR BP Medicine)

The escalation report following each monthly Retention group meeting is presented at:

- OD&P management board
- People & Culture Committee

Increasing staff retention

What

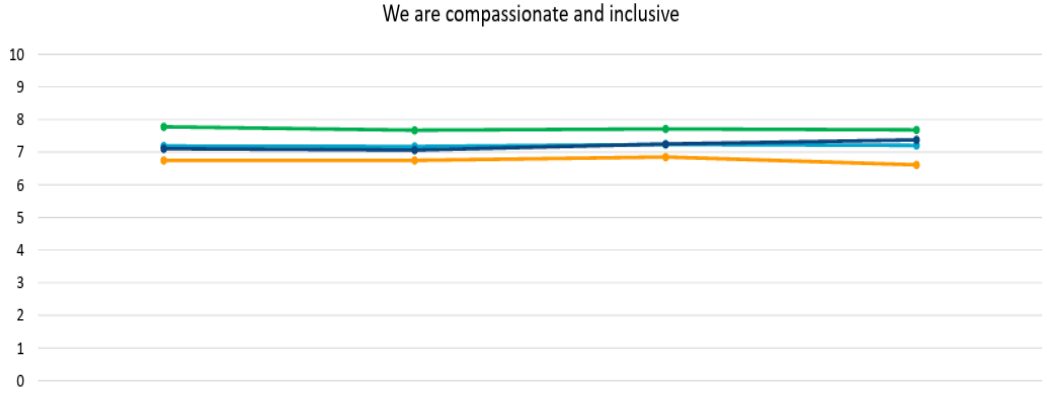
Most action addressing this Vision Metric since 2022 has been through trust-wide breakthrough objectives. Overall Trust Turnover had a target of 13% for 2024/25, the Breakthrough objective (BTO) for 2024/25 targeted the top contributing factor, which was turnover in the Additional Clinical Services staff cohort..
The BTO set an improvement target of reducing from 21% to 15% in 2024/25 & 2025/26.
Counter measures to support the BTO include:

1) Focus on improving Care certificate compliance amongst HCAs (progress 100% September 2025)
2) Introduction of HCA Preceptorship to improve support and induction available (progress 100% September 2025)
3) Overhaul of recruitment and onboarding: improved attraction material, more line manager involvement in selection process and introduction of shadow shifts/buddying for new to care staff & internal 'transfer' policy.

When

2025/26	*2026/27*	*2027/28*
BTO ACS turnover reduction achieved Trust Turnover @ c.12% BTO changed to Staff Availability	Improved staffing availability rates: Reduced absence / unavailability Reduced 'leavers' from the NHS	Sickness absence rates </= 3% Trust turnover rates </= 10%

Promise element 1: We are compassionate and inclusive



	2021	2022	2023	2024
Your org	7.11	7.07	7.25	7.38
Best result	7.78	7.67	7.72	7.69
Average result	7.19	7.18	7.24	7.21
Worst result	6.75	6.75	6.85	6.61
Responses	1816	1857	2254	2639

Staff are treated equitably

Who & Where

Executive sponsorship for this programme has been provided by the Chief People Officer (CPO). Strategic leadership and delivery responsibility are shared between the Associate Director of Organisational Development, Learning and Culture (ODCL), and the Head of Inclusion, Health and Wellbeing.

The ODCL Working Group reviews current workstreams and projects including those against this A3. In addition, a quarterly Equality, Diversity and Inclusion (EDI) Steering Group was established in September 2025. This group is owned by the Head of Inclusion & Wellbeing, currently chaired by the AD of ODCL, and includes a broad membership of key stakeholders, including network leads and heads of service. Its purpose is to oversee, challenge and guide the delivery of our strategic EDI Long-Term Plan 2024–2027 via the Inclusion and Wellbeing Delivery plan. This plan aligns with both the Wellbeing strategy and the NHS EDI Improvement Six High Impact Actions (HIAs).

Escalation reports for this work are received by:

- OD&P management board
- People & Culture Committee

What

Equitable treatment for all staff is the essential foundation upon which genuine inclusion and belonging are built, supported by a strong commitment to staff health and wellbeing so that everyone can thrive at SFT. To achieve this, we are:

- Operationalising the NHS EDI Improvement Plan's Six High Impact Actions as core strategic objectives guiding our approach to inclusion and wellbeing
- Launching Licence to Manage to equip managers with essential skills for people management skills incl Health Passports & reasonable adjustments
- Strengthening the development, reach, and impact of our people networks
- Continuing compassionate leadership programmes & embedding behaviour charters in teams
- Supporting & developing our internationally recruited nurses including mitigating detriment when speaking up
- Regularly raising awareness and celebrating significant events and achievements from our annual inclusion and wellbeing calendar

