BSW HOSPITALS GROUP

NHS
Salisbury
NHS Foundation Trust

Quality Account 2025/26

Glossary of Terms

AFU	**Acute Frailty Unit**
AMaT	**Audit Management and Tracking System** *A system to manage Clinical Audits, NICE compliance and Mortality reviews through real-time data and action control*
AMU	**Acute Medical Unit**
BadgerNet	*A nationally hosted platform designed to provide a complete electronic patient record of maternity care.*
BSW	**Bath and North East Somerset, Swindon, and Wiltshire**
C.diff	**Clostridium Difficile** *A type of bacteria that commonly causes diarrhoea*
CESG	**Clinical Effectiveness Steering Group**
CMB	**Clinical Management Board**
CNST Maternity Incentive Scheme	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme** *The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. The scheme incentivises ten maternity safety actions*
CQC	**Care Quality Commission** *The independent regulator of health and adult social care in England*
Datix	*A patient safety and risk management system that integrates safety, risk and governance elements to support the Trust's overall risk management strategy and help reduce risk and improve patient safety*
DOLS	**Deprivation of Liberty Safeguards** *A set of checks under the Mental Capacity Act 2005 which provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm*
EPMA	**Electronic Prescribing and Medicines Administration** *A system used in hospitals and other healthcare facilities to replace traditional paper-based prescribing and medication administration processes with a fully digital workflow*
EPR	**Electronic Patient Record** *A digital platform that brings patient information together in one place, including notes and assessments, results of investigations and prescribed medications.*
Friends and Family Test	*A feedback tool that anyone can use to give quick, anonymous feedback to providers of NHS services*
GIRFT	**Getting It Right First Time** *A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change*
Health Education England	*A body of the Department of Health and Social Care that supports the delivery of excellent healthcare and health improvement to the patients and public of England*
Improvement Huddles	*Improvement Huddles are where teams come together to work on improvement ideas linked to their goals.*

ICB	**Integrated Care Board** *Each Integrated Care System will have an Integrated Care Board. This is a statutory organisation that will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS*
ICS	**Integrated Care System** *A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area*
LEARN (MLE)	*A web-based system that allows staff to access all their training and development activities.*
Licence to Manage Programme	*A programme designed to equip staff new to line management or who aspire to become a manager with the essential people management skills needed*
Mental Capacity Act	*A law which is designed to help people who cannot make decisions for themselves because they lack the mental capacity to do so*
Medical Examiner	*A senior medical doctor who is trained in the legal and clinical components of the death certification process*
MDT	**Multidisciplinary Team** *A collaborative group of professionals from different disciplines working together to provide coordinated care or address complex issues.*
MARAC	**Multi-Agency Risk Assessment Conference** *A meeting where information is shared on domestic abuse cases deemed to be high risk. Representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors, probation and other specialists may attend.*
No Criteria to Reside	*Patients who are medically fit for discharge*
NEWS2	**National Early Warning Score 2** *A scoring system to help determine the severity of illness in patients*
NHSE/I	**National Health Service (NHS) England/Improvement**
NICE	**National Institute for Health and Care Excellence** *A body of the Department of Health and Social Care that produces guidelines*
NIHR	**National Institute for Health and Care Research** *The NIHR is funded by the Department of Health and Social Care to improve the health and wealth of the nation through research.*
PALS	**Patient Advice and Liaison Service** *Offers confidential advice, support and information on health-related matters and provides a point of contact for patients, their families, and their carers*
POET	**Patient Observation Electronic Tool** *The Trust's platform for recording: clinical observations with graphical charts, neurological observations, lying and standing blood pressures and patient wellness questions (Martha's rule)*
PROMs	**Patient Reported Outcome Measures** *Assess the quality of care delivered to NHS patients from the patient perspective*
PSIRF	**Patient Safety Incident Response Framework** *Outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted*

Patient Safety Partner	*A voluntary role that ensures patient involvement in organisational safety, supporting and contributing to healthcare governance and to the management of patient safety processes*
Scorecard Agreement	*A Scorecard Agreement is a meeting where a team present their chosen driver and watch metrics to their managers and agree what areas to focus on for improvement.*
SDEC	**Same Day Emergency Care**
SFT	**Salisbury NHS Foundation Trust**
SHMI	**Summary Hospital-level Mortality Indicator** *The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of the patients being treated*
Structured Judgement Review	*A process for undertaking a review of the care received by patients who have died*
Sharing Outstanding Excellence	*A method of paying a compliment to a team or a member of staff and a way of learning from when things go well*
UEC	**Urgent & Emergency Care**
UKAS	**United Kingdom Accreditation Service** *The National Accreditation Body for the United Kingdom. They are appointed by the government, to assess and accredit organisations that provide services including certification, testing, inspection, calibration, validation and verification.*
VTE	**Venous Thromboembolism** *A blood clot that starts in a vein*

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Introduction

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

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

Part 1 – Statement on Quality from the Chief Executive

I am pleased to present the Quality Account for 2025/26 for Salisbury NHS Foundation Trust (SFT). This report highlights our performance against key priorities over the past year and outlines our main areas of focus for 2026/27.

Last September, we welcomed our new Managing Director (MD), Nick Johnson, following Lisa Thomas's move to Great Western Hospitals, Swindon as MD.

Despite significant challenges over the past 12 months - including financial pressures, workforce constraints and national change - the Trust has continued to deliver high-quality, compassionate care and a strong patient experience.

We have also made important progress in innovation and improvement. Our continuous improvement methodology, ***Improving Together***, is delivering tangible benefits at SFT. Healthcare Assistants report feeling better supported, more confident, and more likely to remain in their roles, supported by our achievement of 100% Care Certificate compliance. This approach aligns with developing collaboration across the three Trusts in the BSW Hospitals Group (SFT, Royal United Hospitals, Bath and Great Western Hospitals, Swindon). By working, improving and learning together, we are enhancing our ability to deliver modern, effective and high-quality care to our communities.

Partnership working is further demonstrated through the opening of our new Discharge Hub in the Elizabeth Building, improving discharge processes and strengthening collaboration with HCRG Care Group and Wiltshire Council.

I am particularly proud of the progress of our Surgical Same Day Emergency Care (SDEC) unit. Established a year ago through the reconfiguration of the Surgical Assessment Unit (SAU) on Britford Ward, the service has responded well to a 21% increase in demand since 2024. Improvements include a dedicated clinical lead, enhanced triage pathways, extended hours with increased senior medical cover, and direct GP referrals that allow patients to bypass the Emergency Department where appropriate.

These changes have improved performance, patient flow and productivity. Notably, the time from arrival in the Emergency Department to transfer to Surgical SDEC/SAU has reduced from 74 minutes in 2024 to under 60 minutes in 2025, helping to relieve pressure on emergency services.

We have also adopted the Patient Safety Incident Response Framework (PSIRF), which supports a coordinated, data-driven approach to patient safety, with a strong emphasis on compassionate engagement and learning. The Trust remains committed to fostering a just and restorative culture that supports continuous improvement.

Despite ongoing pressures from increased Emergency Department attendances during 2025/26, we have seen improvements in key performance measures, including four-hour performance, ambulance handover times and reductions in long waits. While further progress is needed in some areas, it is encouraging that 78% of patients with suspected cancer are now receiving a diagnosis or an all-clear within 28 days of referral (February 2026 data).

Our staff are our most valuable asset, and we continue to invest in their experience at work. The 2025 NHS Staff Survey places Salisbury in the top half nationally, reflecting positive progress in staff engagement and wellbeing.

We are also proud to celebrate national recognition for our colleagues. This year, Katie Ransby and Champi Dona received the National Chief Nursing Officer's Silver Award, and Vicki Marston received the Chief Midwifery Officer's Silver Award for their outstanding contributions to patient care.

The quality of care we provide is reflected in feedback through our Sharing Outstanding Excellence Awards. One nomination shared:

"My wife and I had been living in the hospital since December, after the birth of our daughter eight weeks early, and the Neonatal Team was fantastic. Team members helped us stay strong together rather than falling apart."

On behalf of the Trust Board, I would like to thank all our staff across every profession. Your dedication and compassion make a profound difference to our patients every day.

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

Cara Charles Barks,
Chief Executive Officer

2A - Priorities for Improvement

Salisbury NHS Foundation Trust

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

Quality Priorities for 2026/27

Introduction

Our Vision and Goals

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

To deliver the Government's 10 Year Health Plan, and the Trust vision, we needed to develop the way in which we all work together and learn. Therefore, in 2020 the Trust undertook a significant conversation with staff. This conversation enabled staff to express in their own words what it felt like to work at the Trust.

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

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

Improving Together

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

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

Our Improving Together approach to delivering our strategy and continually improving has continued to mature throughout the strategy lifecycle and in 2026 we will publish an extension to our strategy so as to maintain constancy of purpose while we form BSW Hospitals Group and the headline Group strategy. All three acute Trusts in our Group have rolled out Improving Together to align and enable the collective abilities of our workforce to transform and continually improve our services. We are seeking to align our direction, goals, and objectives whilst empowering teams at all levels to maximise their contribution and potential in a focused approach. We are focusing on setting clear expectations and using a coaching leadership style to support problem solving.

Our Key Priorities

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

In 2026/27 we plan to improve the quality of care primarily through the Trust's Improving Together programme and the work that feeds into the selection of our primary 18-24-month objectives (widely known as our 'Breakthrough Objectives').

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

Through this process, and in addition to the work of Improving Together, our key priorities for 2026/27 have been identified. These are outlined in this section of the report.

Delivering Quality and Patient Care through Improving Together

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

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

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

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

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

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

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

Our 18-24 month 'Breakthrough Objectives' for 2026/27 are:

- ✓ **Reducing Pressure Injury**

  After successfully reducing the numbers of patient falls and falls with harm, and enhancing our management of patient deterioration this breakthrough objective is our next priority for our reducing patient harm vision metric: reducing the rate of pressure injury per 1,000 bed days. Our target is **a sustained reduction in the rate over a 6-month period.**

- ✓ **Reducing time to first outpatient appointment**

  After a year in which we successfully reduced waiting times to a patient's first outpatient appointment, we will take our learning into 2026/27 and aim **to reduce waiting times further still.** We recognise there are some key specialties requiring further support and a dedicated package of improvement coaching has been put in place to deliver in areas where there is the most opportunity for improvement. **We aim to reduce the time to first outpatient appointment to 90 days in 2026/27.**

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

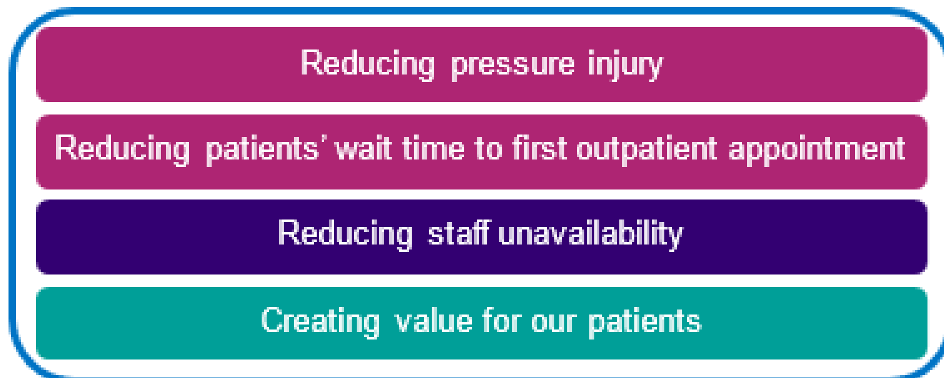
- ✓ **Reducing staff unavailability**
  Flowing from our vision metric to increase staff retention, this breakthrough objective has focused on a top contributor – staff unavailability. Our target is not 0%, as some aspects of unavailability are necessary and desirable, such as annual and study leave. **18% would represent a strong position for the organisation**.

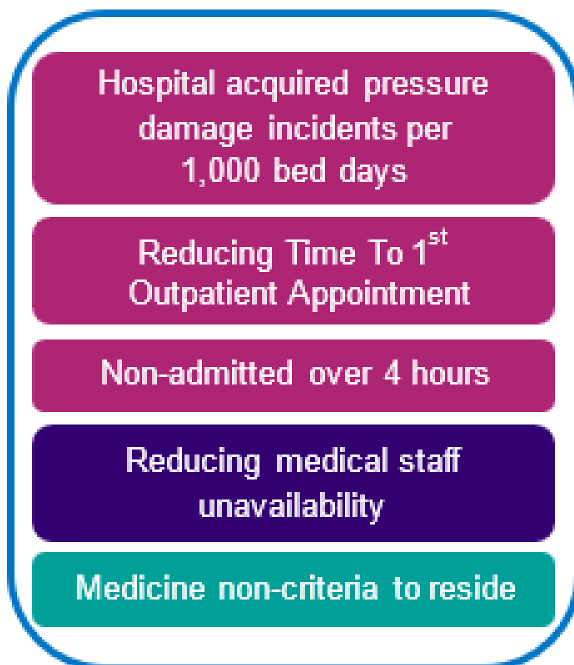
The Trust-wide breakthrough objectives give focus to the top challenges facing the Trust. For example, our vision metric of reducing the total incidents with moderate or high harm show patient deterioration to be the top contributor. Through the Improving Together methodology we first focus on patient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

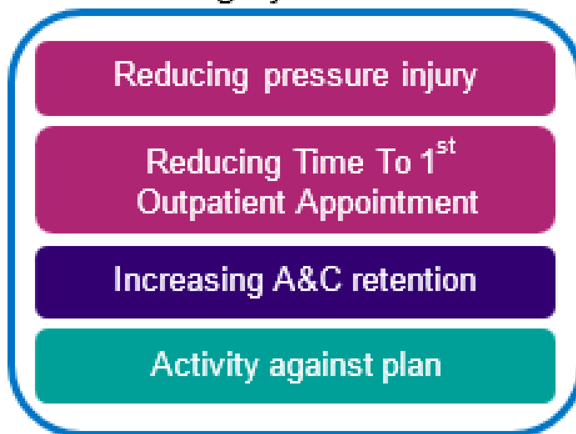
This enables us to prioritise our work and resources to the biggest areas of potential improvement instead of spreading teams too thinly across multiple priorities at the same time.

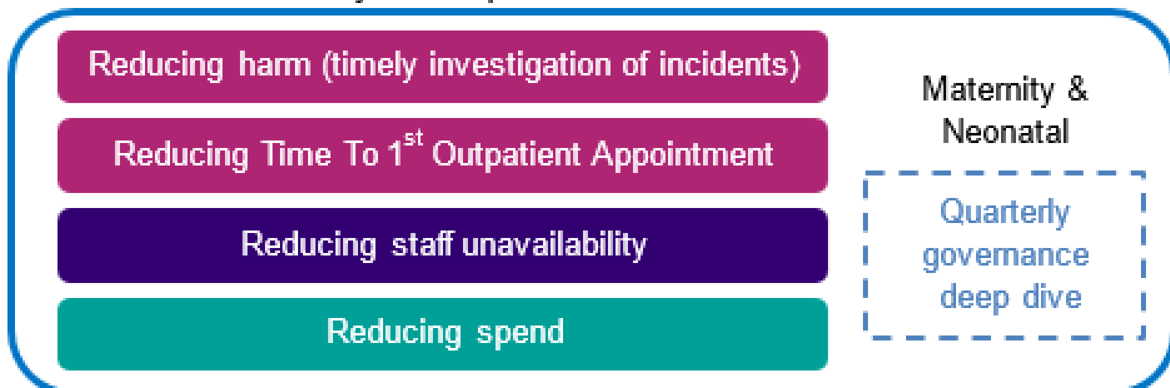
Our approach to quality improvement doesn't stop at the four Trust-wide breakthrough objectives. The Improving Together approach feeds into our Divisions, specialities, and teams. The areas of focus, known as driver metrics, for each Division are listed below.

2026/27 Trust-wide breakthrough objectives and Divisional Drivers









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

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

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

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

Patient Experience

IN 2026/27 WE AIM TO ACHIEVE A MINIMUM RESPONSE RATE OF 18% USING THE FRIENDS AND FAMILY TEST AND MAINTAIN AT LEAST 95% GOOD / VERY GOOD RATING

Priority 1: Improving accessibility to our Friends and Family Test

The Trust continues to invest in the digitalisation of the Friends and Family Test and in strengthening the use of data insights from survey responses to inform service improvement. To support the continued delivery of digital Friends and Family Test surveys and enhance our analytical capability, the Trust is planning for the implementation of a new digital solution.

Response rates and overall experience ratings are currently reported nationally; however, it is recognised that further value can be derived from this feedback through more robust theming and analysis of the qualitative comments received.

We aim to:

- ✓ **Continue with improving overall response rates** to the Friends and Family Test (Improving Together Target of >18% of eligible patients in 2026/27).
- ✓ **Continue to diversify methods for access** (including online, SMS and telephone channels) to improve accessibility and encourage feedback from seldom-heard groups across the Trust.
- ✓ **Improve visibility** of feedback mechanisms in both inpatient and outpatient areas with the addition of PALS feedback boards to all outpatient areas as well as wards.
- ✓ **Increased accessibility and options for inclusivity** (Easy Read, languages, and additional demographic options).
- ✓ **Continue to use data from themes and trends for comparison and benchmarking** with other Trusts within our Integrated Care Board.
- ✓ **Continue to explore and embed triangulation of feedback** of themes with complaints, incidents, compliments, real time feedback, and national surveys.

IN 2026/27 WE AIM TO PRIORITISE IMPROVING COMPLAINTS HANDLING PERFORMANCE, INCREASING THE PROPORTION OF COMPLAINTS RESPONDED TO WITHIN THEIR AGREED TIMESCALE, WORKING TOWARDS THE 85% TARGET AND REDUCE RE-OPENED COMPLAINTS TO LESS THAN 5%

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

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

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

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

WE CONTINUE WITH OUR PLEDGE TO INCREASE OUR RESPONSE RATES TO REAL-TIME FEEDBACK BY >15% IN 2026/27 AND MAINTAIN A 90% POSITIVE EXPERIENCE RATING

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

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

In addition, we plan to continue to develop our pool of service user engagement volunteers.

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

We will also continue to explore opportunities for patients to engage with the Trust, offering varied commitments from one-off projects such as those undertaken for discharge, and the new Urgent Treatment Centre. We also will continue to work with and integrate our Patient Safety Partners across our engagement work.

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

Clinical Effectiveness

IN 2026/27 WE WILL CONTINUE TO USE IMPROVING TOGETHER AS THE VEHICLE FOR DRIVING CONTINUOUS IMPROVEMENT ACROSS THE CLINICAL EFFECTIVENESS PORTFOLIO. WE WILL CONTINUE TO REDUCE THE NUMBER OF MANDATED NATIONAL AUDITS WHICH HAVE PASSED THEIR TARGET DATE FOR COMPLETION.

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

Last year a six-month target was set to reduce the number of overdue mandated national audits by **10%**, with a target to reduce it by a **further 10%** by year end. Although this target has been achieved, work will continue to ensure it is **sustained**. Local results should be discussed and recorded on AMaT within three months of a relevant national audit report being published. Further work will continue, to understand the barriers to reporting local results and to provide guidance and support to audit leads. The actions to improve patient safety should also be completed within the time agreed and if these targets are not met then the audit report is determined as overdue. This will continue to be discussed during weekly improvement huddles (Trust's Improving Together methodology).

Performance

Performance can be monitored by clinical Divisions via the Trust's Power BI dashboards. Audit leads are encouraged to use these charts, along with the specialty reporting available in AMaT, to facilitate performance discussions at their governance meetings.

We will continue to investigate the possibility of speciality reporting on the Trust's Power BI dashboards. Currently only Divisional reporting is available, although Speciality specific performance can be viewed on AMaT, the Trust's clinical audit system.

Support

An updated intranet page is in progress to provide staff wishing to complete an audit project with further support and information. A toolkit of **Process Standard Works** will help reduce errors and variations for all stages of the clinical audit cycle. We are producing a **Frequently Asked Questions** section, along with a checklist of responsibilities for those undertaking, and managing clinical audit projects.

Networking

We will continue to work and learn from other Trusts. We will also share learning from our improvement ideas with other Trusts.

Priority 5: NICE compliance alignment with other care organisations in the BSW Hospitals Group

We will continue to collaborate with teams in Royal United Hospitals Bath and Great Western Hospitals, Swindon to develop a consistent Group approach to NICE compliance reporting in the future.