When

2025/26

10% of our 880 managers awarded Licence to Manage

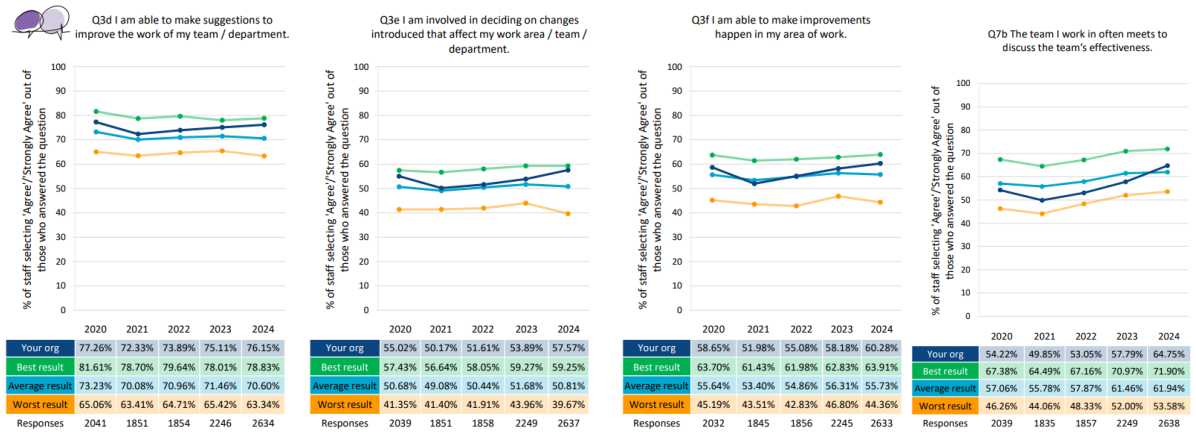
Health & Wellbeing strategy published

2026/27

Improved staff survey scores associated with bullying and harassment of our BME and disabled staff

2027/28

We are Compassionate Inclusive scores in Upper Quartile



	2020	2021	2022	2023	2024
Your org	77.26%	72.33%	73.89%	75.11%	76.15%
Best result	81.61%	78.70%	79.64%	78.01%	78.83%
Average result	73.23%	70.08%	70.96%	71.46%	70.60%
Worst result	65.06%	63.41%	64.71%	65.42%	63.34%
Responses	2041	1851	1854	2246	2634

	2020	2021	2022	2023	2024
Your org	55.02%	50.17%	51.61%	53.89%	57.57%
Best result	57.43%	56.64%	58.05%	59.27%	59.25%
Average result	50.68%	49.08%	50.44%	51.68%	50.81%
Worst result	41.35%	41.40%	41.91%	43.96%	39.67%
Responses	2039	1851	1858	2249	2637

	2020	2021	2022	2023	2024
Your org	58.65%	51.98%	55.08%	58.18%	60.28%
Best result	63.70%	61.43%	61.98%	62.83%	63.91%
Average result	55.64%	53.40%	54.86%	56.31%	55.73%
Worst result	45.19%	43.51%	42.83%	46.80%	44.36%
Responses	2032	1845	1856	2245	2633

	2020	2021	2022	2023	2024
Your org	54.22%	49.85%	53.05%	57.79%	64.75%
Best result	67.38%	64.49%	67.16%	70.97%	71.90%
Average result	57.06%	55.78%	57.87%	61.46%	61.94%
Worst result	46.26%	44.06%	48.33%	52.00%	53.58%
Responses	2039	1835	1857	2249	2638

SFT Trust position showing continued improvement since 2021 against four key questions – demonstrating that SFT is changing faster and further than other Trusts who are/are not adopting operational excellence approaches.

Further reporting using quarterly data (number of teams trained, use of methodology and golden thread) will be tested during Q4.

Who & Where

Exec Owner: Director of Improvement, with Head of Coach House and Continuous Improvement providing leadership support.

- Trust Wide Oversight: Monthly Improving Together Board (Trust wide roll out of nine workstreams). *Approach to be reviewed in line with the 18-month refresh of the latest roadmap (Oct 24–March 26).*
- Working Group: Monthly Dedicated Multi-disciplinary Team reviews the SI A3
- Supporting Group: Monthly Strategic Initiative Clinic Meeting (Trust wide)

Since September the Transformation and Coach House teams have established:

- Quarterly Senior Leadership Team PRM's to include all Execs.
- Monthly Senior Leadership Team Driver Lane Mtgs inc the Director of Improvement – this has helped reinforce routine PDSA cycles around the work of the SI
- Weekly SLT driver meetings

Transformation boards and Divisional Performance Reviews (DPRs)

- The work of the strategic initiative is supported by the standardised A3 thinking approach taken in our planned care and urgent & emergency care boards. Our DPRs support the development of a culture of continuous improvement via the use of a standard work and coaching approach from the Executives and DMTs.

Embedding our culture of continuous improvement

What

- Sharing and celebrating improvements to actively demonstrate the embedding of a culture of continuous improvement
- Building capacity by training staff to use improvement tools, behaviours and embed supporting routines
- Aligning our vision and the SPF so that it is understood and repeated across the organisation using visual management
- OD&L and Improvement training programmes to develop a workforce that can describe and understand the importance of Improving Together and the leadership behaviours
- Supporting staff to understand and describe the Trusts vision and strategy and their individual contribution to delivery via induction, training and the cascade brief
- Working across improvement programmes to increase patient involvement in our work to improve the value we deliver for them
- Establishing a benefits realisation approach across SFT
- Maturing a Trust-wide daily management system aligned to the SHINGO principles
- KPMG maturity assessment review – focus priority and next steps