Patient Safety

IN 2026/27 WE WILL REVIEW AND REVISE OUR PATIENT SAFETY INCIDENT RESPONSE PLAN AND POLICY, TO ENSURE THAT THE TRUST RESPONDS TO ITS CURRENT RISK AND PATIENT SAFETY PROFILE.

Priority 6: Focused improvement work aligned to the Patient Safety Incident Response Plan

During 2025/26, the Trust has prioritised the implementation of its Patient Safety Incident Response Plan (PSIRP) in line with national Patient Safety Incident Response Framework (PSIRF) requirements. The PSIRP sets out how the Trust will respond to patient safety incidents in a way that maximises learning, supports staff, and drives sustainable improvement.

To enhance the effective delivery of the PSIRP, a focused programme of improvement work will be identified across the following key areas:

- ✓ **Strengthening Governance and Oversight**
  The Trust is refining its patient safety governance structures to ensure Divisional accountability, robust oversight of safety learning responses, and visibility of themes and risks. Reporting arrangements are being streamlined to provide greater assurance regarding the quality and timeliness of investigations and learning outputs.

- ✓ **Building Investigation Capability and Capacity**
  A structured training programme is being delivered to develop key skills to support staff undertaking patient safety reviews. This includes embedding systems-based investigation methodologies, improving report quality, and ensuring consistency in approach across services.

- ✓ **Embedding Systems-Based Learning**
  The Trust continues its transition from the previous Serious Incident Framework to a proactive, thematic learning approach. This includes prioritising reviews based on risk and potential for learning and ensuring that contributory factors are addressed at system level.

- ✓ **Enhancing Engagement with Patients, Families and Staff**
  Improvements are being made to ensure that patients and families are meaningfully involved throughout the investigation process. Work continues to ensure that staff are being supported with strengthened wellbeing support to foster a culture of openness and psychological safety.

- ✓ **Monitoring Impact and Demonstrating Improvement**
  Clear metrics are being established to evaluate the effectiveness of the PSIRP, including timeliness of responses and quality assurance of reports. A focus is required to evidence measurable service improvements arising from learning.

What happens next?

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

The organisation remains committed to delivering safe, high-quality care and to ensuring that lessons learned translate into sustainable improvements in practice.

Looking Back at 2025/26 - What did we say we would do?

Background

Our understanding of the 'Improving Together' operational excellence methodology we use to deploy our strategy has matured over the course of 2025/26. We have seen improvement in all of our breakthrough objectives. Our growing confidence in the approach has enabled us to refresh our breakthrough objectives and our clinical Divisions have used this opportunity to agree their priorities (known as drivers) with the Executive for the 18-24 months ahead.

For 2026/27, this has given the Divisions the opportunity to cascade their drivers to the specialities in each Division who now have their own 'scorecard agreements' that formalise these objectives. This completes the golden thread throughout every strata of the organisation – Executive, Divisions, Specialties, ward and frontline. We have also begun to mature our BSW Hospitals Group-level operational excellence framework over the past 12 months, including our emerging risk-based approach and new governance models.

Our work on the UEC pathway, including SDEC, AFU and AMU, has brought improvement across our Medical Division for those needing urgent care. It is a great example of how success breeds success as our continuous improvement methodology embeds across our teams.

The use of improvement tools such as A3 thinking, improvement huddles, process mapping and data analysis is embedding across our teams. It has been a characteristic of 2025/26 that where problems arise our teams are responding more often in a manner of continuous improvement and using the methodology. We are seeing the results of that in areas such as reducing pressure injury, and reduced referral to treatment wait times.

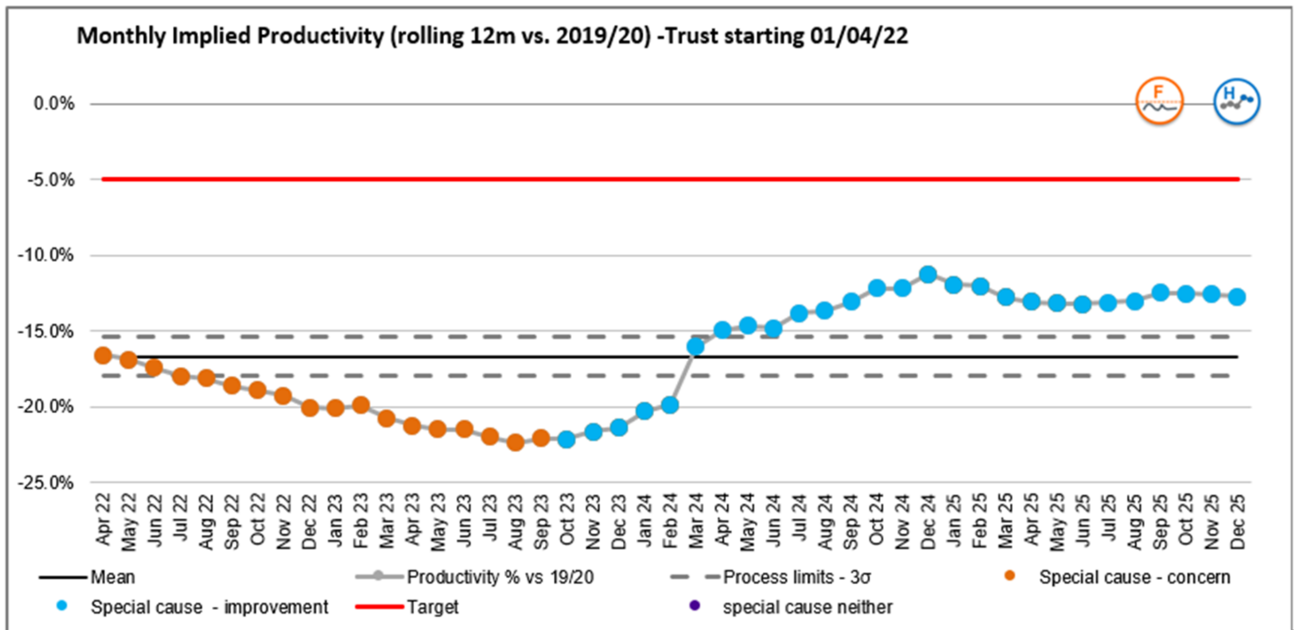
Consultation and Monitoring of our Priorities

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

The priorities that we have selected continue to represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience) and were embedded across our business plans for 2025/26. Our quality priorities were each discussed at their representative steering groups and were also discussed at the Quality Board (CMB).

Progress in the achievement of these priorities will continue to be monitored through regular reporting and discussion at CMB in 2026/27.

Creating Value for Our Patients



Our Target for 2025/26

This focuses our efforts on increasing our productivity and in so doing creating better value for our patients.

How have we performed?

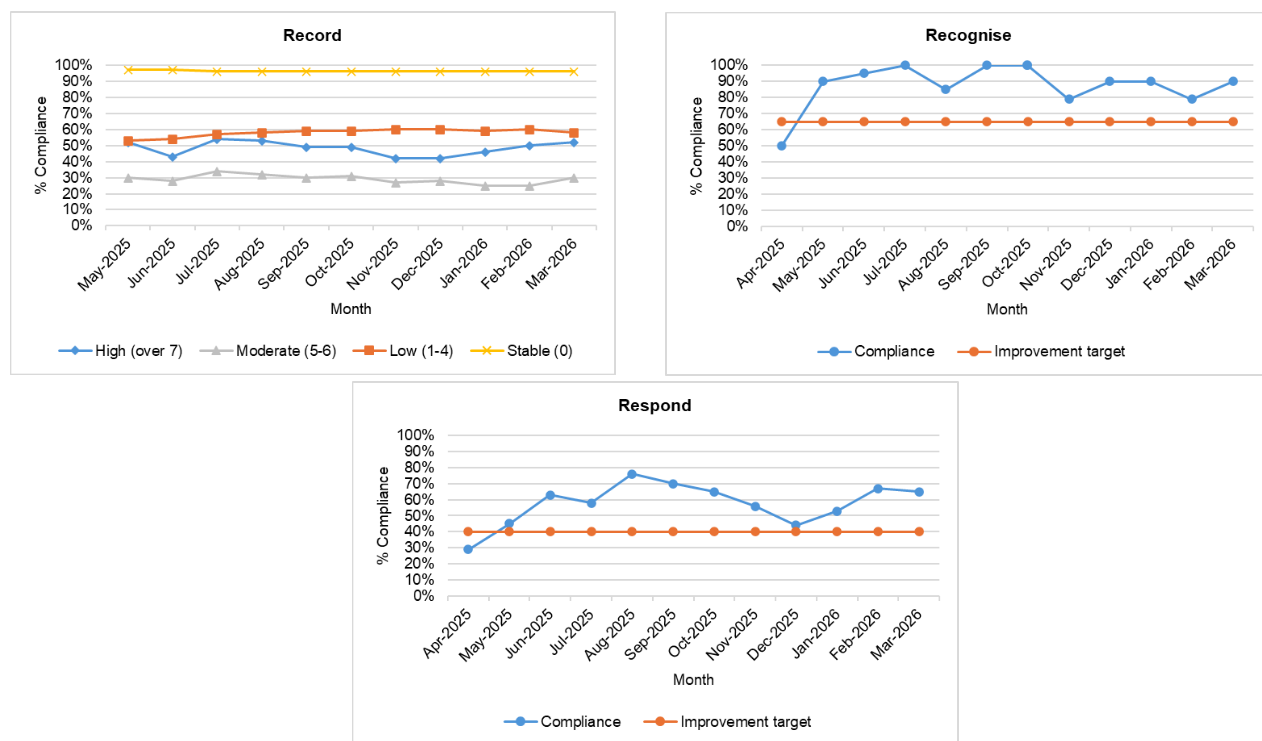
When selected as a breakthrough objective our productivity was at -21% relative to 2019/20, at the end of 2024/25 it had improved to -11%. The position has since failed to improve materially due to complex headwinds arising from both demand on services, increasing demographic acuity, flow to out of hospital services, and staff absence.

Actions included:

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

Our Strategy 2022-26 IMPROVING together

Recognising and Managing Patient Deterioration Well



Our Target for 2025/26

NEWS2 is a track and trigger tool, within the POET system, used by the MDT to monitor a patient's progress. There were delays in the timely recording, recognition and response to NEWS2 in line with local and national escalation guidance. This low rate of timely observations leads to patient deterioration and ultimately increasing risk to patients.

The improved target set across the three elements were:

Record – low risk 65% and stable 95%.

Recognise – 30% improvement from baseline.

Respond – 30% improvement from baseline.

How have we performed?

Multi-disciplinary working across the organisation to make changes to ensure the timely taking, recording of observations, onward assessment and escalation has resulted in improved performance against all three elements of NEWS2, as well as a reduction in ICU admissions, thereby reducing the negative impact of non-timely patient observation.

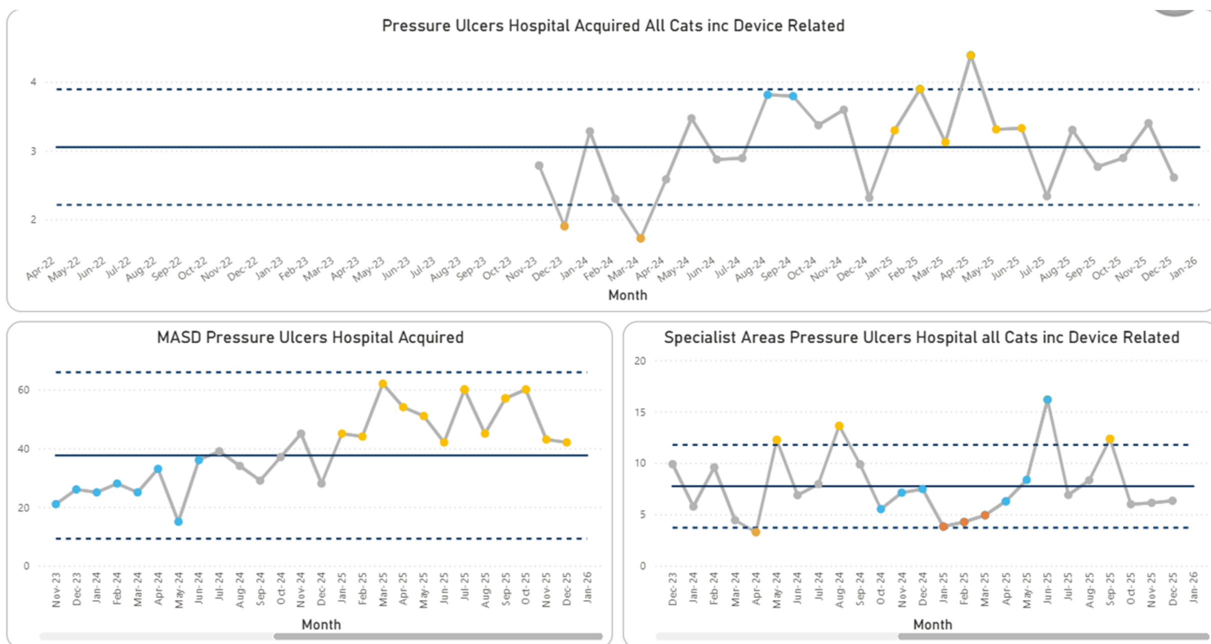
Actions Included:

- ✓ NEWS2 scores reviewed at handover in the morning and evening and added to the daily morning huddle.
- ✓ New routines adopted and embedded across multiple teams.
- ✓ Improved training offer and onward compliance.
- ✓ Improved shared learning from incidents.

Why did we change focus?

Due to consistent delivery of identified performance metrics, successful improvements, improved training compliance, improved use of the POET tool and the embedding of new routines across MDTs, this breakthrough objective has been replaced with reducing pressure injury.

Reducing Pressure Injury



Our Target for 2025/26

Following our success with reducing falls, and managing patient deterioration, our stratified data on how harm is occurring in the hospital led us to the next highest contributor – the rate of pressure injury per 1,000 bed days. Our target is a sustained reduction in the rate over a 6 month period.

How have we performed?

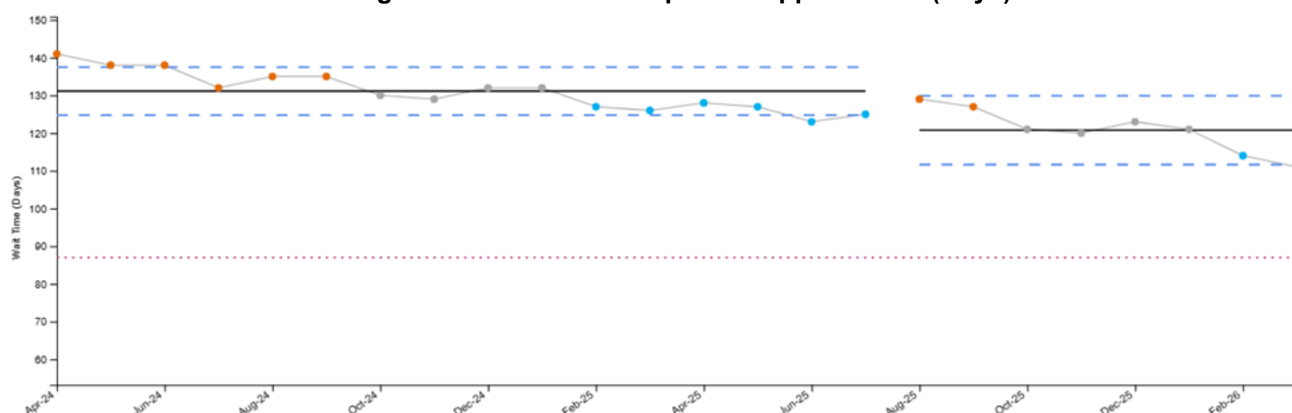
The Chief Nursing Officer has led work across the organisation, including creating a cross functional culture of leadership across tissue viability nursing and broader teams. The performance is currently steady state, with our interventions still just starting to gain traction.

Actions included:

- ✓ Reviewing and validating the data.
- ✓ Establishment of multidisciplinary (MDT) working group.
- ✓ Identification of education opportunities.
- ✓ Development and approval of Trust-wide Wound care management policy.

Reducing Time to First Outpatient Appointment.

Average Wait Time to 1st Outpatient Appointment (Days)



Our Target for 2025/26

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

How have we performed?

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

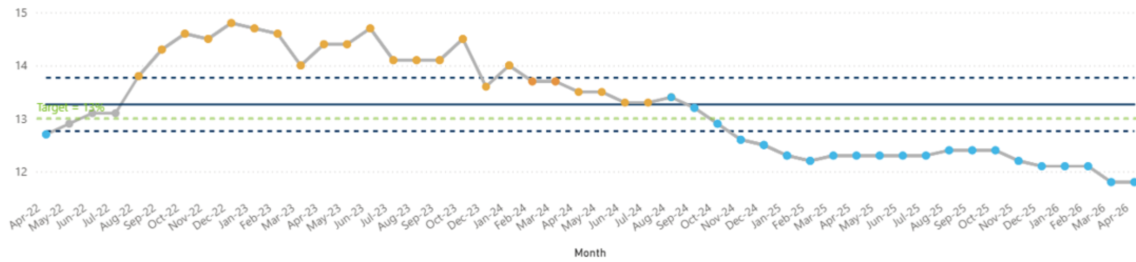
In 2025/26, we have continued this priority as one of our four improvement breakthrough objectives (key priorities for all our teams to focus on) in recognition that while we did improve, we did not see the full impact we wanted in 2025/26 and will continue again in 2026/27. Using our continuous improvement methodology, we will seek to understand our data and focus on local improvements that collectively contribute to a reduction in overall waiting time. We have seen this approach deliver benefits in some specialty areas and will look to understand, share and expand our successes in the coming 12 months.

Actions included:

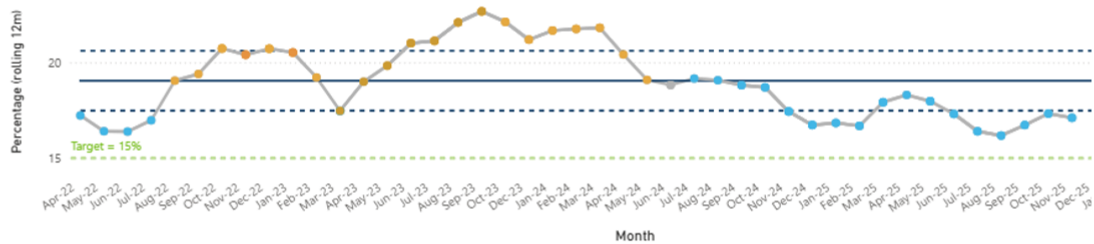
- ✓ Appointment of an Outpatients Associate Medical Director who leads threespecialties at a time through improvement-focused change.
- ✓ Each Division having this as a 'driver' for their teams.
- ✓ Executive shadowing of target specialties.
- ✓ The outpatients team developing a 'model cell' of what a specialty needs to improve.
- ✓ Work with primary care on supporting them to avoid referrals where appropriate.

Increasing Additional Clinical Services Staff Retention

Vision Metric (Trust-wide Staff turnover)



Breakthrough Objective



Our Target for 2025/26

Flowing from our vision metric to increase staff retention, this breakthrough objective focused on the top contributor – retention of our additional clinical services staff.

Since late 2022, this had averaged at 20% and had knock-on effects through the patient pathways to which these staff are vital.

The target was to reduce turnover to 15%.

How have we performed?

Work has taken place across three broad domains of roles and development, recruitment and investigating reasons for staff leaving.