When

2025/26

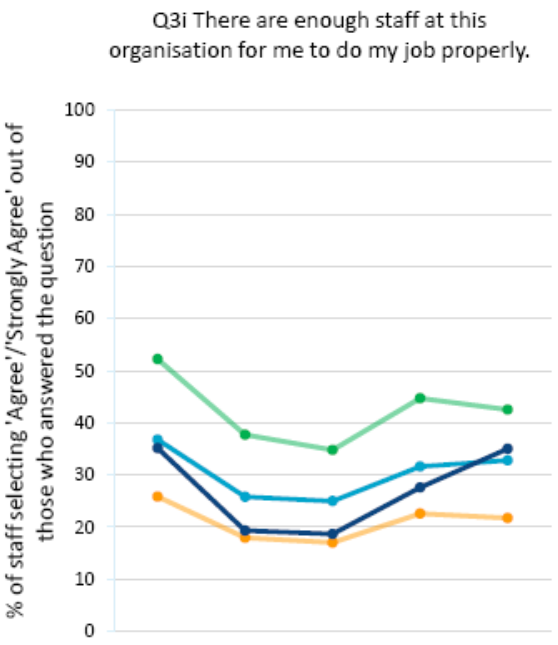
- Continue to develop, and embed, our leadership behaviour framework
- Explore and align our approach to deploying SI's
- Improve engagement and advocacy
- Review current root cause analysis approach and identify recommendations
- Review KPMG maturity review and prioritise top area of focus and opportunity
- Review and refresh Improving Together Board assurance approach

2026/27

- Continue to celebrate & share improvements
- Embed Root Cause Analysis to drive improvement
- Train 100% teams in improver standard by July 2026
- SFT continues to improve staff survey results in Q's 3d,3e,3f,7b.
- Embed continuous improvement self-led maturity assessment Trust wide
- Embed + align benefits mgmt
- Mature the daily management system (flow)

2027/28

- Transformational coaching leadership style for improvement is embedded across all levels of the organisation
- Mature daily management system to realise greater depth and pace of improvement
- The Shingo principles are widely recognised and understood across the TMC group.



	2020	2021	2022	2023	2024
Your org	35.13%	19.32%	18.65%	27.57%	34.99%
Best result	52.21%	37.72%	34.78%	44.71%	42.52%
Average result	36.76%	25.80%	24.95%	31.62%	32.77%
Worst result	25.83%	17.92%	17.00%	22.55%	21.73%
Responses	2034	1855	1855	2248	2634

Who & Where

The Chief People Officer providers executive sponsorship to this strategic initiative with the Deputy Chief People Officer providing leadership to deliver against identified countermeasures.

They are supported by the insights of the Workforce Systems Strategic Steering Group, and the four Working Groups chaired by OD&P Associate Directors which manage people promise initiatives against all seven elements of the people promise

The A3, and associated work that should move the metric, is overseen by the OD&P Management Board, and assured through the People and Culture Committee.

Across the Trust work to support organisational design within individual services is supported by HR Business partners for each Division.

Developing a sustainable workforce

What

Analysis demonstrates that we have insufficient knowledge and skills to develop a sustainable workforce which meets the needs of the Trust in the next 5 years. Therefore, there is a risk that SFT will be unable to provide the care and support to patients that is required in the future. To address this risk, four principle workstreams are underway:

- Cross-trust strategic workforce planning to develop a viable long-term workforce plan, which identifies staff roles, embraces new skillsets and identifies the training requirements to support staff development. Recent work has focussed on action to address the 5 clinical services assessed as frail.
- Advancing our talent management approach to develop capability internally. Initial work has focussed on Execs and the TMC cohort of staff
- The retention focussed breakthrough objective, given its role as the top contributor to the retention Vision Metric.
- Delivering our EDI long term plan with a focus on 6 high impact actions and identified areas of concern, and the furthering of our 'we all belong' Vision Metric understanding.

When

2025/26

Improved metrics associated with our Engagement and retention vision metrics.

Improved line management skills training

Talent management plan initiated.

2026/27

Realised improvements in our retention position following breakthrough objective impact.

Correlation of long term workforce plan initiatives and training requirements starts

2027/28

All associated metrics in the top quartile nationally ('enough staff', retention, WDES & WRES)

Population

our patients and their families

Vision

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

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing Health Inequalities
- Reducing overall length of stay
- Organisational Sustainability

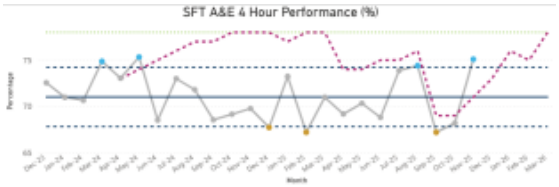
Strategic initiatives 3-5 years

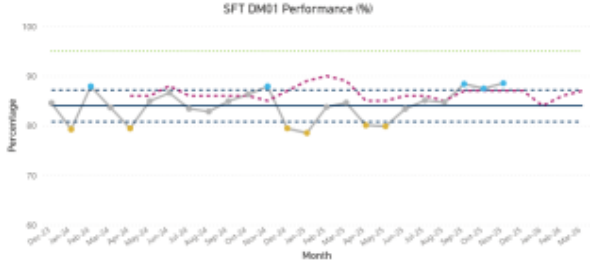
- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients





Who & Where

While this A3 has no specific working group, planned care board covers much of the work.

However, improvements in estate, workforce and digital e.g. RPA will positively impact our performance which aren't covered in this meeting but escalate through other routes and the vision metric lead (Deputy Chief Medical Officer) is given sight of those escalations.