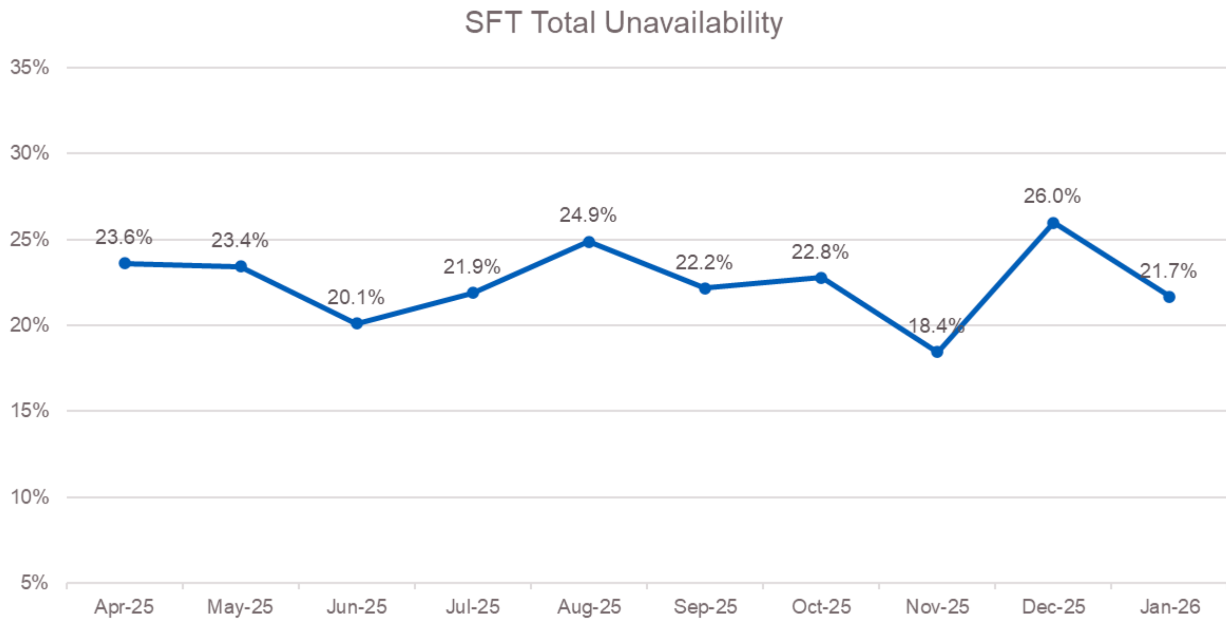
Actions Include:

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

Why did we change focus?

It was recognised that there was an improved and sustained position at vision metric level in Trust-wide staff turnover, however, mindful that the breakthrough objective target had not been reached. A further review of the data to understand latest challenges, was undertaken and a decision made to move from this breakthrough objective to Staff Unavailability.

Reducing Staff Unavailability



Our Target for 2025/26

Flowing from our vision metric to increase staff retention, this breakthrough objective has focused on a top contributor – staff unavailability. Our target is not 0%, as some aspects of unavailability are necessary and desirable, such as annual and study leave. 18% would represent a strong position for the organisation.

How have we performed?

Our performance has proved steady state, however the process change to move this metric is complex and we have not expected to move the dial instantly.

Actions included:

- ✓ Developing a case study of well-deployed team-based rostering.
- ✓ Teams with high turnover identified to triangulate with vacancy, temporary staff usage, and absence data.
- ✓ Stratifying our data at Divisional level.

2B - Statements of Assurance from the Board

Salisbury NHS Foundation Trust

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

Review of Services

During 2025/26 Salisbury NHS Foundation Trust provided and/or subcontracted 54 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 54 of these relevant health services. The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2025/26.

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

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

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

Participation in Clinical Audit

During 2025/26, 58 national clinical audits and 6 confidential enquiries covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 57 / 58 (98%) national clinical audits, and 6 / 6 (100%) confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2025/26, are listed in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1.

Eligible national audits and confidential enquiries the Trust participated in during 2025/26.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
BAUS Data & Audit Programme	British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	✓	100%
	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✗	0%*
Breast and Cosmetic Implant Registry	Audit	✓	100%
British Spine Registry	Audit	✓	100%
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	✓	100%
Cleft Registry and Audit Network (CRANE) Database	Audit	✓	100%
Emergency Medicine QIPs	Adolescent Mental Health	Not Applicable	Not Applicable
	Care of Older People	✓	100%
	Mental Health Self Harm	✓	90%
	Time Critical Medications	✓	100%

* **Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)** – The report will be reviewed, once published, for any applicable learning.

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

* **NACEL** – SFT did not participate in the non-mandated Bereavement Survey. Instead, a local survey gathered feedback from those who were close to the patient.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	✓	100%
	National Audit of Primary Breast Cancer (NAoPri)	✓	100%
	National Bowel Cancer Audit (NBOCA)	✓	100%
	National Kidney Cancer Audit (NKCA)	✓	100%
	National Lung Cancer Audit (NLCA)	✓	100%
	National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	0%*
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	100%
	National Ovarian Cancer Audit (NOCA)	✓	100%
	National Pancreatic Cancer Audit (NPaCA)	✓	100%
	National Prostate Cancer Audit (NPCA)	Not Applicable	Not Applicable
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit (NACSA)	Not Applicable	Not Applicable
	National Congenital Heart Disease Audit (NCHDA)	Not Applicable	Not Applicable
	National Heart Failure Audit (NHFA)	✓	89%
	National Audit of Cardiac Rhythm Management (CRM)	✓	100%
	Myocardial Ischaemia National Audit Project (MINAP)	✓	100%
	National Audit of Percutaneous Coronary Intervention (NAPCI)	✓	100%
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Not Applicable	Not Applicable
	Left Atrial Appendage Occlusion (LAAO) Registry	Not Applicable	Not Applicable
	Patent Foramen Ovale Closure (PFOC) Registry	Not Applicable	Not Applicable
	Transcatheter Mitral and Tricuspid Valve Registry	Not Applicable	Not Applicable

* **National Non-Hodgkin Lymphoma Audit (NNHLA)** – Unable to participate due to insufficient resources and time.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Cardiac Arrest Audit (NCAA)	Audit	✓	100%
National Child Mortality Database (NCMD	Audit	✓	100%
National Clinical Audit of Psychosis (NCAP)	Audit	Not Applicable	Not Applicable
National Comparative Audit of Blood Transfusion	2025 Major Haemorrhage Audit	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Audit	✓	75%
National Emergency Laparotomy Audit (NELA)	Laparotomy	✓	100%
	No Laparotomy	✓	100%
National Joint Registry	Audit	✓	100%
National Major Trauma Registry	Audit	✓	100%
National Maternity and Perinatal Audit (NMPA)	Audit	✓	100%
National Neonatal Audit Programme (NNAP)	Audit	✓	100%
National Obesity Audit (NOA)	Audit	Not Applicable	Not Applicable
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	✓	100%
	Cataract Audit	✓	100%
National Paediatric Diabetes Audit (NPDA)	Audit	✓	100%
National Respiratory Audit Programme (NRAP):	COPD Secondary Care	✓	100%
	Pulmonary Rehabilitation	✓	100%
	Adult Asthma Secondary Care	✓	94%*
	Children and Young People's Asthma Secondary Care	✓	100%

* **Adult Asthma Secondary Care** – although this is a Monday–Friday service, we make every effort to collect and submit data for patients admitted at the weekend, but we recognise that a small number may still have been missed.

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Pulmonary Hypertension Audit	Audit	Not Applicable	Not Applicable
National Vascular Registry (NVR)	Audit	Not Applicable	Not Applicable
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Audit	Not Applicable	Not Applicable
Paediatric Intensive Care Audit Network (PICANet)	Audit	Not Applicable	Not Applicable
Perinatal Mortality Review Tool (PMRT)	Audit	✓	100%
Perioperative Quality Improvement Programme	Audit	✘	0%*
Prescribing Observatory for Mental Health (POMH)	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	Not Applicable	Not Applicable
	The use of melatonin	Not Applicable	Not Applicable
	The use of opioids in mental health services	Not Applicable	Not Applicable
Sentinel Stroke National Audit Programme (SSNAP)	Audit	✓	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Audit	✓	100%
UK Cystic Fibrosis Registry	Cystic Fibrosis - adults	Not Applicable	Not Applicable
	Cystic Fibrosis - children	✓	100%
UK Interstitial Lung Disease (ILD) Registry	Audit	✘	0%
UK Parkinson's Audit	Audit	✓	100%
UK Renal Registry Chronic Kidney Disease Audit	Audit	Not Applicable	Not Applicable
UK Renal Registry National Acute Kidney Injury Audit	Audit	✓	100%

* **Perioperative Quality Improvement Programme –** a BSW Hospitals Group decision was made to not participate in this quality improvement programme because to is deemed to be more research focused.
* **UK Interstitial Lung Disease (ILD) Registry** – Unable to participate due to insufficient resources.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
Audit title	**Details**	**Participation**	**% of cases submitted**
Child Health Clinical Outcome Review Programme	Stabilisation of the critically ill child	✓	This audit is in progress. It is anticipated submission will be 100%
	Emergency Surgery in Children and Young People	✓	100%
Maternal, Newborn & Infant Clinical Outcome Review Programme (MBRRACE-UK)	Audit	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Rib fractures	✓	This audit is in progress. It is anticipated submission will be 100%
	Pleural procedures	✓	100%
	Managing Acute Illness in People with a Learning Disability	✓	100%
Mental Health Clinical Outcome Review Programme	Audit	Not Applicable	Not Applicable

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

The reports of 36 national clinical audits and confidential enquiries that were published in 2025/26 were reviewed by Salisbury NHS Foundation Trust in 2025/26. Of these, 2 were risk scored as moderate or higher and both were therefore reported to the Clinical Effectiveness Steering Group by the clinical lead responsible for implementing the changes in practice. Further examples of national clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can be found in Appendix B.

Local clinical audits

The reports of 99 local clinical audits were registered and reviewed by the Trust in 2025/26. Audit outcomes were discussed at Specialty and / or Divisional meetings and assurance and risk levels agreed. Examples of local clinical audits and the actions SFT intends to take to improve the quality of healthcare provided can also be found in Appendix B.

Research

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

The National Institute for Health and Care Research (NIHR) Research Delivery Network is funded by the Department of Health and Social Care (DHSC) and plays a key role in ensuring research is accessible, well-supported, and embedded within the health and care system.

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

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

The service continues to focus on creating a stronger more resilient base to improve the profile of research in the Trust and to work with our partners to improve the health of our community, in future years. This includes:

- Actively collaborating with partners in the BSW region to form a robust alliance. This alliance aims to tackle health inequalities, strengthen research delivery pathways and optimise resource sharing and utilisation for the benefit of the population.
- The establishment of the Research and Innovation Board. We are working along with the Innovation Team to improve the profile of Research and to have engagement with the Executive Team. This Board will have oversight from the Trust Management Committee
- The development of the Salisbury Research Hub which signifies a strategic initiative aimed at aligning the organisation with leading research partners such as Wessex Commercial Delivery Centre , generating revenue and most importantly addressing health disparities. We are also diligently working on increasing commercial and home-grown research to maximise income both for the department and the Trust.

Patient participation and recruitment continues to thrive:

- We recruited 844 participants over 37 studies from April 2025 to March 2026.
- We continue to be actively involved in conducting the NIHR Patient Research Experience Survey for research studies between April 2025 and March 2026.
- Our engagement underpins our commitment to gathering valuable feedback so we can enhance the patient experience. This is now submitted via the new National Dashboard and SFT is moving across to electronic questionnaires for participants.

Commercial Income

We have opened 3 commercial studies. We are currently setting up 1 additional study; this will increase the number of commercial studies running in the Trust to 4.

We have seen a slight drop in the non-commercial portfolio, though this is reported across the region. Our aim is to have a balance of commercial and non-commercial portfolio.

We have also had enquiries to do research within the Trust. This includes enquiries from students, nurses, Doctors, and other Allied Health Professionals, as we gradually promote home-grown and National Midwifery and Allied Health Professionals (NMAHP) Research.

Studies opened in Financial Year (FY)	FY 2024/25	FY 2025/26
Commercial portfolio	5	3
Non-commercial portfolio	27	20
Non-commercial non-portfolio	2	1
Academic/student	1	1

Home Grown Research

There is one Trust-sponsored, nationally funded project that is open in the Trust.

Short title	Full title
STEPS II	The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial.

All professionals are encouraged to be part of research and we are looking at ways to capitalise on this interest in research.

Other successes

- ✓ We have established connections with Primary Care and GP practices, actively engaged and recruiting to a Paediatric study. Ongoing discussions about future commercial trials are promising, as they will not only improve patient access to research but also help develop specialities that are not currently active at our site.
- ✓ We have expanded our team by appointing two full-time research administrators, a full-time clinical trial Pharmacy technician (part-funded). Additionally, we have recruited a full-time Research Manager, which has allowed us to accelerate the set up and opening of new studies. The Research Department is funding backfill for a senior nurse to create dedicated time for research engagement and to promote NMAHP research within the Trust. This lead nurse is providing mentorship advice and Networking across BSW to increase NMAHP led research
- ✓ We are collaborating with our regional partners to develop a system that incentivises research-active medics (Principal Investigators).
- ✓ The strength of our activity and performance metrics is a positive measure. By maintaining a focus on these areas over the coming year, there is a clear opportunity for future growth.

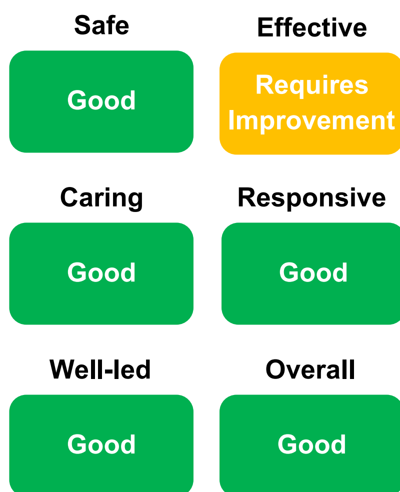
Care Quality Commission Registration

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

Medical Services assessment

On 18 and 19 June 2025, the Trust underwent a Care Quality Commission (CQC) inspection of Medical Services as part of their routine programme of regulatory assurance.

Medical Services were rated:



Inspectors noted that staff consistently reported feeling well supported and valued across the wards visited. Strong teamwork between all professional groups was observed, with effective communication and cohesive working evident throughout clinical areas. Staff demonstrated a clear understanding of the Improving Together methodology, describing it as a supportive and inclusive framework that promotes shared learning and collective ownership of improvement. International colleagues highlighted the Trust's well-structured approach to multicultural integration, emphasising how welcomed and supported they felt as they transitioned into their roles.

The Trust has welcomed this positive feedback and is taking forward opportunities to build on these areas of strength.

The inspection also highlighted some areas where we need to improve. These included making sure infection prevention and control measures are consistently followed, keeping equipment and environments clean and safe, and improving storage and access in some areas. The CQC also found that not all staff had received their annual appraisal and that appraisal and mandatory training completion rates were below our targets. There were concerns about the level of temporary staffing and turnover among healthcare assistants.

The report also noted that some of our performance standards were not being met. These included the stroke 4-hour assessment target, the cancer 62-day treatment standard, and diagnostic waiting times, particularly in Endoscopy. Inspectors also highlighted gaps in Speech and Language Therapy for stroke and Parkinson's patients and noted that national therapy hour standards for stroke rehabilitation were not always achieved.

While many of these issues were localised rather than widespread, they highlight the need to strengthen routine checks, reinforce local ownership of standards, and ensure more consistent application of established clinical and operational processes across Medicine Services.

The Trust has already begun to address these findings and has incorporated the required actions into ongoing quality and safety improvement work. This includes targeted programmes focused on IPC compliance, workforce stability, mandatory training, therapy provision, and delivery against key national standards.

The full assessment findings can be found here: [Salisbury District Hospital CQC Medicine Core Service Report]

Surgical Services assessment

On 16 and 17 September 2025 the Trust underwent a CQC inspection of Surgical Services as part of the routine programme of regulatory assurance.

The inspection team completed their on-site assessment and provided initial verbal feedback before concluding their visit. Inspectors shared positive comments from patients, who said, “they were treated as a whole” and received “personalised, compassionate support.” Staff across all roles were open, honest and eager to share their experiences. The inspection team also highlighted strong practice in pre-assessment, including the involvement of Pharmacy to improve the patient journey. In addition, they were impressed by the recently refurbished Interventional Radiology and Cardiac Catheter Labs, noting the high-quality environments and the new services now available to patients and the wider community.

Alongside these positive observations, the initial feedback also identified a number of areas requiring improvement to ensure consistent compliance with safety, workforce, and performance standards. Inspectors noted a number of environmental challenges linked to an ageing estate, limited space, and storage constraints. There were also observations for improvement in how emergency equipment is organised and accessed. Inspectors also found that communication between some teams could be clearer to support smoother patient journeys.

Whilst the full assessment findings have not yet been published, we have already begun work to address the issues highlighted in initial feedback and strengthen the quality and safety of care across our services.

CQC Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 inspection

On 6 November 2025, the Trust received an announced IR(ME)R inspection focused on Nuclear Medicine. The inspection included document review, observation of clinical practice, examination of records and discussions with staff. Inspectors concluded that the service demonstrated compliance with the majority of IR(ME)R requirements and noted strong multidisciplinary working and effective management of controlled documentation.

No breaches met the threshold for enforcement action. The CQC issued no statutory notices as part of this inspection.

A rating is not awarded following IR(ME)R inspections and findings do not change a provider’s existing rating.

The IR(ME)R inspection highlighted strong working relationships within the Nuclear Medicine team and effective oversight from radiology leadership, alongside good practice in document control and the availability of key governance information. Inspectors also identified several areas for improvement, including better access to referral guidelines for referrers external to the Trust, strengthened processes for reporting significant accidental and unintended exposures, more consistent approaches to the designation of carers and comforters, and improved oversight of equipment used for sentinel lymph node procedures, which currently sits outside the Nuclear Medicine department.

The CQC required an action plan by 19 January 2026, outlining how each recommendation would be addressed. The Trust submitted its action plan well within the required timeframe, which the IR(ME)R CQC Inspection team found to be satisfactory and as a result closed the inspection on 9 January 2026. There is only one action currently outstanding which relates to sentinel node probe quality assurance, this action is owned by the Theatres team and overseen by the Radiation Protection Committee.

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

The Trust continues to strengthen its readiness for ongoing CQC regulatory activity by embedding and maturing key components of the Single Assessment Framework within its governance structures. During 2025, this work progressed significantly through the development of an organisational accreditation programme and the introduction of strengthened quality assurance mechanisms.

A new Trust-wide accreditation programme is currently in development, designed to provide a consistent method of assessing and evidencing quality across all clinical areas. The programme's metrics directly align with the CQC Single Assessment Framework and are deliberately mapped to ensure an even distribution of measures across all CQC key questions. This structured approach will support services in understanding their strengths, identifying areas for improvement, and maintaining continuous regulatory readiness.

Work is ongoing throughout all levels of clinical management and practice across the organisation to ensure sustained readiness against the CQC Single Assessment Framework. At a strategic level, targeted meetings are held with core service groups to review each CQC key question in depth, providing a high-level system overview and supporting teams to undertake detailed gap analyses of their strengths and areas requiring development.

Complementing this, the introduction of quarterly Quality Assurance Days offer individual departments the opportunity to assess their own performance against the framework through structured self-assessment, peer review, and focused action planning.

External Well-led Developmental Review

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

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

There have been bi-annual reports to Board on progress against the key improvement themes and significant progress made against all identified areas for improvement.

The Trust has aligned the key areas for improvement to existing programmes of work to ensure this has oversight through existing governance arrangements. Some of this work now forms part of a wider BSW Hospitals Group corporate governance workstream supporting the move to a Group model. For 2026/27, focus will be on establishing the group operating model and the governance framework.

Data Quality

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

Over 2025/26, the Trust continued work on its Business Intelligence Transformation project which included work to replace our data warehouse and delivering modern tools to support the improvement of data quality and the use of information more widely. The Data Quality Manager continues to lead the Data Quality elements of this project and support implementation.

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

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

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

Data item	SFT 2024/25	National benchmark 2024/25	SFT 2025/26 (M1-9 only)	National benchmark 2025/26
Valid NHS number				
% for admitted patient care	99.8%	99.7%	99.9%	99.8%
% for outpatient care	99.9%	99.7%	99.9%	99.8%
% for Emergency Department care	99.5%	99.1%	99.4%	98.9%
Valid General Medical Practice Code				
% for admitted patient care	100%	99.4%	100%	99.5%
% for outpatient care	100%	99.4%	100%	99.6%
% for Emergency Department care	100%	99.8%	99.9%	99.7%

Data Security and Protection Toolkit Attainment Levels

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

Good information governance means ensuring the information we hold about our patients and staff is accurate, keeping it safe, and available at the point of care. The Data Security and Protection Toolkit is the way we demonstrate our compliance with national data protection standards.

All NHS organisations are required to make an annual submission at the end of June, to assure compliance with data protection and security requirements.

The Trust self-assessment against the 2024/25 Data Security and Protection Toolkit confirmed compliance in all areas, with a status of 'Standards Met'. The self-assessment for 2025/26 is due for submission at the end of June 2026.

Clinical Coding Error Rate

The Trust commissioned an external clinical coding audit from D&A Consultancy (specialist clinical coding auditors) in December 2025 to provide evidence for the Data Security and Protection Toolkit during the reporting period. The error rates reported in the audit for that period for diagnoses and treatment coding (clinical coding) were:

- **Primary Diagnoses Incorrect 1.5%**
- **Secondary Diagnoses Incorrect 5.1%**
- **Primary Procedures Incorrect 3.1%**
- **Secondary Procedures Incorrect 5.1%**

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

Exceeded Level

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

The clinical coding results should not be extrapolated further than the actual sample of 200 Finished Consultant Episodes (50 Urology, 50 Trauma & Orthopaedics, 50 General Surgery, 50 Plastic Surgery).

Freedom to Speak Up (whistleblowing and raising concerns)

The role of the Freedom to Speak Up (FTSU) Guardian remains a vital safeguard within the organisation - often the final opportunity to put things right before concerns escalate into significant risk. Recent national cases have demonstrated the serious reputational and cultural consequences when organisations fail to listen or, worse, penalise individuals for speaking up. These stories persist across the sector, reinforcing the need for a culture where colleagues trust that raising concerns will lead to meaningful action rather than organisational defensiveness.

People approach the Guardian for a range of reasons. At SFT, just over half of all cases this year involved inappropriate behaviours or attitudes, reflecting the national picture. This is significant because workplace culture directly affects quality, safety, retention, and team functioning. In healthcare, we are fundamentally in the relationships business: every interaction with a patient, family member, or colleague shapes outcomes. A healthy speaking up culture is therefore a patient safety issue.

In response to last year's Staff Survey results, particularly those linked to the People Promise themes *We Are Compassionate and Inclusive* and *We Each Have a Voice That Counts*, the FTSU Guardian worked closely with the Organisational Development and People (OD&P) team to strengthen confidence in speaking up. Actions included a robust communications plan promoting the FTSU service, enhanced thematic analysis through expert data triangulation, and collaboration with staff networks to identify barriers to raising concerns.

The Guardian also delivers training across a range of forums, including Trust Induction and Resident Doctors' Core Training, to promote psychological safety and ensure colleagues feel confident that concerns will be listened to and acted upon. The Guardian has direct access to senior leaders, including the Chief Executive and all Board members, ensuring concerns can be escalated swiftly when required.

Quarterly reporting to the Board provides assurance, highlights trends, and shares learning from concerns raised. In 2025–26, a total of 140 concerns were raised—an 8.5% increase on the previous year. Of these, 58 included an element of patient safety or quality, and these were escalated immediately to senior leaders and also a significant increase in worker safety, which includes wellbeing of 89 cases, these were escalated to OD&P to inform future wellbeing initiatives for colleagues.

	Themes	Cases Q1	Cases Q2	Cases Q3	Cases Q4
1	Element of Patient Safety/Quality	15	9	14	20
2	Worker Safety	16	13	24	36
3	Element of other inappropriate attitudes or behaviours	26	17	12	25
4	Bullying/Harassment	6	5	10	7
5	Disadvantageous and/or demeaning treatment (detriment as a result of raising concerns)	1	5	5	3

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

Information on how to access the Freedom to Speak Up service is widely available. Staff Bulletin communications, posters in prominent areas, and business cards issued to all new starters ensure colleagues know how to contact the Guardian and understand the support available.

Consolidated Annual Report 2025/26 on Doctors and Dentists in Training Rota Gaps and Improvement Plan

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

Below is a summary of rota gaps across all training grades and specialties for 2025/26. There are currently 247 resident doctors that are expected to be supplied by Health Education England and 55 locally employed resident doctors (LEDs) in post in the Trust.

Gaps in training posts exist due to a combination of under recruitment, maternity/paternity leave, less than full time working (LTFT) and resident doctors taking time out of the training programme.

Where there is a shortfall in doctors supplied to fill deanery training posts, the Trust aims to mitigate this by covering the gap with LEDs. Ascertaining how many LEDs are in post at any one time is challenging as these posts flux in number according to departmental / specialty demand and training post gaps. There is no defined number of locally employed doctors or total number of doctors for each specialty. LED recruitment is not led by the Medical HR team.

Year 2025/26	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Whole Time Equivalent (WTE) gap Junior Resident Posts	11.6	10.8	10.8	10.8	14.2	9.6	9.6	9.6	10	9.6	11.0	11.0
WTE Senior Resident Posts	9.9	9.9	10.2	10.2	13.2	11.7	12.8	12.9	12.4	12.4	12.0	11.9
Total WTE gap	21.5	20.7	21.0	21.0	27.4	21.3	22.5	22.5	22.4	22.0	23.0	22.9

Despite the fluctuations in fill rate over 25/26 the numbers of unfilled posts has remained relatively stable. Gaps at a more senior level tend to be more difficult to fill with LEDs due to the level of specialty experience and competencies required.

There has been a gradual increase in the number of resident doctors choosing to work less than full time, with a trend to this from earlier in a resident doctor's career. Certain specialties are impacted more by LTFT working, including Anaesthetics and Paediatrics, particularly at the senior resident doctor grades.

Since May 2023 locally employed doctors have been transitioned to the Resident Doctor 2016 Terms and Conditions to allow parity with their deanery appointed colleagues in terms of working patterns and access to exception reporting. This has been updated to reflect the updated T&Cs including exception reporting reforms.

The number of Foundation Programme doctors in the Trust has increased following increases in medical school places in recent years. Where possible these posts have replaced junior LED posts.

Plans for Improvement

- ✓ Introduction of the new electronic rostering system (eRoster) for medical teams has been significantly delayed. This development may provide a greater opportunity for oversight of potential gaps in rotas and therefore understanding of the medical staff required. Introduction of eRoster is now urgent because of exception reporting reforms.

- ✓ Outcomes of the National Postgraduate Training Review are awaited, however initial reports advise

  1. Training must be flexible.
  2. The need to strengthen and recognise excellence across all career pathways, particularly the growing contributions of specialty, associate specialist and specialist and locally employed doctors.
  3. Urgent action is needed to resolve training bottlenecks that are hindering progression and need to be addressed.
  4. It is essential to encourage inclusive team environments where doctors at every training stage feel respected and supported.

- ✓ Local implementation of the 10 Point Plan focused on improving the working lives of resident doctors. To date SFT has made good progress against this national plan, with the aim of continuing to make Salisbury NHS Foundation Trust an attractive place to train and work as a resident doctor.

- ✓ The Trust, clinical Divisions and teams should continue to consider opportunities to convert some LED posts to formal training posts, however the funding arrangements for these new posts does not always mirror the existing deanery funded posts and there is no guarantee that the training posts will be filled, sometimes resulting in short notice rota gaps. It should be recognised that LED / specialty doctors in clinical teams often support senior colleagues in providing continuity and flexibility in the medical team, particularly over changeover periods for resident doctors in formal training posts.

National Core Set of Quality Indicators

Salisbury NHS Foundation Trust

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

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

Domain 1 – Preventing People from Dying Prematurely

Summary Hospital-level Mortality Indicator (SHMI)

National Quality Priorities						
a. Trust SHMI:	**Dec 2022 – Nov 2023**		**Dec 2023 – Nov 2024**		**Dec 2024 – Nov 2025**	
	SFT	**National Average**	**SFT**	**National Average**	**SFT**	**National Average**
The value of the SHMI for the Trust	1.1186	1.0	0.9361	1.0	0.9242	1.0
The banding of the SHMI for the Trust	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
SHMI broken down by Site:						
The value of the SHMI for Salisbury District Hospital	1.0658	1.0	0.9362	1.0	0.9226	1.0
The banding of the SHMI for Salisbury District Hospital	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
The value of the SHMI for Salisbury Hospice	2.4281	1.0	No longer published	N/A	No longer published	N/A
The banding of the SHMI for Salisbury Hospice	Above Expected	Above Expected	N/A	N/A	N/A	N/A
b. Palliative Care Coding:						
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust (all sites). The palliative care indicator is a contextual indicator.	49%	42%	40%	44%	47%	44%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Salisbury NHS Foundation Trust recognises the importance of providing good quality care to people with life limiting conditions and to those who are dying. We are proud to include our local Hospice on site. The proportion of deaths with a palliative care coding has no specific target but is felt to be a measure of how Trusts recognise those in the last phase of their life and provide services to support them and their loved ones during that time (i.e. a higher figure is better).

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

- ✓ The Trust's Mortality Surveillance Group continue to meet every two months for assurance purposes
- ✓ The SHMI has continued to reduce over the past 12-months.
- ✓ A new internal mortality dashboard has been upgraded, giving teams earlier access to mortality trends in their specialties or wards.
- ✓ Developments have been made to our learning from deaths process and the IT system used for recording learning and actions.

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

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

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

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

Patient Reported Outcome Measures

National Quality Priorities												
Patient reported outcome measures (Average Adjusted Health Gain)	Apr 23 – Mar 24				Apr 24 – Mar 25*				Apr 25 – Mar 26			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
i) hip replacement surgery	N/A[*1]	44%	Data not available		Data released as management information*				Data not yet published.			
ii) knee replacement surgery	N/A[*1]	31%	Data not available		Data released as management information*				Data not yet published.			

[*1] *Insufficient records*

** Due to processing challenges and relatively low response rates, 2024/25 data was released as management information, rather than as an official statistic. See Patient Reported Outcome Measures (PROMs) in England, Final 2023/24 data for further information.*

Trust statement

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

The Patient Reported Outcome Measures have been collected by all providers of NHS-funded care since April 2009. Patients undergoing elective inpatient surgery for hip and knee replacement funded by the NHSE are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves.

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

- ✓ 2024/2025 data was published in April 2026 and is currently being reviewed by the Trust to establish if there are any learning or improvements.

Patients Readmitted to Hospital Within 30 Days of Being Discharged

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

National Quality Priorities												
Percentage of patients readmitted within 28 days of discharge from hospital by patient age group	Apr 2023 – Mar 2024				Apr 2024 – Mar 2025				Apr 2025 –Mar 2026			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Age 0 to 15	16.4%	13.2%	69.1%	1.6%	18.8%	13.0%	48.1%	1.2%	Not yet published			
Age 16 or over	12.9%	15.1%	99.6%	1.7%	14.8%	14.9%	40.3%	0.6%	Not yet published			

Trust statement

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

Published data and further information is available on: Compendium - Emergency readmissions to hospital

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

- ✓ SFT is working to develop a co-located Urgent Treatment Centre anticipated to open in Quarter 2 of 2026/27.
- ✓ SFT will be working with community partners to provide consultant geriatrician oversight to Hospital at Home pathways, in development Quarter 1 of 2026/27.
- ✓ Continuation of Power BI data reporting availability and use will enable us to better understand the opportunities to further improve performance in this area.
- ✓ Improved communication with community and partner services and GPs via remodelled discharge processes and services in the community, for people needing care or a bed base (pathways 1-3).
- ✓ Improvement Working group focusing on 2nd stage transformation of complex discharge pathways made up of acute, community and social care partners, supporting resilience of patients in the community setting.

Domain 4 – Ensuring People Have a Positive Experience of Care

Responsiveness to the Personal Needs of Patients

National Quality Priorities															
	Apr 23 – Mar 24 (Data 2022)					Apr 24 – Mar 25 (Data 2023)					Apr 25 – Mar 26 (Data 2024)				
	Response Rate	SFT	National Average	Highest	Lowest	Response Rate	SFT	National Average	Highest	Lowest	Response Rate	SFT	National Average	Highest	Lowest
Overall experience score for National Inpatient Survey	49%	8.0	8.1	9.3	7.4	49%	8.3	8.1	9.3	7.5	49%	8.0	8.2	9.4	7.4

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

Trust statement

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

Each year the Trust participates in the National Adult Inpatient Survey. The Trust's last published survey was released in August 2025 where a nationally agreed questionnaire was sent to a random sample of 1,250 patients and the results analysed independently by the Patient Survey Co-ordination Centre. 621 surveys were returned completed; therefore, we had a response rate of 51.49%.

The National Adult Inpatient Survey was repeated in November 2025 and is scheduled to complete fieldwork by May 2026. Themes from the National Adult Inpatient Survey, the Friends and Family Test and complaints and concerns are identified by each ward and an improvement plan prepared.

In 2025 the Trust has also taken part in the additional following national surveys:

- The Maternity Survey
- National Cancer Experience Survey
- Neonatal Care Experience Survey

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

- **Staffing levels:**
  - ✓ Retention focused to the People Plan, including support networks for staff, flexible working, leadership training and line management support.

Our Strategy 2022-26 IMPROVING together

- ✓ Daily staffing reviews continue to ensure safe staffing levels, triangulation with quality, safety and workforce metrics, skill mix and staffing red flags.

- **Discharge process and follow-up:**
  - ✓ Committed focus remains to enhance discharge and follow-up process led by the Chief Operating Officer working with community partners to eliminate inefficiencies and streamline process.

- **Noise and disruption:**
  - ✓ A quiet restful environment is important to aid recovery, enhance patient experience and ensure a healthy rest cycle.
  - ✓ Improvement Strategies to reduce noise levels include Implementing 'Quiet Hours', fitting soft-close bin lids, relocating noisy equipment, and enhancing staff awareness, all of which will contribute to a reduction of disturbances.
  - ✓ Patient safety partners working with ward-based staff to identify opportunities to reduce noise.
  - ✓ Head of Facilities reviewing curfew for deliveries out of hours which may generate noise near inpatient areas.
  - ✓ The Trust is also linking with colleagues from across Royal United Hospitals, Bath and Great Western Hospitals, Swindon to implement the 'Putting the hospital to bed at night' initiative.

- **Communication:**
  - ✓ Communication improvement initiatives include the nursing teams focusing on improving bedside communication through formal training and patient engagement strategies.
  - ✓ To ensure clear communication, all staff are encouraged to use plain language and then verify the patients and relatives understanding whilst providing opportunities for any queries.
  - ✓ Patient safety initiative "Martha's Rule" implemented, empowering patients, families, carers and staff to request an urgent clinical review if they have concerns about a patient's condition.

- **Getting Staff Attention When Needed:**
  - ✓ Delayed staff responses can negatively impact patient experience and safety.
  - ✓ Matrons have led a ward process review, focusing on call bell audits, staff allocations, and workflow improvements to enhance response times.
  - ✓ Progress will be tracked and reported at the Nursing and Midwifery forum and Patient Experience Steering Group.

- **Refreshment improvements:**
  - ✓ The introduction of hydration rounds has ensured water is accessible to all patients and contributes to the improvement of a patient's hydration status. This initiative is monitored closely by matrons with spot checks and regular audits.

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

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

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

Friends and Family Test – Patient Feedback

National Quality Priorities						
	Apr 23 – Mar 24		Apr 24 – Mar 25		Apr 25 – Mar 26	
	SFT	England Average	SFT	England Average	SFT	England Average
Response rate of patients who completed the Friends and Family test for the ward or Emergency Department						
Emergency Department	0.7%	Not yet published	21%	Not yet published	20%	Not yet published
Inpatients	21.9%	Not yet published	34%	Not yet published	36%	Not yet published
Score of patients who rated the ward or Emergency Department as Good or Very Good						
Emergency Department	79.5%	Not yet published	82.1%	Not yet published	82.47%	Not yet published
Inpatients	96.5%	Not yet published	96.7%	Not yet published	97.03%	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. In June 2024, the Trust introduced a digital SMS Friends and Family Test service and undertook a project to redesign the inpatient feedback card system. These initiatives have had a significant positive impact on response rates. As the current digital service concludes in August 2026, the Trust will procure a new provider to ensure the continued delivery of the service and to sustain the improvements achieved.

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

- ✓ Continue with overall response rates to the Friends and Family Test (Improving Together Target of >18% of eligible patients in 2026/27).
- ✓ Diversify methods for access (including, online, SMS, paper based to make this more accessible to difficult to reach areas of the Trust).
- ✓ Improve visibility of feedback mechanisms in both inpatient and outpatient areas.
- ✓ Increased accessibility and options for inclusivity (Easy Read, languages, and additional demographic options).
- ✓ Continue to use data from themes and trends for comparison and benchmarking with other Trusts within our Group.
- ✓ Continue to explore and embed triangulation of feedback of themes with complaints, incidents, compliments, real time feedback and national surveys.

Staff Who Would Recommend the Trust to their Friends or Family

National Quality Priorities											
NHS Staff Survey Results											
Apr 23 – Mar 24				**Apr 24 – Mar 25**				**Apr 25 – Mar 26**			
SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
The percentage of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends											
62.8%	63.3%	88.8%	44.3%	64.7%	61.5%	89.6%	39.7%	Not Applicable*			
Staff Survey 2025 – Q25d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.											
								61.4%	60.8%	88.4%	34.7%

**Question not included in the 2025 Staff Survey.*

Trust statement

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

All elements of the People Promise fell in 2025 Staff Survey results, and analysis of the results indicates that the financial position of the Trust and the country as a whole, and major change relating to the implementation of a Hospitals Group, are key determinants of this loss of confidence.

The overall response to the Staff Survey for 2025 was slightly lower than previous years and our results reflect the national downturn in scores particularly relating to advocacy for the Trust. Whilst disappointing to see a reduction in overall advocacy as a place to receive care for family or a friend, the Trust remains above the national average at 61.4% who would recommend the Trust to family and friends.

Our responses this year saw a drop in response from clinical and medical staff groups, and therefore a proportionate rise in non-clinical responses, which may have affected the drop in positive responses. What is clear from a number of free text comments is that the financial situation and controls on recruitment and use of temporary staffing have impacted on the perception of staff availability within the Trust, and thus the confidence of staff in the quality of care.

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

- ✓ Delivery of an improved engagement programme, incorporating the current ‘Hearing It’ initiative, sessions with our Staff Council, and engagement with Staffside and Staff Network forums, as well as sessions with clinical teams to better understand the concerns of staff in relation to safe care and staffing.
- ✓ Improved communications to brief out the financial situation, dispel incorrect staff perceptions of staffing levels and share positive staff and patient stories through weekly communications bulletins.

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

Patients Admitted to Hospital who were Risk Assessed for Venous Thromboembolism

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

National Quality Priorities												
Venous Thromboembolism Risk Assessment	**Apr 23 – Mar 24**				**Apr 24 – Mar 25**				**Apr 25 – Mar 26**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
Percentage of patients receiving a Venous Thromboembolism risk assessment	34% (internal audit)	Reporting continues to be suspended.			40%	89%	100%	14%	33%	91.6%	100%	15.4%

Trust statement

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

Salisbury NHS Foundation Trust continues to hold exemplar status for the prevention and treatment of Venous Thromboembolism (VTE). We continue to monitor the rates of VTE and those attributed to hospital care. All events causing concern are discussed within the Divisional learning from incidents sessions, to ensure feedback and guidance is directed to senior doctors and nurses. The VTE service has seen a total of (913) blood clot events in 2025/26, of which (79) (8.65%) were attributed to hospital care. All blood clot events were reviewed and 76 (95.8%) of patients sadly developed their blood clot despite being provided with appropriate treatment (known as thromboprophylaxis).

In 2023, we transitioned from the VTE risk assessment being completed on the paper prescription charts, with a monthly data collection, to a digital system. However, the transition to a digital VTE Risk Assessment system has presented several challenges. The shift from a monthly snapshot audit to a continuous, real-time evaluation has contributed to a decline in the completion percentage figures. While the digital system provides more accurate and real-time data, offering a clearer representation of actual performance, it has also exposed a critical limitation. The current system does not support completion of the VTE risk assessment until an inpatient encounter has been created, which means that when a patient is clerked and medications prescribed in the Emergency Department or by the pre-op assessment team, the risk assessment is unable to be completed or if it is completed, does not then attach to the current inpatient encounter.

Currently the doctors only access the patient's Electronic Patient Record (EPR) to prescribe medication and the VTE risk assessment sits in a different part of the system, all other documentation remains in paper format. Although, we have approached the current provider of the digital system to make changes, they are not willing to do this as the system is due to be replaced in approximately 18 months.

Due to the limitations of the digital reporting system and concerns regarding the accuracy of the data captured, a retrospective audit of paper patient records was undertaken to provide a more reliable assessment of practice.

The audit reviewed whether a documented clinical VTE risk assessment had been completed and whether thromboprophylaxis had been administered within 14 hours of admission.

Each month, 50 sets of patient notes were reviewed, comprising a random mixed sample of both medical and surgical admissions.

The audit findings demonstrate that **92.5% of patients had a VTE risk assessment completed within 14 hours of admission**, and **80% received appropriate VTE prophylaxis within the same timeframe**.