Reducing wait times

What

UEC Board are taking actions to improve ED4h performance. Focus on ED culture and non-admitted breaches, expansion of SDEC workforce now achieved

DM01 is currently challenged from USS, endoscopy and audiology perspective however these are understood with actions to mitigate. Improved utilisation of the CDC through the year will help further improvements in performance.

OPD operational group has now been established to review all aspects of OPD e.g. estates, process, pathways, and booking. With improvements to follow from Q3 onwards

Theatres - Perioperative journey group that links pre-op, central booking and theatres into one team is now fully established and increasing productivity.

When

2025/26

UEC Board improvement work impact on 4hr performance.

Outpatient transformation.

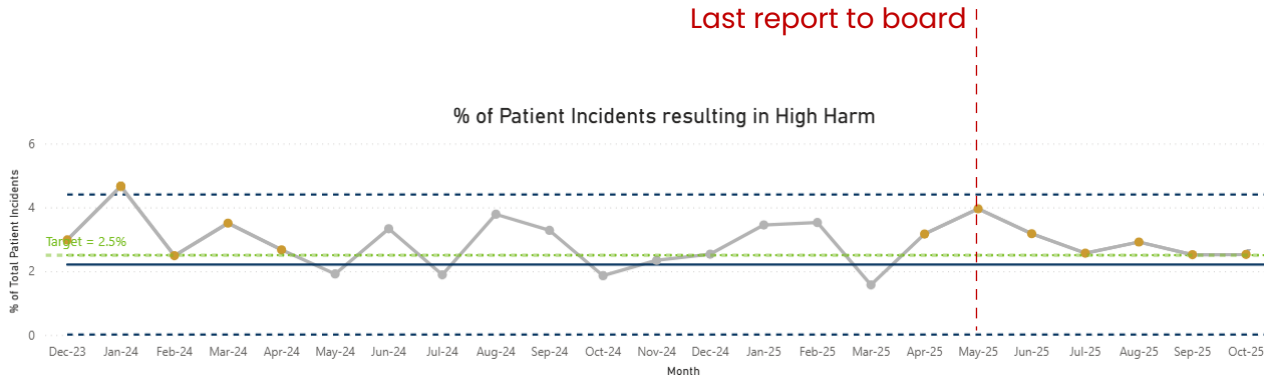
Theatre utilisation and waits work impact.

2026/27

Benefits of outpatient transformation fully felt, i.e. productivity improvements through standardised templates.

2027/28

Return to constitutional standards.



Who & Where

- Breakthrough Objective receives executive oversight at the Engine Room and is worked on within divisions
- Patient Safety Summit (chaired by Head of Risk Management)
- Patient Safety Steering group (chaired by Head of Patient Safety)
- Patient Safety Oversight group (chaired by Consultant Anaesthetist/Clinical Scientist)
- Learning from incidents forum (chaired by Heads of Nursing)
- The Vision Metric working group consists of the Chief Nursing Officer, Deputy Chief Medical Officer, Deputy Chief Nurse, Head of Risk management, and the Head of Patient Safety. This group meets quarterly.

Reducing patient harm

What

The key priority lies in fostering a proactive culture of patient safety—one where staff feel empowered and supported to speak up, report incidents, and raise concerns openly. This approach is critical to ensuring the effective and safe delivery of care.

To achieve this, we will:

- Enhance our understanding of the three most frequently reported incidents—falls, pressure ulcers, and medication errors. Examining the gap between 'work as imagined' and 'work as done,' and embedding a Safety-II perspective that focuses on learning from everyday clinical practice and what goes right.
- Conduct a thematic analysis of these key patient safety categories to uncover underlying contributory factors and inform targeted improvements.
- Triangulate findings across these analyses to develop robust, evidence-based strategies for sustainable improvement.

When

2025/26

Pressure damage Breakthrough Objective (Q2).

10% Falls reduction by April '26.

Medicine Management for omitted and delayed critical medicines

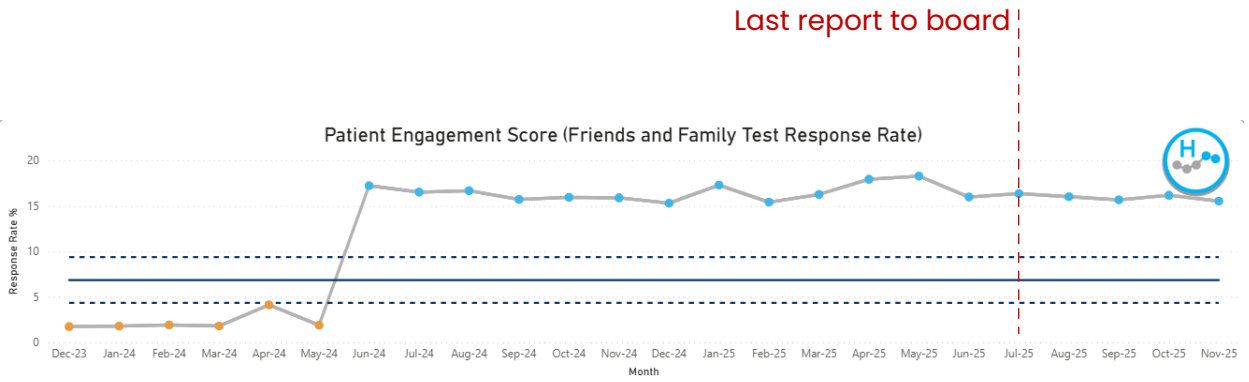
2026/27

Conduct thematic analysis of falls, pressure ulcers, and medication errors using Safety-II principles.