While these results indicate that there are areas requiring further improvement to achieve full compliance with expected standards, the findings provide reassurance that the standard of care being delivered is considerably higher than that suggested by the digital reporting data.

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

- ✓ Conduct detailed enquiries of patients who developed blood clots in hospital to ensure we learn and improve.
- ✓ Maintain our VTE prophylaxis protocols in line with the most recent NICE guidance on VTE prevention, prophylaxis, and treatment.
- ✓ Increase education on VTE prevention across the Trust.
- ✓ Twice weekly ward visits from Clinical Nurse Specialist to provide updated information and guidance to junior doctors to ensure they have up to date information regarding VTE risk and provision of VTE prophylaxis.
- ✓ Monthly newsletter attached to Trust Communication Bulletin providing information on VTE risk and findings of audit data.
- ✓ VTE prevention written information is available on all wards and should be provided to all patients on discharge.
- ✓ Web address has been added to the new electronic discharge summary to signpost patients to Thrombosis UK website to allow them to find further information.
- ✓ Patients receive an SMS message following discharge with a link to access directly to obtain further VTE prevention information.
- ✓ Continued review of the compliance of completing VTE risk assessment, ensuring that we work with our colleagues to ensure that the system in place is the most appropriate to ensure that we can provide effective patient care.
- ✓ Working towards the creation of a new EPR system that will provide a digital VTE risk assessment that will work in conjunction with the Electronic Prescribing and Medicines Administration (EPMA) to ensure greater usability and therefore compliance.

Rate of Clostridium difficile (C.difficile) infection

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

National Quality Priorities												
Rate per 100,000 bed days of C.difficile infection	**Apr 23 – Mar 24**				**Apr 24 – Mar 25**				**Apr 25 – Mar 26**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
Rate per 100,000 bed days of C.difficileinfection amongst patients aged 2 or over	18.1	38.5	149.9	0	18.2	39.7	119.8	0	Not yet published.			

Trust statement

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

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

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

The number of C.difficile cases has continued to increase nationally during the last 12 months, and this is also the experience at Salisbury NHS Foundation Trust. Although numbers have increased, we continue to perform well against the other hospitals in the BSW Hospitals Group.

Learning has been identified from completed case reviews which has shown improvements in patient care outcomes for areas. The clinical Divisions continue to monitor progress with any identified action plans, reporting via the Infection Prevention & Control Working Group and Committee.

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

National Quality Priorities												
	Apr 23 – Mar 24				Apr 24 – Mar 25				Apr 25 – Mar 26			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Number of patient safety incidents	7,416	*Not published.			8,527	*Not published.			10,112	*Not published.		
Rate of patient safety incidents (per 1,000 bed days)	15.98	*Not published.			17.39	*Not published.			22.97	*Not published.		
Number of patient safety incidents that resulted in severe harm or death	36	*Not published.			24	*Not published.			22	*Not published.		
% of patient safety incidents that resulted in severe harm or death	0.49%	*Not published.			0.28%	*Not published.			0.22%	*Not published.		

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

Trust statement

At SFT we strive to ensure that systems and processes are aligned to reduce the risk of patients coming to harm whilst in our care. While zero harm is a worthy ambition, our goal is for a continual reduction of harm.

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

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

- ✓ We continue to educate staff on the positive impact of reporting incidents and near misses.
- ✓ All incidents are discussed at the morning Trust-wide patient safety incident huddle so that immediate support can be provided and actions taken to reduce the risk where possible.
- ✓ All incidents are quality checked by the Risk team. Where potential gaps in processes or systems, or significant learning opportunities are identified, incidents are initially reviewed at the weekly Trust Patient Safety Summit.

- ✓ Where further analysis is required to gain a deeper understanding and maximise learning, a more detailed review is undertaken, and the findings are reviewed by the Patient Safety Oversight Group.
- ✓ Call for Concern was launched at SFT in 2025. This is SFT's local adoption of the national Martha's Rule. This will allow a patient, family member or staff member to invoke Martha's Rule, by calling the dedicated Call for Concern phone line, (available 24/7), if they feel their concerns about the patient are not being heard and addressed by the attending team. If the Critical Care Outreach Team determines a prompt review is required, they will make an appropriate referral for another clinician to attend and review the patient.
- ✓ Through Martha's Rule a daily patient wellness question is asked, this has been rolled out to inpatient areas across the Trust.
- ✓ It is crucial to learn from every incident and near miss that happens at SFT and ensure the learning is shared widely from these reviews. The Divisions have developed monthly Learning from Incident Forums and wider learning is shared at a Trust-wide Learning from Incidents Summit held quarterly. These forums are multidisciplinary in nature, and all staff are encouraged to attend to promote shared learning and continuous improvement.
- ✓ The Patient Safety Incident Response Framework (PSIRF) continues to evolve in SFT enhancing our patient safety reviews by developing a systems-based and multi-disciplinary approach.
- ✓ To support this, the Trust is committed to creating foundations that foster a just and restorative culture that is supportive and compassionate.

Part 3 - Other/Provider Content

Salisbury NHS Foundation Trust

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

Quality Overview

Quality is commonly recognised as having three dimensions: patient safety, clinical effectiveness, and patient experience. At Salisbury NHS Foundation Trust we have three steering groups, representing these arms of quality, which each meet monthly and report upwards to our Quality Board (CMB). It is here that all aspects of quality are scrutinised and discussed. In 2025/26, improvement huddles for the Quality department continued. Representatives from each team are expected to attend the huddle twice a month. As with team huddles, the discussion of improvement projects creates opportunities for shared learning, problem solving and facilitates collaborative working. It also ensures that improvement projects align with the Quality department strategy, which in turn aligns with the Trust's strategy for improvement.

The huddles focused on three main drivers for improvement; **Wellbeing**; **Identity**; and **Sharing & Engagement**. These areas for improvement will be developed over the year ahead.

Organograms of the Quality Governance Structure can be found in Appendix C.

Patient Experience

Overview of Key Priorities 2025/26 (as outlined in part 2A)

Patient Stories

Patient Stories continue to be a highly valued part of our commitment to ensuring the voices of our service users are heard. The examples presented below highlight some of the themes emerging from stories shared so far this year.

Dave's story - Following a diagnosis of bowel cancer Dave commenced chemotherapy following an operation. Unfortunately, due to side effects the chemotherapy had to stop after 4 months. A subsequent 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.

A governor's story – "*My oldest friend had spent nearly 3 months at SDH, initially on Downton and most recently on Breamore ward. As a governor and volunteer, I carry out Real Time Feedback and have glimpses of life on the wards. Visiting my friend very regularly, I noticed so much more.*

Our staff are amazing and not only the nursing staff. The cleaners, HCAs, therapists, all members of the ward teams, deliver compassionate, friendly care day in and out. My friend has dementia and lives in the moment, so is unable to tell me anything of her day, but I now know that she has been entertained, taken part in therapy sessions, listened to live music and encouraged to draw, as she is an artist.

I completely support everything that Breamore Ward is wishing to achieve. The therapists had her out of bed, joining in chair exercises, going into the garden, laughing and joking and enjoying life on her terms."

Her husband and I knew none of this as she could not tell us and when we saw her, she was generally in bed. However, I was on the ward one day as the Physios were encouraging patients out of bed and into the day room. That was when I learned that my friend was always in the thick of the activity.

Thank you so much to everyone for giving her such wonderful care. She has now moved to a care home where she will be safe and well looked after, and I will be able to continue to visit her"

Patient-led service improvement panels

This year we would like to highlight the work of our Learning Disabilities (LD) and Autism focus group or our 'Hospital Helpers' as we call them. The group was established 12 months ago and has continued to go from strength to strength with particular highlights being, reviewing our outpatient clinics and how they support someone with Learning Disabilities or Autism, informing us how our webpages for patients with LD and Autism should look on the internet and reviewing the Trust's Easy Read documentation to give them their stamp of approval but also to highlight where we still hadn't got things quite right. This year we are hoping to facilitate a work experience opportunity for one member. This will help develop their skills but also be an invaluable source of knowledge for us. We intend to continue our walkabout outpatient reviews and work towards implementing the recommendations identified through these reviews.

The Trust also has other well established patient-led panels for Cancer, Spinal and Stoma services. The groups have been instrumental in developing and improving Trust services.

All forums continue to develop their governance with formal escalation reporting into the Patient Experience Steering Group being trialled.

Friends and Family Test

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

Implementation of a further new digital solution is now needed to continue with the growth of our responses. The Trust has been able to consistently exceed its 15% response rate target and has demonstrated additional benefits for more robust analysis of data, aiding triangulation with other patient experience measures. We are currently looking to align with Great Western Hospitals in our new provider.

Real-time feedback

Real-time feedback was re-launched in February 2023 and continues to go from strength to strength. This year, over 340 surveys have been conducted by the patient's bedside. The aim of the feedback is to give a "real-time" view of a patient's perspective of their care. Feedback is currently gathered by some of our volunteers and Governors.

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

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

Hard of Hearing Project

This project was launched two years ago now following a patient story and has continued to gain traction with the introduction of hard of hearing support boxes in all inpatient and most outpatient areas and adoption of an on demand British Sign Language (BSL) service available in our Emergency Department, Maternity and from PALS. In addition, this year, voice amplifiers are now available on all wards and on loan from the PALS department. Reviews will be taking place to establish if there is further need for this service in other areas.

Patient Safety Partners

The Patient Safety Partner (PSP) role is continuing to embed within the Trust; with three PSPs each aligned to a Division each. They are regular attendees at various forums representing the patient voice and patient safety agenda. This includes Patient Safety and Patient Experience Steering Groups and Learning from Incidents Forums.

Readership group

We continue to develop this group and are actively encouraging all new patient literature to be reviewed by the readership group, before coming to the Patient Experience Steering Group for approval. All literature that has been through this process is indicated with the patient reviewed logo.

Working with our communities

Veterans

The Trust is proud to have achieved its Gold reaccreditation for veteran awareness from the Armed Forces Covenant and has over 280 registered and trained Armed Forces Champions, and this continues to grow.

Our Help for Heroes Nurse-led service along with the services of the Armed Forces network, has initiated a regular audit that has allowed us to review our inpatients' veteran statuses.

Hero Bear regularly spends time in PALS and likes to visit patients and staff. Having this presence in the Hospital at times is a fun way of highlighting our Help for Heroes nurse and work with the armed forces and veterans.

Learning Disabilities & Autism

The Trust has now purchased Photosymbols Software licences to enable the Trust to produce more Easy Read patient information using nationally recognised images and styles. These methods will be used to construct patient information where applicable alongside the current Widget Symbols software.

Carers

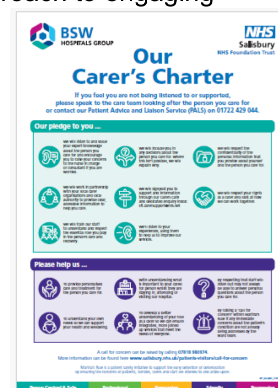
We continue to actively promote the Carer's Passport to ensure carers are recognised and supported when accessing our services within the hospital. Information about eligibility and the benefits of the scheme is routinely shared with staff, patients, and families to encourage uptake.

Whilst we no longer facilitate the Carers Café ourselves, we remain committed to ensuring carers have access to supportive community spaces. We now signpost carers to several established carers cafés and support groups available across Salisbury, enabling them to access regular peer support, information, and social connection within the local community.

Carers Charter

Our Trust Carers Charter continues to be displayed prominently across all wards and departments, reinforcing our commitment to recognising and valuing carers as key partners in care.

By ensuring the Charter is visible in clinical and non-clinical areas, we aim to raise awareness among staff, patients, families, and visitors, and to promote a consistent approach to engaging with carers. The presence of the Charter across the organisation also serves as a reminder of our responsibility to uphold these standards and to actively support carers throughout their interaction with our services.



Listening to our patients in partnership with our hospital charity

Stars Appeal funded – animal visits

Mr Kellogg's, the miniature pony, is now a regular visitor to the Hospital, most recently in December he came for a visit on Imber, Sarum and Spire wards.

We were also kindly donated a session by Critter Cuddles to visit several wards. They bought along Chinchillas, Guinea Pigs and Rabbits. We visited Breamore, Imber and Sarum wards. The visit visibly lifted the patients and staff in the wards.

Stars Appeal funded - Aromatherapist

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

This continues to be a highly valued service amongst our patients and is currently offered to parents of babies on our Neonatal Intensive Care Unit, and patients undergoing burns and cancer treatments along with the newly added Sarum (paediatrics) and Longford (spinal) wards.

The service has just been renewed for a further four years.

Stars Appeal and League of Friends funded Inpatient movie afternoon

Just before Christmas, various teams came together to help Miguel Vasconcelos, Matron for Medicine, bring to life his idea of a Cinema afternoon for patients. With the help of an external company and ward funds from Stars Appeal, the screening took place in the Spire Memory Café. League of Friends and Tesco kindly donated snacks, and patients and relatives were invited to relax and watch a screening of 'It's a Wonderful Life.' Our Trust volunteers, staff from the wards and Therapists helped patients attend from a variety of wards. One patient commented "how wonderful it was to have such an experience whilst in hospital."

Plans are now being made for a Springtime outdoor cinema experience.

Clinical Effectiveness

Overview

In Salisbury clinical audit is recognised as the stepping stone for improving and sustaining practice to benefit patients in our care. Along with **national audits** and **quality improvement programmes**, there were 180 local audits registered in 2025/26, out of which 28 have completed action plans and 24 were completed with no action plans required. The remaining 128 are still in progress. As part of our assurance for patient safety, a risk and assurance score is completed for all audits, and those with a score of moderate or above are discussed at the Clinical Effectiveness Steering Group (CESG).

Improving Together is the vehicle for improvement for the team, who attend weekly huddles to discuss performance and improvement ideas. With support from an improvement practitioner, the team undertook a service review that will help them strengthen operational efficiency following the impact of recruitment pressures. Trust-wide accessibility to monthly performance monitoring data is now available, enabling Divisions to view and spot statistical trends. Networking continues with teams from Bath and Swindon, along with other Trusts from the South West and nationally.

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

Other areas of improvement:

- The Clinical Audit and Effectiveness team has been providing support to clinical specialities through **attendance at Department / Divisional governance meetings** and has been identifying new forums and opportunities for engagement. New staff are signposted to clinical audit information during their Trust induction.
- The Clinical Audit and Effectiveness team has continued to use **Improving Together** as their method for prioritising improvement. Weekly huddles help the team focus on priorities, agree improvements, and celebrate successes. The team prioritised reducing the number of **mandated national audits which have surpassed the target date for completion** and have made a statistical improvement.
- 38 audit reports, with a patient safety **risk score** of moderate or above, were discussed at CESG. This change in processes occurred in 2023/24 to ensure that actions and audit outcomes are linked to patient safety concerns, and that these risks are discussed at Trust governance meetings. This supports our drive to have more focused discussions centred around making improvements for the delivery of patient care and clinical pathways, rather than discussing numbers. It also facilitates shared learning and support for improvement across the Divisions.
- The team has collaborated with teams at **Royal United Hospitals Bath** and **Great Western Hospitals Swindon** to develop a consistent Group approach to NICE compliance reporting in the future.

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

Clinical Audit & Effectiveness Service Review

The recent **service review** highlighted areas which could be improved and developed. **Process standard works** (PSWs) will help reduce errors and variations for all stages of the clinical audit cycle by documenting the sequential steps for each process. The Clinical Effectiveness team have produced a toolkit of PSWs to support staff wishing to complete a clinical audit project.

An updated **intranet page** is being produced with greater signposting to resources and information. It will also include a **Frequently Asked Questions** section and a checklist of responsibilities for those undertaking and managing clinical audit projects.

Greater Visibility of Monthly Audit Performance for Divisions

Performance can now be monitored by Divisions via the Trust's **Power BI dashboards** which helps identify statistical trends, shifts, and outliers. Audit leads are encouraged to use these charts, along with the specialty reporting available in AMaT, to facilitate performance discussions at their governance meetings.

Learning from Deaths

The Trust's Mortality Surveillance Group continues to meet every two months, and this group provides the governance and oversight for matters relating to mortality at Salisbury NHS Foundation Trust (SFT).

Deaths that occur at SFT are reviewed (scrutinised) by a medical examiner shortly after death. This is in accordance with national guidelines which state that deaths in England and Wales must now be independently reviewed by a medical examiner unless investigated by a coroner. An internal review (for instance a Structured Judgement Review (SJR)) may be recommended should there be potential learning identified following the death of a patient. This could be identified through a review of the medical records, or following consultation with the clinical team or relatives/carers of the bereaved.

In addition to the SJRs, clinical teams are encouraged to complete any other mortality reviews using an online platform. These abbreviated reviews use some of the same fields as the SJRs, including those related to learning points and capture any actions arising from them. This allows areas of good practice and areas for improvement to be documented and shared in a consistent way. Reviews may also be commissioned in response to national benchmarking publications or when local data highlights an area requiring further investigation.

The total number of deaths and the total number of Structured Judgement Reviews completed during each quarter of 2025/26 are shown in the table below.

The number of Structured Judgement Reviews undertaken relating to deaths during 2025/26 was 366, and this represents approximately 40% of all deaths. These were completed in addition to circa 100% of inpatient deaths being scrutinised by the medical examiner this year.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
Inpatient Deaths (inclusive of Emergency Department and Hospice)	234	201	238	243	916
1st Scrutinised by the Medical Examiner	233	201	237	243	914
Structured Judgement Reviews undertaken related to deaths during 2025/2026 *	30	83	132	121	366
Structured Judgement Reviews undertaken related to deaths during 2024/25 *	92	19	5	1	117
Patient deaths judged more likely than not to have been due to problems in the care provided to the patient (Hogan Score)	<5	<5	<5	<5	<5

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

Summary of Key Highlights

- The Summary Hospital-level Mortality Indicator (SHMI) metrics are made available by NHSE to all Trusts and provide detailed data on mortality by diagnosis groups combined with benchmarking. The Trust is using this data for an overall picture, as well as notification of any diagnosis groups which are alerting. The latest SHMI trend figures from NHSE confirm a steady improvement in the Trust's performance from an outlying position in 2022/23. Further information about the SHMI and publication of this data can be found on the NHS website: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital

- A total of 483 online mortality reviews were undertaken by relevant teams in 2025/26. This was in addition to/after the initial step of cases being first reviewed by the medical examiner. The medical examiner recommended further reviews, known as Structured Judgement Reviews (SJR) in only 6% of cases. Further information about the national Medical Examiner System can be found on the NHS website: NHS England » The national medical examiner system

- Learning points are collected in the online mortality review platform using a standard set of categories (such as, *Communication with relatives/carers*; *Assessment, Investigation or Diagnosis; Documentation*) which enables identification of themes and patterns across the Trust as well as within individual teams or wards.

- The online mortality platform is enabling alerts to be successfully and promptly investigated by analysis of data held within the platform. Previously alerts had often required a cumbersome and prolonged paper case note review to be completed on paper proformas which would sometimes take several months from commissioning to conclusion.

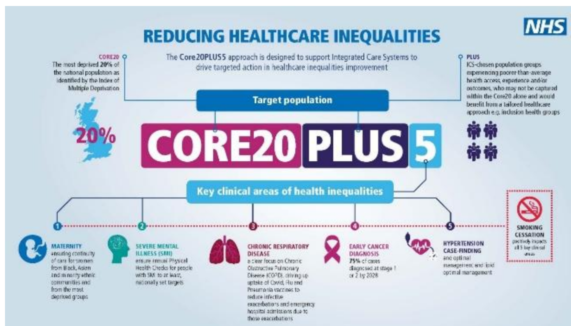
- The Trust's mortality Power-BI dashboard has been developed further this year to enable all teams access to mortality trends in their specialties or wards. This presents an opportunity to identify concerns earlier and enable steps to be taken at an earlier stage to mitigate deterioration and alerts being triggered. There is also now the functionality to quickly identify positive and negative trends in the data by alerts being flagged within the dashboard.

Health Inequalities

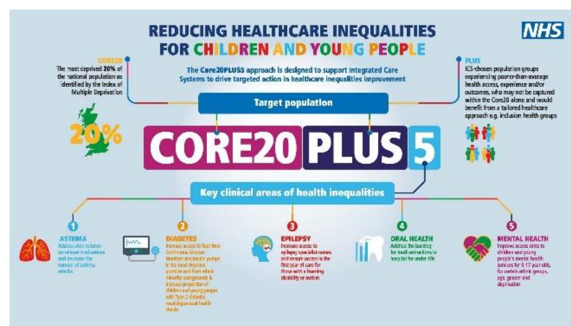
Health inequalities are unfair, avoidable, and systemic differences in health outcomes from different groups of people. The CORE20PLUS5 approach continues to guide our work on health inequalities. The ‘Core’ references the 20% most deprived communities in England. In Wiltshire we have eight geographical areas in the poorest 20% nationally, and three of these are in Salisbury.

The ’PLUS’ represents defined groups that experience disparities in health outcomes within our local geography. In the case of BSW this is Gypsy, Roma, Traveller, and Boater communities, as well as routine and manual workers. Military populations are considered here too. For children there is a focus on mental health, and the children of Gypsy, Roma, Traveller, and Boater families. The **‘5’** represents the key clinical areas of focus – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension in adults. Smoking cessation is a theme through all five.

Core20PLUS5 (adults)



Core20PLUS5 (children and young people)



The Joint Strategic Needs Assessment (JSNA) is a document produced by all English local authorities; Wiltshire’s can be found here: JSNA Wiltshire Intelligence. It provides high level data on our population and helps us take a data driven approach to defining our interventions for tackling health inequity. There was a refresh of this data in 2025, and this data is helping us to define the local priorities for 2026/27 that will benefit our local population and ensure that the services we provide are fair and equitable.

Our vision at Salisbury NHS Foundation Trust (SFT) is to ensure that our population are treated fairly and that health inequalities become part of everyone’s business. As part of our Trust strategy, health inequalities feature within our strategic framework (‘vision metric’), and this ensures there is a high level of focus on this work with Executive oversight. To support this wider agenda, the Wiltshire Health Inequalities Group (WHIG) continues to meet monthly, and this group is co-chaired by a Public Health Consultant from Wiltshire Council and the Health Inequalities Lead at SFT. A new BSW inequalities strategy is expected to be published this year, and work has already begun to ensure that our local priorities are aligned and to see whether there are further opportunities to work together across the BSW Hospitals Group on shared programmes of work. There is likely to be a greater focus on supporting our military population and their families this year as part of the new strategy.

During 2026/27 we plan to:

- Co-host a workshop with Wiltshire Council Public Health Department to review the latest data and launch the new local strategy to set priorities for 2026/27. We will continue to use the CORE20PLUS5 as a framework to support this work.
- Run a health inequalities awareness week in conjunction with RUH and GWH hospitals in the Summer of 2026.
- Refresh our local priorities (using the A3 thinking Improving Together methodology); to specifically include programmes of work to:
    1. Increase staff awareness of health inequalities
    2. Standardise our approach for considering health inequalities – for instance by:
        i. reviewing existing/new data sources and,
        ii. ensuring fairness of services is routinely considered by staff and managers when designing new services or making changes to existing services or clinical pathways.

The above will be achieved through furthering our partnership with Wiltshire Council and the Wiltshire Health Inequalities Group (WHIG) and working even more closely with the health inequality leads within the BSW Hospitals Group.

Last year, a total of £863,195 was allocated to Wiltshire (from BSW ICB) to help fund projects that will reduce health inequalities. As a result of this, SFT was successfully awarded funding to support two specific projects which will be continuing to work over 2026/27 to:

1. Reduce low uptake of screening and late cancer presentation.
2. Enable equality of access for children and young people to secondary care and CAMHS (child and adolescent mental health services) in Salisbury.

Getting It Right First Time

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking,and presenting a data-driven evidence base to support change.

The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

The GIRFT methodology has been applied across more than 50 different areas of clinical practice in Surgical and Medical specialties and cross-cutting themes, including Diagnostics, Day Case Surgery, Outpatient Services and Clinical Coding.

The programme takes a detailed look at individual specialties' performance based on a number of metrics including mortality rates, length of stay, post-surgical infection rates and hospital re-admission rates.

The model consists of five key strands:

Data gathering – a broad data-gathering and analysis exercise, generating a detailed picture of current national practice, outcomes and other related factors.

Peer reviews – direct clinical engagement via visits or virtual meetings between Clinical Leads and Trust teams.

A national specialty report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside clinical resources such as best practice pathways and guides.

Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver recommended improvements via the Further Faster programme and other focused support mechanisms.

Studies and Research – GIRFT fellowships support Resident Doctors, Nurses and Allied Health Professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT-identified improvements in their host provider, system or region.

Since GIRFT has expanded its remit there has been fewer peer reviews, and the decision has been taken by the Board to incorporate the learning from GIRFT publications into the improvement streams within the Divisions and Trust, rather than have a separate reporting GIRFT stream. This incorporates key learning themes across relevant areas and incorporates Improving Together methodology to facilitate change.

Peer review 2025:

Interventional Radiology	Good practice included: • Impressive response to clinical demand. • Flexible and responsive consultant team. • Positive feedback and engagement from clinical teams. • High staff morale. Areas to work on included: • Improvement to IT infrastructure at University Hospital Dorset to facilitate cross-site working. • Review booking process to code appropriate activity and income generation. • Establishment of regular Morbidity and Mortality meetings across the Department.

Patient Safety

Call For Concern (A Martha's Rule initiative)

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

This initiative was launched following the tragic case of Martha Mills, a 13-year-old who died from sepsis after her family's concerns were not acted on in time.

In 2025, SFT launched Call for Concern – a part of Martha's Rule empowering patients, families, carers and staff to request an urgent clinical review if they have concerns about a patient's deteriorating condition.

There are 3 components to this initiative which have been rolled out to designated areas within SFT:

1. SFT has implemented a daily patient wellbeing question whereby the patient is asked how they feel today compared to yesterday.
2. Staff can refer a patient to the critical care outreach team for a rapid review should they have concerns.
3. SFT has a designated phone line that all patients, families, carers and advocates can access to raise concerns to request a rapid review from the critical care outreach team.

Are you worried about a patient's condition?

Don't wait, escalate!

At Salisbury Hospital your observations and concerns matter. A 24 / 7 service is now available for patients and families seeking a rapid review.

This service is available to both adults and children staying in our inpatient areas.

Call For Concern Mobile: 07818 980974

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

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

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

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

What have we done to improve adult safeguarding in 2025/26?

- ✓ We have continued to provide Adult Safeguarding, Mental Capacity Act & Deprivation of Liberty Safeguards and Domestic Abuse training, advice, and support across the Trust.
- ✓ The number of s42 Safeguarding & Multi-Agency Risk Assessment Case Conference (MARAC)referrals completed by SFT has remained static at around 250 a year.
- ✓ The number of Urgent DoLS authorisations completed by SFT has increased by 17% to 1,054 a year.
- ✓ Continued developing the Ward and Department Safeguarding and Learning Disability Champions, by providing bi-monthly workshops.
- ✓ We continue to provide bespoke training to individual wards, departments, and teams.
- ✓ We continue to attend the Wiltshire MARAC weekly.
- ✓ We have re-started the provision of Adult Safeguarding Supervision across the Trust following appointment of a Band 7.
- ✓ We continue to support the Divisions in investigating and learning from any Safeguarding concerns within the Trust.
- ✓ We continue to support the Multi Agency aspect of Safeguarding across our 3 local authorities.
- ✓ The Team successfully recruited into the Specialist Safeguarding Practitioner post.
- ✓ The Team has been involved in the Safeguarding, Mental Capacity, Cognition & Restrictive Practice EPR workstreams.
- ✓ The Team has led the change in practice of reporting hospital acquired tissue damage to the Adult Multiagency Safeguarding Team.
- ✓ 30% of Trust staff will have completed Oliver McGowan Mandatory Statutory Training.
- ✓ Continued to add Learning Disability (LD) & Autism alerts onto Lorenzo while awaiting an IT fix.
- ✓ Started an LD & Autism Focus Group to support the development of accessible information, making reasonable adjustments and providing first-hand accounts of their experience at the Trust.
- ✓ Provision of 'Sensory Bags' to wards and departments to support LD & Autism care. These include ear defenders, sensory fidget items and simple communication aids.

Safeguarding Children

Salisbury NHS Foundation Trust is committed to safeguarding children and promoting the welfare of children and young people. In accordance with the Children Act 2004, all individuals working within health organisations must be appropriately trained and competent to recognise when a child or young person may require safeguarding measures. Staff must also understand how to respond appropriately to concerns in line with local and national safeguarding procedures. Section 11 of the Children Act 2004 places a **statutory duty** on NHS organisations. NHS organisations must ensure that their functions and any services they commission are carried out with regard to the need to **safeguard and promote the welfare of children**.

This means safeguarding must be embedded in governance, recruitment, training, supervision, and service delivery.

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

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

What have we done to improve safeguarding children in 2025/26?

- ✓ Level 3 safeguarding children's training has continued to be delivered through face-to-face sessions to promote engagement, discussion and reflective practice. A total of 10 training sessions were facilitated. The training is regularly reviewed and updated to strengthen staff knowledge and reinforce the Trust's commitment to safeguarding best practice and statutory guidance.
- ✓ External Safeguarding Assurance: in March 2025 Wiltshire Safeguarding Vulnerable Peoples Partnership (SVPP) conducted a safeguarding walkabout at SFT. The aim of the visit was to quality assure and test safeguarding systems in place for children and vulnerable adults across the organisation. The walkabout provided opportunities for the SVPP representatives to review safeguarding processes and speak to staff and assess the effectiveness of safeguarding arrangements. The final report was received and concluded 'in conclusion the SVPP representatives were assured around safeguarding processes at SFT'.
- ✓ Two Safeguarding Children audits were undertaken: An Integrated Front Door referral audit and a staff knowledge awareness audit. The findings of both audits were formally disseminated to relevant forums and operational leads. Where areas for improvement were identified, comprehensive action plans were developed and implemented to strengthen practice, enhance compliance, and ensure continued adherence to statutory safeguarding responsibilities.
- ✓ The ICON programme has been commissioned across BSW to strengthen early help and safeguarding support for families with infants. Refresher training has been delivered to midwives, neonatal nurses and maternity support workers, with additional targeted sessions for paediatric nurses in the Children's Ward and Emergency Department to ensure a consistent cross-departmental approach. ICON materials are now prominently displayed in maternity and paediatric areas to promote parental awareness, encourage help-seeking, and reinforce key

safeguarding messages, thereby supporting early intervention and reducing the risk of non-accidental injury in infants.

- ✓ The Female Genital Mutilation (FGM) self-assessment audit has been completed, with a detailed action plan developed to address identified improvements. Trust guidelines have been updated in line with national recommendations, clarifying mandatory reporting requirements, escalation pathways, ICB notification, and processes for children presenting with suspected FGM in the Emergency Department. FGM dataset requirements have been reviewed to ensure accurate statutory reporting. Refresher training for midwives and maternity support workers has reinforced risk recognition, documentation, information sharing, and multi-agency safeguarding processes, strengthening overall compliance and assurance.

Our Workforce

People Promise

From 2022 to 2024 Salisbury NHS Foundation Trust was a People Promise Exemplar site, sponsored by NHSE and the seven elements of the People Promise were incorporated into our Salisbury NHS Foundation Trust Long Term People Plan. We have continued to implement that plan year on year, setting new ambitions and projects to support our staff and continuing to deliver against the People Promise. During our journey staff satisfaction significantly improved, taking us from below average in all but one area of the People Promise in 2022 to average or above average in 3 areas by 2023 and to above average in all areas by the 2024 NHS Staff Survey. However, early results indicate that we have since seen a drop back down to average in all areas in the 2025 survey. A number of factors may have influenced this drop which will be further explored at a strategic and Divisional level in 2026/27. Below is an overview of some the activity undertaken during 2025/26.

Breakthrough Objective: Staff Unavailability

Our breakthrough objective has been to reduce staff unavailability, primarily to reduce temporary staffing usage. We have seen an overall improvement and will continue this focused work until we reach our Trust target of 16%.

- ✓ **We are compassionate and inclusive:** We continue to consider and to embed inclusive processes and practices when recruiting so that we can fill our vacancies appropriately and efficiently.
- ✓ **We each have a voice that counts:** We continue to foster and support speaking up. We continue to encourage psychological safety for our people.
- ✓ **We are safe and healthy:** We achieved Safe Effective Quality Occupational Health Service (SEQOHS) accreditation for our Occupational Health Service. We continue to actively manage absences, paying positive, proactive attention to our staff wellbeing.
- ✓ **We are always learning:** We continue to develop our apprenticeship offer and improve our talent management processes to encourage staff to grow their careers at the Trust.
- ✓ **We work flexibly:** We are supporting departments to use team-based rostering to give individuals greater control over when they work.
- ✓ **We are a team:** We offer bitesize training to support managers to deal with absence, sickness, and other issues appropriately and in a timely way as well as delivering full training sessions as part of the Licence to Manage programme.

Staff Engagement

Our vision metric includes the aspiration to increase staff engagement to the upper quartile for NHS acute providers in the NHS Staff Survey by 2027. We aspire for people to recommend the Trust both as a place to work and somewhere to receive care.

- ✓ **We are compassionate and inclusive:** We continue to embed our Leadership Behaviours Framework and to deliver our leadership and coaching training offers. We continue to develop policies and practices to support a Restorative, Just and Learning Culture.
- ✓ **We are recognised and rewarded:** We delivered the Trust's annual Staff Awards and recognition events. We are developing a refreshed every day thank you and SOX process. We are planning Tent Talks and Open Day for 2026.
- ✓ **We each have a voice that counts:** We continue to hold a regular Staff Council, as well as 100-day, one year and Hearing-it listening events, using the information received to inform actions and to feedback activity to teams.
- ✓ **We are safe and healthy:** We re-launched the wellbeing offer for staff including an updated portal and access to an employee assistance programme.
- ✓ **We are always learning:** We continue to work with Divisions and teams on improving appraisal compliance rates and the quality of the appraisals completed.
- ✓ **We work flexibly:** We continue to roll out communication and engagement activities that encourage an understanding and use of flexible working for all staff groups.
- ✓ **We are a team:** We continue to review and refresh our My First 90 Days induction programme to ensure it is fit for purpose, engages and supports people during their first 90 days at the Trust.

Staff Turnover

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

- ✓ **We are compassionate and inclusive:** We support the Staff Networks to thrive by delivering a range of cultural awareness events and activities that encourage a sense of belonging at the Trust.
- ✓ **We are recognised and rewarded:** We continue to deliver our retire and return offer, keeping our people in the Trust for longer.
- ✓ **We each have a voice that counts:** We continue to review the data from our Freedom to Speak Up service and explore ways to reduce detriment or harm as a result of speaking up.
- ✓ **We are safe and healthy:** We continue to support the wellbeing of our people and to understand why people leave so that we can better support them if there are alternative options to leaving.
- ✓ **We are always learning:** We launched a talent management approach to enable a more proactive approach to developing people's careers at the Trust.
- ✓ **We work flexibly:** We continue to train managers to embrace and fully understand flexible working as part of our Licence to Manage programme.
- ✓ **We are a team:** We have trained coaches, mediators and trainers to better support people in their roles, helping them to grow their skills and capabilities and to proactively resolve issues as and when they arise.

An Inclusive Employer

Our people vision is to create an environment where our people recognise and experience the Trust as an inclusive employer. We aspire for a more positive trend against all of the seven Workforce Disability Equality Standards and four Workforce Race Equality Standards indicators in the staff survey. By April 2027 we aspire to achieve the median for our benchmark group across the workforce standards at the Trust.

- ✓ **We are compassionate and inclusive:** We continue to build on our action plan to support the six high-impact actions related to inclusive recruitment and promotion. All leaders are required to demonstrate a personal objective in support of equality.
- ✓ **We each have a voice that counts:** We continue to expand our networks and to monitor the feedback we receive from colleagues to ensure that all groups are proportionally represented.
- ✓ **We are safe and healthy:** We continue to develop our wellbeing offer for all staff, based on the relevant data to reduce inequalities and improve access to relevant services and offers.
- ✓ **We are always learning:** We will continue to roll out our Equality, Diversity and Inclusion training, making cultural awareness training available to all new starters and current members of staff.
- ✓ **We are a team:** We deliver cascade briefings that help all of our people to feel informed. Our listening events are designed to give opportunities for all of our people to feel listened to and to see the actions taken.

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Highlights from our Clinical Divisions

Medicine Division

Key achievements for 2025/26

- Successful **CQC** visit with the service rated **Good** overall.
- **Staff Survey** results improved across the Division, with teams reporting that they felt proud to work in the team.
- **Continued innovation** in the UEC pathway saw the expansion of the SDEC team and clinical pathways, further development of the Acute Frailty Model, opening of a Clinical Decisions Unit, and streaming to the Walk-in Centre.
- Refurbishment and redesign of our estate continued with the development of a new **Urgent Treatment Centre (UTC)** and refurbishment of Tisbury ward.
- Extensive innovation in the **discharge process** took place with the development of Early Supported Discharge teams helping to ensure the Breamore **No Criteria To Reside (NCTR)** model continues to thrive and NCTR levels reduce.

Improvements made in 2025/26

- Extensive mapping and improvement took place across the **inpatient wards** with morning discharges, weekend flow, and NCTR levels all seeing improvements.
- A review and redesign of the **complaints and concerns process** as well as the patient exclusion/warning process has ensured that the Division continues to be transparent and responsive to our patients.
- Additional business intelligence dashboards have enabled a more detailed view of the performance of the Division and greater insight especially in the UEC and ward pathways.
- **Improving Together** methodology was used across a range of **outpatient services** including Cardiology, Rheumatology, and Respiratory to map out current processes and improve performance. This enabled extensive improvements in some areas of performance.
- Continued improvements in **workforce sustainability**, including reduced reliance on Registered Nurse agency staff, strengthened oversight of bank usage, and improved retention within the Health Care Assistant workforce, supporting safe and high-quality patient care.

Objectives and plans for 2026/27

- Open the UTC and redevelop the **Emergency Department model** and estate to meet current demand and improve **4 hour performance**.
- Launch **electronic triage** and integration with the wider Integrated UEC pathway (111, Pharmacy First etc.) to improve time from ambulance arrival at ED to handover to ED staff (known as W45) and 15 minute triage
- Further expand the **Early Supported Discharge Team** to reduce Length of Stay (LoS).
- Create an **Integrated Frailty Assessment Unit** to complement AFU and enable a fully integrated frailty pathway to allow hospital-level care provided at home and increase 0-day LoS.
- Expand **weekend hospital provision** to reduce overall LoS and NCTR delays.

- Create a ‘rhythm of the day’ and set of watch and driver metrics for every ward to enable oversight and management of daily flow and performance.
- Complete comprehensive **demand and capacity** exercise across all outpatient specialities to right-size teams and ensure sustainability. Use **private sector partnerships** to create resilience and enable a rest back to 18-weeks.
- Launch **one-stop-shop** clinics across all specialities to improve time to 1st appointment and work with **primary care** to develop integrated pathways utilising shared resource.
- Launch **Discuss and Refer** with all primary care teams having the opportunity to query patients with the consultant and therefore reduce referral demand.
- Prepare for launch of **Oracle Cerner Millenium** and further expected CQC visits.
- **Complete utilisation programme** in the Cath Lab and expand the offer at the Trust to include Electrophysiology Services and Ablation as well as more complex devices and investigations. Use this work to enable a wider refurbishment of the Cath Lab equipment.
- Further develop **Community Diagnostic Centres** and pathways to ensure all Diagnostics Waiting Times and Activity (DM01) is completed within **6 weeks** including echo and sleep study.
- Achieve our **financial plan for 2026/27** through reducing unavailability, bed base, and increasing productivity and activity.

Surgery Division

Key achievements for 2025/26

- **Surgical SDEC,** launched March 2025. Following SDEC regional review we have achieved an upgraded maturity score from 2 to 4 (Mature).
- **Katie Ransby and Champi Dona** awarded the National Chief Nursing Officer's Award.
- **Mutual aid** provided to RUH Bath and University Hospital Southampton (UHS).
- **Mr Johann Jeevaratnam** awarded an OBE for gallant and distinguished services in the field in his 2025 deployment.
- **National Joint Registry (NJR) Quality Data Provider gold award** achieved for the 10th Consecutive year. Credit to Becky Stainer (Orthopaedics).
- Completion of the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) **Days Matter** program for Urology and Lower Gastrointestinal (GI) pathways.
- **Joint Advisory Group on GI Endoscopy (JAG) accreditation** secured.
- **GI GP** education event well received.