Establish baseline metrics for incident rates and staff reporting culture

2027/28

Develop sustainability plan for continuous improvement beyond 2028



While FFT provides part of the picture, and is our largest means of collating feedback, further metrics are under developing focussed on tracking our increasing patient involvement in service design.

Who & Where

The Chief Nursing Officer providers executive sponsorship to this vision metric with the Head of Patient Experience, and Deputy Chief Nurse, providing leadership to the A3. They are supported by the insights of

Work is underway across the organisation beyond the vision metric leadership and A3 iteration forums, for example:

- Cancer services are increasing targeted patient engagement, i.e. through outreach to our traveller population.
- The Stoma, Parkinsons, and learning disability groups are maturing.
- We have matured to a place where each specialty has patients available to engage with on service design. PALS continue to help facilitate 'how' those patients are brought in to that work.

Our population help improve our services

What

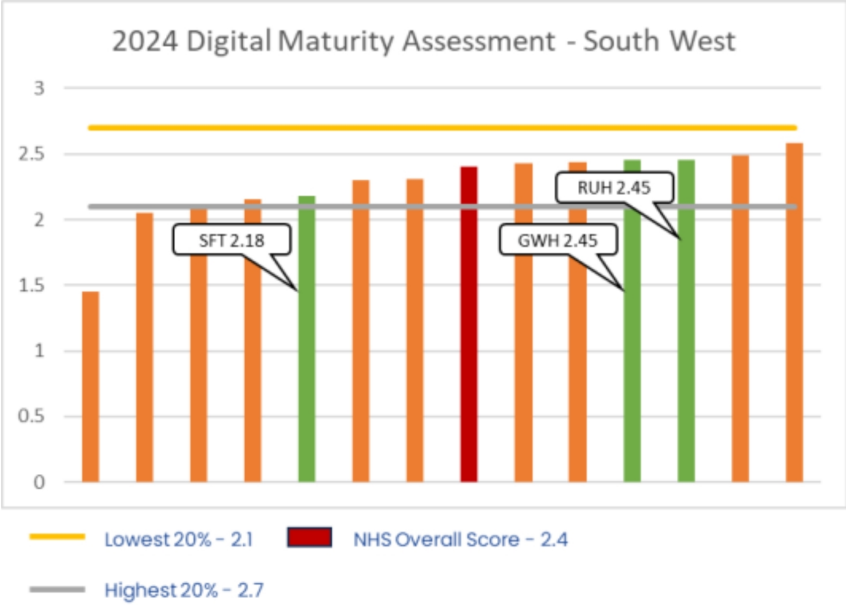
Key pillars of work affecting the metric have included the digitisation of the process, ensuring a more visible PALS presence around the estate, and the establishment of quarterly meetings to pull together all of the activity impacting how our population can improve our services.

Specifics include:

- Replacement of FFT signage and consideration of a PALS presence in the main entrance of the hospital.
- Improvements to the SFT website and showcasing patient led initiatives internally through divisional updates and patient stories to Board.
- Increased inclusion of patients in service redesign, such as in the new strategic initiative 'Designing services to meet population needs'.

When

2025/26	*2026/27*	*2027/28*
FFT response rate >17%. 95% rated good or very good. Increase patient involvement through service design panels.	Centralised co-ordination of patient engagement in service design. Clear process for measuring patient engagement with designing services.	No service redesign or pathway development will take place without patient involvement.



Metric #2: Bi-Annual pulse score

Q. "I have a good overall experience when using technology and business intelligence tools in my place of work." (agree or fully agree)

July 2024: 49.1%

Agreed to be included each January and July in pulse survey to ensure consistency.

Who & Where

The Trust's digital agenda is overseen through Digital Steering Group (DSG) which chaired by the Chief Medical Officer, has executive members plus a range of digital team and wider members.

The Corporate Project Prioritisation Group (CPPG), prioritises new requests that require resourcing with all divisions represented.

Digital Leadership ensures delivery of overarching requirements across the digital portfolio including effective digital governance and risk management below DSG. The Group Transformation and Innovation Officer (CTIO) holds the executive digital portfolio. Both the CTIO and the Chief Information Officer are members of the ICS Digital Board.

Digital Clinical Leadership in place to support engagement and drive the use of technology and data to enable change.

EPR Governance in place with Board EPR sub-committee with executive leads from each Trust as members. Key executive and senior leads for the Trust sit on the wider EPR governance below this including EPR Programme Board, Clinical Design Authority and Operational Readiness Group. A local EPR Delivery Group (chaired by Deputy Chief Operating Officer) looks to ensure local activities are delivered on time.

Delivering digital care to improve pathways

What

Key activities to support improvement of digital maturity include:

- Implementation of the Shared EPR and optimisation post go live. Post Go Live optimisation includes key clinical pathway redesign across the hospitals group.
- Implementation of complementary systems to the EPR, supporting sharing of information and improved clinical pathways. i.e. BadgerNet Neonates and GP ICS Order Comms.
- Implement and embed an improved digital engagement and digital literacy model across the Trust.
- Increase the availability of end user devices and networked medical devices to ensure staff can function in a paperless fashion and implement improved network capability as a key enabler.
- Implementation of a Hospitals Group Digital function to ensure we have the resilience and right structures to support the future needs of digital and analytics.