Improvements made in 2025/26

- **Sustained reduction in Nursing Agency spend,** helping with the Division's financial position.
- **November 2025** saw the launch of the revised complaints process. With the aim of reducing time to respond and the accuracy of complaints response**.**
- **Theatre Productivity Group** reported capped utilisation consistently above 85% (national target).
- **Time to First Outpatient Appointment,** continued improvement.
- **DM01 performance in Endoscopy** improved and stabilised.
- **Elective Care Centre / Diagnostic Hub** national funding secured.
- **Sustained improvement in NEWS 2 compliance:** stepped down from Divisional Driver metric.

Objectives and plans for 2026/27

- **Time to First Outpatient performance,** to continue to focus on reducing Time to First Outpatient Appointment performance.
- Progress **partnership** with UHS regarding Plastic Surgery and Oral and Maxillofacial Surgery provision.
- Focus on **support** to line managers and colleagues for sickness management, appraisal and MLE compliance.
- **Eradicate 52 week wait** for treatment.
- Commence planning and business case for **Elective Care Centre / Diagnostic Hub** to draw down funds.
- **Mutual aid**, continue to support the system with 52 week wait targets.
- Stabilise **Day Surgery Unit (DSU)** operating model in view of altered DSU footprint use.

Family & Specialist Services (FaSS) Division

Highlights from **Maternity and Neonatal** services can be found on the next page.

Key Achievements for 2025/26

- **Pathology Career Day** high number of attendees with positive feedback.
- **Child Health** outstanding approach to holistic end of life care for a young patient and their family.
- New resources to support people with **Learning Difficulties and Autism** coming to the **Radiology Department**.
- New **Nurse Led** Paracentesis Service, reduces patient wait time and need for overnight stay.
- **General Medical Council** positive feedback for medical trainees in **Paediatrics** and **Obstetrics & Gynaecology**.
- Suzannah Hakes (Pharmacist) celebrated **45 years of NHS working.**
- **Staff Awards**: Over 100 nominations, 13 shortlisted and 4 winners, including Mortuary, Orthotics, Maternity & Neonatal and Laboratory Medicine.

Improvements made in 2025/26

- **Waiting time** for first appointment in **Clinical Psychology** reduced from over 20 weeks to under 3 weeks, through change in assessment process.
- **Pharmacy dispensing** 65% of all take home medications direct from the ward with an average waiting time of 22 minutes.
- **Patient Care:** Continued focus on ward teams' recognition of changes in patient condition (deterioration), aiming to share good practice.
- **Improving Together:** Further Divisional departments now using Trust 'Improving Together' approach to improving services for patients.
- **Medical Physics:** Establishment of the majority of required Medical Physics roles (safe and effective use of diagnostic equipment).
- **Staff Survey** results in **Pharmacy** improved across all areas.

Objectives and plans for 2026/27

- Focus on delivering **excellent patient experience within our inpatient wards**.
- Work with Divisional teams to manage **staff availability** (sickness and other absence) and reduce use of bank/agency staff, so that staff resource is used most effectively for patients.
- Improving response to **patient safety incidents**, to ensure learning is shared quickly and **potential for future harm reduced**.
- **Reducing Outpatient waiting times**: Reduce wait to 90 days or under for first outpatient appointment in Child Health.
- **Medical Physics**: Finalise agreement with partner hospital for essential Medical Physics role (Radiation safety).
- Transition to **SPECT CT imaging**, where pictures from two different types of scans are combined to show how different parts of the body are working and identify problems more clearly.

Maternity & Neonatal Services

Key Achievements for 2025/26

- **Chief Midwifery Officer Awards** for Vicki Marston (Director of Midwifery) and Leah Millard (Maternity Support Worker).
- **Minimal vacancy rates** across all areas, excellent responses to recruitment leading to stable workforce.
- **10/10 Compliance** to Maternity Incentive Scheme.
- **Badgernet phase 2 roll out**, including the digitisation of fetal heart monitoring and central surveillance platforms for this on the labour ward.
- Excellent feedback from Insights visits from regional and ICB lead teams.

Improvements made in 2025/26

- Roll out of **Team-based rostering** across neonatal nursing and community midwifery teams.
- **Significant improvement** in compliance to the Maternity and Neonatal Three-Year Delivery Plan
- Roll out of **Obstetric Bleeding Study UK** in conjunction with national team. Commended by study partners on our swift implementation and team engagement.
- New **community midwifery hub** opened in Amesbury

Objectives and plans for 2026/27

- Maintaining **safety & quality** in Maternity & Neonatal services, ensuring a good experience for all who use them.
- Improved **parent antenatal education programme** including face-to-face classes which offer support to all women and families which is inclusive and accessible.
- Development of **communication channels for both women and families**, and staff that are informative, responsive and digitally progressive.
- Improved **transitional care offer** to ensure there is a fully functioning model in line with British Perinatal Institute standards.
- Focus on **Infant Feeding** service to ensure the Trust has a model which offers support to all women and families that is accessible and within the Baby Friendly Initiative (BFI) gold standards.
- Increasing **appraisal rates** and effectiveness, to improve staff wellbeing.

Other 2025/26 Highlights

Benefits delivered in support of strategic priorities through the project delivery system – supported by the Trust-wide Transformation Team

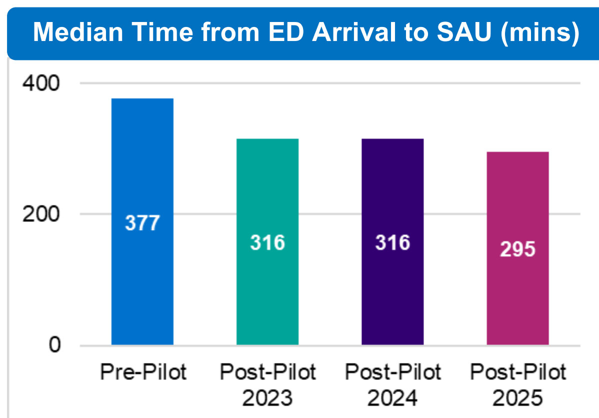
Creating Value For Our Patients

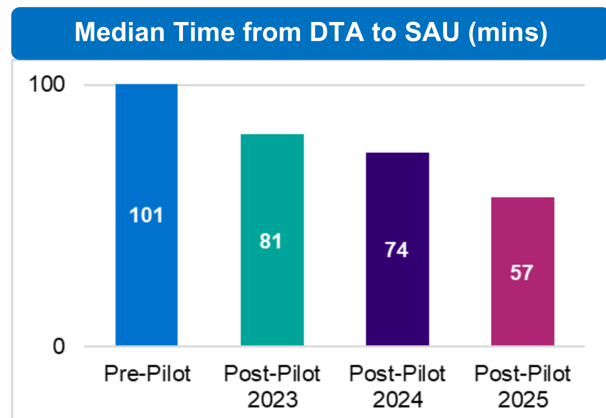
Urgent Emergency Care Projects: Medical Same Day Emergency Care (SDEC)

- ✓ Improvement in ED four-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 three days in July 2025.
- ✓ **AFU** % 0-day Length of Stay performance saw a reduction in variation and continuing upward trend.

Surgical SDEC

The 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):

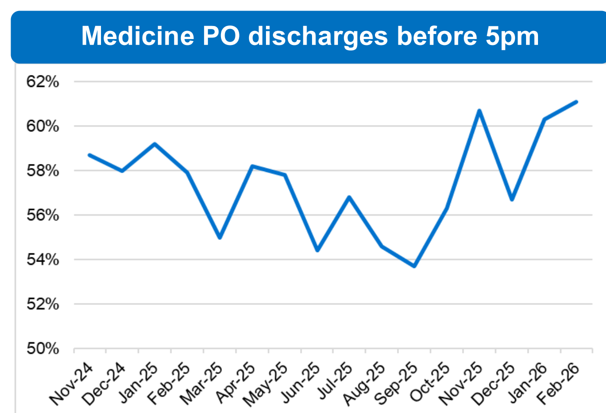




These projects closed in Q3 and are now being operationally led through the Operational Management System at a local divisional driver level. This is a positive sign of the developing improvement capacity and capability within our teams.

Getting patients home sooner - Increasing discharges before 5pm

In the last six months, the Trust has increased the number of discharges before 5pm for patients requiring discharge to their usual resdience without additional care package requirements. The Improving Together methodology has supported a positive shift in culture on the wards to pro-actively understand what their data is telling them and the small steps they can take to support improvements in their work areas and processes.



Reducing time to first outpatient appointment

Outpatient Elective Reform

9% improvement in Trust Time To First Outpatient Appointment (TT1OPA) performance between December 2024 (132 days) – November 2025 (120 days).

Multidisciplinary Outpatient Operational Group has overseen the implementation of the OPERA approach across SFT. Working with three focused specialties over a three-month period to explore challenges, test improvements, and strengthen outpatient pathways, with the aim to support TT1OPA performance.

The three specialties (Rheumatology, Respiratory and Trauma & Orthopaedics) engaged through the support process between October – December 2025 show the following improvement so far.

Specialty	Before OPERA Approach	After OPERA Approach
Rheumatology	183.6 days	149 days
Trauma and Orthopaedics	157.4 days	146.8 days
Respiratory	153.7 days	158.4 days

The next set of focus specialties (Ear Nose & Throat, Cardiology and Gynaecology) began their three-month support in January 2026.

Central and satellite booking teams were supported to use Improving Together methodology, such as A3 thinking, collaboratively identified improvement countermeasures and delivered sustainable change in their working practices. This has **reduced the time to fill short-notice outpatient appointments by up to 86%,** by using DrDoctor Broadcast Messaging to tell patients about available slots.

Patient Led Validation Service

In **March 2026,** the Trust went live with a digitised Patient Led Validation service. SFT is the fifth Trust in the UK to utilise this module, which sends validation campaigns to routine patients to confirm whether they still require their first outpatient appointment. Aligning with the Trusts outpatient communication pathways, these validation campaigns utilise the DrDoctor platform.

The project is aiming to improve patient experience through regular communication with patients to confirm their waiting list status and give them the opportunity to request removal if they have sought treatment elsewhere or no longer require their appointment. This will enable the Trust to meet the NHSE requirements to validate outpatient pathways every 12 weeks and contribute to the wider strategy to ensure our waiting lists are accurate and reduce wait times for patients.

It is expected that around 1,000 patients will be contacted per week by the Validation Team as a result of this new process. Response and discharge rates will be monitored over the next few months to track benefits achieved.

Appendix A – Strategic Planning Framework 2026/27

Vision

To provide an outstanding experience for our patients, their families and 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

Breakthrough Objectives 12-24 months

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

Appendix B – Audit Examples and Actions

Examples of National Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Heart Failure 2025 (data: 2023-24) National Institute for Cardiovascular Outcomes Research (NICOR)/ National Cardiac Audit Programme (NCAP) Presented to CESG in August 2025	This audit aims to drive quality improvement in the care and outcomes for patients with heart failure (HF) both during and after an admission to hospital. **Successes:** Continued to achieve above 70% target for ascertainment Increased input from cardiologist; 2022/23 (16%) 2023/24 (31.4%) Continued to achieve 90% target regarding reviewing HF patients by specialist team Significant increase in terms of discharge planning; 2022/23 - 43.4% 2023/24 98% - SFT maintained >70% target for case ascertainment **Concerns:** Proportions of HF patients that were looked after in Cardiology ward was below 60% target (SFT 20.9%), however this follows the national figure where none of the participating Trusts were able to achieve this. 0.60 % reduction in cardiac rehab provision Slightly below its peers in achieving 90% target in performing echocardiogram (within 48 hours of admission) for HF patients	1. Send communication to bed managers that patients admitted with acute heart failure should be prioritised to come to Tisbury ward ahead of any general medical patients. A local audit to be completed in 6 months. 2. Send communication to all medical consultants to highlight need to refer to the inpatient HF team within 24hrs any patient that has been diagnosed with acute heart failure. 3. Discuss with Echocardiography department whether patients admitted with suspected acute heart failure can be prioritised to have echo scan within 48 hours of request.

Examples of National Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Recovery Beyond Survival - A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit Presented to Surgery Division Clinical Governance meeting in January 2026 Presented to CESG in March 2026	The aim of the study was to evaluate the rehabilitation provided to critically ill adults within Intensive Care Units (ICU), as well as throughout the recovery pathway to encompass both ward-based and community care. **Successes:** Physios complete a Short Clinical Assessment (SCA) within 24 hours of patient's admission to Intensive Care. Physios set rehab goals within 4 days of admission to Intensive Care and review weekly. This is undertaken with the patient, where appropriate. Physiotherapy (PT) rehab is provided 7 days a week. Physiotherapist attendance at ICU follow-up clinic where goals are reviewed and patients referred to onward services as required. **Concerns:** Lack of Occupational Therapist and Rehabilitation Coordinator. Inability to follow-up patients discharged from ICU to the ward by the known PT. Shared therapy assistance across acute wards not available to assist on ICU.	1. Speech and Language Therapy (SALT) to review their service due to upskilling of acute team and potential for introductory ICU service. Review to include: a. regular complex dysphagia SALT contact with ICU to facilitate earlier intervention, including Fibreoptic Endoscopic Evaluation of Swallowing. b. provision for assessment - no capacity for regular rehab with current staff provisions, possibility of ICU link assistant to facilitate swallow rehab for complex patients. 2. Introduce an annual audit on goals, SCA and transfer documentation within the physio specialty. 3. Complete business case to introduce Occupational Therapy service for ICU. 4. Complete business case to introduce Rehab Coordinator role in ICU. 5. Dieticians to start using indirect calorimetry and nutrition screen for High Dependency Unit patients 6. Invite other members of MDT to board meetings (SALT, Dietetics, Pharmacists). 7. Production of information board for nursing staff (re: rehab). 8. Link role for nursing staff to be established for 'Nutrition' (to include SALT and Dietetics rehab). 9. Ward therapists to include ongoing therapy needs/goals on electronic discharge summary for GPs - which will also be available to physio at follow-up outpatient clinic.

Examples of National Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Royal College of Emergency Medicine (RCEM) 2024 Care of Older People (Year 1, data: 2023) Presented to CESG in October 2025	The objectives of this Quality Improvement Project (QIP) were: • To identify current performance in Emergency Departments (EDs) against clinical standards and show the results in comparison with performance nationally and in the ED's country to facilitate QI. • To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected and assess the impact of the QI initiative on their weekly performance data. **Successes**: 1a: 3.18, national average 14.38 1b: 3.03, national average 43. 79 1c: 7.88, national average 53.06 Overall screening is well below national average **Concerns:** Below national average for standards 2 and 3.	1. Continuation of Year 3 data collection (data: 2025). Year 3 inclusion period: Patients who attended between 1 January 2025 – 31 December 2025. 2. Use of frailty Advanced Clinical Practitioners in ED, further use of Older Person's Assessment & Liaison service (OPAL) and identification of patients for OPAL in ED. 3. Teaching for ED staff in frailty scoring and delirium scoring in elderly patients presenting with falls.
RCEM 2024 Mental Health (Self-Harm) (Year 2, data: 2023 - 24) Presented to CESG in October 2025	The objectives of this Quality Improvement Project (QIP) were: • To identify current performance in EDs against clinical standards and show the results in comparison with performance nationally and in the ED's country to facilitate quality improvement. • To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected and assess the impact of the QI initiative on their weekly performance data. **Successes:** Time to mental health triage: 47 minutes- streaming since introduced Time for risk assessment completion: <15 minutes- 28.03, <30 mins- 39.77 Time to ED clinician review 72.41 mins Proportion who had a risk assessment by ED clinician met the standard- 91.13 %, 100% had physical health assessment Standard 2: observation 30.56 Time to review following referral- 157 minutes, Parallel assessment: 42.8% Total time in ED 6.36 hours Safe discharge plan from Mental Health Liaison Team 100% **Concerns:** None recorded	1. RCEM Mental Health project continuing into Year 3 (2025 data collection). Data submissions to continue for a full year of data collection, Year 3 inclusion period: Patients who attended between 1 January 2025 – 31 December 2025. 2. Focus on early identification from streaming, with mechanism to catch medium and high risk patients being flagged for earlier assessment. 3. Any patient needing enhanced observation highlighted to Emergency Physician In Charge and Nurse In Charge and decision made and documented as to what level and grade needed.

Examples of Local Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Admission Criteria in Spinal Rehabilitation unit: Current Practice & Recommendations Presented to Consultant meeting in December 2025 Presented to CESG in March 2026	The objectives of this audit were: 1. To assess whether admissions to the spinal unit comply with established admission criteria. 2. To evaluate whether current criteria adequately reflect patients' fitness for rehabilitation, rehabilitation potential, medical complexity, and likelihood of benefit from intensive multidisciplinary rehabilitation. **Successes:** The project clearly demonstrated the scale and seriousness of non-compliance with spinal rehabilitation admission criteria, providing objective evidence where previously there had been limited visibility. The findings have resulted in increased awareness at both consultant and managerial levels, prompting meaningful discussion around admission practice and accountability. The audit identified which specific admission criteria were most frequently breached, allowing focused review rather than broad, unfocused change. The work has facilitated MDT discussion and agreement on practical actions, with initial plans developed to address the most problematic areas and reduce inappropriate admissions where possible. The project has established a baseline against which future improvements and re-audit can be measured. **Concerns:** The high rate of non-compliant admissions raises concerns regarding patient safety, service effectiveness, and appropriate use of specialist rehabilitation resources. Inappropriate admissions were associated with increased clinical complications, safety incidents, complaints, and delayed discharges, representing both patient harm and system inefficiency. The absence of a clearly documented, standardised process has contributed to variability in decision-making. Admission decisions were at times insufficiently transparent, with limited documentation of rationale when patients did not meet agreed criteria.	1. Review and clearly define admission and exclusion criteria, including minimum rehabilitation readiness. 2. Request clear documentation of the rationale for admission, particularly when criteria are not fully met. 3. Use clear standard operating procedures and MDT support to reduce reliance on single-clinician decisions. 4. Strengthen assessment of cognitive, functional, and frailty factors prior to admission. 5. Provide clear guidance to referrers on eligibility and realistic rehabilitation goals. 6. Re-audit admissions and monitor key indicators (compliance with criteria, delays, complaints). 7.

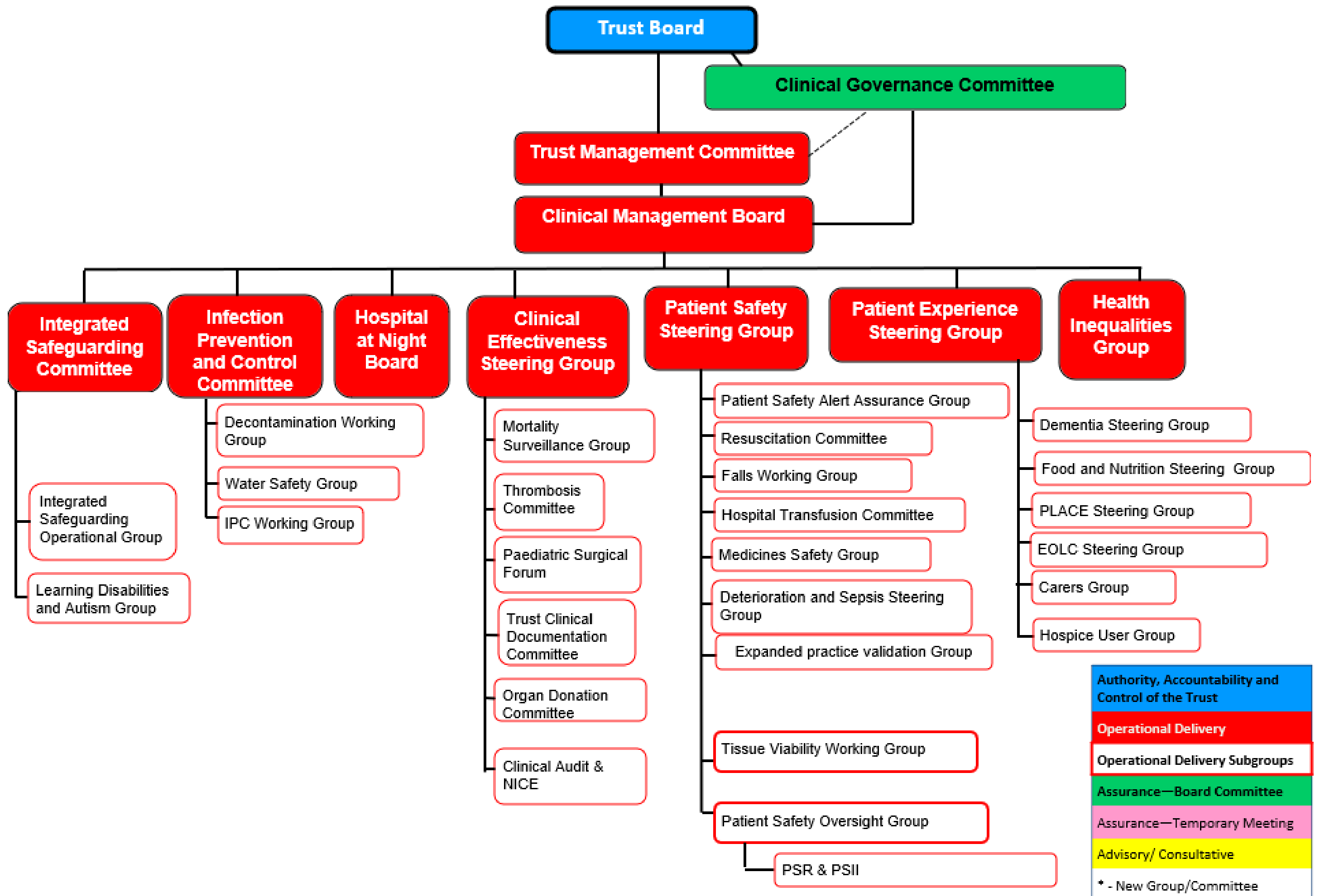
Examples of Local Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Access to translation services (data: 2024/25) Audit presented to CESG in August 2025 Re-audit presented to CESG in February 2026	The aim of this audit is to establish whether a language barrier was identified during the booking appointment and if this was considered during labour. **Successes:** The audit identified a significant increase in compliance across the standards. This demonstrates an improvement and recognition of the need for non-English speaking service users to have routine access to translation services. **Concerns:** Inconsistent use of the translations service, during antenatal appointments. Lack of translation services during the intrapartum period. Inability to access a translator upon request.	1. Increase access to over the phone translation services. There is an expectation that all non-English speaking service users are offered a translator, adopting a 'opt out' rather than an 'opt in' approach. 2. Completion of the evaluation of the AI translation device, Pocketalk. 3. Implementation of an Equality Diversity and Inclusion group in Maternity and Neonatal services. 4. The provision and access of cultural competency training for all maternity staff. 5. Development of a Health inequalities clinical dashboard.
Audit of Paediatric Early Warning Score (PEWS) (Data: December 2024 to March 2025) (Emergency Department (ED)) Presented to Deterioration & Sepsis Group in May 2025 Presented to Patient Safety Steering Group in June 2025	The aim of this audit was to audit against specific standards and develop an improvement action plan where necessary. **Successes** There is good assurance that PEWS charts are completed for Children and Young People, however, improvements are needed in relation to escalation when patients have been triggered and for reviews to be undertaken in the required timeframe as currently results are quite variable. **Concerns:** Documentation of escalation from nursing staff to medical staff and their response. All scores below 50% Gaps in compliance in certain observations and checklists being completed such as the sepsis tool.	1. Implement core group of nurses from ED to regular work in Children's ED. 2. ED team to complete PEWS training on LEARN (MLE). 3. Use improving together to implement Children's ED huddles

Examples of Local Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Audit of incidents of restrictive practice (data June 2022 to April 2024) Presented to Learning Disability & Autism Operational Group in March 2025 Presented to Integrated Safeguarding Operational Group in April 2025 Presented to Integrated Safeguarding Committee in May 2025	The aims of this audit were to review practice in line with Restrictive Practice Policy in particular: 1. the use of escalation techniques; 2. adherence with the Mental Capacity Act; 3. care for patient after physical and/or chemical restraint. **Successes:** Potential for dysregulated behaviour was evidenced in patient records. This provides an opportunity for risk assessment and planning for preventative interventions. In 76% of episodes of cases there was evidence of some de-escalation or prevention in place. Evidence of Medical Team escalation in 79% of the incidences. 80% of patients restrained had evidence of a legal framework consideration. **Concerns:** In 78% of episodes identified there was no evidence of a documented Capacity Assessment having been completed prior/ after the episode of restraint. In 42% of episodes there was no documented evidence of contact with family/ friends to inform them of the episode of restraint or restrictive practice. Where in place, daily review of the Enhanced Therapeutic Risk Assessment was identified in 26% of episodes. The Enhanced Therapeutic Risk Assessment provides a structured approach to assessing and mitigating risk of patient dysregulation that increases the likelihood of a need for restrictive practice and restraint.	1. Establish Group to identify areas of low adherence to process and develop quick reference flowchart 2. Identify levels of attendance by ward area at MCA Training and Violence Prevention Training 3. Include process in quick reference guide

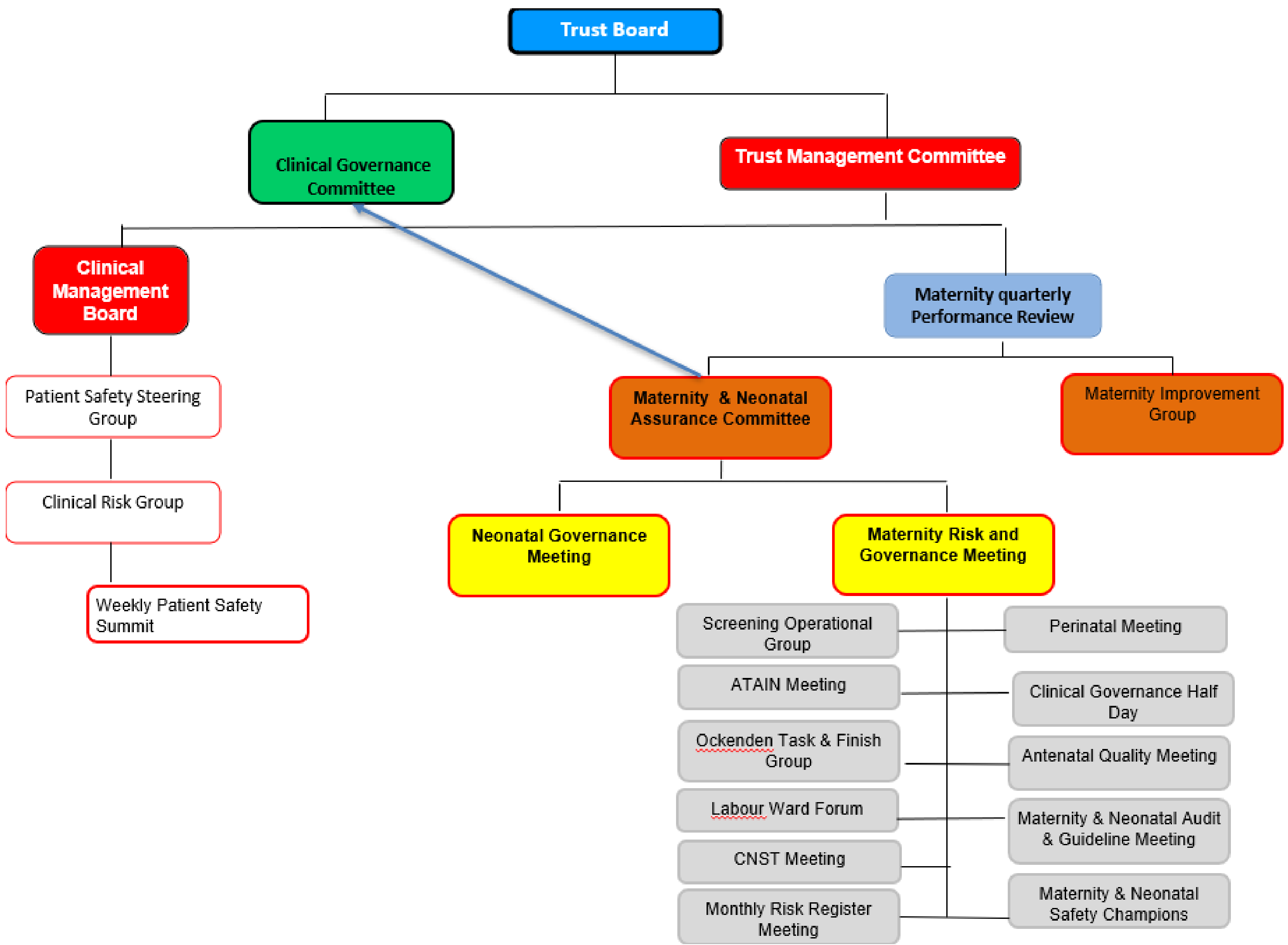
Examples of Local Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Re-Audit on Local Anaesthetic (LA) Use in Theatres Presented to Surgery Division Clinical Governance in December 2025 Presented to CESG in December 2025	**Successes:** 80% of cases had LA formally discussed (16/20), increased from 69% at our previous cycle. 100% of cases had LA checked (20/20), increased from 50% in Nov 2024. **Concerns:** 75% of cases had LA documented (15/20).	1. Poster circulated to operating teams recommending explicit mention at brief of who will check and administer LA. 2. Re-audit after new pro-forma has been introduced to see if documentation has improved.
Forgotten Biliary Stents; a retrospective review of practice at Salisbury District Hospital Presented to MDT in September 2025 Presented to CESG in February 2026	The aims of the review were to: • To review record keeping and follow-up plans for stents inserted through Endoscopic Retrograde Cholangiopancreatography(ERCP). • Make changes to the process of follow-up and record keeping of stents. • Re-audit after making necessary changes to ensure protocols are being followed. **Successes:** University Hospital Southampton is effectively actioning our referrals in the appropriate timeframe Our previous audit identified that 22.6% of patients did not have a documented plan for stent removal. In this review, 100% of the stents had a documented plan for removal or appropriate referral, reflecting a positive outcome from the corrective measures introduced. **Concerns:** Lack of a structured follow-up process has resulted in uncertainty regarding whether stents have passed spontaneously or remain in situ.	1. The introduction of the referral proforma and improved inter-hospital communication aims to eliminate such gaps in information exchange, ensuring that every referral is accounted for and followed up appropriately. 2. We will continue to refine the newly implemented system to guarantee that the population receives timely and optimal care.

Examples of Local Clinical Audits presented in 2025/26		
Audit Title	**Summary of Successes and Concerns**	**Actions to improve quality of healthcare**
Reduced fetal Movements re-audit (data: 2025) Presented to CESG in December 2025	The aim of the audit was to assess compliance with and provide assurance for element 3 of the Saving babies Lives Care Bundle version 3, which is a mandatory part of the CNST Maternity Incentive Scheme. **Successes:** Targets are set for each section by the Local Maternity and Neonatal System (LMNS) to strive for an initial target and then to strive for a reaching target once achieved. Therefore, an overall aim to continually improve and maintain a successful service. When looking at the figures it was clear to see that we were doing well in key areas, and it showed us areas to strive to achieve better results. The use of computerised Cardiotocographs (cCTG) are generally an embedded practice alongside our inductions of women who are pre 39 weeks gestation purely for reduced fetal movements. The audit clearly outlined that there are difficulties with ensuring patients who present with reduced fetal movements receive a next working day Ultrasound Scan (USS). We previously have been achieving this and therefore every effort should be made to bring this compliance back up. **Concerns:** Scanning capacity in Antenatal clinic. Drastic drop in compliance with relation to the changes in the administration team within reception. Referral system now digital therefore requires referral being triaged within a timely manner by a member of staff and not triaged over the weekend. .	1. Conversations with risk team have taken place. 2. Discussions have been had with antenatal clinic (ANC) lead midwife and also main receptionist on ANC to discuss importance of offering these women next working day USS. There may be a need to move others' appointments. The link to patient experience could be challenging. 3. Lead to complete a report to present at the Maternity Audit & Guidelines meeting to further understand any developing trends or mitigating factors. 4. Communications out to the team surrounding this. 5. For the risk team to ensure that the LMNS are aware of the current work streams. 6. Ensure that the Senior leadership team are aware and able to support with higher escalation. 7. For a meeting to be held between maternity and Surgery Division around the concerns we have surrounding the lack of administration staff within antenatal clinical which is having a direct result in the mailbox not being triaged within a timely manner.

Appendix C – Quality Governance Structures



Maternity and Neonatal Structure



Appendix D – Letters of Assurance

The following were all invited to comment and provide assurances on the content of the Salisbury NHS Foundation Trust Quality Account 2025/26.

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

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

Statement from Wiltshire Health Select Committee, 12 June 2026

Wiltshire Health Select Committee welcomes the opportunity to provide feedback on the 2025-2026 Quality Account of Salisbury NHS Foundation Trust.

The Chair and Vice Chair of the Committee appreciated the briefing provided for members on the Quality Account and raised the following points.

- The summary report and glossary were a welcome addition to the Quality Account and a recognition that people outside the NHS would be reading the report.

- The committee was pleased to see the work being undertaken with patient-led service improvement panels and the co-production with the LD and autism group to improve communications.

- Committee members in the catchment area for the hospital commended the efficient communication between primary care GP practices and the Trust.

- While noting some patients had experienced long waits in the emergency department, the committee appreciated the progress being made to manage demands on emergency care through the introduction of the new surgical Same Day Emergency Care.

- The committee, reflecting on the benefits of an Urgent Treatment Centre in Bath welcomed the news that the Trust were due to open a similar Centre later in the year.

- It was good to hear about the partnership work been undertaken with the Council around improving health inequalities and discharge from hospital.

- There seems to be a mixed picture around staffing in 2025. While the percentage of staff recommending the trust as a provider of care remained higher than the national average, the targets for staff retention were not being met. The committee had recently heard about plans the Trust had to improve availability of temporary staff and had requested an update in early 2027.

Wiltshire Health Select Committee looked forward to hearing more about the work of the Trust in the coming year.

Cllr Jane Davies
Chairman of Wiltshire Health Select Committee

Statement from the Governors – June 2026

The Quality Account for 2025/26 shows how the Trust has performed against its priorities this year and sets out the main areas of focus for 2026/27.

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

The Governors have been given an opportunity to provide feedback on the Quality Account in draft. We acknowledge the significant progress made in the 3 areas listed above and especially in the collaborative and collective work going on across the 3 trusts in the BSW group – Salisbury, the Great Western in Swindon and the RUH in Bath

We endorse the 'breakthrough objectives' provided for 2026/27, both at Trust and Divisional level. These build on work in previous years and we feel facilitate enhanced patient and staff satisfaction in the Trust.

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

NHS finances always cause concern and there is never enough money to achieve all that the Trust desires. As Governors we are pleased to see that the quality of services and of the outcome of patient interactions is foremost in the discussions around the "money".

Pressure continues to build on the hospital as more patients attend A&E with more complex problems. However, a number of initiatives such as the Same Day Emergency Care unit are making a marked change and leading to a better patient experience. We look forward to more initiatives in the coming and subsequent years.

With a significant military veteran population within our catchment area, it is especially pleasing to see the Trust awarded Gold accreditation from the Armed Forces Covenant.

Anticipating future years work the Governors look forward to the BSW Group becoming fully effective in removing the variation in quality of service provision across the 3 Trust's catchment areas and providing more treatment choices to our patients. Underpinning and supporting this is the long awaited electronic patient record shared across the 3 Trusts. Deployment of this is work for a future year, but preparation continues apace in the coming year and works hand in glove with many of the breakthrough objectives.

The Governors would like to thank our staff at every level and in every role for the outstanding work they have done and continue to do, to deliver compassionate and high-quality care to all our communities.

Peter Russell, Lead Governor
Jane Podkolinski, Deputy Lead Governor

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

Statement from NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB) on Salisbury Hospital NHS Foundation Trust Quality Account for 2025/2026

NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB) welcomes the opportunity to review and comment on Salisbury Foundation Trust's Quality Account for 2025/2026. Insofar as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate, in line with information presented to the ICB via contractual monitoring and quality visits, and aligns with NHSE Quality Account requirements.

BSW ICB notes the comprehensive overview of the Trust's achievements, challenges, and future priorities, aimed at supporting the continued delivery of high-quality care. It is the view of the ICB that the Quality Account reflects Salisbury Foundation Trust's ongoing commitment to continuous improvement in patient care and safety and recognises the Trust's key achievements in the following areas:

- Continued improvements in patient flow and urgent care pathways, including the development and maturity of Surgical Same Day Emergency Care (SDEC) and reduced transfer times from the Emergency Department.
- High levels of patient satisfaction, with Friends and Family Test inpatient ratings exceeding 97% positive feedback.
- Achieved Gold reaccreditation for Veteran Awareness under the Armed Forces Covenant, demonstrating a continued commitment to supporting the health and wellbeing of the Armed Forces community.
- Strong performance in clinical audit participation, with 98% participation in national audits and 100% participation in confidential enquiries.
- Measurable improvements in mortality outcomes, with Summary Hospital-level Mortality Indicator (SHMI) reducing and remaining within the expected range.
- Successful implementation of the Patient Safety Incident Response Framework (PSIRF), demonstrating a commitment to learning and a just culture.
- Launched the 'Call for Concern' initiative as part of Martha's Rule, empowering patients, families, carers, and staff to request an urgent clinical review where they have concerns about a patient's deteriorating condition, strengthening patient safety and escalation processes.

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

- Investment in workforce development and staff experience, including improved retention initiatives and positive NHS Staff Survey positioning.
- Strong performance in innovation and improvement programmes, including the continued embedding of Improving Together across the organisation and the BSW Hospitals Group.

The ICB recognises the Trust's 2026/27 plan to improve the quality of care, primarily through the Trust's Improving Together programme and the agreed breakthrough objectives. Specific areas identified for further development during 2025/26 are:

- Reducing pressure injuries and continuing to improve patient safety outcomes.
- Further reducing waiting times for first outpatient appointments, with an ambition to reach an average of 90 days.
- Improving productivity and value for patients.
- Reducing staff unavailability and strengthening workforce sustainability.
- Enhancing patient experience through improved feedback mechanisms, complaints handling, and real-time engagement.
- Continuing to embed PSIRF and strengthening governance, investigation capability, and system-wide learning.

These priorities are aligned with system ambitions and reflect a continued focus on improving outcomes across the domains of patient safety, clinical effectiveness, and patient experience.

We look forward to seeing progress with the quality priorities identified in this Quality Account, alongside the continued maturity of PSIRF and the Trust's contribution to system-wide learning and improvement through programmes such as Martha's Rule and the further implementation of the Prevention, Identification, Escalation and Response (PIER) framework.

NHS Bath and North East Somerset, Swindon, and Wiltshire ICB is committed to sustaining strong working relationships with Salisbury Foundation Trust and, together with our wider stakeholders, will continue to work collaboratively to achieve our shared priorities as an Integrated Care System in 2026/27.

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

Yours sincerely,

Shelagh Meldrum
Cluster Chief Nursing Officer
NHS Bath and North East Somerset, Swindon and Wiltshire, NHS Dorset and NHS Somerset

Healthwatch Wiltshire Response to Salisbury NHS Foundation Trust Quality Account 2025/26

We thank you for the opportunity for Healthwatch Wiltshire to respond to the Trust's Quality Account for 2025/26.

We recognise the continued progress made over the past year, particularly the embedding of the *Improving Together* approach and the Trust's focus on patient safety, learning, and continuous improvement. It is also positive to see sustained attention to patient experience, including the use of real-time feedback and patient engagement mechanisms, alongside strengthened partnership working across the wider system.

We also recognise the challenges the Trust is facing. Waiting times for outpatient care and diagnostics continue to impact on patient experience, and we welcome the Trust's commitment to addressing these. We also note the focus on improving complaints handling, which reflects issues regularly raised through feedback from local people.

Workforce pressures continue to influence the consistency of care, and ongoing efforts to support staff experience and availability will be important in sustaining improvement. We would also encourage continued attention to reducing health inequalities and ensuring that feedback and services are accessible to all communities, particularly those whose voices are less often heard.

Healthwatch Wiltshire values working with the Trust and looks forward to continuing working together to ensure that the experiences of local people inform service improvement.

Healthwatch Wiltshire
June 2026

NHS
Salisbury
NHS Foundation Trust

Statements of Directors' Responsibilities for the Quality Report

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

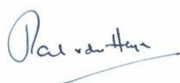
NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2025/26.
- The content of the quality report is not inconsistent with internal and external sources of information
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the quality report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the quality report is robust and reliable and conforms to the specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- There is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the quality account for 2025/26. Therefore, no limited assurance report is available on the quality account report in 2025/26.

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

By order of the Board.



Paul von der Heyde
Chairman
Date: 15th June 2026

Cara Charles Barks
Chief Executive Officer
Date: 15th June 2026

Nick Johnson
Managing Director
Date: 15th June 2026

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SFT676-1_05/26