When

2025/26	*2026/27*	*2027/28*
EPR engagement and digital literacy plans implementation. Roll out Phase 2 network improvement and end user devices. Implement Group Digital Function.	EPR implementation programme. Refresh of Group and local Digital Plans. Group dashboard alignment	EPR Go Live . Commence clinical pathways redesign using EPR. Phase 3 of network improvement programme. Implementation of GP ICE Order Comms. BadgerNet Neonates.

Partnerships

working with us

Vision

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

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Partnerships
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- Recognising and managing patient deterioration well
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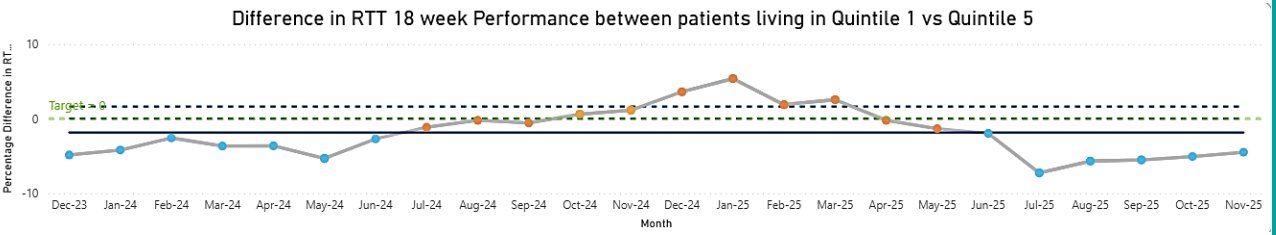
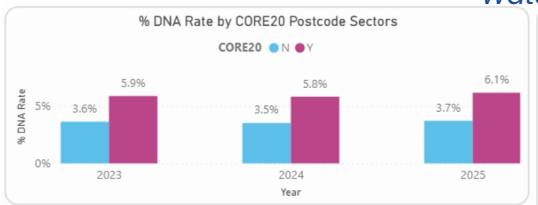
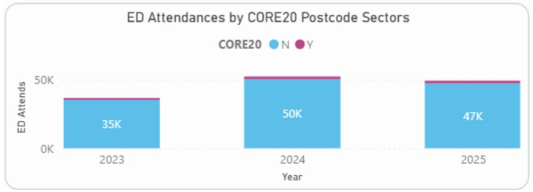
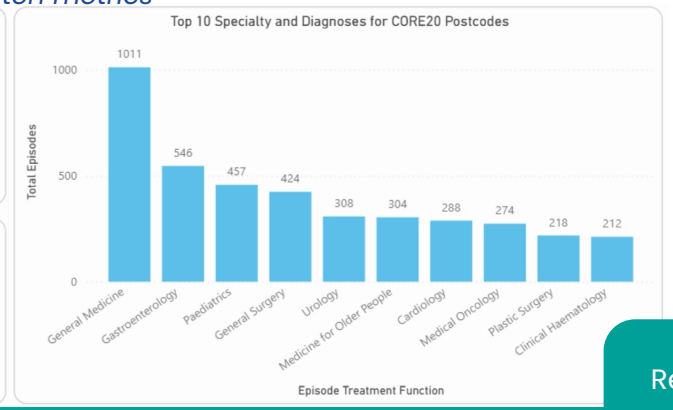
***NEW** metric to align with Group IPR.*



Watch metrics







Who & Where

The iteration of the A3 takes place quarterly within the internal A3 development group. This is made up of the Chief Medical Officer, Associate Medical Director for Health Inequalities, Associate Director of Strategy, and a Wiltshire Council Public Health Consultant.

The WHIG meets monthly and the below working groups report to it.

- The SFT Health Inequalities Ops Group, which meets monthly and is chaired by the Deputy Chief Operating Officer with representation from across the divisions.
- The 5 clinical specialties that make up the CORE20PLUS**5** model chaired by respective clinical leads for those specialties

The WHIG reports to CMB, BSW Inequalities Steering Group, and to Wiltshire Council H&W Board quarterly.

Reducing Health Inequalities

What

With health inequalities covering both health*care* inequalities (largely a function of access) and health inequalities in the population we have chosen to focus most of our organisational effort on healthcare inequalities where we can have the most impact. We will continue to influence forums for broader health inequality work such as the Wiltshire Health Inequalities Group (WHIG) and their efforts in broader public health.

We have completed projects internally and externally such as the improvement sprint which resulted in a 30% reduction in time LDAN patients wait for care. Externally we have leveraged system funds to improve the diet of local children, and in 2025/26 will have live projects on paediatric DNA rates and cancer screening.

When

2025/26

Paediatric 'not brought' (DNA) reduction project.

Cardiology pathway inequity investigation.

Impact on families of military personnel.

2026/27

Impact of U5 Health project in target LSOAs – i.e. dental.

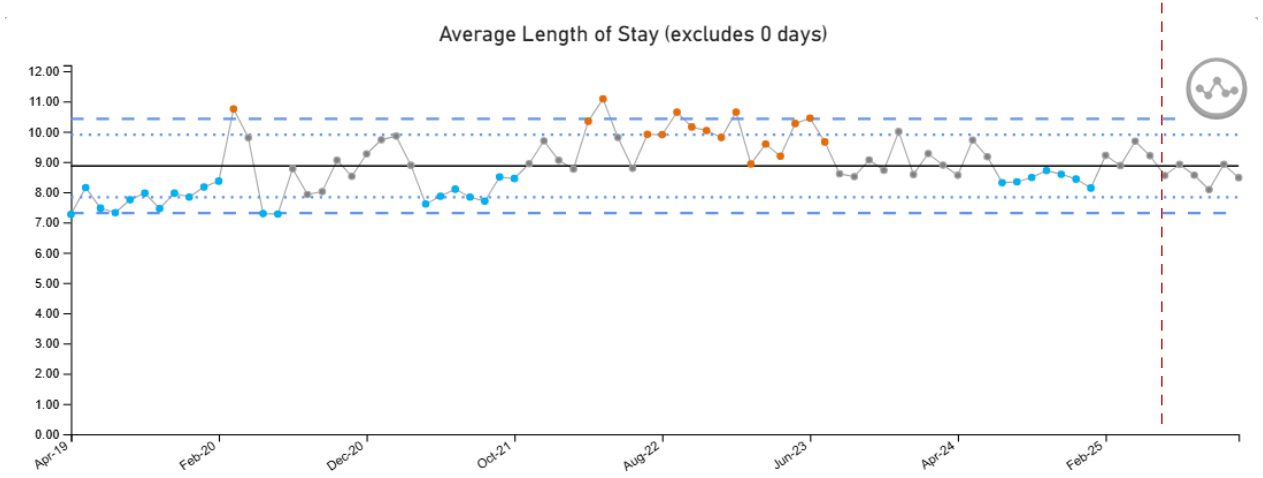
Support to BSW work with PLUS group access to care.

2027/28

Embedded impact of Ops group policy / SOP changes.

EPR pathway design opportunities and protected characteristic flagging.

Last report to board



Who & Where

- Draws on aspects of work from planned care board and UEC board.
- Shared EPR model pathways will have a positive impact on LoS and that work is underway within the programme and will be escalated through Digital Steering Group.
- Work with HCRG on flow takes place at both executive and working level bi-lateral engagement.
- Work to improve LoS on the wards is taking place using our Improving Together methodology and by empowering local teams to make the changes that will have a local impact.

Reducing overall length of stay

What

Several workstreams across the organisation will impact on our LoS position:

NCTR – We have positive impact data from the introduction of AFU and the work on Breamore. Headline numbers remain high but interface delays have been reduced

SDEC expansion will take more 1+ day LoS spells down to 0-day LoS, this is slated for Q2/3 2025/26 and includes both expansion to 7 days and specialty expansions (Surgery and frailty). Recruitment now complete with new model of working currently being determined

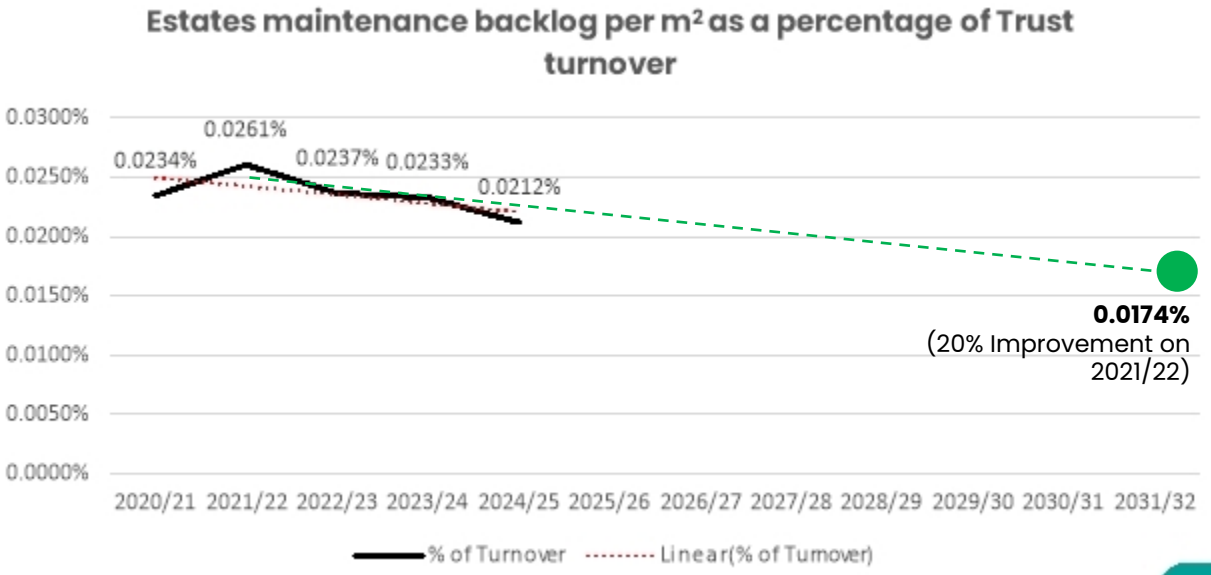
Acute Frailty Unit (AFU) has resulted in significant reduction in LoS (17 days to sub-5) and is maintaining this performance.

Ward Process working group – newly established looking at culture and standardising care on in-patient wards.

Broader work with **HCRG** as they take on the community services contract will target reducing LoS beyond NCTR through flow-out improvements.

When

2025/26	*2026/27*	*2027/28*
HCRG community services transformation is part of system plan to reduce NEL demand by 3.6%. SDEC expansion will make immediate impact.	Maintained performance realised, in light of increasing demand, a positive outcome of our interventions.	Realisation of integrated neighbourhood teams and left shift will result in fitter patients and better flow. EPR model pathway deployment.



Who & Where

- The Value Breakthrough Objective receives executive oversight at the Engine Room and is worked on within divisions thanks to 38 individual drivers. There are also 3 Trust-wide deployable resource tickets allocated to the work. The Vision Metric executive sponsor is the Chief Financial Officer, and the responsible leads are the associate directors of finance and strategy.
- Further contributions to, and scrutiny of, the relevant work takes place at:
  - Financial Recovery Group
  - Strategic Capital Committee
  - Sustainability Committee
- The Vision Metric working group consists of:
  - Chief Finance Officer (Executive Sponsor)
  - Deputy Director, Strategy & Operational Planning
  - Associate Director of Finance (Responsible Lead)
  - Programme Director
  - Head of Facilities (and sustainability lead for the Trust)

Organisational Sustainability

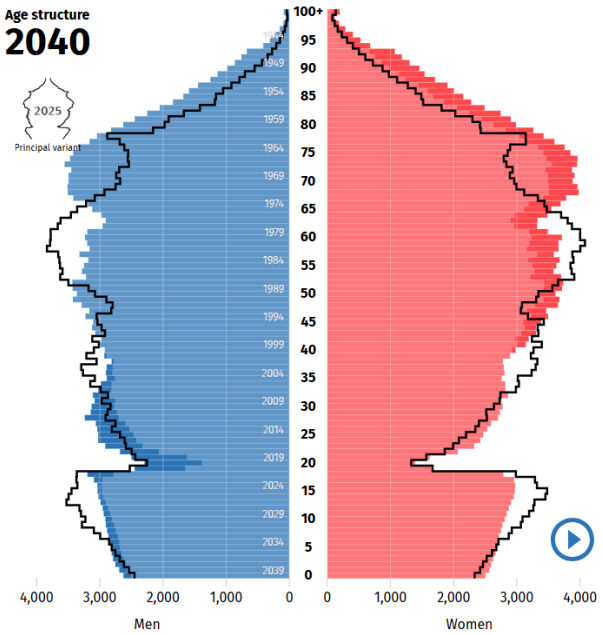
What

The key elements which underpin this priority include: financial sustainability, having an infrastructure that reflects the needs of a modern hospital (including environmental sustainability), and our role as an anchor institution. To address these we are:

- Driving short term change through our 'Creating Value for our Patients' Breakthrough Objective.
- Addressing backlog maintenance through specific programmes of work (DSU, Spinal, Maternity) in line with our 10-year campus masterplan.
- Progressing our decarbonisation work through opportunities to heat the site through local ground source heating.
- Options appraisals underway on the use case for South Newton since acquisition.

When

2025/26	*2026/27*	*2027/28*
Breakthrough Objective 10% improvement in productivity. Continued addressing of backlog maintenance.	Medium term DSU replacement plan online. Spinal refurbishment and reprovision.	Estates master plan roadmap actions such as maternity improvements.



As an emerging strategic initiative, the metric is to be determined. Current candidates to show the right progress include ED attendances per 100,000 of population, referral free pathways as a percentage of total pathways, hospital readmission rates, as well as acute and primary care caseload relative to population size.

Who & Where

Executive sponsorship is provided by the Chief Operating Officer, with the responsible lead for the programme of work being the deputy director of strategy & operational planning.

A working group has been established and is currently completing a series of A3 workshops. This group includes representation from community and primary care, internal SFT colleagues including clinical staff, performance and data colleagues, public health, ICB place leadership, and the patient voice.

Designing services to meet population needs

What

As a new strategic initiative the methodological process is underway to refine the problem statement, apply an appropriate metric, build a team to iterate the programme of work, and define by when benefits will be realised.

Workshops with representatives from across the system took place in May and July to iterate the problem statement and begin root cause analysis.

What is clear is that our services must change to meet the demographic shifts in our population, including the outsized demand in population growth affected by long term conditions and Wiltshire's (nationally significant) ageing population.

When

2025/26	*2026/27*	*2027/28*
Initiative defined with clear problem statement, metric, root cause analysis and programme of work stood up. Early pathway redesign opportunities identified.	Clear programme of work to innovate across our services, including realising left shift and associated service change.	Clear evidence of services redesigned to meet the changing needs of our changing population..

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	8 January 2026		

Report title:	Register of Seals			
Status:	Information	Discussion	Assurance	Approval
	✓			
Approval Process: (where has this paper been reviewed and approved):	Approved by Nick Johnson, Managing Director			
Prepared by:	Sasha Godfrey, EA and Board Support Officer			
Executive Sponsor: (presenting)	Tapiwa Songore, Head of Corporate 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 November 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.

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
394	30 October 2025	SDH North Refurbishment	Rob Webb	Mark Ellis	-
395	20 November 2025	Part of Block 40, SDH and Oxford Health – Supplemental Lease	Laurence Arnold	Mark Ellis	Nick Johnson
396	29 December 2025	Salisbury NHS FT and GT Energy UK Limited Innovation Partnership Agreement	Rob Webb	Mark Ellis	-

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